

Exploring Oral Medication Administration From the Perspective of Older People in Scottish Care Homes: A Hermeneutic Phenomenological Study

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Helen Davies, NursD, MSc, MEd, BSc (Hons)¹ , Karen Watchman, PhD, MSc, BA (Hons), PG Cert¹  and Louise Hoyle, PhD, MSc, BNurs (Hons), PG Cert¹ 

Abstract

Introduction: Older people in care homes experience multi-factorial problems when being given oral medication. Practices of modifying tablets, crushing and mixing with food, in attempts to administer medication, remain widespread globally. Care home routines are time-pressured, and there are incidences of disempowering practices and language associated with processes of medication administration. Evidence in this field reveals very little from the residents' experience, representing this group as passive recipients of medication.

Objective: The aim of this research was to explore, for the first time, the experience of residents of care homes for older people at the point of receiving support from care staff to take medication.

Methods: Observation of medication administration and semi-structured interviews were conducted in Scotland with eight residents between the ages of 84 and 95 living in three care homes, therefore including a perspective and a participant group often neglected in research. Data was analyzed in accordance with a philosophy of hermeneutic phenomenology, with a commitment to understanding the participants' experience.

Results: Three major themes emerged from the data: "being in control/relinquishing control," "being comfortable in routine," and "trusting." Interpretive exploration of these themes revealed the importance of facilitating individual routines when taking medication, and that a trusting relationship with staff can be an indicator of vulnerability.

Conclusion: The risks to autonomy in relation to taking medication, and an imbalance of power for care home residents who are given medication to take, emerged as an overarching concept. Recommendations for practice focus on the potential for empowering practices in relation to taking medication.

Keywords

medication administration, long-term care, resident experience, empowering practice, hermeneutic phenomenology

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Introduction

While there are differing models and terminology used to describe long-term care facilities globally, between 2% and 5% of older adults worldwide receive 24-h care in an institutional setting (Burton et al., 2017). Care home residents in the United Kingdom have profound levels of dependency, multimorbidity and cognitive impairment, increasing over the past 20 years (Barker et al., 2021). The overlap of physical and mental health disorders, with attempts to manage multiple concurrent diseases and symptoms, can lead to the issue of polypharmacy.

Older people in care homes are prescribed large quantities of medication (Guthrie et al., 2015), and while the prevalence

of polypharmacy in the United Kingdom is beginning to show signs of decline, global trends are increasing (Lee et al., 2023), with the most dependent residents having the most complex medication regimens (Chen et al., 2019). The time taken for, and difficulties with the administration of large quantities of medications, can be burdensome, particularly when the medicine round dominates the morning and

¹University of Stirling, Stirling, UK

Corresponding Author:

Helen Davies, University of Stirling, Stirling, UK.

Email: helen.davies32@nhs.scot



interferes with more pleasurable activities, including eating, drinking, and social interaction (Kelly et al., 2009). This is a multi-disciplinary challenge which is not readily positioned within a single professional group (Kelly et al., 2010). Instead, there is relevance to pharmacy, geriatric medicine, general practice, nursing, and social care.

What is “Administration of Medication”?

When a resident is unable to take responsibility for managing their medication, staff need to ensure that the person is given the correct medication, at the correct time, in the correct way. This is termed “medicines administration,” as is defined by the Care Inspectorate, the Royal Pharmaceutical Society Scotland and Social Work Scotland (Care Inspectorate/Royal Pharmaceutical Society/Social Work Scotland, 2015):

Administration of medicines is one, all, or a combination of the care worker doing the following:

- Deciding which medicine(s) have to be taken and when this should be done
- Being responsible for selecting the medicines
- Giving a person medicines to swallow, where the person receiving them does not have the capacity to know what the medicine is for or identify it.
- Giving medicines where a degree of skill is required to be exercised by the care worker to ensure it is given in the correct way.

Guidance for practice in the UK centers on procedures and policies for storage and record-keeping, safety checks and risk assessments and does not incorporate the perspective of the residents themselves (Care Inspectorate, 2012; NICE, 2014; Royal Pharmaceutical Society/Royal College of Nursing, 2019).

