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ORIGINAL ARTICLE OPEN ACCESS

"A Strange, Grey Area"—Care Relationships in Learning Disability Residential Settings in England From the Perspective of Support Staff

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ABSTRACT

Introduction: Support staff (e.g., support workers) play a key role in the lives of adults with a learning disability in residential settings in England. However, the care relationship between the two seems under-researched with potential care practice implications.

Methods: We conducted online interviews with 23 support staff, exploring their perspectives on care relationships and what makes them positive. We used reflexive thematic analysis and generated four themes, namely *The care relationship as a conundrum*; *Care relationships in a material and ideological reality*; *The skilled worker*; and *Relationships matter*.

Findings: The care relationship is 'a strange, grey area', a conundrum occurring within staff's and residents' intertwined realities. The material and ideological conditions surrounding the relationship can facilitate or hinder it. The *person* expands beyond the resident. Building and restoring relationships requires various skills. The absence of positive relationships can be detrimental.

Conclusions: Praxis is at the core of care relationships as they operate within emotional, practical, and socio-political spheres, directing us towards a care ecology. Staff's and residents' (shared) humanity can be used relationally.

1 | Introduction

In England, approximately 950,000 adults have a learning disability (Mencap n.d.a), entailing 'a reduced intellectual ability and difficulty with everyday activities' (Mencap n.d.b). Adult social care focuses on supporting people live well in the community and long-term residential services are part of this support (Foster and Harker 2024); here *long-term residential settings* encompass spaces that people use long-term or permanently and see as home, including care homes, domiciliary care, and other arrangements. Approximately, 500,000 adults with a learning disability and/or autism in England are supported in such settings (Skills for Care 2021).

Around half a million workers support adults with a learning disability and/or autism in residential settings (Skills for Care 2021). Roles are poorly defined (Manthorpe et al. 2010) and standard job titles include 'support worker', 'care worker' or 'personal assistant'. Here, *support staff* encompasses all different titles, including senior staff (e.g., home managers) who often transition from direct care work roles, and, in many cases, alongside their management duties, they may also support residents directly. Support staff are 'providing face-to-face care and other support of a personal or confidential nature [...][1] however, crucially, they do not hold qualifications accredited by a professional association and are not typically formally regulated' (Saks 2020, p. 1).

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Summary

- We researched care relationships between support staff and adults with a learning disability in care homes and other residential spaces in England.
- We spoke to 23 staff.
- We found that the care relationship is *professional* and also *personal* and balancing the two is not always easy. Things like how appreciated staff feel can impact care relationships. Building positive relationships takes skills and knowledge. Staff and residents do not live happy lives when their relationship is not positive.
- We think that care relationships are about what people *do* and about the moments that staff and residents share in life. Appreciating staff and residents as humans, and finding the things they have in common, is important for building relationships.
- This study helps us better understand care and relationships. We hope that staff, residents, and services will use this study to improve relationships.

Relationships are at the core of human life (Reis et al. 2000). Here, *care relationship*(s) refer(s) to the interpersonal, professional relationship between support staff and residents with a learning disability. Relationships are fundamental to person-centred care and key to the quality of life framework (Schalock et al. 2002) used in UK learning disability services to assess outcomes (Department of Health and Social Care 2001).

1.1 | Study Rationale

Care relationships in residential settings are somewhat unique. Care is embedded in everyday life, not provided only during crisis, yet everyday life has uncertain boundaries (Gjermestad et al. 2017). Relationships may become long-term as residents live in these settings long-term or permanently. Adult social care in the UK has been facing chronic underfunding and high turnover (Skills for Care 2021). Its workforce has low salaries and minimal professional recognition (National Association of Care and Support Workers n.d.).

Unlike other relationships (e.g., therapy, nursing), care relationships remain relatively under-researched (Hastings 2010). This matters given their significance and uniqueness; the workforce's size and aforementioned working conditions; and the number of adults with a learning disability supported in residential settings.

International research (e.g., Johnson et al. 2012) has shown an interest in this area. In the UK, some studies have examined rapport and enabling relationships (e.g., Baker et al. 2017). Despite its undeniable importance, some of this research may vary in scope (e.g., children-focused) or conceptually (e.g., merging paid and unpaid carers). International findings may also be less applicable due to differences in policies and practices.

The present study aspired to transcend the aforementioned constraints and address the need for deepening our understanding of care relationships. We sought to achieve this by focusing on the perspectives of support staff.

1.2 | Research Questions

This study drew on our earlier work (i.e., Mamolis et al. 2024). We posed four questions:

- What are staff's conceptualisations of (positive) care relationships?
- What processes and practices do staff employ to build relationships and restore them when disrupted?
- What factors hinder and facilitate positive relationships?
- What impact do positive relationships, or lack thereof, have?

