



Knowledge needs and use in long-term care homes for older people: A qualitative interview study of managers' views

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Funding information

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Abstract

We explore the views of managers' knowledge needs and use to optimise care practices and enhance the life experience for older people living, and staff working, in long-term care homes (with and without nursing). This paper contributes to previous research by offering insights into the knowledge types drawn upon and used by managers to inform efforts to better support gaining and mobilising knowledge. Using a pragmatic qualitative approach, we undertook 19 semi-structured interviews with managers and leaders in 15 care homes in the South West of England, varying in geographical location, size and type of ownership. We did a thematic analysis of the data using Framework Analysis. Our interpretations were informed by the existing literature on knowledge types. We identified three themes from our analysis as to managers' knowledge needs and use when implementing changes. First, views about training and formal reports or "explicit knowledge" consisting of the two sub-themes "gaining explicit knowledge" and "research knowledge". Second, perspectives relating to practical experience or "tacit knowledge" and judging the use of knowledge in particular cases or "phronesis". Third, the role of emotion in managers' knowledge needs and use. We found that having knowledge was positively valued by managers and leaders for improving care practices and enhancing the lives of people residing in care homes. Tacit knowledge and phronesis were particularly highly valued and we note challenges with the perceived applicability, relevance and use of research evidence. We identify that emotions are an important component within knowledge use and a need to further understand how to support the emotional wellbeing of managers so they can support care staff and residents. Greater consideration is needed as to how to optimise gaining and mobilising all knowledge types - "know-what," "know-how," "know-when" and "know-feel" - to benefit people living, and staff working, in care homes.

KEYWORDS

care homes, knowledge mobilisation, management, older people, qualitative research

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1 | INTRODUCTION

There is global recognition that our ageing populations require a more comprehensive public-health response, one that acknowledges the potential for long-term care to help ensure that people live fulfilled lives; this requires a care workforce that is extensively trained, supported and valued (WHO, 2015). In the UK, around 18,000 care homes provide 24-hr care for over 400,000 people (Buisson, 2018). The sector is mainly independent with for-profit (the majority), and (a few) not-for-profit and charitable Providers. Thus, care home provision differs regionally and locally depending on Providers, local demographics, supply structures and actions of local authorities (Competition & Markets Authority, 2017). The sector also faces significant pressures relating to staffing, finance and regulation (Smith et al., 2019). Many older people living in nursing (personal care with nursing) and residential (personal care without nursing) care homes have increasingly high levels of dependency, cognitive impairment and multimorbidity (Gordon et al., 2014). Mostly, residents receive good care with the sector performing a vital public service staffed by many dedicated and caring individuals (Competition & Markets Authority, 2017). The number of older people in the UK is growing substantially with the proportion aged 85 and over expected to almost double over the next 25 years (Office for National Statistics, 2019); this will lead to increasing demand for high-quality long-term care and support.

This article concerns knowledge use or mobilisation, in long-term care defined as the processes and activities aimed at reducing the gap between what is known and what is done (Nutley & Davies, 2016). Over a decade ago, Levenson and Morley (2007) reported difficulties in bridging the gap between currently provided care and what research knowledge in particular indicates should be provided; highlighting that many diverse influences affect how care home practitioners select, interpret and apply knowledge to make changes. There remains a need to further understand how knowledge is disseminated, implemented and used within the care home settings, and which approaches are effective (Berta et al., 2010; Boström, Slaughter, Chojecki, & Estabrooks, 2012; Breimaier et al., 2013; Cammer et al., 2013; Rahman, Applebaum, Schnelle, & Simmons, 2012; Resnick et al., 2018).

Much debate exists about how to appropriately approach this “knowing-doing gap” challenge. Best and Holmes (2010) propose that conceptual approaches to knowledge mobilisation belong to one of three generations of models. First, linear models where knowledge is seen as a product or package moving through discrete and predictable in stages, mainly in one direction from researcher producer to research user. Second, relationship models, involving the development of linear models, in which those producing and using knowledge work in close collaboration in creating knowledge through the core processes of linkage, exchange, collaboration and shared learning. Third, system models which build on the first two models and recognises that diffusion and dissemination processes are “shaped, embedded and organised through structures that mediate the types of interactions that occur among multiple agents

What is known about this topic

- There is global recognition that our ageing populations require a workforce, particularly in residential long-term care, that are extensively trained and better supported and valued.
- A significant challenge is understanding how to mobilise existing high-quality knowledge to benefit people living, and staff working, in care homes with and without nursing.
- Limited research attention has been given to care home managers’ and leaders’ perspectives on how they gain and use knowledge to implement continuous changes to practices to improve and evolve the lives of older people to meet the rapidly increasing expectations of future generations of potential residents.