Review of Literature

Altering of medication, such as crushing tablets or mixing with foods, to facilitate the administration of medicines to older people is widely reported from care homes in parts of Europe and Australia (Forough et al., 2020; Garratt et al., 2021; Solberg et al., 2021). Jani et al. (2022) found that almost half of the solid medication given to care home residents was not able to be taken as intended, requiring breaking into pieces or mixing with foods. Staff feel pressured to find ways to ensure that medication is taken (McGillicuddy et al., 2017). The routines of care home life can result in a time-pressured environment where medication administration may be delegated to staff who do not know residents well (Odberg et al., 2019) and are required to support several residents at once (Qian et al., 2018). Residents are portrayed as disempowered, playing a passive part in being given medication (Damiaens et al., 2022, Hughes & Goldie, 2009, McGillicuddy et al., 2017). The assumption that none of the

residents can speak for themselves (McGillicuddy et al., 2017) contrasts with the law (Scottish Executive, 2000), which encourages individuals to exercise residual capacity even if they are cognitively impaired. This places a responsibility on professionals to make efforts to enable a person to exercise self-determination wherever possible. The supervised administration of medication has been defined as “enforced compliance,” where residents cannot opt out even if they wish (Hughes, 2008). Reporting of residents’ opinion in this field has to date been limited to small elements within studies with a wider focus (Damiaens et al., 2023; Hughes & Goldie, 2009), but has identified an attitude of resignation of residents towards their lack of involvement in the process of medication administration.

Theoretical Framework

The principal gap in knowledge is the experience of the care home resident. This voice is either absent or represented passively in the literature. Our research was designed to answer a single question, “what is the experience of residents of care homes when medication is administered” and took a hermeneutic phenomenological stance, placing the resident firmly in the forefront. Creswell (2014) defines phenomenological research as describing the lived experiences of individuals about a phenomenon, as described by participants themselves. Hermeneutic phenomenology rejects the notion that a researcher can suspend personal opinion and accepts that all description is essentially interpretation. Thus, a proactive approach to reflexivity was adopted as integral to the conduct of this study (Spence, 2017). The lead author was interviewed at the start of the study to establish her beliefs and biases towards the topic, and a reflexive research journal was kept throughout, maintaining transparency in acknowledging such potential influences on the data (Biggerstaff & Thompson, 2008).

Methods

Data collection commenced in February 2020, with recruitment halted by the COVID-19 pandemic, and was completed between May and September 2021. Eight residents between the ages of 84 and 95 were recruited from three care homes providing long-term care in Scotland. Participants were identified by purposive sampling (Dibley et al., 2020). Inclusion criteria (Table 1) maximized the potential for any resident to take part if they had the capacity to consent and wished to do so.

Ethical Considerations

Capacity to consent to participate was a key inclusion criterion. A diagnosis of dementia or known cognitive impairment did not preclude the capacity to consent. Ethical approval was granted for the lead researcher to assess capacity using the

Table 1. Inclusion and Exclusion Criteria for Participants.

Inclusion Criteria	Exclusion Criteria
Residents of care homes for older people, who are administered oral medication by care home staff.	Residents who are able to administer their own medication.
Ability to communicate in English.	Residents who cannot communicate in English.
Capacity to give informed consent to participate.	Residents who lack capacity to give informed consent to participate.

UBACC tool (Jeste et al., 2007). Participants who were unable to write were enabled to give consent verbally, witnessed by care home managers.

Reliance on assistance from staff was inherent to the conduct of the study, and careful coordination was required to ensure that an appropriate time was built into the day for participants to take part without causing detriment to their care or the care of other residents. Participants were not excluded on the basis of being unwell or in a terminal phase of illness. In the context of a care home, this is a likely occurrence, and individuals in these situations are typical of the study population. The lead researcher is a specialist nurse with extensive clinical experience in this field and was vigilant to avoid unnecessary distress throughout.

Data Collection Methods

Two methods were used for data collection: observation and interview. Administration of medication in care homes is highly individual to each resident. Due to age and co-morbidities, potential was recognized for residents to exhibit a range of practical challenges, whether postural problems or swallowing difficulties in addition to personal preferences. The purpose of the observation element in this study was not to describe problems, which have been previously demonstrated in the literature, but instead as part of the process of gathering information from within the context of the care home environment. In contrast to previous research

in this field (Garratt et al., 2025), the focus was clearly defined away from observing individual staff practices, and instead towards achieving an holistic understanding of the lived experience of the resident while they were being supported to take their medication. While observation is not often used within phenomenological approaches, it can be justified if it is used as part of the experiential analysis of the situation (Van Manen, 2016). An unstructured, open approach was used, with a single episode of administration of morning medication being observed for each resident as it unfolded, in whatever was the usual location for the individual (Punch, 2014). Five participants were observed in their personal rooms, while three were in a communal dining area. Descriptive notes about the act of medication administration were recorded at the time, alongside the researcher's reflexive notes. The duration of the observation varied in accordance with how long it took each participant to take their medication, ranging from 2 min to 45 min.