2 | Methodology

2.1 | Design

Qualitative design grounded in an interpretive paradigm and experiential approach, guided by the participants' experiences whilst remaining active data interpreters (Braun and Clarke 2022).

2.2 | Methods

We devised a short Demographics & Eligibility Questionnaire to assess eligibility and gather demographic and work-related information. Online semi-structured interviews were undertaken.

2.3 | Recruitment & Data Collection

The Tizard Centre Ethics Committee granted approval in June 2022. Data collection occurred between July 2022 and April 2023, with 23 participants. Participants were recruited through care services via networks such as the CHAIN Network and NIHR ENRICH.

2.4 | Procedure

Interested individuals received information via email. All interviews were recorded. Participants were informed about receiving a copy of their anonymised transcript and a findings summary. All received a digital Certificate of Participation and were offered a £10 payment; some accepted, others declined or donated it.

2.5 | Analytic Framework

Reflexive thematic analysis (Braun and Clarke 2022) conducted in NVivo.

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3 | Analysis

To enhance analytic depth, we adopted a combined *Results* and *Discussion* section where study findings and the wider literature told an analytic story together under the heading *Analysis* (Braun and Clarke 2022).

3.1 | Participants

Participants came from 16 organisations with a mean ($\bar{x}$) tenure of 7 years and 8 months in their current setting. Tables 1 and 2 provide more information.

3.2 | Themes

Table 3 provides summaries of our four themes, before analysing them in detail.

Theme 1. *The care relationship as a conundrum*

Care relationships are embedded in everyday life, entailing how residents participate in it as members of society (Gjermestad et al. 2017). Sarah explains that 'it's definitely a relationship of..[2] caring and supporting the person [...] be it.. um.. personal care [...] watch a movie or to the pub or shopping'. Enabling everyday life can create positive relationships ('they like you because you got them up', Molly). Echoing previous research on learning disability social networks (Harrison et al. 2021), staff and residents are exposed to each other a lot ('I spend more time with the people we support than I.. do with my own.. partner', Ethan). For relationships to happen, 'it needs time to establish that communication [...] that trust' (Doug). The time spent together creates closeness, 'the exposure I think it makes it [relationship] positive', Lara explains. Nonetheless, closeness may also generate a monotony where 'they can get contemptuous of you and you can get.. irritated and bored with them' (Liam). Working closely involves shared experiences and intertwined emotions ('they're having a great day [...] I have a really good day', Hannah); a two-way relationship where staff and residents do the work and enjoy the outcomes ('have to trust him as much as he trusts you', Chloe). This echoes earlier work (i.e., Norah Fry Research Centre 2010) highlighting the role of mutuality.

Relationships are subject to change ('she now has to be hoisted', Catherine). Staff try to be 'that constant, familiar face' (Phoebe) creating stability: 'if [residents'] behaviour goes way off the scale [...] the week after you're walking back [...] that really takes that relationship and they kind of go [...] you're okay, you're here' (Doug). A positive relationship goes beyond task-oriented practices ('not just about getting them up', Molly), capturing the residents' complexity ('social [...] emotional [...] physical one, the psychological', Donna). It helps residents achieve their potential ('support somebody to do something that they.. are maybe a little bit anxious', Phoebe) and is a positive experience altogether. This reflects positive care cultures that emphasise relational practices and openness to potentiality (Bigby and Beadle-Brown 2016).

The residents' home is simultaneously the staff's workplace (Levinson 2005). As a workforce, staff follow procedures ('someone's saying we should go and play football and you're

TABLE 1 | Participants' demographic and professional characteristics ($N = 23$).

Gender	
Woman	17
Man	6
Ethnicity	
White British	17
Mixed British	1
White Other	3
Asian Other	1
Black Other	1
Age range	
18–34	6
35–54	14
55+	3
Highest academic qualification	
National Vocational Qualification (NVQ)	14
Undergraduate/postgraduate degree*	9
*Subjects mainly included *health and social care*, *psychology*, or *social sciences*	
Your care role[a]	
Support worker/senior support worker/Shared Lives carer[b]	13
Team leader/deputy team leader	5
Home manager/deputy home manager	5
Employment	
Full-time	21
Part-time/zero-hours contract	2
You support people with	
Various levels of learning disability (mild, moderate, and severe/profound)	13
Mild learning disability	2
Moderate learning disability	3
Severe/profound learning disability	5
Hours per week providing direct support	
30+	17
7 to 14	4
Various hours/other	2
Previous experience working with adults with a learning disability	
Yes	13
No	10
Residential setting	
Supported living	8
Care home	7
Multiple settings (e.g., supported living & domiciliary care)	4
Domiciliary care/Shared Lives	4
The organisation that manages the residential setting is	

