My Home Your Workplace – The Impact of Health and Safety Regulation on Care Homes for Older Adults

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Abstract

It has been argued that concepts of independence and care are often interpreted differently and more restrictively for older adults. Services are typically more concerned with issues of safety than with enabling participation or inclusion. Whilst the rhetoric of housing and care for older adults tends to be underpinned by ideas about independence, privacy, dignity and choice, there appears to be a paradox between these concepts and the goals of regulatory policy with its emphasis on safety, performance, and monitoring. Care homes exemplify this paradox where an imperative for 'homely values' contrasts with the application of safety regulation designed to protect people 'at work' from harm.

This study offers a new and original qualitative data set providing an empirically grounded and context based understanding of how important social and regulatory policy has been translated into local policy, applied by staff and ultimately experienced by residents. The research design comprises qualitative semi-structured interviews, observation and the evaluation of documentary sources positioned within an eight care home case study framework. The primary sources of data are care home inspection reports and semi-structured qualitative interviews with residents, staff and home managers. The analytical framework includes thematic analysis within a system oriented Grid and Group typology designed to elucidate how the different case study homes apply regulation, interpret risk, and subsequently how this shapes participant experience.

The findings would suggest that the contemporary regulation of residential care homes has placed a greater emphasis on the application of health and safety law than ever before. This appears to have had the effect of setting a 'risk' and 'rule' based agenda that has proved highly influential in terms of the cultural orientation of the case study homes and the choices available to those who live within them.

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List of acronyms

Acronym	Meaning
AQAA	Annual Quality Assurance Assessment
BBC	British Broadcasting Corporation
BUPA	British United Provident Association
CHR	Care Homes Regulations
COSHH	Control of Substances Hazardous to Health
CPA	Centre for Policy on Ageing
CSA	Care Standards Act
CSCI	Commission for Social Care Inspection
CT	Cultural Theory
CQC	Care Quality Commission
DIA	Daily Interpretive Analysis
DoH	Department of Health
HASWA	Health and Safety at Work etc. Act
EHO	Environmental Health Officer
EU	European Union
HELA	Health and Safety Local Authorities Enforcement Liaison Committee
HSC	Health and Safety Commission
HSE	Health and Safety Executive
HSG	Health and Safety Guidance
INDG	Industry Guidance
LAU	Local Authority Unit
MoU	Memorandum of Understanding
NMS	National Minimum Standards (for care homes)
NPM	New Public Management
NVQ	National Vocational Qualification
RCN	Royal College of Nursing
RIDDOR	Reporting of Injuries Diseases and Dangerous Occurrences Regulations
RMA	Registered Managers Award
SAE	Stamp Addressed Envelope

Chapter 1 – Introduction

1.0 Introduction

Help the Aged (2002), argue that concepts of independence and care are often interpreted differently and more restrictively for older people. Services are typically more concerned about issues of safety than with enabling participation or inclusion. Parker et al (2004) have also argued that a focus on health and safety requirements in care homes for older adults can create environments which act against quality of life. However, there is also evidence to suggest that care homes can be unsafe places and from this perspective a focus on the health, safety and welfare of residents might be regarded as an important consideration (HSE, 2009). This PhD is concerned with the role played by health and safety legislation in shaping the experience of older adults living in residential care homes. In the context of this thesis the care home is one which provides accommodation and basic social care only and not nursing or specialist care for adults with physical or mental impairment such as dementia[1].

Care homes are interesting because they represent a clear juxtaposition of the person's home, whilst at the same time they are also highly regulated places of work. As 'regulated places' care homes also epitomise people's worst fears about ageing and of losing control over their lives (Bland, 2005). Whilst providers from across the mixed economy of welfare may espouse the 'homely' values of independence and choice, the thesis will explore how these values are translated into practice and experienced by residents within the context of the regulated home. The research was conducted from the perspectives of those who live and work in a sample of eight case study care homes. The sample represents a cross section of the mixed economy of residential care and includes local authority, voluntary sector, and private sector homes.

The thesis is divided into 9 chapters. Chapters 1, 2, 3 and 4 represent the background and theoretical context to the thesis, whilst chapters 5, 6, 7, 8 and 9 represent the methods used, the empirical work underpinning the thesis and the conclusions. This introductory chapter is structured in two main parts. Part one will outline the research

[1] At the time of the fieldwork none of the case study homes were registered for people with dementia, although many of the homes did have residents diagnosed with this condition.

aims, questions and the context within which the thesis is written. Part two will provide a broad overview of the thesis in accordance with two principal themes. First, meanings of 'home' and 'care' are thought to be important underpinning concepts in the context of the residential care home. Second, the terms 'risk' and 'regulation' are central themes within the thesis which underpin and contribute to debates about the regulatory framework controlling care homes. These discussions also inform the theoretical framework within which the thesis is framed (Chapter 4).

1.1 Research aims and questions

The aims of this thesis are threefold. The first aim is to explore how safety legislation is applied within care homes for older adults and to evaluate which values tend to dominate. The second aim is to explore providers' and residents' perceptions and experiences of safety legislation in terms of their relationship with independence and choice. The third aim is to evaluate the extent to which the separate regulators of health, safety and care promote an integrated and enlightened approach to service delivery. Six research questions derive from these aims which are subsequently used to guide and to operationalise the research:

1. What mechanisms drive the interpretation and implementation of the health and safety regulatory framework in care homes for older adults?
2. Are there inherent contradictions within the regulatory framework that confuse managers and lead to the paradox of risk averse practice whilst failing to apply important control measures?
3. What role does organisational and professional culture play in the interpretation and management of risk in care homes for older adults?
4. Are current processes of risk assessment and management appropriate?
5. To what extent are 'homely values' allowed to flourish in the regulated domain of the care home?
6. To what extent are residents empowered to influence the management of the home and its safe working practices?

