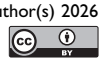
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Dementia
2026, Vol. 0(0) 1–19
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Navigating Leadership Challenges: Care Home Managers' and their Staffs' Experiences of Enabling Person-Centred Dementia Care, A Qualitative Study

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Abstract

Care home managers' leadership is widely recognised as shaping how staff provide care for people living with dementia. However, evidence remains limited on what enables managers to enact this role and sustain person-centred approaches within day-to-day care. This study explored managers and staffs' experiences of facilitating person-centred care using an interpretative phenomenological approach. Twenty participants (ten managers and ten staff) from ten care homes took part in online semi-structured interviews. Data were analysed using Colaizzi's seven-step method. Participants viewed managers as key enablers of person-centred care, yet described this role as constrained and not always achievable in practice. Organisational and regulatory demands such as staffing shortages, administrative burden, and limited autonomy were perceived as major barriers, shaping what staff and managers felt able to prioritise. Managers countered these pressures, by being visible and available to staff, encouraging open communication, using staff meetings and appraisals to address concerns, and supporting staff reporting of poor practice. Values-based recruitment, emphasising empathy and kindness over formal qualifications, were also described as central to sustaining person-centred practice. However, staff were often unaware of these leadership strategies, which were frequently experienced as workarounds rather than embedded organisational processes. Examples of person-centred care focused on supporting residents' choices in everyday routines and taking additional steps to understand individuals' backgrounds when information was limited. Peer learning groups were valued for reducing managerial isolation and promoting shared problem-solving, whereas online and mandatory training were widely seen as insufficient. Findings highlight a persistent tension between managers and staff aspirations for person-centred care and the realities

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of practice shaped by system pressures, risk management, and resource constraints. Sustaining culture change requires long term organisational commitment, context sensitive leadership development, and structural support that extends beyond individual managers' efforts.

Keywords
leadership, care home managers, person-centred care, residents, staff

Introduction

Around 920,000 people are living with dementia in the UK (Watson et al., 2021), and the majority of this population are aged 65 and over (Evans, 2016). Dementia is the main determinant of admission to care homes for older people (Bruck et el., 2025). There are approximately 251,000 older people residing in care homes in England, with 80% estimated to be living with dementia (Wittenberg et al., 2020). In England, person-centred care is promoted by the regulator and all those involved in commissioning care as the guiding approach for how care is provided (Mongan & Thomas, 2021).

Person-centred care is structured around a comprehensive understanding of an individual's psychological, physical, social, and emotional needs (Jonsson et al., 2025; Kitwood, 1997; McDermott et al., 2019). In care homes, person-centred dementia care necessitates the active involvement of the individual, or those who know them best, in decisions that determine how care is delivered and what is prioritised (Daly et al., 2018). However, the sustainability of this approach is dependent upon staff attitudes, the time allocated for professional development, and the extent of managerial support provided by care home leaders (Berkovic et al., 2024).

Studies examining the influence of care home managers' leadership styles on dementia care delivery have identified a strong association with how they shape the culture within a care home to foster job satisfaction, a positive environment, and minimise conflict (Cummings et al., 2010; Haunch et al., 2021; Penney et al., 2022; Zonneveld et al., 2021). However, several reviews highlight that while the manager's role is universally regarded as central in care homes, there is limited evidence on how their leadership supports staff to promote a culture of person-centred care (Jordal et al., 2022; Moenke et al., 2023; Orellana, 2014; Orellana et al., 2017).

Aim and Objectives

The aim of this study was to explore care home managers' experiences of facilitating the delivery of person-centred care for people living with dementia. The objectives were to:

> Explore managers' experiences of organisational and individual support to carry out their leadership role;
> Understand how the perceived influence of managers' leadership styles on staff affects care delivery; and
> Identify how managers and staffs' experiences of leadership training, education, and ongoing learning affected their ability to deliver person-centred care

Methods

Design

This study used an interpretative phenomenological approach (Mjorud et al., 2017; Vassbo et al., 2018) to explore care home managers and staffs' lived experiences of promoting person-centred care for people living with dementia. Phenomenology is commonly applied within healthcare research (Koch, 1996; Rodriguez & Smith, 2018), and allows the researcher to understand data from lived experiences relating to caring work and practice improvement (Holloway & Galvin, 2016; Husserl, 1970). This approach reflects the researcher's (LM) orientation to practice and service improvement by focusing on how participants' experience and attach meaning to the day-to-day work of supporting and providing person-centred care for people with dementia. The study did not adopt a single definition of person-centred care, but drew on the work of key writers that focus on ensuring the person living with dementia is treated as an individual, with dignity and respect fostering meaningful relationships and involvement in decision-making about their care (Daly et al., 2018; Rosengren et al., 2021).