(Continues)

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Independent/voluntary/charity/third sector	14
Private sector	6
Local authority/Council	3
You work in a setting located in	
Southern England	8
East of England	3
Midlands	6
Yorkshire & Northern England	6

[a]Providing paid direct care and support to adults with a learning disability as part of one's role was a key eligibility criterion, among other criteria, which was assessed through our Demographics & Eligibility Questionnaire. All participants confirmed providing paid direct care and support.
[b]Shared Lives is a scheme that matches people with a learning disability, among other groups of people, with an approved Shared Lives carer. The Shared Lives carer shares their home and community with the person and provides care. Some people move in the Shared Lives carer's home, while others visit them regularly. More information can be found here: Shared Lives schemes.

TABLE 2 | Participants' care roles ($N = 23$).

Participant[a]	Care role
Mark	Support worker
Hannah	Senior support worker
Donna	Deputy home manager
Phoebe	Senior support worker
Molly	Support worker
Doug	Support worker
Lara	Senior support worker
Liam	Support worker
Ellen	Home manager
Catherine	Support worker
James	Team leader
Lucy	Home manager
Casey	Shared Lives carer
Isabelle	Home manager
Sarah	Support worker
Ethan	Senior support worker
Chris	Support worker
Charlotte	Team leader
Grace	Team leader
Evelyn	Team leader
Chloe	Support worker
Sophie	Deputy team leader
Emma	Home manager

[a]The names provided in Table 2 are not the participants' real names. All participants were assigned pseudonyms to protect their identities.

going hang on, I just need to fill in your daily diary', Liam), have duties ('protect my colleagues or protect other service users', Donna), and entitlements ('we are allowed some holiday', Casey). Care relationships are understood as professional; staff behave professionally ('if [...] you're getting frustrated and angry, keeping like.. calm', Sarah) and set boundaries. Echoing Bowler and Nash (2014), professionalism may serve positive relationships by defining their scope ('first thing I said to him was.. if you break your conditions of your release, I'll be calling the police', Chris) and preventing overinvolvement.

Acknowledging whilst contradicting professionalism is where the conundrum lies: 'there's quite a strange, grey area between being a support worker and being a friend or family member' (Chris). Staff and residents may see themselves more like friends or family ('they think of me as, as a friend [...] because we'll go and watch football', Chris). Doug describes this as the 'double-edged sword of professionalism' where 'there needs to be a certain degree of, em.. of professional distance [...] sometimes if you live very, very closely [...] that can blur that boundary'. Staff build care relationships 'as you would build with anyone' (Sarah), meaning that 'you don't just meet someone and you're close [...] you spend time with them, you get to know them' (Chloe), therefore 'personal relationships are care relationships' (Doug). Lucy elaborates: 'worked for local authority [...] you didn't talk about your personal life [...] those things are natural human interactions, and I think they help build relationships'. Relating with residents beyond the strictly professional might be something to strive for. Lucy discusses how her organisation allows residents to 'come to your house for a cup of tea' if it enriches their lives, and Doug describes a type of administrative liberation during the Covid-19 pandemic: 'left to just share our relationships with our [residents], and it felt like a positive impact both ways'. Casey adds how Shared Lives is all about family: 'don't necessarily see myself as a carer [...] they are our family'. Rogers (2016) acknowledges 'these fractured boundaries' (p. 123) and, like the participants, situates relationships in *being human*.

In a conundrum fashion, participants return to the *professional* to balance the *personal*. 'It's just another member of the family', Charlotte explains, 'but again, keeping that boundary'. 'Sometimes if you get too emotionally involved in the client, they can get scared', Ethan warns, 'allegations can come up'. This signals an organisational culture that safeguards residents (Collins and Murphy 2021). Although staff aim to provide stability, 'you're a paid support worker, you're.. you're going to leave at some point' (Lucy), hence maintaining some professional distance becomes imperative.

Friendship is 'embodied through the things that people do and experience together' (Bigby and Craig 2016, 183). Participants seem to use *friendship* to articulate their investment in residents ('think me [...] as a good friend to share with me his concern', Mark), inviting us to reflect on friend*ship* versus friend*liness*, seemingly gravitating towards the latter. A 'professional friendship' (Ellen), what Liam calls 'friendly without being friends', the 'relationship that you would have with a friend [...] go out [...] help them [...] whilst maintaining the boundary that you are not their friend'. *Family* is seemingly used in a similar way ('comfortable [...] as they would with a family member', Evelyn), and links between everyday care work pragmatics and understandings of *family* are also reflected ('they see you as being their family [...] when you ask them to budget properly, to.. the skills you're building with them. The personal care, the going out', Donna).