1.1.1 Key research themes

Figure 1 shows the main themes and sub-themes of the research in terms of how they cut across different homes belonging to different providers. These providers operate within what has been termed the 'mixed economy of welfare', characterised by a growing movement towards welfare pluralism involving local authority, private for profit, and the voluntary sector (Powell, 2007; see also Chapter 3). Each provider group was thought *likely* to present a different environment in terms of how they conceptualised and operationalised the key themes (see Chapters 4 and 5). 'Care' is conceptualised as cutting across these main themes in terms of its central position within the role of the 'care' home. Chapter 2 examines how 'care' has become associated with a 'duty to care' of being 'looked after', 'taken care of' or 'protected' (Meagher and Parton, 2004). Within the thesis 'care' is operationalised in terms of care plans and the health and safety actions of home staff. The principal participants in the research are shown in Figure 1 - the managers, staff and residents whose experience of regulation, home and risk is the basis of the empirical phase of the research.

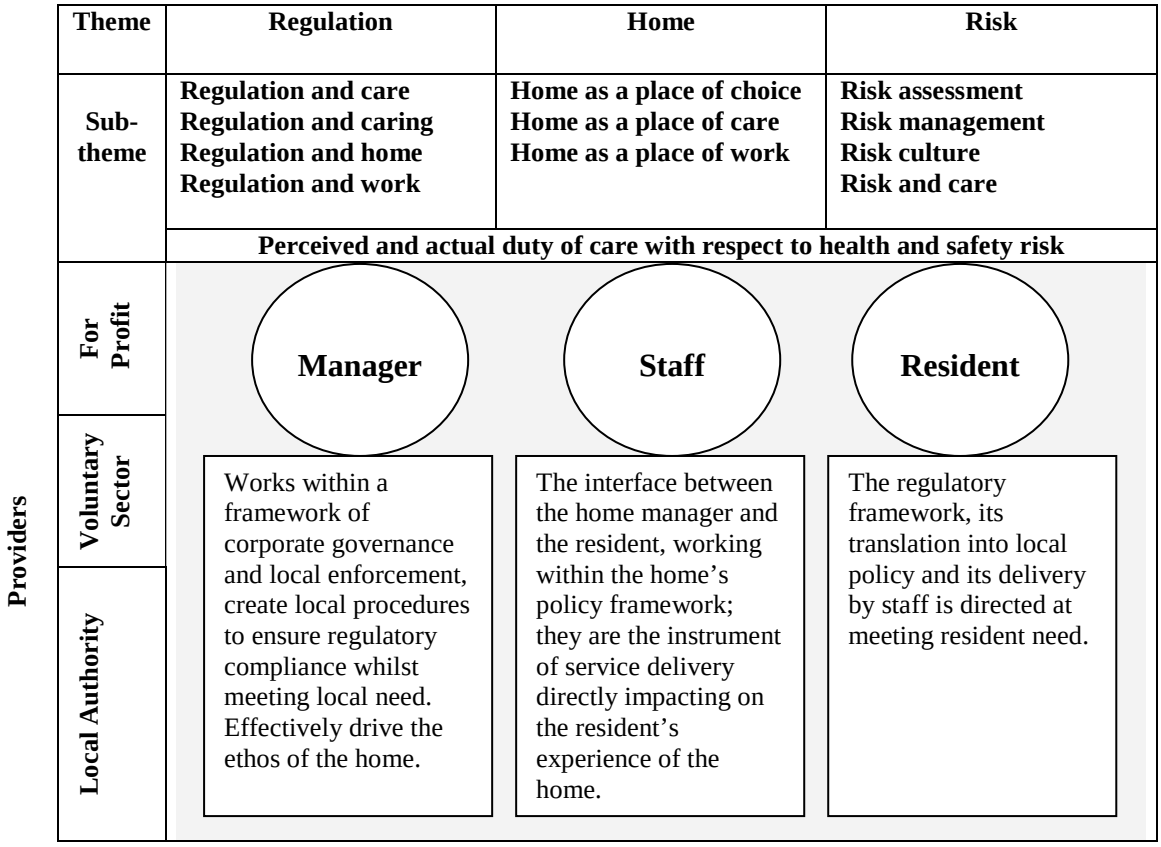


Figure 1: Cross cutting themes.

1.1.2 Context

The research is located within the context of what has been a rapidly changing and increasingly regulated market place for care. Over the last three decades there has been a paradigm shift in emphasis from 'welfare' to 'consumerism' in social care (Allen et al, 1992). In 1979 a Conservative Government began a process which saw local authority residential homes lose their dominant position, becoming part of a mixed economy of residential care now dominated by the private and voluntary sector (See Chapter 3 for a fuller discussion).

One consequence of this approach appears to have been the concentration of ownership of an increasing number of homes with a much smaller number of large corporate providers (Holden, 2002). Such homes are often larger in scale and size and are characterised by a corporate identity with uniform policies and procedures designed to demonstrate legal compliance to funders and regulators. Demographic changes within the market place for care have also meant that smaller care homes have become relatively rare. According to the Commission for Social Care Inspection (2006-7), the average care home now has around 24 beds, and homes of fewer than 4 beds account for only a tiny fraction of all care homes across all sectors (Peace and Holland, 2006: 399: Table 1). A significant proportion of the cost of running a contemporary residential care home is arguably regulatory compliance, which means that the balance between care-home managers' caring and non-caring tasks could be seen to have shifted in recent years towards the latter (Matosevic et al, 2006).

This contributes to a paradox whereby the needs of individuals are perhaps secondary to the goals of corporate policy which are likely to prioritise compliance with regulatory standards. Thus the important concept of 'choice' where older adults are enabled to 'be themselves' (Tester et al, 2004) may be diluted by an expedient to 'comply'. Such a paradox is perhaps exemplified by an imperative for 'homely values' contrasting with the application of safety legislation primarily designed to protect people at work. Burton attributes the '*national dislike of residential care to the stigmatisation of dependency, the prevalent blame culture and the current drive to eliminate risk which can make residents feel oppressed and persecuted by the regulatory apparatus of the state*'(2005: 18).