A single semi-structured interview was conducted with each resident after they had received their medication, with questioning designed to engage the participants in describing their experiences, drawing out what was important to them without directing or leading to an expected answer (Dibley et al., 2020). An interview guide (Figure 1) was used flexibly to prompt conversation; the first question was used as an opening, with subsequent questions used as needed, encouraging respondents to lead the way, telling their own stories.

The interviews were digitally recorded and transcribed. Non-verbal communication, such as gesture and facial expression, were recorded as annotations on the interview schedule, and added to transcripts where they contributed to a representation of the resident's experience.

Data Analysis

The process of analysis in hermeneutic phenomenology is not linear, but is a back-and-forth movement between pre-understandings and the new evidence which has been gathered, gradually revealing meanings (Dibley et al., 2020). Systematic frameworks of analysis are paradoxical to the philosophical background; however, there is

Tell me about how you had your medication today
 Can you tell me more about that, describe the stages in what happens?
 Tell me what the staff do when they help you with the medication?
 And what do you have to do?
 Can you describe a time when taking your medication was difficult
 Can you describe a time when taking your medication went well
 Do you have any other stories to tell about taking your medication since you have been here?

acknowledgement that a “non-methodical method” (Van Manen, 2017, p. 820) is needed to support the process of gaining insight into the phenomena, while maintaining an open perspective. Such a framework is provided by Dibley et al. (2020), and this gave structure to the analysis. It is described as a series of steps, but its conduct is iterative. A summary of the process of analysis is illustrated in Figure 2.

Openness, concreteness, and resonance are key to expressing rigor in a hermeneutic phenomenological study (De Witt & Ploeg, 2006). Openness was evidenced throughout the analytical process by meticulous record-keeping, from raw data, through analysis and interpretations. NVivo was used as a data management tool to provide an audit trail of analytical processes over time. Extensive notes were made as interpretations developed. Concreteness reflects the relationship between the findings and the real world. The findings are presented in an understandable format, so that the reader can appreciate and relate to the situation within the participant's world. The participants' words are used extensively, with commitment to their experience at the core. Resonance refers to the impact that the findings have on the reader, the extent to which they make sense and are meaningful. Sufficient excerpts from the data are presented to present a credible account which makes sense to a reader, who will go on to make their own interpretations (Crist & Tanner, 2003). In hermeneutic phenomenology, there is an appreciation that achieving data saturation is fundamentally impossible (Dibley et al., 2020). The researcher does not aim to provide a definitive answer of “this is what this experience is like for everyone” (Dibley et al., 2020, p. 61). Each individual's experience brought different insights which was the intention, rather than continuing until no new information was identified.

Results

Participants were allocated pseudonyms as an aid to reading and to reinforce individuality (Vandermause & Fleming, 2011). See Table 2 for additional demographics.

Three main themes emerged:

1. Being in control/Relinquishing control

Early in the analytical process, a code of “autonomy” captured some of the recurring expressions of “I can do it.” Participants spoke of what they took control of, in relation to taking their medication. An opposing theme was named “helplessness.” In continuing to work with the data, it became clear that there was a fragile balance between the two. They were not polar opposites, but a continuum, with a series of steps along the way. Four distinct threads expand thinking on this theme.

Knowing What I am Taking

Knowing what their medication looked like in terms of numbers and shapes of tablets was important to several of the participants, demonstrating some element of control over the process. Medication was prepared out of their sight, but it was important to them to check the contents themselves. Annie said, “*I just pick the smallest one and put them in... And then... take the bigger ones at the end. And then I get the two at lunchtime, and just have them, where I get more in the morning.*” Annie looked out especially for the smallest one first, and her carer pointed out the “*wee diddly one*” to her as she tipped the pot of pills into Annie's hand so that Annie could be sure it was there.

Barbara was almost blind. Staff helped her by putting the tablets in the palm of her hand, but she exercised control during the process of carefully picking them out one by one, checking and counting as she went to be sure that it all felt like it should. She said, “*I can tell the sizes and the shades of colour, so I know each one as I am picking them up.*”

Marion knew the pattern of what she took, picking up her pot of tablets to look at the contents twice, checking that all was as she expected it. Afterwards, she checked again that the pot was empty.

Renee perceived changes in her medication, saying,

Sometimes they give you a different medicine, it just looks different, or its shaped different. That throws me slightly... You do it for a couple of months, and you don't think anything of it, and then suddenly somebody comes along, and gives you tablets, and you have to say to them, 'what are they?', because you're not sure what they are. Well, I do. 'Cause I like to know what I'm taking.....The only thing that, it does niggle, cause I like to know what I'm shoving down my mouth.