Friendship and *family* perhaps signify a desire for more equal care relationships (Antaki et al. 2007). Power is unequally distributed ('you have head office [...] colleagues [...] But.. he,

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TABLE 3 | Theme summary.

Theme 1 The care relationship as a conundrum	Care takes place in the realm of everyday life. The lives of staff and residents are intertwined. The care relationship is a conundrum, a "strange, grey area" between the *personal* and *professional*.
Theme 2 Care relationships in a material and ideological reality	Care relationships do not exist in a vacuum. A material and ideological reality is casting its shadow, sometimes facilitating and others hindering them.
Theme 3 The skilled worker	Unlike discourses that frame care work as unskilled work, support staff are skilled workers who engage in various processes and practices to establish positive relationships and restore them when disrupted.
Theme 4 Relationships matter	Positive care relationships can be truly transformative for both staff and residents, and their absence can be detrimental.

you're his support', Chloe). Residents may have some power ('give you.. um.. anger and frustration because I'm [resident] frustrated', Ethan), but this seems like 'kicking against the system' (Ethan), attempting to reclaim some power. Some participants engaged critically with power ('we're guests in their home', James) aspiring for a 'meeting of equals' (Liam). The conundrum returns as understanding the care relationship as a 'parent/child relationship' (Charlotte) assumes a potentially patronising staff role. Discoursing residents as children ('an adult, but he's got a mind like a child', Chloe) and vulnerability as a child state ('as a child [...] they need [...] mental support and some physical support', Mark) was not uncommon but also not unproblematic ('annoys me when people give them flipping orange squash [...] I go it's not a child', Casey). This echoes Rogers (2016), who notes that infantilising people with a learning disability can dehumanise and exclude them. Alluding to our earlier research (i.e., Mamolis et al. 2024), dilemmas arise from trying to balance greater equality and the *professional*: 'His choice. But that's reflected on me giving care', Casey elaborates.

Theme 2. *Care relationships in a material and ideological reality*

Care relationships do not exist in a vacuum. In residential settings, the relational environment is material; the bedrooms, communal spaces, and geographical locations. Materiality can elevate relationships ('individual flats.. on a long corridor [...] you then make a relationship with all the staff', Donna) or hold them back ('[they] are used to drink their coffee [...] if there is no coffee, it is very bad', Mark). There is also the non-material, 'stress-free environment' (Sophie) that benefits relationships. The material and the non-material are connected: 'move that [device] [...] so that, you know, they can sing to their heart's content and the others can watch TV and there's no conflict' (Molly). The material and the non-material create a sense of homeliness where people can 'live a full life [...] it's not like a dumping ground' (Doug). Care pragmatics also shape the material and the non-material, and relationships. Having meals together 'might not.. suit everyone' Catherine explains, as 'there are some restrictions being in a care home'. The residential setting is a physical home, where space influences the residents' sense of homeliness and belonging, and a social home, where residents relate with staff and others (Chinn et al. 2024).

The material reality also involves the socio-economic realities of care work, situating care relationships in the socio-political sphere (Rogers 2016). Reflecting the adverse conditions in social care in England, 'funding is withdrawn' (Ellen) leading to the inability to 'use your staffing [...] to give a little bit more one-to-one time' (Emma), thus hindering relationships. Staff are low-paid with limited career prospects and these conditions may affect relationships as 'gonna go in there, can't be bothered [...] I'm not getting paid enough' (Chloe). The job is hard and 'everybody in the sector is struggling' (Emma) with recruitment and retention. Having 'different staff members, high turnover, agency use' (Emma) may disrupt relational stability ('if you're an agency [...] [residents] not gonna give a monkey's', Liam). Although time is crucial, it remains fragmented (Rubery et al. 2015), 'too many demands' (Charlotte) in care homes and 'even with having the minimum of an hour call,[3] sometimes you are stretched' (Sophie) in domiciliary care, and inadequate staffing can exacerbate time constraints and hinder relationships ('people have hidden depths [...] you don't.. see them if you don't have that time', Isabelle).

Material conditions interact with ideological ones. Uncertainty ('people are very frightened of care homes', Doug) and economic policies shape care ('when we joined [...] dealt directly with the local authority [...] as time has progressed [...] it went out to [...] private companies', Casey). A 'divide almost' (Lucy) between health and social care seems to exist. Evelyn explains that 'got the clap at the beginning of Covid, but then, you know, all you get is, like, minimum wage', comparing social to health care statuses ('NHS staff [...] there is [...] positivity around that role [...] not sure, um, that the care staff feel like they're really supported by society'). Reflecting a lack of recognition (NACAS n.d.), dismissive narratives seem prevalent as 'support workers in general, are seen as disposable' (Lara). Such ideological conditions influence 'people's motivation to build good relationships' (Evelyn).