The care home is now demonstrably a more heavily regulated place than ever before, where the Government is a regulator, and the various caring professions are regulators too. Such regulation was in part designed to ensure accountability in paid caring relationships (Peace and Holland, 2001). However, this has arguably resulted in a situation where care homes are now: '*embattled by regulatory oversight*' (Braithwaite et al, 2007: 330). Against this backdrop, it is, however, important not to diminish the very real risks associated with caring for some older adults and the clear benefits to be derived from the appropriate application of health and safety law. It is significant that the Health and Safety Executive continue to note that accident statistics[2] for care homes have actually been increasing for both employees and residents (HELA, 2009). In 2007/08 there were a total of 4,503 injuries reported for employees and 1,049 for residents (HSE, 2009b). The average number of fatalities has increased from 5 between 1997/98 and 2000/01, to 20 from 2001/02 and 22 between 2003/04 (HSC, 2004: 18). In 2006/07 the number of fatal accidents[3] had increased to 23 and the number of non-fatal injuries had increased to 1002 (HSE, 2008), although the non-fatal injury figure is said to fluctuate each year with no clear trend (HSC, 2004).

The Health Survey for England (DoH, 2003) also found that for those aged 85+, adding in the care home data had the effect of increasing the annual accident rate from 10 to 17% for men and from 18 to 28% for women, although these figures are apparently not statistically significant (DoH, 2003). The most prevalent major injury to residents arose from slips, trips and falls. The causes of the fatal injuries were varied and arose from slips, trips and falls, drowning, asphyxiation, and contact with harmful substances (HSE, 2008). Research undertaken by the Health and Safety Laboratory (Corbett et al, 2006) would suggest that poor housekeeping is responsible for a number of these slip and trip injuries within care homes.

Given that the UK population of care home residents is estimated to be around 420,000 (Laing & Buisson, 2007), these accident statistics would appear *relatively* small in comparison. There is however some evidence of under reporting of accidents under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995

[2] Statistics are based on figures obtained via the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995. These regulations require home managers to 'report' certain events to the HSE.

[3] The fatal accident figure had been 27 in 2005/06, showing a slight *decrease* between 2006/07

(RIDDOR) and therefore the actual number of accidents may be much higher than this (Kelly, 2006; Davis et al, 2007). What this data arguably does suggest is that despite a far greater regulation and regulatory scrutiny with respect to health and safety in care homes, the reported trend in accidents has not reduced, indeed, it appears to have increased. Thus the application of health and safety law has not necessarily been matched with a correspondingly significant improvement in the reported accident data. Paradoxically, the espoused 'over-application' of health and safety regulation has resulted in some criticism and calls for moderation. For example, the Better Regulation Taskforce suggested that: '*Prescriptive regulation is taking away people's choices*, [where] *even the temperature of bath water is not a personal choice for someone who lives in a care home*' (Arculus, 2004: 15, Better Regulation Task Force).

In 2005 the HSE, The Local Authorities Coordinators of Regulatory Services (LACORS) and the Commission for Social Care Inspection (CSCI) established a 'Risk and Safety in Social Care Project Board' (RSSCPB) with a remit to: '*promote sensible risk management in the social care sector which strikes the right balance between enabling adults and children who use care services to lead independent and dignified lives and the need to avoid and prevent unnecessary harm to them and their carers*' (HELA, Local authority circular: 23-21, 2007, item 11; Kelly, 2008). However it has been difficult to see the impact of this project board upon any of the case study homes or indeed how it might have impacted upon any of the key literature such as the National Minimum Standards for care homes or any of the associated guidance[4]. In conclusion, Moran presents an interesting and relevant insight into the apparent paradox of the highly regulated residential care home when he observes that '*command regulation is typically…..a symptom of problems not a solution*' (2002: 397).

1.2 'Home', care homes and care

In housing related studies the home is one of the fundamental places giving shape and meaning to people's lives. According to Clough (2000) there is no one accepted model or framework for residential care, however, care homes are generally regarded as 'home' for those who live there. A key theme of the thesis is therefore the meaning, role and concept of being *at home* whilst being in a care home. Chapter 2 evaluates

[4] This assertion is based on a review of the literature and a review of the relevant NMS. See Chapter 3.

some of the extensive research on 'home' and homes (Sixsmith, 1990; Saunders, 1990; Gurney and Means, 1993; Means, 1997; Ahmed, 1999; Fox, 2002) in order to distil the likely meaning of 'home', which it is argued is fundamentally a place of *choice*, generally free from regulatory interference (Peace and Holland, 2001). It is at this interface that the thesis explores how ideas about 'regulated' caring and risk may conflict with the idea of freedom of choice within the care home. Research suggests that residential care homes can promote so called institutional regimes (Garner and Evans, 2000). Whilst residents might, for example, appreciate being looked after and the physical security associated with 'care', they also want a certain amount of independence, control and choice over important aspects of their lives (Redfern et al, 2005). Concepts of 'care' and 'caring' may however become linked with ideas about the dependency of residents which for Dant can be understood as '*a form of relationship characterised by an unequal distribution of power*' (1988: 171).

The experience of the older adult within the residential care home is therefore likely to depend on the extent to which they are perceived as either *independent* or *dependent*, at risk or able to take risk. Bland (2005) has suggested that ageist attitudes and policies deriving from a 'medical model' of ageing have come to characterise older adults as dependent, vulnerable and in need of protection from risk. It could be argued that health and safety law and the general management of risk, including personal risk, have to some extent become conflated causing confusion and anxiety amongst many home managers about their statutory duties. Parsloe suggests that '*the notion of a 'duty of care' is ripe for exploration*' (1999: 228). Parsloe draws upon the literature to argue that a new form of institutionalisation has developed where residents may become '*entangled in webs of overcautious surveillance by professionals*' (Harrison, 1997: 37). The idea of the resident as an independent, autonomous *person*, who is a distinct individual with rights, might somehow become subordinated to an overriding expedient to protect them from harm and thus diminish their individual rights (Parker, 2001). A central tenet of this thesis is that the older adult entering a care home, even though they may have a mental or physical disability *does not* lose their status as an adult with the same rights and freedoms *in law* as anyone else living in their own home. The Mental Capacity Act 2005 (fully implemented in October 2007), recognises these rights by providing a statutory framework designed to empower and protect people who may lack

capacity to make certain decisions for themselves because of illness, or mental health impairments such as dementia.