What this paper adds

- In an under-researched part of the care workforce, we sought to explore how care home managers view their knowledge needs and use to improve practice.
- We provide insights into how explicit and tacit knowledge and phronesis are used by managers and identify the need for a variety of approaches to addressing the mobilisation of knowledge and optimising the use of all knowledge types in practice.
- We identify the significance of emotion within knowledge use by managers and discuss the implications of our analysis for mobilising knowledge to improve care practices and the lives of older people living, and staff working, in care homes.

with unique worldviews, priorities, languages, means of communication and expectations.” (p.148). Another useful conceptualisation of knowledge concerns the distinction between “know-what” and “know-how.” The former, called explicit knowledge, is described in formal language, print or online including research findings; the latter, called tacit knowledge, is action-oriented and embedded in, usually collective, work practices (Brown & Duguid, 1998; Smith, 2001). Combining “know-what” with “know-how” and then judiciously and beneficially using or mobilising to a particular situation is captured by Aristotle’s term phronesis (Flyvbjerg, 2006).

Turning to research knowledge, various factors influence how this informs (or not), care practices and experiences (Breimaier et al., 2013). Organisational factors that may help and hinder include: belief in the utility and feasibility of different care approaches; education or information; motivation and career development of staff; available support; staffing levels and turnover; workload; costs and the fit between an initiative and the philosophy of care (Breimaier et al., 2013; Resnick et al., 2018). In addition to a scarcity of good-quality studies, research knowledge often competes

with other knowledge, such as tacit, gained from the experience of doing care work (Sandvoll, 2017), and with established practices and values (Rutter & Fisher, 2013) such as the medical model of care. A critical influence is how managers within a care home guide staff, balance regulatory requirements and support the implementation of best care practices, processes and new initiatives to impact positively for people living in care homes (Andre, Sjøvold, Rannestad, & Ringdal, 2014; Colón-Emeric et al., 2016; Levenson & Morley, 2007; Szczepura, Clay, Hyde, Neilson, & Wild, 2008; van der Zijpp et al., 2016; Woo, Milworm, & Dowding, 2017).

Previous research has considered the role of managers. Anderson, Issel, and McDaniel (2003), exploring the relationship between nursing home management practices and resident outcomes, concluded that strategies for improving outcomes need to go beyond the care processes and the skills of direct care staff to include the management practices that increase the level and quality of connections and interactions among people. A recent scoping review of the evidence about care home managers found their role is crucial for shaping a homes' culture; stating more studies are needed on the impact of management styles on care practices and their knowledge use (Orellana, 2014; Orellana, Manthorpe, & Moriarty, 2017). More broadly, the regulatory body for care homes in England, the Care Quality Commission, includes the criteria "Is it well-led?" (CQC, 2013) as well as is it safe? Caring? Responsive? and effective? The National Institute for Health and Care Excellence, a Non-Departmental Public Body sponsored by the Department of Health and Social Care, published a resource for managers of care homes to support the mental wellbeing of older people in long-term care (NICE, 2013). This indicates that management practices within care homes should assume a priority.

To the best of our knowledge, limited research attention has been given to care home managers' and leaders' perspectives on their knowledge needs and use in providing the best care and holistic support to older people living and thriving in long-term care. Orellana et al. (2017, p. 375) propose, "Much may be learnt from care home managers as well as about them in building up knowledge of what helps a care home manager to deliver optimal care and support for homes' residents." Accordingly, we undertook a study to explore the care home manager role with the aim of understanding how knowledge is (or is not) needed and used by managers and leaders when implementing changes. In this paper, we share our thematic findings and consider the implications for improving care practices to benefit older people living, and staff working, in care homes.