Subtheme

Person-centredness in the plural: The person is us—the person in us

Participants situated positive relationships in person-centredness, a key ideology for UK learning disability policy and practice (Department of Health and Social Care 2001). Residents are at the centre, principally ('they're top of the tree [...] they're the sun', Isabelle) and practically ('hate football, but I'll still sit and talk with him about football because he loves it', Sophie). They are

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involved in decisions ('making care plans, including them into it', Donna) and care relationships happen 'in a way that's sympathetic' (Doug) to the residents' individuality.

In line with person-centredness, empowering residents and enabling independence facilitates positive relationships ('not there to mother them [...] encourage them to do something for themselves', James). People's institutionalised pasts provide context ('maybe they've been in hospital for 20 years [...] been told when they can eat and when they can drink', Ethan) and so do some current practices, where staff 'do it for [residents]' (Donna) to make the shift easier or because they 'underestimate the capacity of that person' (Donna). Banks (2012) observes that empowerment and independence may be interpreted narrowly and hinder relationships by emphasising residents' responsibilities disproportionally. Levinson (2005) warns that stressing residents' independence can reinforce control and deepen power relationships. Held (2006) questions the *fully autonomous individual*, contrasting this with interdependence as central to being human and human survival.

Person-centredness is problematised and discussed in plural terms; the *person* as *us*, not *I* ('not just them [...] they've got a family', Isabelle). A positive care relationship is facilitated through collaboration with families, offering insights that staff 'would never know without them' (Isabelle), and by observing how families are 'handling that relationship' (Donna). The *person* also includes other residents, 'local authority, social workers, all MDT [multidisciplinary team] people' (Casey) and 'your colleague [...] manager [...] everybody' (Mark). Through teamwork, staff share institutional knowledge and provide effective support ('because we worked together [...] the person got on [transport] and was like a child in a candy store', Phoebe). Teamwork also entails to 'lean on our colleagues' (Charlotte) and, importantly, the 'organisation' (Sarah) to 'feel like.. someone else has your back' (Sarah). This facilitates positive relationships because 'how can you support the person if you don't feel like you are supported?' (Evelyn). Organisational support is material ('need any equipment [...] they provide you', Mark), emotional and managerial ('a brief of the month [...] realising what's going well, what's going not so well', Chloe). Collaboration with MDTs is imperative, 'having a learning disability nurse [...] speech and language assessment [...] lets the person know that you are trying to develop that relationship' (Doug). All this echoes McCormack and McCance (2016), who argue that person-centred care involves relationships among organisations, practitioners, care recipients, and significant others, as well as Power et al. (2022), who highlight how the personalisation agenda tends to ignore the relational reality of care and support.

Conflicting aspects of the plural *person* shape relationships. Sophie explains that 'a couple [of residents] [...] I stopped going [...] because of their family' whilst Catherine notes the challenges of trying to 'balance everyone's needs' in care homes. Teams do not always work in unison ('I knew how to deal with [resident's family].. correctly, other members of staff and things didn't like that and they tried to kind of intervene', Hannah), and organisations may dismiss initiative. Collaboration with MDTs is vital but health systems may be struggling ('CBT therapies [...] we can't seem to access those', Lara), reminding us that the plural *person* is understood within its material conditions.

Staff must act professionally somewhat becoming 'a great big brick wall' (Hannah). Liam argues that 'the guidelines [...] are based on the, the idea that you're coming to work in a perfect mood' and wonders, 'what about me? I'm having a bit of a shit time [...] people are doing sort of two or three jobs at a time', noting that 'your primary focus needs to be on the person that you're supporting. But equally.. you can't do it without happy, healthy staff'. The plural *person* includes one more key component: the staff. Hannah emphasises: 'we are human and amongst all of this great big brick wall'. Staff's humanity is recognised, the *person* as *us* and within *us* is a person. Staff have limits ('you can become a bit snappy or a bit tired', Chloe), they come to work bringing attributes, and go home feeling 'restless or hopeless' (Ellen) or 'with a smile' (James) depending on how their shift went. Equally, residents are not labels, but human, and staff must recognise their agency ('cause you've got a learning disability, it doesn't mean that you're free, free access to anybody', Isabelle). Staff and residents are human also in a connected sense ('human being just, just like me [...] their stresses are, are similar to mine', Liam) and their shared humanity can facilitate relationships ('not only about, like.. doing, doing your role and ticking the boxes', Evelyn). The care relationship is not perfect, but *human*; 'it's an inevitability', Chris explains, that some staff and residents will not 'get along', however, 'minimising the impact' is crucial.