1.2.1 Regulating risk in care homes for older adults

The evolution of a mixed economy of welfare and its perceived failure to drive out poor quality provision has resulted in political demands for increasingly rigorous forms of public scrutiny (Waine, 2004). Chapter 3 explores the evolution of the regulatory frameworks controlling the provision of 'healthy and safe' residential care. The chapter traces the evolution of contemporary care home regulation including the New Labour Government's introduction of a series of reforms leading to the Care Standards Act 2000. All care homes are now inspected and assessed against National Minimum Standards (NMS) which are designed to '*guarantee the public interest*' (Drakeford, 2006: 936). The NMS effectively require care home providers to comply *in full* with health and safety law and to manage specified areas of risk. Thus laws designed to protect people from the hazards and risks associated with *work* have been subsumed into the standards defining the management of care *homes*. The way that the Minimum Standards are written, and subsequently used, is thought to be an important consideration within the thesis and they are therefore evaluated in some detail in Chapter 3.

Risk in a care home setting can have multiple meanings (Kemshall and Pritchard, 1997; Parsloe, 1999; Kemshall, 2002) however in the context of this thesis it is principally conceptualised as the legal duty arising from the Health and Safety at Work etc Act 1974 which is also discussed in Chapter 3. In this context risk is something that arises out of or in connection with the *work* activities of the care home. *Work* might be thought of as anything to do with the 'conduct of the undertaking' i.e. care, maintenance and management practices, the fabric of the building, its contents and any equipment or substances used. Work clearly does not include the *personal* realm of the resident and *personal* choices made by the resident. For example if a resident trips over their own slippers or falls following a dizzy spell, this is not 'work' and would not *necessarily* constitute a 'failure' of the application of health and safety law. Nonetheless, the

application of health and safety law and the perceived duty *to care* might be thought of as occupying a 'grey' area.

Risk can be differentiated into broad paradigms including the *techno-scientific* and *socio-cultural* paradigms (Lupton, 1999). The techno-scientific paradigm is important because it is most closely associated with the legal imperative to identify potentially harmful work activities and to control 'risk'. In a residential home this is likely to include all aspects of the building and the care and management practices that take place within it. The socio-cultural paradigm is central to the thesis and yet is perhaps a more elusive concept to define and conceptualise. Fox (1998: 666), for example, suggests that: '*risk is in the eye of the beholder*'. Thus to view hazards and risks in absolute terms is to ignore their social context and the cultural perspective of the observer. Douglas (1992) locates risk historically and socially, acknowledging that risks are perceived by different people and groups in different ways, giving rise to reciprocal 'blind spots'. Choices deemed a normal part of everyday adult life such as going into the kitchen to make tea or doing the laundry, may become 'unacceptable' within the regulated environment of the care home where they are regarded as 'risks'. Thus laws designed for the world of work might be used in ways that reduce or eliminate choice. Homely values might become subordinated to a preoccupation with avoiding risk (Bland, 2005) and laws drafted with supportive intentions in mind *may* become controlling in effect (Burton, 1998).

1.2.2 The theoretical framework and methods used for data collection

Chapter 4 discusses a theoretical framework that applies a socio-cultural and systems based perspective to understanding the regulation and management of risk in residential care homes. The framework encompasses the *structural features* of the system that influence the residents' environment in the form of social policy, attitudes and opportunities. A systems based framework acknowledges that the care home is greater than the sum of its parts and that the outcome of activities can be both planned and expected or unplanned and unexpected. It acknowledges the pivotal role played by external factors such as the National Minimum Standards for care homes, as well as factors that are within the direct control of the home such as its written and unwritten

practices and 'rules'. This study thus envisages 'systems' as operating within a socio-cultural context where regulations, practices and rules are culturally mediated. Cultural Theory (Douglas and Wildavsky, 1982 and Thompson et al, 1990) is therefore the principal means for conceptualising the regulated home within this thesis.

1.3 Conclusion

Whilst there is a strong academic tradition within the social sciences including the work of Townsend (1962), Peace et al (2001), Clough (1998), Oldman and Quilgars (1999), Bland (2005), Leeson et al (2003), explaining the lived experience of older adults in residential care settings, this literature provides few insights into how safety legislation impacts on the management of care from the perspective of those who must both live and work within the constraints and demands of the residential environment. This study offers a new and original qualitative data set providing an empirically grounded and context based understanding of how important social and regulatory policy has been translated into local policy, interpreted by managers, applied by staff and ultimately experienced by residents. The intention here is not to represent older adults in care homes as vulnerable and in need of 'protection' by regulated means. Indeed, this thesis argues that ideas about 'risk' in residential care should be based on what older adults themselves value and wish for in their care homes and not necessarily the assumptions of policymakers, providers or home staff about what they consider to be 'safe'. Simultaneously, the broad premise that the role of 'health and safety' is to protect people from 'harm' is not fundamentally rejected. Rather the thesis sets out to explore how health and safety law is interpreted and applied within care homes for older adults and how this may impact on the daily lives of residents.

Chapter 2 – Concepts of home and caring

2.0 Introduction

This chapter is in two parts. The first part will explore the general meanings of home and how certain positive images and concepts of home might then be used to define so called 'homely values' (Peace and Holland, 2001). In evaluating notions of home it takes a multidimensional approach, considering how architects, housing professionals, lawyers, carers and sociologists view and define home. The primary objective is to juxtapose the domestic dwelling traditionally associated with home with institutional forms of care in order to understand the principal factors involved. The second part will explore the concept of 'care', both in a general and in an institutional context and how care may be interpreted for those defined as *dependent.* Whilst there is an apparent abundance of rhetoric from both regulators and providers claiming an agenda based on choice and independence, a key question is the extent to which *regulated care* might actually realise this rhetoric in terms of an enabling or disabling agenda.