2 | METHODS

We used a pragmatic qualitative approach in our wider study exploring the role of care home managers, their routes into the role and how they use knowledge to implement changes to improve care practices. We carried out semi-structured interviews with people working in management and leadership roles in residential and nursing care homes for older people in the South West of England. We

chose this method as the most effective and efficient form of gaining in-depth views given the time and job pressure constraints experienced by people in these roles. Data collection took place between May 2016 and December 2017.

The interviews (topic guide available on request from authors) were designed to explore (a) how and why people progressed into their role, (b) the differing components, skills and qualities perceived to be needed in the role, (c) how they might positively influence the culture of a home and make changes, (d) the key challenges they face in the role, (e) where they do or might gain and seek knowledge, (f) to whom do they go to when they have problems and need support, (g) to what groups and networks they might belong and (h) anything else relevant to the role. The study included an involvement group consisting of a senior manager representative from a Provider and two people with older relatives who either recently lived or were living in a care home. They feedback on the protocol for the study, the interview guide and interpretations from the analysis. All participants were provided with an information sheet about the study and an opportunity to ask any questions before giving their written informed consent.

Our approach to selecting participants involved a purposive and maximum variation sampling approach (Miles, Huberman, & Saldana, 2014) to identify people working in leadership and management roles in care homes taking into account factors our involvement group considered relevant: the setting (urban and rural), size of the home (small, medium and large), ownership type (not for profit, private sector, state-owned), gender identity (male and female), and time in role (3 years or less, 3 to 7 years, 7 years or more). We sought to interview 15–20 participants to provide sufficient variation to enable data saturation (Saunders et al., 2018). We contacted homes and organisations through existing links we have developed with research and care home networks in the South West. We explained what the study involved and provided an information sheet, following this a consent form was signed by each participant. JD (a psychologist and researcher) and IL (a consultant in public health and researcher) approached 25 people from 19 care homes to take part in interviews, we subsequently interviewed 19 people from 15 care homes in person on a one-to-one basis. 16 took place at the participants' care home and three at the university. The interviews were 45–95 min in length, digitally audio-recorded, professionally transcribed verbatim and anonymised. Reflective notes were completed immediately or as soon as possible after each interview and were included in the analysis.

JD and IL managed and analysed the data using NVivo 11 software (NVivo 2018) following the four phases of Framework Analysis (Gale, Heath, Cameron, Rashid, & Redwood, 2013; Ritchie, Lewis, McNaughton Nicholls, & Ormston, 2013). First, familiarisation and immersion with our interview data including generating a summary of our overall impressions from each interview and a list of potential codes. Second, developing a coding framework to manage, organise and reduce the data based on our research focus (deductive) and capture unexpected codes (inductive). Interview transcripts were coded in NVivo, we discussed our initial coding of two transcripts to

ensure consensus and resolving discrepancies via discussion leading to minor amendments to our framework. Third, we extracted our codes from NVivo and manually produced matrices noting themes by entering summaries of the interview data into the relevant codes (columns) by participants (rows). We used the matrices to develop interpretations to describe or explain the data by making comparisons between and within each participant interview and incorporating our reflective notes (Ritchie et al., 2013). We resolved discrepancies via discussion. Fourth, we considered relevant concepts to inform our interpretations drawing on the following knowledge types: explicit, tacit and phronesis. To ensure rigour, we held one session with our involvement group to share our developing analysis and we discussed our interpretations in two meetings with senior leaders from a Provider interested in the research.

Review and approval for the study were obtained from the University of Exeter Medical School Research Ethics Committee (reference 41/09/55).

3 | FINDINGS

The participants and care home characteristics are presented in Table 1. All 19 participants worked in management and leadership positions, 16 in residential homes and three in nursing homes. Eleven were employed as registered managers (RM), three as deputy managers (DM) and five as owner-managers (OM) - three as an owner and registered manager and two as owners closely involved in management.

We organised our findings around the distinctions between types of knowledge: explicit, consisting of the sub-themes gaining explicit knowledge and research knowledge, tacit and phronesis. We identified an additional theme of emotion. We provide slightly edited quotations to illustrate our findings using a participant identifier.