Having a Sense of Achievement

There were several references to a sense of achievement when taking tablets. John told me,

I've been doing that for the last two years now, and I find that's the most... easiest way. It works for me, it wouldn't work for anyone else, probably, but it's the only way it works for me now. I feel most successful that way. That's the way I do it, the way I find easiest.

Residents were congratulated after taking their tablets, as if they had overcome something challenging. Annie's Carer said, “*Gone? Well done!*,” when the tablets had been swallowed. Donnie felt that he managed his medication by himself, “*No problem. They didn't really have to help, I can manage it myself.*” Morag had a severe tremor and postural difficulties, being unable to lift her head. She undertook an intricate procedure to take her tablets. However, when interviewed afterwards, she said, “*I just pop them over. It's easy*

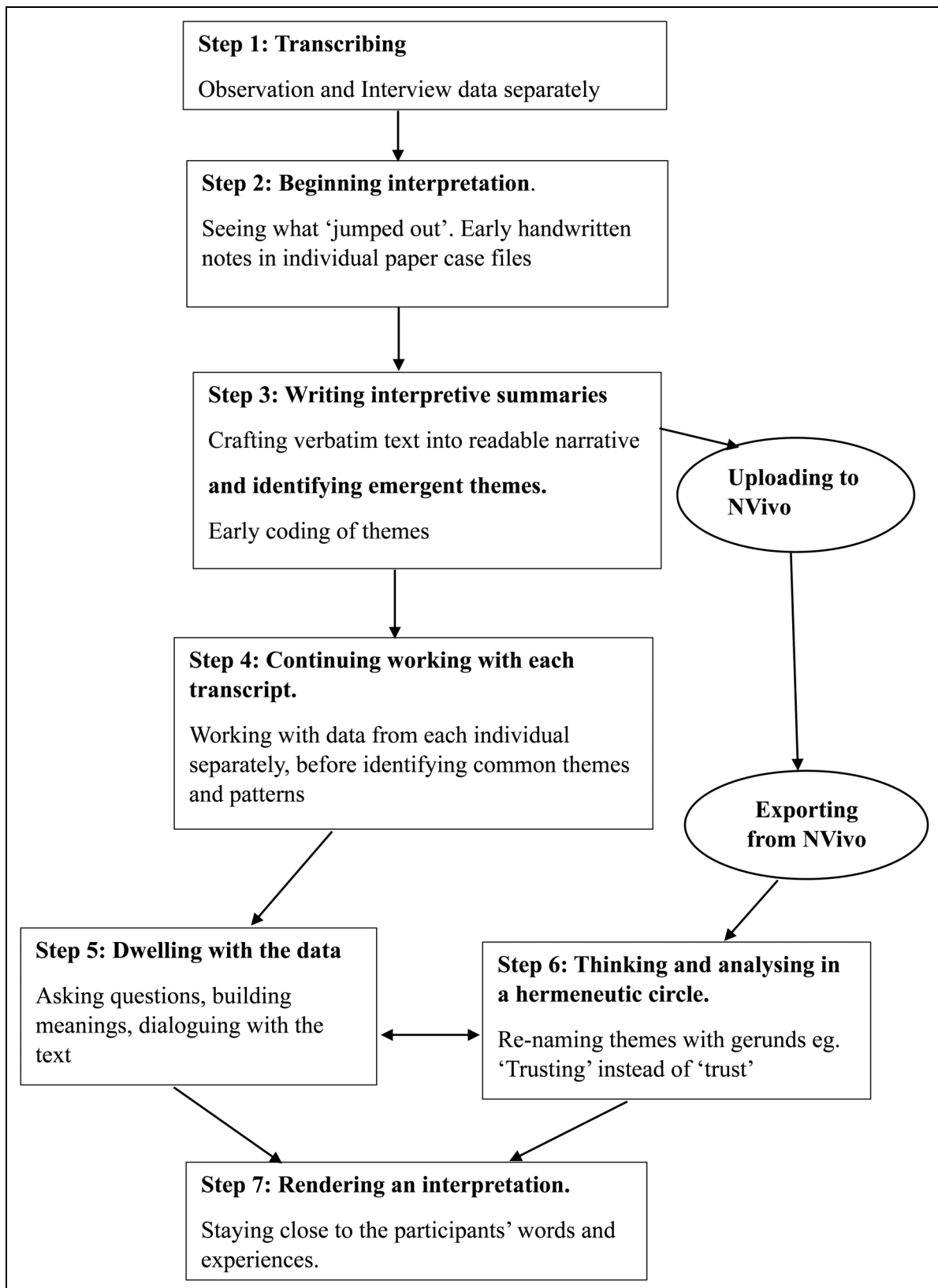


Figure 2. Summary of the process of analysis (adapted from Dibley et al., 2020).