Theme 3. *The skilled worker*

Care relationships involve demanding behaviours, difficult decisions, and responsibilities including 'financial management [...] fire checks, home checks' (Casey). 'Care for others', Donna explains, 'could.. drain you', it is 'not just [...] go to day service, come home [...] it's a lot more than people think' (Casey). This echoes the emotional and practical spheres of care (Rogers 2016). Various skills are required, and staff are skilled workers using different processes and practices.

Everyday life includes human activities and the environments within life is lived (Pink 2012). Staff skilfully use everyday life to establish relationships ('some of them like orange juice [...] you provide them without them asking', Mark) and to understand residents on a 'granular level' (Liam). Activities, from 'cooking a meal' (Ellen) to 'going to the cinema' (Donna), serve building and maintaining relationships ('find an activity that I know they really enjoy so [...] I can work alongside them', Hannah). This reflects previous learning disability research (e.g., Totsika et al. 2008) that emphasises how personalised activities build relationships, highlighting practical, yet relational, everyday care (Rogers 2016).

Staff use engagement skills; they show an interest in 'what [residents are] thinking and what they're feeling' (Ethan) and create similarity ('matching people who enjoy similar activities', Evelyn); they have 'good times together' (Evelyn), reassure and praise, and use humour relationally ('in Greg's [...] he made a cheeky remark and I went, right, for that you can go buy me a doughnut', Sophie). These processes echo findings (e.g., sharing the moment) from Johnson and colleagues' work (2012). Relationships take courage ('I would sit close to him. People didn't

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get to sit close to him', Donna), expanding the residents' horizons ('everybody was telling me that she will never get a job and I did it [...] she's got a large community now', Lara).

People may not have 'the same outlet' (Sarah), with staff tailoring their communication ('say to somebody to help them make a cup of tea, but for somebody else, they might need a little bit more of: you need a cup [...] this [...] that', Emma). Communication is embodied; staff interpret the residents' body language and are mindful of their own. Communication requires being attuned to residents ('some people [...] go into a place [...] bubbly and.. all excited [...] but the person [...] won't.. react to that', James). Emotional intelligence is part of a broader skillset where staff employ 'empathy and kindness' (Lucy), 'providing the best care for [residents] that you'd want to.. experience yourself' (Catherine) in a 'non-judgmental environment' (Lara). Emotional skills also involve self-regulation as 'you can get really frustrated' (Sarah), and patience ('somebody takes an hour and a half to hoist [...] they want to have a conversation [...] can't rush them', Molly). These processes not only point towards Carl Rogers (1957) conditions (e.g., empathy, non-judgemental attitude) for establishing positive (therapeutic) relationships, but also go back to Chrissie Rogers (2016) emotional sphere, framing emotional work as a facet of care work (Fisher 2021) and relationships.

Echoing previous research (e.g., Williams et al. 2009), getting to know residents 'as a person' (Chloe), their 'hobbies, enjoyments, favourite food' (Ethan), is crucial. Long-term care facilitates this 'because you will support them through the difficult times [...] the happy times' (Evelyn). Being a *knowing* staff is truly a skill, offering intuition ('if she's [incomprehensible] shouting off the roof, then you know she doesn't want to. But if she's saying it just in general [...] she does wanna get up', Sophie). *Knowing* staff differ from *know-it-all* staff as knowing is ongoing ('people say: I know he likes this. He's not always gonna like this thing.', James). Being *knowing* also entails self-awareness, knowing 'what you're comfortable with' (Sarah). Ultimately, 'trust is everything' (Isabelle). Trust is not a given ('without going in [...] thinking [...] this guy's gonna like me because.. I'm, I'm a carer', James), it is built while navigating the residents' stories ('[resident] has got past trauma [...] not just gonna be welcoming everyone with open arms', Chloe). Trust is a key theme reported in the accounts of residents with a learning disability (e.g., Giesbers et al. 2019) and across different care settings (e.g., secure units; Fish and Morgan 2021).

Behaviours that challenge may disrupt relationships. To restore them, staff de-escalate, emphasise the upside ('shall we go and get a Costa?', Ethan), and apologise 'even if you don't feel you're sorry because you, you did the right thing' (Lucy). They try not to hold grudges and engage in reflexive practice with residents or their teams ('several setting events to that which led to them giving me a clip around the ear', Liam). Staff remain flexible and make adjustments ('for some [...] increasing the level of restriction [...] makes their communication easier, because they've got much less on their plate [...] for other people we've opened the world up a little', Doug). Challenges disturb staff's relational position, yet you must 'continue to be yourself' (Sophie), 'continue with the same support [...] it just falls back into a positive relationship' (Grace). Challenges may become opportunities, motivating staff to spend 'more time with that person [...] so that we can create those relationships' (Chris). These practices reflect person-centred and Positive Behaviour Support principles embedded in UK learning disability care work.