TABLE 1 Characteristics of the participants ($n = 19$) and the care homes ($n = 15$)

Participants ($n = 19$)		
Time in role	3 years or less	8
	3–7 years	3
	7 years or more	8
Gender identity	Women	16
	Men	3
Care homes ($n = 15$)		
Ownership of home	Not for profit	5
	Private	9
	State-owned	1
Location of home	Urban	11
	Rural	4
Size of home	Small (20 beds or less)	3
	Medium (21–40 beds)	6
	Large (40 or more beds)	6

3.1 | Explicit knowledge

3.1.1 | Gaining explicit knowledge

Participants' describe varied sources of explicit knowledge to assist them to implement changes in care practices including reading (books, reports, trade publications); websites and emails from organisations such as Skills for Care; the Social Care Institute for Excellence, Regulators and Local Authorities; attendance at training and conferences; visiting other care homes; speaking to their peers, staff and residents. Social media was perceived as a valuable source of ideas to inform improvements. A recurring issue is the need to keep up to date in a changing world where a substantial amount of knowledge, of varying quality, is available:

I get emails, a whole load of shit, don't you? Which I have to plough my way through and sometimes I may plough my way through the wrong thing and miss something. So it's difficult because you do get so much stuff. (OM11).

Alongside a concern about what you may not know:

It worries me sometimes that we're due an inspection and they will say, "Oh you haven't done this and that," but we wouldn't know we're supposed to until they arrive. (RM7).

Participants highlight the value of networks for gaining knowledge. Managers working for larger providers refer to an infrastructure involving a central office within their organisation for communicating knowledge; whereas participants in smaller businesses spoke highly of a Local Authority-led and a Provider-led local network for knowledge sharing about practices and preventing professional isolation. We identified geographical variations across the South West in the support available from local authorities, general practitioners, district nurses, social workers and regulators. DM5 describes their difficulty accessing training for staff from health professionals, whereas RM16 values a local authority team supporting their home through visits, networking events and training, "I think that makes a difficult job a lot easier" and OM18 highlights, "The other people that helped me a lot was the hospice, they were fantastic, and the nurses give a lot of training." In addition, OM18 and RM2 actively sought support from independent consultants to gain knowledge and help improve their care practices.

A lack of formal continuing professional development for managers who had been in their role a long time was perceived as a significant challenge, regardless of the size of the Provider:

If you've got those sort of qualifications, yes you're sought after and head-hunted, but it stops then, and it's really hard to get more qualifications 'you're qualified enough' although the [regulators] want to see that you are trying to progress and learn more...

It's just really hard and a bit disheartening really. (RM1).

Some participants questioned the adequacy of their management qualifications for preparing people for the role stating they do not address business and people management (and development) skills sufficiently. They emphasise a need for formal learning to be complemented by "on the job experience" and supportive organisational structures. Deputy managers may differ in their knowledge needs with a greater emphasis on operational management skills whereas registered managers or owner-managers require both leadership and management. The support of owners and directors was viewed as crucial for developing a manager - particularly for those working in small businesses where an owner's support is vital. The worth of knowledge gained from training varied and we identified 'training waste' where courses were undertaken but a participant did not think they gained from attending or they could not use the knowledge. For example, one manager trained in an advanced course when caring for people in their own homes was unable to use this in their residential role. Two knowledge needs were highlighted in our analysis when responding to situations when people's behaviour living in care homes is perceived as sexually inappropriate or aggressive:

We don't really get any training to deal with that sort of [physical] violence. Usually, if a member of staff said, 'So-and-so's shouting and slapping out' I would say, 'Walk away, back off.' (RM6).

3.1.2 | Research knowledge

Our analysis indicates limited reference by participants to using research evidence which is often gathered systematically and provided in reports, articles and evaluations (Walter, Nutley, Percy-Smith, McNeish, & Frost, 2004). Research knowledge was used tactically to defend care practices within the home - particularly to regulators - or persuading owners and staff to make changes. Participants refer to an openness to research and being proactive:

To be a strong manager you have to be willing to research, you have to be willing to take time out to read. (RM07).

A few participants report their homes were involved in university-led studies and their experience was generally perceived as positive. We note reservations about the applicability of research knowledge to care work, how much knowledge is needed to change practice and the importance of research knowledge compared to other types:

Again, what I find frustrating with research, how they come over ... be realistic, don't talk about things that you haven't experienced ... come to our home, spend

a day, look what happens, follow us around. Then you have a real taste of what it is. (OM18).