Table 2. Characteristics of Participants.

Allocated Name	Age	Gender	Care Home
Marion	85	Female	A
Norman	94	Male	A
Barbara	87	Female	B
Morag	88	Female	B
John	86	Male	B
Annie	95	Female	C
Renee	84	Female	C
Donnie	85	Male	C

enough for me. I don't think it's difficult to manage." Marion used the phrase, "I can manage, I can manage, fine." She stressed how she could manage, and she could, leading to the question when observed of whether she could manage the whole of the administration of her medication by herself?

Letting go of Control

Based on existing evidence, it was expected that the participants would always want to do things for themselves if they were able to do so. As data analysis continued, this became less clear. Some described voluntarily relinquishing control, and that this was a relief to them. Donnie said, "They've got all my medication there. They just give me it, and I swallow it." He came across as accepting of his situation, maybe resigned, but perhaps because he felt secure. John compared how things were different from how they were when he was at home,

They set them, put them in the container for me.... Quite frankly I don't know what they're all for, but I take what they, they know what they're giving me. It's so much better. I wouldn't go back to that again. I'd never manage that now.

Annie used the word "feed" twice, which seemed a particularly passive term. Sometimes they "feed" the tablets to her, when she was quite capable of "feeding" herself. It appeared from observing her that she was really very capable and perhaps could have taken responsibility for the whole process of self-administration of her medication. It was not clear if this choice had been offered to her, or perhaps she had chosen to hand over the responsibility. Resigning responsibility for something, in exchange for a feeling of security and comfort, may have been an active choice, an exercising of autonomy in itself and not a straightforward loss of control.

Losing Control

There is a distinction between acceptance of being given medication and a defeated helplessness, which is more negative and was expressed by some of the participants. Control had been relinquished, and not always voluntarily. Norman

felt it was a lack of respect to have the tablets taken away from him, "You feel like you are no longer in control of your own activities, and dependent on other people which you've never been all your life, it's very difficult."

Morag described when her tablets had been changed, but she did not understand why, "Oh dear no, probably to discover this, that and the next thing. Yes, well I don't know, I let them get on with it ... and it was a bit annoying to myself it was." Feelings came across of passivity and loss of control, but then also with a spark of annoyance in her voice.

Renee placed herself in a subordinate position, saying "I fall in line with whatever it is they give me, 'cause I have to, and they know better than me." She described some of the difficulties she had with swallowing her tablets, but made a conscious decision to not let it trouble her, "But they don't bother me to any great extent. I don't let them anyway.... (laugh). It's no use, it's just a waste of space, a waste of time, I think...." She struggled to manipulate the little medicine pots in her arthritic hands, saying,

Those pots are a pain, because they are so tiny, you don't have much room for manoeuvring them. My hands are very stiff first thing in the morning. The glass is a lot bigger, sometimes, it feels too big, so it's just... You feel as if you are being a pest, well I do, you know....

It was manifest that being given medication was an unpleasant experience for Renee. Both her language and non-verbal expressions demonstrated that she found the experience a burden.

2. Being comfortable in routine

Observing morning medication was inextricably merged with breakfast routines. For some participants, it seemed an oddly public activity, with residents sitting at meal tables and the medication administration going on around. Perhaps medication was not seen by staff as a confidential issue. Donnie was alone at a breakfast table. The carer fetched his medication, saying, "I've got you some water." She tipped a little pot of pills altogether into the palm of his left hand. He had his upturned palm out ready, showing that he knew what to expect. He didn't even look at the tablets in his hand at all, just put them in his mouth.

Annie was given her medication in her room. She was up in a chair in her dressing gown, with breakfast in front of her. The television was on loudly, positioned between Annie and the carer who was preparing her medication. Annie was watching the morning news while she ate her breakfast. She appeared to just enjoy the routine, and the security of it all. She knew the pattern of the tablets she expected, and she enjoyed the way things are done, telling me, "I've really quite enjoyed the routine."

Marion said, "I have my breakfast before I take my tablets, once I'd finished my toast, I take them." She had a meticulous

routine, slow and steady, alternating each of her eight tablets with a drink. The whole practice of taking medication was an important part of Marion's day, seeming to be an enjoyable routine, something important for her to take part in. Barbara was blind, and although the carer said very little throughout, Barbara appeared to be comfortable with the routine without any verbal explanation of what was happening.