The *skilled worker* is situated in the person, their motivation, and attitude. Motivation often comes from valuing the job, with participants explaining that care work is not just 'for the money' (Lucy). Motivation also comes from a deep investment into the residents who sense motivation or lack thereof 'regardless of how profound their disability' (Liam). Relational skills are intertwined with staff attitude. A 'positive mindset' (Mark), a persevering spirit ('you're not ready to get up, I'll come back', Lucy), an emphasis on respect and language ('I'm taking such and such. You're not taking [...] you're supporting', Ellen), and an understanding of 'how important some, some of the practices and our behaviours are as support workers' (Lara), all signify attitudes that facilitate positive relationships. Interestingly, Daly and Fisher (2023) explain how intrinsic motivation can also be seen as almost archetypical, explaining how this may essentialise care as part of 'a person's nature or character' (p. 82).

Nonetheless, the *skilled worker* is a *becoming* construct. Staff may come from diverse work backgrounds ('somebody who's working in a supermarket', Casey), yet existing skills can be expanded and new things can be learned. This can be done by becoming more theoretically knowledgeable ('done endless research [...] to better understand him', Charlotte) and by receiving 'a lot of training' (Phoebe). Training is not always 'classroom training' (Charlotte), it could be 'training on the job' (Chloe). This echoes Bradshaw and Goldbart (2013), who describe support staff as a Community of Practice that prefers learning by *doing* over more conventional teaching. This does not dismiss teaching-based training, but highlights that it needs to be meaningful. Liam elaborates:

> *understanding autism [...] health and safety [...] none of it really.. mentioned that it's incredibly important to have a good relationship with the person [...] not much discussion about.. how do you feel? -the support worker [...] they need to be incorporated into the training.*

Theme 4. *Relationships matter*

Positive care relationships make everyone feel good (Johnson et al. 2012); they are 'fulfilling, rewarding and transformational' (Charlotte), and their absence can be detrimental. The residents feel valued ('they think there is one person who understands', Mark) and more confident. Mental well-being improves, they engage more ('lot of them will plan [...] certain activities around that day knowing that I'm there', Chris), and relational disruptions are navigated easier ('when he is displaying.. challenging behaviour [...] he does tend to listen to the people more.. that he has the better relationships', Chloe). Positive relationships help residents transform and grow, expanding their skills ('when he first come to me, you couldn't hear him [...] now [...] people were saying: oh my God [name], he offered me a cup of tea', Casey).

Residents achieving their potential makes staff's 'heart swell' (Isabelle) and the message is shared (Johnson et al. 2012) as

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'although, it was a couple of individuals' kind of.. initiative [...] the team are reeling on that as well' (Hannah). Staff get a sense of pride and meaning ('a good relationship [...] with people that pose challenges to.. 95% of the professionals [...] pleased with the fact that I can make these relationships', Chris), wanting 'to stay to work' (Ellen). Their confidence is boosted ('able to support [residents] in any situation', Sarah), and they grow alongside residents. Knowing the resident builds positive relationships and these allow staff to get to know residents more ('through that relationship [...] be able to read [...] his triggers', Donna). These accounts add context to research on care staff's positive perceptions of their role (Hastings and Horne 2004) despite adverse working conditions (Daly and Fisher 2023).

The absence of positive relationships underscores their importance. 'There is no happiness' (Mark), residents can become 'really withdrawn' (Hannah). They may disengage ('everything you ask them to do, or try help them do, they're just defiant', Hannah), impacting their health as 'they might not come to you for things that they need' (Molly). There might be an 'increase in, in distress and behaviours [...] to tell you that everything's wrong' (Doug). Staff's motivation declines, and care work feels 'like you banged your head against a brick wall' (James). Care standards may weaken as you are not working to 'your potential as a support worker' (James). Staff can doubt themselves, with uncertainty reducing engagement ('staff will be on their phone [...] not sure what to do or how to support that person, and that's like an escape', Evelyn). Lacking positive relationships 'can drag you down a bit' (Phoebe), leading to 'lots of sickness' (Donna) or turnover ('you think you are not productive [...] you prefer to leave', Mark). It can have a knock-on effect as Chloe explains: 'if someone's been with him [...] that doesn't have the best relationship [...] and just let him sit on the sofa all day. Then you come in the next day, and you have to rebuild'.

Relationships and their impact travel through time, whether they are positive or have experienced challenges ('you made me do something I didn't want to do [...] in some of the things that he [resident] tells, it's still there', Ellen).