A study that I read recently, and I am tempted to believe it, although I never believe anything I read without cross-referencing at least three or four other things and testing it myself ... but the consensus of what we do is as valid as what a researcher does in a laboratory with a white coat. (OM15).

One benefit to using knowledge is to project a professional and credible reputation as a Provider as OM18 states:

When you show [research] knowledge, you're not just making up nonsense, then it makes all the difference ... why you are using a plate with a rim, not just because it's pretty. (OM18).

Finally, the benefits of undertaking a research project in the management qualification for developing critical analysis skills, gaining new insights and observing practice more closely to improve understanding of how to make changes to care practices was highlighted:

Maybe the [highest qualification] helped me a little bit because we had to do a research project and this makes you study and think a bit more. (RM17).

3.2 | Tacit knowledge and phronesis

In our analysis of participants' accounts, we identified importance given to first-hand knowledge of care work that tends to be tacit, personal and context-specific (Walter et al., 2004). This 'know-how' is hard to articulate and enables managers to adapt, select and shape their environments to achieve their goals (Nestor-Baker & Hoy, 2001). This is illustrated in the emphasis given to 'doing' management:

I'm going to be completely honest, the [management qualification] didn't help me a lot ... it's just a diploma which helps you to move forward ... I think I learn more from practice. (RM17).

I think you need to have quite a lot of hands-on experience and I feel because I've done it for so long it's really given me a good grounding to actually be able to answer questions to families...I think you need the experience to be able to have compassion and empathy. (RM3).

Particularly important is knowing the home and people living there as RM16 states 'I very much like to know my home and what's

happening.’ Of similar importance was striking a balance between being ‘hands-on’ and ‘hands-off’ care practices:

I do work on the floor sometimes and help the girls out which is very good, they can see me getting in there and doing - I don't ask them to do anything that I wouldn't do myself and I feel that's actually quite important. But also you've got to be very careful that you don't end up working on the floor all the time, 'cos actually no-one does my job. (RM8).

We identify the role of phronesis, “know-when”, from participants’ accounts and the application of generic knowledge to a particular situation or case. This knowledge is oriented toward action and is pragmatic, variable, and context-dependent emphasising practical wisdom, professional judgement, values, beliefs, morals and ethics (Flyvbjerg, 2001, 2006; Ward, 2017) as illustrated below:

With the gentleman, they're [staff] are all saying he is a problem, he shouts a lot, he's rude to other residents. But I don't see him as a problem, I see a man that's been in the hospital for four and a half months, he's come somewhere new and he needs reassurance ... he's a lovely man. I'm saying to them when you talk with him, joke with him, he's a very jokey man ... so for me it's learning more about residents because you're always learning. (RM06).

Such knowledge can be shared in less formal ways to enable collective care practice:

I hope this doesn't sound arrogant, I actually feel that I am becoming wiser, might have taken a long time [laughs] and I feel I can be quieter in that wisdom and pass it on better. (OM19).

3.3 | Emotion

This theme captures the ‘know-feel’ component of knowledge needs and use by managers to optimise people's experience of living, and working, in a care home. This idea links closely with the concept of emotion work defined by Bolton (2005 p. 50 cited in Clarke, Hope-Hailey, & Kelliher, 2007) as, “the act of attempting to change an emotion or feeling so it is appropriate for any given situation” for the benefit of others. In our analysis, participants emphasise knowing their staff members’ emotional wellbeing which may impact on residents’ lives:

Oh, and being a counsellor, because I know every staff member's problem going on ... and what we can do to support them. (RM3).

TABLE 2 Nestor-Baker and Hoy's (2001) tacit knowledge types and managerial success

Type of tacit knowledge	Definition
Managing people - interpersonal	Knowing how to work with and direct the work of others
Managing tasks - organisational	Knowing how to manage and prioritise day-to-day tasks
Managing self - intrapersonal	Knowing how to maximise one's performance and productivity
Managing career - reputation	Knowing how to establish and enhance one's reputation

You've got to have happy staff to have happy residents. (RM10).

The importance of knowledge of whether they are providing a homely environment was identified by participants managing small and medium-sized homes:

Many people come in and say we're a friendly home. That's important - like people going into your house and saying, 'I really enjoyed coming and visiting you', and that's great. (RM1).