Setting

Private care homes for profit, offering care with and without on-site nursing within one locality in the East of England were identified through online searches of Care Quality Commission registered care homes. In England, care homes vary in sizes, including small (1-10 beds), medium (11-49), and large (50+) (CQC, 2017). To reflect current trends toward consolidation and the development of larger providers of long-term care, care homes approached to participate in this study were medium and large. These care homes provided service to self-funded and local authority funded residents, and were registered with the Care Quality Commission to provide nursing, personal, and dementia care.

Recruitment

An introductory email and a participant information sheet were sent to managers of care homes in the chosen region in July 2022 explaining the details of this study, and to determine their interest in participating. Upon recruitment of the care home manager, care staff were approached to participate. Due to restrictions with the Covid-19 pandemic for visiting care homes, study recruitment for staff was via managers. Participating care home managers were asked to distribute the information sheets to their staff. Staff then made contact directly to the researcher (LM) to confirm their interest in the study. Where interest was expressed by more than one eligible member of staff (three care homes), selection was guided by their potential to provide rich accounts from their lived experience of providing care to people living with dementia. Where individuals were equally able to contribute, availability to participate within the study time frame was used as a pragmatic criterion for inclusion. Data collection was undertaken during the pandemic. Therefore, written consent was completed electronically, with signed consent forms return by email ahead of the interview. Consent was established verbally at the beginning of each interview prior to data collection. Interviews were arranged without the involvement of any other party and could be cancelled or stopped by the participant.

Participants

Participants were purposively selected relevant to the research objectives (Guest et al., 2006). Managers, care assistants and senior care assistants working in the participating care homes were

eligible. Those with longer lengths of employment were anticipated to have deeper experiential insights into the practices within their care home that supported person-centred approaches. Additionally, high staff turnover is associated with less than 12 months employment in care homes (Costello et al., 2019). Thus, participants were required to have held a minimum of 6 months employment in their current position in the care homes.

Data Collection

To ensure interviews captured participants' own interpretations of person-centred care, the term was intentionally not defined in the recruitment materials or during the interview introductions. Semi-structured interviews were conducted online, all were completed by LM, who had experience of working as a care home manager. Interviews occurred between July and November 2022, and varied in length between 35 to 60 minutes with each participant. Prompts were used to explore participants' experiences of overseeing and providing care, focusing on the role of the manager in supporting the care of people living with dementia in their care home.

Data Analysis

Audio recordings from interviews were transcribed using Zoom (Zoom Video Communications, Inc). Voice recordings and transcripts were checked with additional recording on a Dictaphone for accuracy. Data were organised and mapped using NVivo qualitative software, (Lumivero, 2018, Version 12). Analysis followed Colaizzi's (1978) seven-step approach of phenomenological analysis, to explore participants' accounts of delivering person-centred dementia care in care homes systematically and iteratively. The analytic process involved: (1) repeated reading of participants' interviews to develop a comprehensive understanding of their overall experiences; (2) identification of significant statements which pertained to the phenomenon; (3) formulation of meanings of each significant statement; (4) organisation of formulated meanings into theme clusters; (5) comparison of theme clusters against data to refine themes and sub-themes; (6) development of exhaustive descriptions of themes and sub-themes to support discussion and interpretation between the research team; and (7) validation of interpretation of meaning with two participants.

A two-phase reflexivity process was employed (Smith et al., 2009). The interviewer (LM) had over three years of experience as a care home manager, which facilitated contextual understanding of participants' roles and helped establish early rapport during interviews. However, this prior experience also posed a risk of influencing interpretation of participants' accounts (Drew, 1999). To ensure rigour, trustworthiness, and credibility, a reflexive journal documented the researcher's reactions to interviews and critically examined how these were shaped by their professional background. This process enabled systematic assessment of the potential impact of prior knowledge on data collection and analysis (Smith et al., 2009). Additionally, regular discussions with the research team explored potential biases in interpretation. For example, repeated examples of participants feeling 'lucky' to attend training prompted reflection on how LM's prior experiences may have sensitised her to some of the assumptions and norms within care home settings. These group reflexive discussions facilitated critique of early interpretations of the data, and supported the development of themes.