In contrast, Norman related an experience when his routine was disrupted,

My second dose of tablets, I usually get about 6 o'clock. Two or three nights ago I was wakened at half past 9 at night, by the girl who'd forgotten to give me my afternoon dose. You're waiting for it, there's no harm done. They're not all as meticulous, And that can be a bit frustrating.....It's a long day, and you tell yourself.. they'll come eventually, but, when you're waiting for somebody and they're not showing up, it can be very frustrating [raises his hands in a sort of shrug]. When you've nothing else on your mind but when your next tablets are coming, it can get very frustrating.

Likewise, it was a change in routine which "threw" Renee, as demonstrated in Theme 1. When the appearance of her tablets changed, she experienced anxiety and a loss of control over the process of taking her medication. A predictable routine helped her to keep hold of that feeling of control.

3. Trusting

There is a huge amount of trust in accepting medication prepared by another person, usually unseen. Several of the participants described trust explicitly, and observations supported the existence of a trusting relationship. Barbara demonstrated trust in the staff, putting out her palm for her tablets, believing that she is being given everything properly. She said, "I trust the staff. I used to know exactly what I was taking, now I find that I cannot recall the names, but I know they will be right." Donnie did not even look at his tablets in his hand at all. They were tipped in his hand and into his mouth in such a way that he could not have been aware of what he was taking.

They could be poison maybe and I wouldn't know it. (laughter). It doesn't bother me.... I know they'll not give me anything that'll harm me. I'm quite content to take the tablets as they give me them.

The way in which John took his tablets provided a visible demonstration of a trusting relationship. He made a single swift movement from pot to hand to mouth to swallow them. He had absolute trust in the carer, saying,

They set them, put them in the container for me, what I have to take..... I trust them. Oh absolutely, I absolutely trust, that what they give me, I trust them implicitly... it's so much better.

Morag also said, "I just take it for granted that they know just what they're doing."

Marion and Norman also described the building of a relationship of trust between themselves and their carers, being trusted to take their own medication unsupervised. Norman described how the staff left the tablets on his table for him,

They don't do that with everybody, they do that with me because they trust me, some people have to be watched and supervised... But M (named carer) knows that I won't slip up.

They both described this as an achievement, a positive fact about their self-efficacy.

In summary, the analysis brought to light an interwoven pattern of themes in the experience of these care home residents. There was a fine balance between keeping some control over the process, finding individual ways to manage the physical aspects and keeping track of what was being taken, to handing over that responsibility and sometimes having responsibility taken away. The routines of care home life around taking medication contributed to a feeling of security, and in some ways facilitated the ability for residents to maintain control over aspects of taking their medication. A trusting relationship with the staff was clearly important to the participants.

Discussion

Trust as an Indicator of Vulnerability

Initially, the theme of trust may be perceived as a positive feature, with connotations of comfort and safety. However, analysis highlighted that a trusting relationship between residents and staff may be founded on the residents' position of powerlessness. Trust is a response to, and a way of managing vulnerability (Gilbert, 2020). Gilbert argued further that the act of conferring trust actually increases the trustor's vulnerability by making them more dependent on the trustee. This vulnerability intrinsically implies asymmetry in the relationship. Gilleard & Higgs (2017) describe this in terms of an imbalance of power, with residents being unable to resist the institutional systems of governance in the home. In effect, there can never truly be a choice to trust (Brown & Meyer, 2015).

While trust has been regarded as the foundation of any therapeutic relationship, Dinç and Gastman (2013) suggested that training for nursing staff should include developing an awareness of the nature of trust, ensuring that nurses understood that trust inherently involves vulnerability and dependency on the part of the people for whom care is provided. No literature has been identified in relation to training about trust for social care staff who may be less aware of this power imbalance in their relationship with residents. Care home staff are accustomed to negative stereotypes and may not see themselves as powerful (McGilton et al., 2020).

Demonstrating Autonomy in Taking Medication

All the participants talked about what they could do for themselves when taking their medication. Using two methods of data collection was a valuable approach because, at times, observation revealed that participants were not as independent as they wished to portray themselves in the interview. However, even the two residents who were the most physically impaired stressed the elements that they were, or were trying, to remain in control of. The expressions of self-efficacy from the residents in this study contrast sharply with previous evidence where assumptions were made by staff that the residents in their care did not have any opinion about taking their medication (Hughes & Goldie, 2009; McGillicuddy et al., 2017) or accepted their loss of control without question (Hughes & Goldie, 2009). Older people moving into a care setting associate this with potential for loss of autonomy (Shin, 2015), and reduce their expectations for autonomy downwards, to fit in with what they perceive as the rules of the home (Boyle, 2008).