2.1 Home a multidimensional concept

Home has been described as a '*complex, richly textured, infinitely variable and deeply layered part of human life which impacts, and is affected by, many spheres of experience and social interaction*' (Tipper, 2003: 9). Research into understanding meanings of home is multidisciplinary and extends across a range of research paradigms and as Twigg (1999: 382) remarks it '*is shadowy territory for researchers*'. Home might be a place where someone lives, a fixed residence, and a permanent abode. It is generally a private territory and a personal space which contrasts with the public world of the institution. It has particular significance for older people because it is a familiar environment in which they have confidence, and, generally, can behave as they wish (Groger, 1995; Twigg, 1997). Home might be associated with where people come from (their roots), who they are (their identity) and the place that they feel safe. However, it is not clear whether these characteristics refer to a place, a space, feelings, practices or some other state of being or relationship with the world (Mallett, 2004).

The word home has powerful meanings, as it evokes images of warmth and belonging. For example the idea of family and home are inextricably linked. Bowlby et al write that although '*non-family households also have homes, a crucial element of the everyday understanding of home is the notion of a place within which children are or will be reared*' (1997: 344). In its widest meaning however, home can be broader than a particular place or locality, such as town or country. Home does not even have to be a physical place; it might for example be regarded as the 'spiritual home' (Mallett, 2004). What is, or at least appears to be clear is that 'house' and 'home' are clearly different concepts, whilst they are related they are not conflated. A '*physical dwelling unit is not the same thing as a home*' (Harrison, 2004: 705). A house might be a physical reality, and a home instantly familiar, yet the concept and meaning of home is not at all easy to pin down. Douglas (1991), views home as a kind of space or localisable idea whilst other phenomenological literature views home as: '*being-in-the-world or a form of emplacement from which the individual engages with the world*' (Bhatti, 2006: 321). Fox (2002) identifies a classification which groups values of home into four broad categories: home as a physical structure, home as territory, home as a means of identity and self-identity for its occupiers, and home as a social and cultural phenomenon.

Heller (1995: 7) identifies two representative types of home experience: the '*spatial*' and the '*temporal*'. In the spatial home-experience there is no movement, it is place that furnishes a person with a sense of the 'familiar'. The temporal home is, however, experienced by someone who travels a great deal and looks forward to returning to a familiar place. Ahmed (1999) takes a very wide view of home as relating in some way to where someone lives, where their family live or their native country. However, native country might not be *felt* as a home. Home is therefore not necessarily a single place or location - it is more a '*state of being*' which Ahmed equates with a permeable boundary or '*second skin*'. Moving away from home affects how 'homely' one might feel or fail to feel (1999: 341).

Understanding home as an extension of self has been explained by two conceptually related theories: the Theory of Place Attachment and the Theory of Place Identity, whereby people develop a relationship with a certain place, incorporating it into their self identity (Leith, 2006). Geographical space becomes a place to which we attach meaning through long-lasting emotional involvement through the personal life

experiences and social interactions accumulated over time (Leith, 2006). Thus the longer someone stays in a particular place, the stronger the connectedness to that place (Groger, 1995). Home might therefore be understood in terms of the changing transactions and experiences gathered throughout the life course. It becomes an important source of identity, a material expression of the self and of important memories. To lose the home or to 'suffer its radical rearrangement' under the direction of care professionals might therefore be to lose an aspect of self identity (Parfitt, 1995; Twigg, 1997: 228).

Understanding home might also derive from the concepts of privacy, privatism and privatisation (Saunders and Williams, 1988). Privacy refers to freedom from surveillance and role expectations where you can be yourself free from public scrutiny. Privatism is about withdrawing from communal life and orienting activities around the home, whilst privatisation refers to the shift to owner occupancy, perhaps best characterised by the 'right to buy' initiative enabled by the 1980 Housing Act. In the latter half of the twentieth century Britain became a nation of home owners, and this included half of those aged over 60 (Peace and Holland, 2001). Gurney (1999) shows how notions of home ownership have been *normalised* within British culture, perhaps to the detriment of other forms of tenure. Numerous studies have also linked home ownership with living longer and staying healthier than those who rent (Hiscock et al, 2003). Saunders (1990) stresses that identification with the home as a source of independence and self-expression is also greatest for owner occupiers. In contrast those who rent identify more with the neighbourhood or local community. According to Dittmar (1992 in Béland 2005) ownership is a crucial source of personal identity in advanced industrial cultures, a fact that has been exploited in the field of social policy where personal ownership has been framed as a powerful symbol of autonomy (Béland 2005). Older adults are now more likely to be owner occupiers with occupational pensions than previous generations (Hancock, 1997). They *may* therefore perceive that they have more to lose in terms of security and a legacy for their family, by leaving their home to enter residential care (Peace and Holland, 2001).

The idea of home as an intrinsically private space has however received criticism. Sommerville argues against Saunders and William's conception of the private home as intrinsically more worthwhile than the public sphere. It is also far from obvious that

home is a fusion of house and household (Sommerville, 1989). Residential care homes, for example, are not private households, yet for some individuals they are experienced as 'home' (Groger, 1995) and 'houses' have never been exclusively private places (Tosh, 1996; Mallett, 2004). Older adults may have a sense of greater autonomy and independence in a residential care home setting, when key dimensions of choice and control have been lost within the private sphere of their own home (Peace, 1998). Similarly, if social contact is highly valued, this may be more easily achieved within the public sphere of the residential home (Richardson and Pearson, 1995). Bland (1999) argues that it is appropriate that residential care homes are promoted as being the home of the older adult, something which Danish legislation has already attempted to do. The concept of home is given status by providing care home residents with the same basic tenancy and consumer rights as older people living in their own homes (Christophersen, 1999 in Leeson et al, 2003).

2.2 Home as a legal concept

There are some very tangible examples of how the legislative framework in England promotes and supports concepts of home. Fox (2002) points out that it is difficult to overstate the everyday importance and legal significance of home, as an instrument of social engineering. It frames how the law impacts on citizens as home owners, occupiers, tenants, licensees or even as squatters. The law is quite explicit about the value of home and its wider meanings, for example the importance of *family* and *privacy* are enshrined in the Human Rights Act 1998 (HRA introduced in October 2000), which incorporates a range of civil and political rights into UK law. These rights include the right to life (Article 2), the right to liberty (Article 5) and the right to private and family life (Article 8). A human rights perspective on old age highlights the importance of independent living as a means of ensuring that older adults are able to exercise their rights. Such an approach also assists in the development of general principles which can be used to assess social care practice generally, but in particular in relation to the promotion of independent living. For example: respect; equality; personal autonomy; social inclusion and participation. The law also promotes support for older adults to 'age in place'. The National Health Service and Community Care Act 1990, encourages the development of domiciliary, day and respite services to enable

people to live an independent and dignified life at home wherever this is deemed feasible and sensible.