Public Involvement and Engagement in this Study

The primary research protocol and other supporting ethics documents were reviewed by members of the University of Hertfordshire Public Involvement in Research group with experience of

supporting family members with dementia and/or visiting care homes. The feedback from this group led to changes in how the study was introduced to the care homes favouring a more accessible summary in the information sheets.

Ethical Considerations

The study protocol was approved by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee (approval no. LMS/PGR/UH/04984). As described above, all potential participants were provided with written study information and informed that participation was voluntary. All participants provided written, informed consent.

Findings

Twenty participants from ten care homes took part in this study. Participants' characteristics are summarised in table one. The majority were female (60%). Most care home managers (80%) and staff (80%) had been in their current positions for under six years. The majority of care home managers (70%) were over 50 years old; while most staff (60%) were under 40 years old (Table 1).

A Summary of Participants' Accounts

All participants emphasised that person-centred care was regarded as a fundamental component of promoting care quality for people living with dementia. However, their accounts focused on the challenges of achieving this within the everyday constraints of staffing and organisational priorities.

Table 1. Characteristics of Participants

	Care home managers	Care home staff
Sex		
Female	5	7
Male	5	3
Age range		
18–24	0	1
25–29	0	2
30–34	0	2
35–39	2	1
45–49	1	2
50 & over	7	2
Current employment duration		
6–24 months	1	4
2–5 years	7	4
6–10 years	0	1
16–20 years	2	0
20+ years	0	1

Themes Identified From Participants' Accounts

Two overarching themes captured how care home managers and staff characterised their experiences of supporting person-centred care. The first theme addressed system-level challenges and access to resources, summarised as: (1) Challenges in leadership which promotes person-centred care. The second theme focused on individual strategies managers employed to support everyday person-centred practice, summarised as: (2) Care home managers' perceptions of enabling person-centred care. Figure 1 outlines the sub-themes associated with each theme.

Theme 1: Challenges in Leadership Which Promotes Person-Centred Care

This theme comprises two interrelated sub-themes that illuminate the systemic and operational challenges encountered by care home managers in fostering and sustaining person-centred dementia care. Drawing on participants' accounts, the analysis identified:

1. Dissonance in the conceptualisation and delivery of person-centred dementia care
2. Training support for staff and skills development

Collectively, they highlight the tension between managerial aspirations for personalised care and the structural limitations imposed by organisational priorities, regulatory compliance, and staffing constraints.

Dissonance in the Conceptualisation and Delivery of Person-Centred Dementia Care. Care home managers' accounts of how they enabled the use of person-centred dementia care were described as dependent on the level of senior manager/owner's support for this. Some managers described limited opportunities or an absence of shared values to be able to have meaningful discussions about

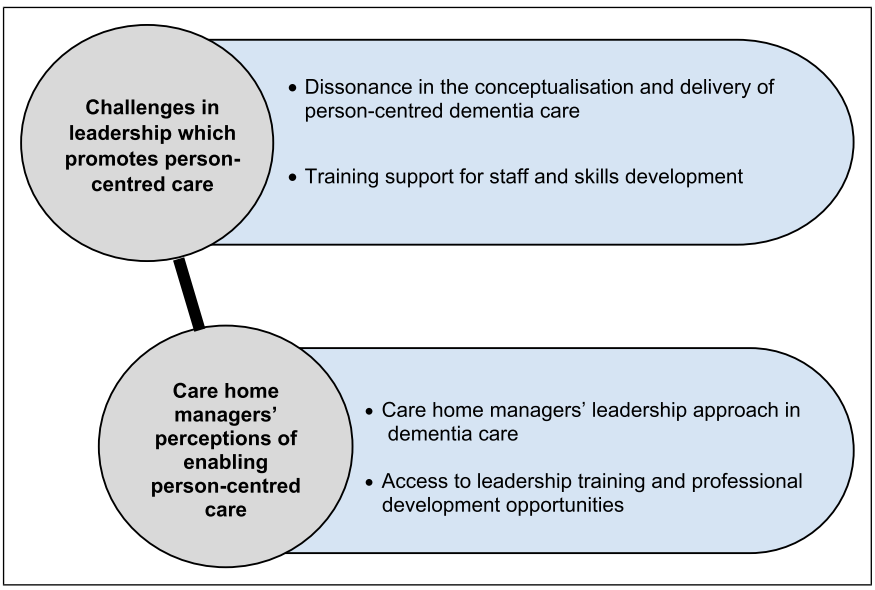


Figure 1. Themes and sub-themes

care with owners. Implicit in this narrative was that business priorities and the ethos of person-centred care are incompatible:

> I find owners the biggest challenge as some owners can be quite combative and can actually put further obstacles in your way when you're telling an owner that something has to be done….They're just constantly worried about filling the beds. I find that the hardest thing to manage. (Care Home Manager, Lines: 141–147; 2–5 years in current employment)

Care home staff observed that where there was an organisational culture that limited the manager's scope of leadership autonomy and decision, this had an impact on their experiences of support from the manager to provide person-centred care to residents. This staff member described it as the manager's hands being tied:

> I think my manager…has directors above him who are saying you can't do this, you can't do that; you've got to cut this….We're working on the weekend and there should be support from the management too….I do think that our managers are supportive, but they've got their hands tied as well. (Senior Care Assistant, Lines: 162–164; 174–177; 6–10 years in current employment)

In addition to a perceived conflict between commercial priorities and the principles of person-centred care, care home managers consistently reported that organisational emphasis on risk management and residents' physical safety often constrained their ability to tailor services to individual needs. One manager illustrated this by describing how efforts to support residents' mobility and choice in the care home were hindered by the absence of a lift and stairs unsuitable for people at risk of falling. This failure to invest in infrastructure was seen as evidence of a broader organisational reluctance to invest in resources necessary to enable choice and personalised care:

> There is no lift and our residents are frail and getting frailer. Erm, so I proposed the question that you need to have a lift for people to be able to travel safely. Also, there is no stair safety and our residents that live with dementia…they are at significant risks, and there isn't a risk assessment in the world that mitigate that risk enough. (Care Home Manager, Lines: 157–163; 2–5 years in current employment)

The influence of regulatory requirements was frequently cited as reducing managers and staffs' capacity to provide care that focused on residents' interests. The administrative burden associated with demonstrating compliance, such as the extensive documentation was perceived as detracting from managers' involvement in direct care and fostering a culture of risk aversion aimed at avoiding punitive evaluations of care quality:

> As a manager, you've probably got the worse job….These days everything is paperwork….It's more paperwork than care to me if I'm being truthfully honest….I can understand that paperwork needs to be done, but it's just too much of it.…People suing if you don't do your paperwork. I think it's got worse; I think, over what the few cases that we've had, whether it's been care concerns, every care home or company is now super careful" (Senior Care Assistant, Lines: 168–169, 182–183, 190–192; 6–10 years in current employment)

Managers felt powerless to support staff to provide person-centred care at times of increased workloads. Repeated references were made by all the participants on the impact of inadequate staffing levels and access to relevant resources. This pressure was recognised as affecting both

residents' well-being and individual staff capacity and confidence to provide person-centred care. This quote demonstrates how a senior care assistant felt blamed for examples of poor care practices:

> Where we are supposed to have seven carers on duty for a shift or on a particular day, we end up with just four carers working, which means the four people all have to put in almost double shift just for us to be able to maintain the care home service for that particular shift. So, it has a rippling effect on everything….Not a good idea for everybody. (Senior Care Assistant, Lines: 172–178; 6–24 months in current employment)

Training Support for Staff and Skills Development. The lack of recognition and resources to foster the skills required for care home staff to deliver dementia care to residents was a concern by participants, and directly linked to how funding issues affected enabling person-centred care delivery:

> I find it difficult to provide sufficient training to my staff and this is about funding issues and all that, so there is a really big gap there on what can be offered to them….More support should be provided to staff to develop their competence. (Care Home Manager, Lines: 183–187; 2–5 years in current employment)

Ensuring staff were up to date in fostering a culture of person-centred care was linked to completing training which requires frequent access and support. As this quote demonstrates, offering additional training annually was seen as important to stimulate staff and counter the tendency to adopt routinised approaches or assumptions that people with dementia were all the same:

> We do our dementia training once a year for all staff, but I don't think once a year training is enough…because dementia changes for different people….Training would be good for staff every six months. You know, just to refresh their memory, because staff do get stale in their job. (Senior Care Assistant, Line: 413–419; 6–10 years in current employment)