Collopy (1995) distinguished between “autonomy of execution” and “decisional autonomy.” Decisional autonomy is characterized by the capacity to make personal decisions and choices, irrespective of being able to carry them out independently (executorial autonomy). The participants in this study may not be able to exercise fully the autonomy of execution, being unable to manage all the aspects of administering their own medication, reading labels, manipulating packets, or pouring out measured doses. However, they retained decisional autonomy, with the capacity to make decisions about their personal choices and values. Boyle (2008) found that older people who lacked executorial autonomy also had their decisional autonomy constrained, as care staff tended to make decisions for them. This is reflected in the findings here, particularly for those residents who resigned themselves to giving up control over their medication.

Autonomy in a Risk-Averse Culture

The findings highlight the importance of considering individual needs and wishes and suggest that the activity of administration of medication may currently be a missed opportunity to enhance the ability of residents to exercise their autonomy. There is a heightened sense of responsibility, fear and anxiety among staff concerning medication management, and medication is routinely taken away from residents and locked up for safekeeping (NICE, 2015). In a hospital context, Watson (2006) described this as “a ritual confiscation,” and that staff would do all in their power to prevent the patient from having access. The National Care Forum (2019) identified that when a person enters a care home, staff automatically assume responsibility for managing their medicines. It is recommended that self-administration should be the default position for all residents, with risk assessments to determine the level of support needed (The Care Quality Commission, 2022). The

findings from this study would indicate that this guidance may not always be evidenced in practice.

There are directly conflicting ethical principles here, presenting challenges for care homes that have to balance the need to minimize risks to protect a person from harm versus maximizing their independence and capacity to take risks. Care home staff in Ostaszkiewicz et al.’s (2016) study were described as working in a climate of fear, constantly concerned about getting into trouble, both with their own management and with regulatory bodies. This led to them adopting overprotective behaviors towards residents in their care in what was described as a zero-tolerance approach to risk. It is difficult to see how this can be reconciled with the principles of “dignity of risk” (Ibrahim & Davis, 2013) when considering enhancing self-care in relation to taking medication, particularly in view of the real risks of serious harm from medication-related adverse events. Zomorodi and Foley (2009) argue that there is only a thin line between advocacy and paternalism, where staff may think they are acting in the best interests of those in their care, and unwittingly cross the line from advocacy into denying autonomy.

Imbalance of Power for Residents of Care Homes—A Hierarchy of Institutional Power

A care home is an environment where there is a great imbalance of power between the residents and those who care for them (Bowers et al., 2009). Residents in Tuominen et al.’s (2016) research settled into institutional procedures so as not to cause trouble. A resident in Nakrem et al.’s (2012, p. 6) study said that they had to conform to the routines, “*sometimes we are forced... staff want to have their way.*” Patients in Manias et al.’s (2004) study of self-administration of medication felt that there would be a “power struggle” if they were allowed to perform this role. When Morag said that she “*let them get on with it, even though it was a bit annoying*” for her, and Renee, who felt that she had to, “*fall in line, cause I have to.... and I don’t see the point of complaining.*” Their conforming to their situation against their wishes was obvious.

The care home itself is subject to extensive regulation. It operates its own systems of power, with corporate governance and staff regulation, a hierarchical structure of power which leaves the residents the most powerless (Gilleard & Higgs, 2017). The power of regulatory bodies to which staff are subject is known to have adverse consequences for the residents (Colón-Emeric et al., 2010; DeForge et al., 2011; Ostaszkiewicz et al., 2016). Staff in Kalaitzidis and Harrington’s (2018) study felt that regulations directly influenced the ability of residents to exercise choice and control, and that their practice was limited by organizational policy. However, an interesting observation was made by Woolford et al. (2020) that senior policy makers from the care sector all agreed that the individual residents’ rights were

paramount. At no time did they consider that an organization had any rights, yet the multiple levels of power appear to place the resident at the bottom.