There are also social and cultural conventions associated with being a good neighbour and ensuring the safety or protection of visitors and neighbours. Such conventions might be supported by civil and criminal law. For example the Occupiers' Liability Acts of 1957 and 1984, establish a strict *civil* duty of care towards visitors, invited and uninvited. The Occupiers' Liability Act 1957 sets out the duty of care occupiers owe to visitors, whilst the Occupiers' Liability Act 1984 sets out the duty of care owed to people *who have not been invited* such as trespassers. Whilst a trespasser might have no right of uninvited access to the home, modern social and cultural conventions are intolerant of them coming to harm whilst they are there.

Criminal statute protecting visitors is arguably much less clear in the domestic setting of the home. The Health and Safety at Work etc Act 1974, discussed in Chapter 3, applies to all people at work with the single exception of domestic servants in private households. Thus the constraints that might be afforded by health and safety regulation within a conventional workplace do not necessarily apply to domestic work carried out by the householder, their family, friends or domestic servants within their own house[5]. In practical terms this means that the householder is not required to undertake risk assessments, to institute safe systems and to provide training as they would have to do, by law, if their home was designated a workplace.

2.3 Possessions and space

A home has been described as an environment of physical objects (Fairhurst and Vilkko, 2005). The meanings and experiences of home are tied to the physical objects and their arrangement within the physical space of the house. It is these objects which differentiate the physical shell or container, called the house, from the home. A useful way of distinguishing between house and home that sits comfortably with the notion of home as independent of its location is proposed by McKechnie (2006). He refers to the *process* or the emotions associated with home whilst the *product* refers to the physical

[5] Contractors coming into the home are required to comply with health and safety legislation. Some safety critical activities such as work on the gas or electrical installation are also regulated and must only be undertaken by competent individuals who are appropriately qualified and registered.

structure and possessions or contents of the house. Home therefore becomes both an emotional world over which people have control and a reflection of their practical achievements and aspirations. The *product* aspects of home might include possessions and facilities that allow for and signify independence. An individual's ability to invite friends for a home-cooked meal relies upon having access to the necessary facilities. Within the residential care home access to such facilities may be denied on the basis of some regulatory expedient. This may in turn impact upon their sense of being in control and therefore of being 'at home' (Groger, 1995).

Possessions are the outward reflection of the occupier's interests and aspirations. The objects in a home carry biographical meanings, expressed through decorative items, memorabilia, furnishings and other objects connected to the domestic space. The biographical domain is particularly significant because it connects with the individual's sense of self-identity (Clarke, 2000). People form sentimental attachments to their possessions which keep alive the memories of work, leisure and family. Possessions might represent an important link between an older adult in residential care and their past clearly shaping their updated sense of home. Space within the home might also be important where it is personalised, enabling interests or hobbies to be continued or developed (Rowles, 1993; Percival, 2002). The idea of objects and space are important for the thesis in that they can arguably cross the boundary from home to care home. If the residential care home adopts a policy of restricting what the resident can bring with them, the individuals sense of continuity with their past and thereby their well-being may be affected. Whilst some 'domestic' objects are clearly part of the *product* aspects of home in terms of their functional relationship with the house, they also contribute to the *process* aspects of home in terms of the meanings that they convey. Going into the kitchen and making a drink or relaxing in a hot bath can carry significant biographical meaning for people. The bath, for example, can be particularly meaningful as something more than a means of keeping clean. It has a long connection with 'indulgence and pleasure' and as a source of relaxation and recovery (Twigg, 1997).

2.3.1 The garden

The garden as a space is particularly associated with growing older. When people retire they may aspire to spend more time in their garden. A garden has been described as an important part of the care setting, providing, amongst other things, sensory stimulation (Barnes, 2002). For the residents of sheltered housing or care homes, the sensory sensations of the garden can be enjoyed by everyone, including those with dementia (BBC news, 2001). Bhatti (2006) contends that a focus on the garden throws new light on recent debates about the notion of 'home' for older people, and deepens our understanding of social, physical and cultural change in later life. The garden contributes to the process or construction of home in a number of ways, for example, it represents part of the domestic routine of 'home making'. There is a spatial ordering through which gardens shape life experience (Bhatti, 2006). The physical changes that people encounter as they get older often mean that the physical activity required to create a home changes towards the latter phases of their lives, thus whilst a 'third age[6]' adult might be strongly engaged with their garden deriving both pleasure and healthy physical exercise from it, the onset of age related frailty *might* (but not necessarily) curtail these activities. This relationship between older adults and gardens is potentially an important theme. Whilst outside spaces may be added to care homes as decorative features, they may not be considered in terms of their therapeutic benefits (Barnes, 2002). For some residents, the garden might be a place of continuity with their past, and therefore may help them to feel at 'home'.

2.3.2 Home a place of work and conflict

As previously noted, home is a contested and a multidimensional concept (Mallet, 2004); the house or dwelling is merely one aspect of home. Whilst home is often characterised as an inherently positive, safe, and inviting environment, home can also exhibit the negative characteristics of institutions (Askham et al, 2006) and be a place of oppression associated with domestic slavery, violence and despair (Mallet, 2004; Rosenstein, 2005).

[6] Laslett (1989, 1996) uses the phrase 'the *third* (and indeed *fourth*) age' where he argues that old age should no longer be seen as a residual stage of the life course whose members are preoccupied with decrepitude and death.