4 | Conclusions

We hope that, in this article, we provided a wholistic account of care relationships in learning disability residential settings, aiming to expand knowledge in an area where knowledge is limited and, consequently, inform care practice. The conclusions discussed here should be read in conjunction with our four themes, as the former are grounded in and complement the latter, and our analysis and conclusions assembled seek to tell a comprehensive story.

The care relationship is a 'strange, grey area' (Chris), a conundrum, that occurs in the realm of everyday life. Praxis is at the core of care relationships. A cyclical direction seems to exist, for instance, being *knowing* staff underlies positive relationships and these help staff to know the resident better.

Care relationships operate within care work's emotional, practical, and socio-political spheres (Rogers 2016) and could be likened to an organism connected to its (social care) ecosystem (Burn and Needham 2023). This may parallel ecological models of human development (Bronfenbrenner 1994), directing us to develop a *care ecology* with interconnected levels. The micro-level, where everyday interpersonal processes (i.e., emotional and practical; Rogers 2016) establish relationships. The meso-level, where care organisations and significant others (e.g., family) influence relationships. The macro-level, where policies, material, and ideological conditions (i.e., socio-political; Rogers 2016) shape relationships further.

In this schema, staff may reproduce stigma (e.g., treating residents as children) or witness it ('he [member of public] said, well, don't bring him [resident] out then', Casey). Crucially, staff may experience stigma for being staff ('people look down on you a little', Charlotte). Daly and Fisher (2023) explore how stigma can be tied to the working-class connotations of care work or to stereotypical perceptions of it being 'beneath' English people, a job for migrant workers. Staff and residents, albeit differently, can be stigmatised for providing and receiving care.

We emphasised staff and residents' (shared) humanity, ultimately, humanising the care relationship. Doug highlights, 'we talk a lot about meeting needs [...] for me, most people in their lives, really just want another human being to sit with them and say: it's alright, we're together'. Care, interdependence, and vulnerability are fundamental parts of being human (Rogers 2016). Humanising care relationships entails moving beyond the egoism/altruism binary and viewing those providing care as 'acting for self-and-other together' (Held 2006, 12). Care work is thus not romanticised as 'selfless or self-sacrificial' (Rogers 2016, 36), echoing critiques of normative expectations around care in a highly feminised care sector (Fisher 2021). Emphasising staff and residents' humanity argues for a pro-resident *and* pro-worker approach.

The *human* in care relationships expands what *being human* means. Goodley and Runswick-Cole (2016) use *dis/human* to show how (learning) disabilities disrupt norms of humanness while affirming the *human*, recognising 'the pragmatic and political value of claiming the norm, but we always seek to trouble the norm' (p. 5). Care relationships could be thus described as 'simultaneously normative and non-normative' (p.12) as 'you build a relationship with the people you support as you would build with anyone' (Sarah). This could help with revisiting understandings of care relationships as friendship or family.

5 | Strengths & Limitations

Most participants were women between 35 and 54 years old, reflecting age and gender patterns among support staff (Skills for Care 2021). Most participants identified as White British and, despite our efforts, we could have included more migrant and non-White British staff. Including a Shared Lives carer enabled us to reflect on care relationships in less 'conventional' residential arrangements, which, nonetheless, still exist within the social care system and are influenced by the conditions surrounding it. The participants supported residents with different levels of learning disability, resulting in more holistic insights. Despite their benefits, online interviews may feel more task-focused.

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6 | Suggestions for Future Research

Future research could explore care relationships by involving significant others (e.g., family) and residents with a learning disability. Studies focusing on less 'conventional' learning disability residential arrangements (e.g., Shared Lives) could be conducted to investigate how these shape care relationships. Future research could employ ethnographic methods to observe care relationships in real-time, bridging people's perception of their actions and what people *actually* do.

7 | Suggestions for Care Practice

This study could be used by support staff and managers to inform care relationship building; individuals involved in training staff; residents with a learning disability and significant others to emphasise avenues to achieving positive relationships; and regulators to inform care inspections.

8 | Suggestions for Policy

The sections of our analysis about (a) accounts of adverse working conditions and devaluation of care work, and (b) the key role that support staff play in the lives of residents, could serve as evidence to policymakers for greater recognition of the social care workforce, improved working conditions, adequate funding, and perhaps the reimagining of residential services with an emphasis on relational praxis.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Anonymised data from this study may be made available upon reasonable request.

Endnotes

[1] *[...]* edit made by the authors to shorten a quote.

[2] The .. indicates a short pause.

[3] For context, domiciliary care workers in England often have significantly less time to provide care than what this participant is describing. For instance, domiciliary care staff may only have 15 min to spend with a person, before having to go to a different location to visit another person.

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