Participants discussed the limited opportunities for interactive learning where they could exchange ideas and ask questions, reflecting that these could encourage a shared approach within the care home. Online training was not seen as appropriate for staff where learning outcomes were not applied to practice. One care home manager referred to this type of training delivery as a "tick-box," seeing this as repetitive and outdated, and unlikely to encourage active learning:

> We went over to E-learning…and it's all just the same thing, but worded differently….The training is basic tick-box….I can flick through my E-learning…and go to the questions at the end which are all multiple choice and you need to get 70%….You can even tick the box without watching the course. (Care Home Manager, Lines: 210–212, 226–231; 2–5 years in current employment)

This manager expressed scepticism that training alone was sufficient to deliver person-centred care. She emphasised that for residents to be treated with dignity and respect, the personal or professional experience staff bring to their role is a much more valuable asset:

> Most of the training are done using DVD. It doesn't work….I try to recruit the right people and sounds easy, but trust me it's not….I think in the whole country, to work with people with dementia, experience counts for everything. It's right down to the tone of your voice, the way you speak to somebody. (Care Home Manager, Lines: 327–336; 16–20 years in current employment)

Theme 2: Care Home Managers' Perceptions of Enabling Person-Centred Care

The second theme focuses on participants' perceptions of their roles and strategies they used to support staff in delivering person-centred care. This reflected what was thought possible within the care home and how additional support could lead to improved practice, specifically around:

1. Care home managers' leadership approach in dementia care
2. Access to leadership training and professional development opportunities

Care Home Managers' Leadership Approach in Dementia Care. Most care home managers emphasised working closely with staff to promote person-centred dementia care and to enable staff to recognise and take ownership of their role in delivering it. This approach included fostering open communication, encouraging and promoting teamwork. These were strategies managers described as essential for supporting staff and strengthening connections within the care home:

> They have an option to speak to me directly, because we have an open-door policy. So, they can always come and speak anytime when we are in the office about our ongoing facilities….If we are not in there, still they have an opportunity to speak on the weekend or in the evenings….So, there will be one person all the time 24/7….We listen to the staff and then we action that. (Care Home Manager, Lines: 59–70; 2–5 years in current employment)

Supporting staff in their work was conceptualised by care home managers as achievable, even within the organisational constraints described above, and was closely linked to certain personal attributes.

The extract below describes how the manager encouraged approachability based on their leadership style and personality to build a good working (and trusting) relationship with staff:

> I don't really have a directive style….I'm quite a bit more engaged with people….If I had spent all my last for 35 years in social care trying to battle people, I don't think I'd still be here now. You've got to work with people. (Care Home Manager, Lines: 87–91; 6–24 months in current employment)

To implement an open-door policy, some care home managers felt the use of staff meetings created opportunities for staff to raise concerns, and to have a sense of purpose in their work. However, not all staff described this approach as helpful when they suggested staff meetings related to what staff were required to do and not how management responded to issues raised:

> We have meetings once a month, but it's not really a meeting for us to make a discussion. It's like the manager telling us what the head office wants us to be doing and not to hear what we've got to say….So, staff in the end don't bother saying anything because they know it's not going to go any further." (Senior Care Assistant, Lines: 285–291; 6–10 years in current employment)

An alternative strategy used by care home managers was promoting an open-door policy, with a particular focus on alerting them to poor practice (whistle-blowing). They saw this as key for maintaining standards, particularly as they were unable to physically oversee all aspects of staffs' work. However, a few staff mistrusted this as a route for raising concerns and therefore did not use it:

> I encourage them, erm, from day one, if you see that something should not happen, please do not hesitate and come is whistle-blowing, and tell. It's not about me….It's about mistakes that have happened….If this is not addressed, the mistakes will happen again and again. (Care Home Manager, Lines: 295–300; 16–20 years in current employment)

Both managers and some care home staff identified appraisal meetings as a valuable mechanism through which managers supported staff and reinforced the delivery of person-centred care for people living with dementia. One staff member described how an appraisal meeting fostered a sense of ownership in her role and enhanced her performance in dementia care:

> I explained during my last appraisal that I would like to do an NVQ 3 programme and my manager called me into her office few months later to tell me that there was external funding available for NVQ 3 and I was enrolled on it.…I can say that the appraisal is helpful for staff to improve their skills and knowledge in dementia care. (Care Assistant, Lines: 159–164; 6–24 months in current employment)

In addition, one-to-one supervision could be effective for providing a safe space for staff to express their views about what they believed should (and not) be happening within the care home:

> I think the one-to-one supervision is a lot helpful….Staff can be free to say how they feel and what they think needs to be done in the care home….It's not a group thing with other staff involved. (Care Assistant, Lines: 155–159; 6–24 months in current employment)

While staff revealed the importance of their managers' physical presence to support their work and how person-centred care could be achieved for residents, they viewed such practice as inconsistent. This manager's quotation suggests that working alongside their staff to support them was often a response to a crisis, rather than being present to model best practice, especially when the care home was fully staffed:

> When they have a crisis, when they have a problem on the floor, like shortage of staff, I work with them. Looking after the staff is very important. (Care Home Manager, Lines: 106–108; 2-5 years in current employment)

It is a finding of the study that care home managers in this study believed that their leadership approaches, such as being accessible and building relationship and trust with staff supported how staff achieved person-centred care. However, despite probing during interviews, participants provided limited detail about how these leadership approaches were operationalised to support the care of people with dementia.

The quotation below was a striking example of how a care home manager and her staff made extra efforts, and found time to get to know a resident who had no family member to speak on her behalf, by obtaining their personal information (e.g., life story or history) through the residents' possessions and photo albums:

> I've just taken a new lady in…and we don't know anything about her and she's been placed with me by a solicitor….It was very hard to get that picture of her background for us to work with. ….So, [staff] came with me to her bungalow and to bring anything that I thought was important like clothes….We spent an hour on photograph albums…the photographs told me more about her." (Care Home Manager, Lines: 60–65, 70–73; 16–20 years in current employment)

Care home managers identified other ways of promoting person-centred care for residents when they recognised that this type of care could be extended to staff, to support their well-being by reducing workload pressure and ensuring work-life balance is achieved for staff:

> It's not only person-centred care for residents, it's also person-centred care for staff, because if you haven't got a happy staff, you haven't got a happy resident….A staff came to me, I'm overstretched, I do need annual leave for one week, and I told her, take your break when you're ready, come back….The same it is on their shifts, if they're overstretched, take a break." (Care Home Manager, Lines: 106–108, 340–342; 16–20 years in current employment)

Access to Leadership Training and Support. Leadership training and support were presented as crucial in facilitating care delivery for people living with dementia and fostering effective relationships with staff. Opportunities for peer support were described by participants as a key factor in enhancing their confidence and competence and a preferred way of professional development. However, limited access to such support was observed to impact how care home managers developed their professional skills.

The two participants' quotations below detail how one leadership support programme funded by their local authority, provided managers with the opportunity to reflect on what was (and was not) happening within their care homes:

> [Programme] was a real eye opener. It taught me a few things on dealing with situations and improve my leadership skills. I became much better on how to approach staff issue….That made a difference to staff morale. (Care Home Manager, Lines: 188–198; 2–5 years in current employment)

> I became consistently involved with the clinical team and care staff….I also realised that there are always new things out there to try to improve the service. (Care Home Manager, Lines: 157–160; 2–5 years in current employment)

There were additional benefits to completing the leadership support programme with managers being able to connect with one another through shared experiences. Action learning and realisation that managers from different care homes were facing similar challenges on what was not (and should be) happening within their care homes were perceived helpful:

> [Programme], and that was supported by the [University] and we used to go to a meeting, erm, once a month, where other care home managers will meet up; yeah, and they would all obviously compare stories of what they've learned from their experience, and that was extremely helpful….There was a huge amount of owners of care homes that didn't really support their managers…That really was quite sad. (Care Home Manager, Lines: 221–225, 237–241; 16–20 years in current employment)

In addition, the leadership support programme gave care home managers the permission to work beyond how they had previously interpreted their role as enablers of good care. This was observed to make a difference to the culture of the care home:

> I must say that I became much more observant of the staffs' work. I did more supervisions with them….Erm, so, I feel that the extra supervision in turn, improved how staff were providing care to the residents with dementia. (Care Home Manager, Lines: 197–201; 2–5 years in current employment)

Despite the importance of leadership education and training, allocation of time to pursue the opportunity was not offered to care home managers as revealed by this participant:

> I would say that one of the challenges for us managers is the time to attend training. This is a big problem. We don't have that time. (Care Home Manager, Lines: 163–165; 2–5 years in current employment)

None of the narratives about experiences of peer learning described by five managers, whilst very positive, suggested that access to leadership training was a regular or an expected source of support; nor was there evidence of individual progression:

> I feel that a refresher leadership course is necessary for care home managers, but it's not that accessible especially in dementia care or person-centred care….When you have achieved your Level 5 in leadership and management, it stops there for care home managers. (Care Home Manager, Lines: 217–219; 224–225; 2–5 years in current employment)

Discussion

This study identified two overarching themes in how care home managers facilitated person-centred dementia care: (1) challenges in leadership that promotes person-centred care, and (2) care home managers' perceptions of enabling person-centred care. Findings suggest it is misleading to place so much responsibility on the care home managers alone to ensure person-centred approaches for people living with dementia. Consistent with Hunter et al. (2015) and Backman et al. (2025), this study reinforces that person-centred care is an organisational endeavour rather than an individual responsibility. Deuling et al. (2025) similarly argue that leadership influencing person-centred care is primarily associated with formal management roles, but requires collective processes such as feedback, trust, active listening, teamwork, and staff empowerment. While managers in this study demonstrated awareness of the resources needed to support residents and staff, their ability to reconcile competing priorities was constrained by organisational structures and the variable access to professional support and resources.

Managers reported limited autonomy to influence organisational priorities, particularly regarding dementia training, and online training was widely perceived as inadequate for staff. However, managers also emphasised that person-centred care extends beyond training, highlighting the importance of staff attributes, such as empathy and patience. This supports Groothuizen et al.'s (2018) advocacy for values-based recruitment and McCormack and McCance's (2006) framework of "prerequisites" for person-centred practice, as well as Matosevic et al.'s (2007) assertion that "staff cannot care for people unless they care about people."

Competing demands between enabling person-centred care and meeting Care Quality Commission requirements were evident. Administrative tasks and extensive documentation were perceived as detracting from direct care and fostering a risk-averse culture. Over ten years ago, Orellana et al.'s (2014) call to reduce bureaucratic burden and Johannessen et al.'s (2020) later findings on duplication and inefficiency suggest little has changed. Digital solutions have been proposed to streamline documentation (Masoli et al., 2023; Nelson et al., 2023), yet evidence suggests that for this to be helpful, staff need to be confident of how documenting care supports their caring role as opposed to being administrative tasks away from direct or hands-on care (Musa et al., 2022).

Resource constraints, particularly staff shortages, were described as placing staff in difficult situations, echoing Johnson's (2015) concept of "emotional labour" and Kinman and Leggetter's

(2016) findings on emotional exhaustion. Participants' accounts also revealed gaps in understanding person-centred care, often framing it as requiring additional time and resources rather than as an embedded practice. This mirrors Lee et al.'s (2023) findings and underscores the need for reflective approaches to support staff comprehension. Matas et al. (2025) suggest tools such as digital life stories can enhance understanding and affirm residents' identity; while Dewing (2008) advocates for relationship-centred frameworks to address limitations in Kitwood's (1997) model. These findings again raise the question about how seeing person-centred care as a series of individual encounter and recognising the individual's autonomy is achieved, purely through offering choice and how decisions are made for everyday care (Pilnick, 2023).

Relational strategies emerged as critical. Managers emphasised open communication and teamwork as mechanisms to support staff to foster a culture of person-centred care, reflecting transformational leadership principles (Asante et al., 2021; Ree, 2020). However, formal communication methods such as staff meetings, appraisals, and supervision were inconsistently applied and rarely used to improve care practice, corroborating evidence that inadequate supervisory support undermines skill development (Ashurst, 2025; Raikkonen et al., 2007).

There were suggestions that encouraging staff to identify and report poor practice (whistleblowing) was a positive managerial strategy to improve quality and support person centred care. This arguably illustrates the tension that many of the managers and to a lesser extent care staff characterised about the uncomfortable duality of their experience. Focusing on remedying poor practice rather than building on and encouraging evidence of person-centred practice in the care homes reflects values typically linked to hierarchical organisations and not working environments that value relational working, trust and collective endeavours. Others have argued that when the values of person-centred care are superimposed on systems that emphasise competing values such as task completion, routine efficiency, standardisation and cost control it is very difficult to make person centred care for people with dementia an everyday reality (Armstrong & Braedley, 2023). Although, there are examples of how care staff advocacy can have a major impact on the culture of care (Toebes, 2023).