The contested association between family, gender and home is discussed extensively by Mallet (2004), where she highlights the contribution of feminist theory and debates, in identifying home as a site of oppression, tyranny and the domination of women. Bowlby et al (1997) assert that 'home' is a site for doing gender, in that family care, cleaning or house maintenance (repairs) are gendered tasks that assert and affirm gendered identities. Such stereotypical identities may be perceived as limiting and constraining where home becomes a site for the exercise of power. For unpaid carers (who are usually women), home may become a place of work and oppression (Oakley, 1976; Bowlby et al, 1997; Williams, 2002). For example, the likely impact of providing long term care for someone 'at home' may become arduous and strain the '*physical, emotional, intellectual and spiritual resources of* [those] *individuals* [involved]' (Williams, 2002: 147). According to Nelson (2002) whilst information on the extent of actual 'elder abuse' is scant, the few population studies that have been done suggest that 4-6% of older adults have been abused in the home, indeed the Domestic Violence, Crime and Victims Act 2004 was introduced to increase the protection, support and rights of victims and witnesses involved in all forms of crime perpetrated by relatives or carers within the home.

2.4 Home in old age

Retirement has traditionally marked the onset of old age (Hyde et al, 2004) and as such it has been seen as the beginning of the end (Townsend, 1963). Old age has been described as a time of shrinking horizons (Oldman, 2001) where reduced mobility and social opportunities due to less income and the death of friends result in disengagement with social life and the formation of a much stronger attachment to home. The 'house' therefore becomes important because it is closely associated with intimate relationships, cherished memories, and a sense of historical continuity (Leith, 2006). There is however no systematic evidence to suggest that old age is necessarily associated with systematically reduced opportunities, and theories of disengagement with society have thus been heavily criticised for these negative connotations of old age (Clapham, et al 1990).

Since the 1960's the meaning of home to older adults has been the subject of extensive research (Townsend, 1963; Sixsmith, 1986; Saunders, 1990; Gurney and Means 1993;

Means, 1997; Ahmed, 1999; Fox, 2002). Much of this research has been used by Government to frame social policy and tends to adopt an optimistic view of growing old at home which has been given the term 'ageing in place' (see for example Andrews and Phillips (2005). This is based on the fact that many older adults of today do not have the same characteristics as those who retired 20 or 30 years ago. Access to non-state incomes has given some older people a comfortable income in retirement (Department for Work and Pensions, 2000). The percentage of pensioner families in the lowest household income quintile has fallen from roughly 50 per cent in 1979 to just over 20 per cent in 1997 (Hill et al, 1999 cited in Hyde et al, 2004: 280), meaning that many 'third age' older adults are able to enjoy hobbies and other leisure pursuits associated with home. Arguably, older adults increasingly want to remain as independent as possible with home seen as a place where they can express their individuality as well as their desire to retain control over their own lives (Means, 1997). Among future generations of older people, often referred to as the 'baby boomer' generation of the 1950's and 60's their present home is seen as the most favoured accommodation in old age, even if it becomes too difficult to cope alone (Leeson et al, 2003). It is indeed striking how central *the home* is to the concept of independence both in policy terms and in the statements of older people.

The literature on older people and care suggests a wish to remain living as independently as possible, which in policy terms has been interpreted as a willingness to stay at home with a corresponding reluctance to move into any form of institutional care. Indeed residential care does not feature prominently in (contemporary) Government commissioned literature. The Royal Commission on Long Term Care (1999), the Green Paper *Independence, Well-being and Choice* (2005) and the Department of Health's most recent publication *A Recipe for Care* (2007), all recognise the increasing role of home based care over the coming decades, and the right of older adults to have access to a range of services over which they can exercise a degree of choice. Their vision for diverse quality services is however couched in 'cost neutral' terms that appear to emphasise home care or sheltered housing whilst almost dismissing residential care altogether. Some commentators and providers are indeed concerned that the Government are trying to convince people that care homes are not a good choice for long term care (Anchor Trust, 2005). This vision might however be flawed in some key respects as the '*true*' cost of providing care to a dependent older adult in sheltered

housing may in fact exceed the cost of residential care (Bland, 2005). In addition extra care sheltered housing is estimated to accommodate less than 40,000 people compared to 450,000 older adults living in residential care (Burke, 2006). 'Ageing in place' however, appears to be the Government and local authorities' preferred option, aided by increasing home care services and investment in 'Telecare[7]'. Relatives as well as neighbours are seen as a resource for caring and enabling the older person to live 'independently' at home. Because many people are living longer and healthier lives with more disposable retirement income, much policy rhetoric emphasise that old age should be seen as a time in which people are free to develop their interests and enjoy their home.

Critics of this view note that '*independent living has become the new mantra and like motherhood and apple pie is almost impossible to contest*' (Oldman, 2001: 6). Whilst home might be a personal space and a private terrain embodying self-identity, personal control, autonomy, privacy and intimacy, it may at the same time hide the lack of care and poor quality conditions so often criticised within residential care institutions. Older adults might be 'in the community' but they are not part of it, other than through TV sets and 15 minute visits (Oldman and Quilgars, 1999: 373 cited in Oldman, 2001). It is easy to be critical of Laslett's (1989) bleak and controversial imagery of a 'fourth age' characterised by dependence and disability on the basis that these states can be transitory and experienced at any time in the life course. There is, nonetheless, likely to be a stage where some older adults require significantly more care and support than can, realistically, be provided 'at home'. Intensive forms of care can stress relationships with relatives, be very expensive for the individual or too expensive or impracticable for the state to provide 'at home'.

When care services enter the home, particularly when adaptive or medical equipment is involved, it is to be anticipated that established meanings and the activities that constitute the lived home will be disturbed (Dyck et al, 2005; Fairhurst and Vilkko, 2005). The consequences of this are multiple, but inadvertently the act of helping someone to remain in their own home may in fact change their concept of home and indeed create unforeseen risks. In some cases, for example, the home may need to be

[7]Telecare uses sensors, such as movement detectors and door alarms to monitor lifestyle changes and possible emergencies in order to manage the risks associated with independent living.