I think a good home is where you actually feel welcome, you feel warm and you can see good interactions and the residents seem happy and content. (RM16).

Our participants, particularly those working for small businesses, held positive views of the autonomy in their role, however, they all describe high levels of accountability, pressure and vulnerability:

A lot of people have said they wouldn't want my job... because of the responsibility, because the buck stops with you ... [regulators] come in and they chat to your staff but it still reflects on the manager. One of the sections is 'Is it well-led?' that's more or less your manager and how your staff are looked after and supported. So it's a pretty hard role ... when you're on your own it's a very isolating job. (RM1).

Alongside this is knowing that state of one's wellbeing which may impact on the ability to do the job well:

I think when that empathy stops, that's when my job should stop. I don't think of care as just a care job. (DM5).

I'm slowly disengaging from this, I don't expect to be doing this for much more than another year as I can't keep going for my sanity or wellbeing. (RM2).

Our analysis further explored how managers obtain emotional support. Participants described gaining this within the care home by talking to others (administrators, senior managers, directors and owners), outside (family, other home managers and leaders) and from leisure activities such as creative writing, pet ownership and physical activity. A few participants describe additional needs for coping with emotionally-demanding situations such as when a resident dies. Knowledge of one's emotional wellbeing and the staff working in the home informs participants' approach to implementing changes:

[Be] open to change, don't be frightened of change. You have to be positive, show a happy front, even when you've got other stuff going on, whether it's personal or it's work-related pressures because that will stress the team out as well. (RM3).

4 | DISCUSSION

We sought to understand how care home managers view their knowledge needs and use for improving practices to benefit older people living in care homes, identifying themes informed by existing conceptualisations of knowledge - explicit knowledge, tacit knowledge and phronesis - and additionally emotion.

Our analysis suggests abundant sources of explicit knowledge - "know-what" - are available to managers with varying quality. For managers who've been in their role a long time, we note issues with accessing continuing professional development activities. Generally, inconsistent opportunities for support and development were perceived across the region, within the sector and from regulators or the wider health and social care system. Our finding extends earlier research identifying challenges in supporting a sector that has a wide range of Providers and knowledge users with varied access to libraries, technology, and training and development budgets (Rutter & Fisher, 2013). Consequently, further work to address how to engage managers in research (Smith et al., 2019) and improve the relevance and usefulness of research knowledge would be beneficial. As Nutley, Davies, and Hughes (2019) argue, there is a need to be realistic about the extent to which research-informed recommendations will be compelling in a sector where tacit hierarchies of evidence may look very different from explicit methodological and technical hierarchies. Particularly because of the significant influence of factors such as context, acceptability, practicality, feasibility, personal experience, pre-existing schemas, power relations, politics and emotions. For some areas of care there is a scarcity of good quality research evidence to inform practice and so certainty around 'what works' might not be easily ascertainable (Rutter & Fisher, 2013). We identified one area, developing efficient research search and retrieve skills, which may be beneficial for managers.

The practical experience of doing care management work - "know-how" - is highly valued. Our findings resonate with previous

research concluding that many of the skills needed within care homes are tacit, difficult to codify and are picked up through the experience of doing the work (Himmelweit, 1999; Sandvoll, 2017). This does not mean that explicit knowledge is not important but it is unlikely to be viewed as sufficient to ensure optimal care practices. A potentially relevant concept is 'mindlines' from Gabbay and le May's (2004) study of mobilising evidence-based knowledge in general medical practice. 'Mindlines' are collectively-reinforced, internalised, often tacit guidelines informed by brief reading, practitioners' professional interactions with peers, building on their early training, and practice-based experience. Important for supporting managers is identifying how and when the knowledge of key opinion leaders, to whom they may turn to, can be informed by research evidence.

The role of phronesis was valued and this knowledge was used by managers to inform their actions in particular instances in a manner which is consistent with the concept of person-centred care (Edvardsson, Winblad, & Sandman, 2008). This highlights the importance of 'know-when' to changing care practices involving values, professional judgement and ethics in this process. Furthering the understanding of how tacit knowledge and phronesis is used by managers would be useful; building on work such as Nestor-Baker and Hoy's (2001) typology summarised in Table 2.