That organisational recognition and structural support for managers remain limited are not new findings. Orellana et al. (2017) note that the role is often undervalued, Previous research suggests that educational qualifications alone are insufficient preparation for the role (Forbes-Thompson et al., 2006), and leadership development requires sustained investment (Backman et al., 2023; Fitzpatrick et al., 2023). It was striking in this study that access to leadership training was viewed by managers as a luxury rather than an expectation and necessary foundation for them to be effective managers.

Strengths and Limitations

This study is one of the few pieces of research in the UK to explore care home managers' experiences of facilitating person-centred dementia care. The recruitment strategy, sample size, and focus on participants' individual experiences did not include in the analysis the most recent regulatory assessment of their care home. Participants demonstrated an awareness of the importance of regulatory ratings and their impact on risk management and decision making on what was best for the resident or the care home. However, none of the interviews referred to the most recent rating of their own care home or how this affected their care work. Despite semi-structured interviews with open-ended questions (Bearman, 2019) allowing detailed responses from participants, it was not always possible for them to differentiate between their experiences of providing care and the specifics of enabling care delivery that was person-centred and dementia sensitive.

Face-to-face interviews are traditionally used to conduct primary research. However, the use of online interviews created flexible access to arrange interviews, and increased the opportunity for participants to participate in this study at their preferred location. This may have also increased openness to their participation in this study (Keen et al., 2022).

Eligibility of participants was based on length of service to facilitate rich accounts of the practices and experiences that supported person-centred care within the care home. Excluding staff with less than six months' employment may have introduced selection bias by omitting the perspectives of newer employees. However, this criterion was adopted to ensure participants had sufficient experience within the care home environment, routines and organisational culture to reflect meaningfully on care practices. Additionally, as staff turnover is highest during the early stages of employment, newer staff may have been more focused on role adjustment and induction processes than on broader care practices.

Rigour was ensured with the use of a reflexive journal during "bracketing" process for data collection and analysis. The researcher's positionality (Holmes, 2020) with previous experience of managing a care home may have influenced the depth of experience participants shared. For example, most participants in this study openly expressed feelings of frustration and disappointment about their organisation failing to recognise their needs and improve care quality for people living with dementia.

Some participants experienced workload pressures, including doing additional overtime due to the pandemic, which impacted how interviews were scheduled. However, considering this study identified ongoing limited resources within care homes, it is possible that most participants were those who were able to manage and overcome the demands in their care homes more comfortably than others. Care home managers might have suggested experienced staff with more skills and resilience in dealing with work related pressures to participate in this study.

Conclusions

Supporting care home managers to enable person-centred care requires sustained financial investment and organisational commitment and whole-systems approach for the delivery of person-centred dementia care. One that addresses the described interactions of factors across multiple levels of the care system, including care home organisational structures, leadership, workforce resources, care practices, and relationships with residents and families. From this perspective, sustainable improvements require more than changes at the level of individual staff or managers alone. This is essential to challenge the experienced divide between the business priorities of long-term care and the resources staff need to deliver person-centred care for people living with dementia. It is problematic to position the care home manager as the sole driver of a person-centred culture without addressing the structural requirements for staff development and improvements in the working environment.

Despite the constraints and challenges identified in this study, including regulatory demands, staff shortages, and limited access to training, participants demonstrated resilience and a strong commitment to providing quality care. Their accounts suggest that under the right conditions, staff could achieve significantly more. Future efforts should focus on creating organisational structures that prioritise person-centred care as a collective responsibility, supported by adequate resources, leadership development, and policies that enable managers and staff to work collaboratively towards this goal.

Acknowledgments

The authors would like to thank recruited care home managers and their staff for participating in this study.

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Ethical Considerations

The study protocol was approved by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee (approval no. LMS/PGR/UH/04984).

Author contributions

All authors contributed to the study conception and design. Data collection and analysis were performed by LM and the process was supported by MH and CG. The first draft of the manuscript was written by LM and MH and CG commented on subsequent versions of the manuscript. All authors read and approved the final version of the manuscript.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This project was part of a self-funded PhD at the University of Hertfordshire.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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