Empowering Practice—Person-Centered Care

While empowerment is not synonymous with autonomy, it can be a way to promote autonomy. Much is written advising a shift in emphasis to empowering practices, enhancing mastery and decision making with regard to daily life within care homes. Improving flexibility about what to eat and when, choosing when to take a shower or a bath and what to wear, getting themselves dressed even if this was more time-consuming for staff, and being in control of what time to get up and go to bed are all discussed in the literature (Boumans et al., 2019; Hedman et al., 2019; Tuominen et al., 2016; van Corven et al., 2021; Yee et al., 2021). Boumans et al. (2019) concluded that all aspects of living in residential care needed examining, for opportunities to facilitate empowering practices. Yet, there has been no previous research that explores the potential for developing person-centered practice in the process of administering medication. Given our findings, it can be assumed that the principles of empowering practice could, and should, be extended to the practice of medication administration. Residents in this study all had highly individual routines when being helped to take their medication. This has been established in domestic settings (Vatcharavongvan & Puttawanchai, 2022), but has never previously been reported from the experience of care home residents. Embedding the taking of morning medication within unique breakfast routines was identified by Sanders and Oss (2013) as the most common way that older people at home managed to take their medication as intended. Swanlund et al. (2008) also identified factors which older people at home used to help them manage their own medications, including establishing habits and schedules, placing visual cues and prompts.

Strengths and Limitations of This Research

This research is the first to bring to light an understanding of the experience of residents during this activity in their daily lives. While observation of medication administration had been previously used as a method of data collection, the innovative use of observation within a hermeneutic approach revealed clear evidence of what was important to residents, in addition to that which was explicitly spoken.

The research was conducted with a small sample of residents, purposely selected, from three care homes who agreed to take part. This may be considered a limitation, especially as the geographical location was restricted to a single health board area in Scotland. However, it was considered more important to include an often-neglected participant group with direct lived experience with the potential for transferability of findings in what is a novel study. Data collection for

each resident was limited to a single episode of observation, which may not have reflected their experience on other days; however this was mitigated by the addition of interview data.

A further limitation is that recruitment was restricted to those with the capacity to consent. This had the effect of recruiting the more cognitively able residents who were perhaps not typical of the wider care home population (Stewart et al., 2014). While this may be a limiting factor in relation to the general population of care home residents, it provides impetus for further research.

Implications for Policy and Practice

Transferability of findings is, in the strictest sense, impossible from a small-scale hermeneutic study. Nevertheless, some applications of the issues uncovered in this study throughout the wider care home population can be recommended. The findings from this study have implications for those who provide nursing and social care:

1. Attempts should be made to establish what level of control over their medication administration that each individual resident might want to take, leading to strategies to facilitate individual needs and wishes.
2. Care planning should support individual routines, considering providing prompts and cues to help residents who wish to manage some or all of their own medication administration. This should be seen as an extension to the scope of person-centered, empowering practices.
3. Awareness should be raised of the potential for unintended consequences of an overly protective safety culture regarding medication. This may need addressing at every level in the care sector, from individual care homes through senior management and to regulatory bodies, as the current hierarchy of levels of power, may be contributing to a denial of power to the residents in their care.
4. Nursing and care staff involved in medication administration need to be made aware of the levels of trust which resident place in them during this process, and the potential consequences of this relationship.

For educators:

There are implications for those who provide education and training across wider fields, including those who train carers in both residential care settings and in care-at-home, but also for pre-registration nursing students who will be involved in administration of medication in hospital and community settings.

Educators should consider how they can actively incorporate the principles of empowering practice when preparing nurses and carers to administer medication, including

introducing the concept of compassionate ageism, and the significance of the trusting relationship between residents/patients and those who administer their medication.

Conclusion

The findings of this study are not surprising when examined in the context of the wider literature about routines, trust, autonomy, and power. However, this is the first study to explore this topic and to demonstrate the relationship between the administration of medication in care homes and these concepts. Exploring the experience of this specific activity within this specific context has highlighted the importance of facilitating personal routines when administering medication in a care home setting, and that these strategies may be helpful in promoting self-care. Residents' expressions of trust in the staff and in their medication may be an indication of their vulnerability. While residents may wish to maintain elements of control over the processes of medication administration, there are considerable cultural and structural barriers to their autonomy in this area. Overall, the phenomenon which rose to the fore is the experience of powerlessness which care home residents experience at the bottom of a hierarchy of power.

ORCID iDs

Helen Davies  <https://orcid.org/0009-0008-3662-6685>

Karen Watchman  <https://orcid.org/0000-0003-0000-3589>

Louise Hoyle  <https://orcid.org/0000-0001-9900-552X>

Ethical Approval

The study was approved by the NHS, Invasive or Clinical Research (NICR) Committee at the University in September 2019, and by the Social Care Research Ethics Committee of the NHS Health Research Authority in December 2019 (REC ref. no. 19/IEC08/0055).

Informed Consent

All participants in this study gave informed consent.

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