A significant theme from our research is the emotional work and knowledge - 'know-feel' - used in the management role and making changes to practices. This involves recognising and responding to the emotional needs of people living, and staff working, in care homes and being astute to their wellbeing. This raises questions about how support is provided in the sector and the high level of self-sufficiency which could leave some managers isolated. This has similarities with other roles such as head teachers, prison governors, and general practitioners. Our findings support previous work recognising the significance of people's leadership and management styles for developing emotional authenticity and meaningful relationships within care homes (Lopez, 2006). Managers are likely to require high levels of emotional literacy and intelligence (Salovey & Mayer, 1990; Steiner, 2003; Steiner & Perry, 1997) to monitor their own and others' emotions and mobilising this knowledge to guide their actions and build a community to benefit people living in care homes.

4.1 | Strengths and Limitations

A strength of our study is investigating an under-researched topic by focusing on the views of managers and leaders working in care homes. Our study could be strengthened by including observations of practice, other staff group views and involving older people living in care homes. All the homes at the time of data collection were rated by regulators as 'good' or 'outstanding', although four homes had recently dealt with care practice issues. Our findings may not transfer to care homes requiring significant improvement or to contexts that are more populated and ethnically diverse than included in this study.

4.2 | Implications

We identify four key implications. First, optimising explicit knowledge use through improving the relevance and use of research knowledge in care home settings. The diversity within the sector of Providers and users means there is unlikely to be one single approach to the creation and dissemination of research evidence and so using a variety of knowledge mobilisation techniques is needed such as creative science communication, knowledge brokers, co-producing research and supporting practitioner research (Gladman, Conroy, Ranhoff, & Gordon, 2016; Lightowler, Stocks-Rankin, & Wilkinson, 2017). Second, enabling managers to bring tacit knowledge to the surface, articulate, share and critically appraise to support and enhance innovative care practices (Khotari et al., 2012; Pawson, Boaz, Grayson, Long, & Barnes, 2003). This includes creating the time and space to critically reflect on and discuss practice - and tacit - issues through methods such as reflective groups and appreciative dialogue to facilitate practice development (Sandvoll, 2017). Third, although there are perceived benefits to the high levels of autonomy some managers' experience further empirical work is needed to understand optimising support for their wellbeing and the emotional work they undertake. Finally, developing approaches for the various knowledge types - 'know-what', 'know-how', 'know-when', 'know-feel' - to integrate rather than compete (Boaz & Nutley, 2019; Salter & Khotari, 2016) to enhance the quality of life of people living, and staff working, in care homes.

5 | CONCLUSIONS

Our thematic analysis of managers' knowledge needs and use for implementing changes in care homes identified that having knowledge, particularly tacit and phronesis, and being knowledgeable are highly valued by our participants. We note challenges to the perceived usefulness, relevance and applicability of research knowledge and highlight the significance of emotions drawn on and used by managers in practice. Implications for optimising knowledge use include improving the use of research knowledge through a variety of knowledge mobilisation techniques; supporting sharing and reflection of practice knowledge; further research to optimise emotional wellbeing support; and developing approaches to integrate the various knowledge types to benefit older people living, and staff working, in care homes.

ACKNOWLEDGEMENTS

The authors thank the participants for sharing their time, views and experiences, the staff who helped to identify people to invite to participate in the study and those who helped to make sense of the data. The authors also thank Dr Rebecca Hardwick and Geoffrey Cox for their thoughts and suggestions on a draft of this manuscript.

This is independent research funded by the National Institute for Health Research Applied Research Collaboration South West Peninsula. The views expressed in this publication are those of the authors and not necessarily those of the National Institute for Health Research or the Department of Health and Social Care.

Due to ethical concerns, the research data supporting this publication are not publicly available.

CONFLICT OF INTEREST

All co-authors confirm that we have no conflict of interest to declare.

AUTHOR CONTRIBUTIONS

All authors contributed to study concept, design and data interpretation. JD and IL contributed to data collection and analysis. JD drafted the manuscript and authors SD, NR, JH and IL provided input and revisions. IL supervised the study. All authors read and approved the final manuscript.

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How to cite this article: Day J, Dean SG, Reed N, Hazell J, Lang I. Knowledge needs and use in long-term care homes for older people: A qualitative interview study of managers' views. *Health Soc Care Community*. 2020;00:1–10. <https://doi.org/10.1111/hsc.13162>