'adapted' to improve its safety and to accommodate the needs of the older person. However, aids and equipment literally 'take up' space whilst adaptations re-define a space (Fairhurst and Vilkko, 2005). Care 'at home' can begin to take on the features of an institution with the routinisation of a person's day focusing around home visits, risk avoidance and the delivery of intimate care. All aspects of life can indeed become part of a condition or its treatment (Twigg, 1997). Thus, although the processes of institutionalisation have come to be associated with residential care, Askham et al (2006) have shown that Goffman's three defining characteristics of custodial care, routinisation, surveillance and mortification[8] of the self were present in the lives of some older adults being cared for at home by relatives or friends. Care tended to become routines designed in order to accomplish specific tasks, surveillance was restrictive and prevented both the carers and those they were caring for from doing things that they wished to do. Perhaps for these reasons *some* older people make a positive choice to move in to a care home in order to free themselves from the pressures associated with trying to live 'independently' at home. Research by Oldman and Quilgars (1999) suggests that for some a move into a care home is seen as actually increasing their independence as they no longer feel reliant upon relatives and friends for their care.

2.5 Care homes

According to Clough there is no one *accepted* model or framework for residential care, its function is however '*to create good environments in which people can live, environments which will allow and encourage the provision of good physical and environmental care*' (2000: 66 - 68). The Wagner Report *Residential Care: A Positive Choice* (1988) tried to raise the profile of residential care, reasserting its value, and seeking to challenge the view that residential care is the 'last resort'. The *Caring in Homes Initiative* (1993) attempted to encapsulate good practice and identified the concepts of quality of lifestyle and opportunities for fulfilment. These included the 3 themes of: an enabling environment, recognising and mediating different interests and creating opportunities for individual and collective feedback and commentary.

[8] In this context 'mortification' may involve stripping away the status and the dignity of the older adult. Personal and intimate care may be experienced as degrading, even humiliating.

These concepts articulate two important principles that transcend the regulatory framework immediately applicable to residential care: the *environment* or m*ilieu* in which care is provided and the mediation of different interests. Bland (1999), argues that hotels generally exhibit such characteristics, having a customer oriented approach that is receptive to the needs of its guests. She goes on to assert that care homes adopting such a model are more likely to be responsive to, and prepared to meet, the stated and implied needs of their residents. Therefore, for residential care homes to be like 'home' they must first determine what constitutes 'home' for the individual resident i.e. they must arguably be customer focussed. The extent to which a hotel model is indeed able to emulate 'home' is open to question, but if freedom of choice and a non-oppressive m*ilieu* are characteristics of home then being sufficiently flexible to a variety of needs may at least represent good practice. Atherton asserts that a 'self-conscious concern with order' is what actually distinguishes the residential home from the hotel. Indeed within the care home it is '*permissible, desirable and even necessary to interfere in the lives of residents*' (1989: 61).

The experience of residential care is intimately connected with the working lives of the staff and their relationships with residents. The impact of the regulatory framework or the manager's interpretation of this framework is felt most keenly at this interface. Whilst the physical environment and resources offered by the building, facilities and routines are important, it is the social, emotional and inter-personal factors that are more highly valued (Youll and McCourt-Perring, 1993). An emphasis on the physical aspects of housing and the routines of care on the other hand may be associated with the less than homely values associated with institutions, underpinned by the work of Foucault (1998), Goffman (1961) and Townsend (1962). Bland (2005) has observed for example that homes who see their primary function as providing 'physical care' were much less likely to *allow* residents to 'take risks' and were more likely to apply 'rules'. Interestingly, these ideas resonate with Herzberg's (1966) 'Motivation-Hygiene' Theory[9] which suggests that the building and functional aspects of an environment are simply 'Hygiene factors' in the sense that they are necessary to avoid *dissatisfaction*, but by themselves will not provide *satisfaction*. Thus, whilst care homes need, by law,

[9] This is primarily a theory of motivational management research applied to the workplace; however, the concept of facilities as 'hygiene' factors is felt to be a useful illustration or concept.

to be well designed, equipped and managed, these factors are not, by themselves, the things that make the individual feel 'at home'.

2.5.1 The care home as an institution

Giddens (1989) makes a historical link between prisons and workhouses that have subsequently evolved into contemporary residential 'homes'. Workhouses provided food and accommodation for those without work in return for extremely hard work. The workhouse also became a place where the sick, aged, and mentally ill were placed when no one else was prepared to care for them. They were designed with the same utilitarian logic as other large institutions and as such there was absolutely no imperative for them to emulate *home*.

Research suggests that the contemporary residential environment also has the potential to promote negative consequences for residents, arising from so called institutional regimes (see for example Garner and Evans, 2000). Such regimes may deny residents control over key aspects of their day to day lives, leading to what has been termed 'induced-dependency' (Booth, 1986; Redfern and Ross, 2005). Instead of accepting that risk may be an inevitable part of everyday life, the *care culture* of some care staff, home managers and some proprietors might feel that risk must be eliminated. This may be driven by the perception of accountability - that whenever something goes wrong *someone* must be to blame, a perception perhaps linked with the no-win, no-fee system introduced by the Woolf civil justice reforms (1999). It may also be driven by a misunderstanding or misapplication of the regulatory framework where those with responsibility for care feel uneasy about accepting and managing risk as a normal part of adult life. In this respect some residential homes may be conceptualised as performing the function of 'warehousing' (Bond, 1993), rather than providing a home. Older adults in such homes arguably have neither control nor choice and thereby begin to lose their identity as an independent, autonomous adult. Meagher and Parton (2004) suggest that the social work profession itself has been complicit in what might be called the control agenda that arises from contemporary regulation and societal expectations surrounding risk. Healy notes that proponents of critical social work have '*persistently challenged the occupational self image of social work as a caring profession by*

emphasising the complicity of social workers in the reproduction of the oppressive conditions within the practice context and beyond it' (2000: 3).

Social scientists have considered institutions in terms of certain common qualities which affect those in them. For example, living within an institution is fundamentally different from normal life in the community. While it is a 'normal' arrangement for most individuals living within the community to sleep, work and play in different places, with different people, and without an overall rational plan, the central feature of the institution is a breakdown of the barriers separating these features of life (Barton, 1959; Goffman, 1961; King et al, 1968, 1971). Higgins (1989: 15) proposes a typology of characteristics that differentiates institutions from domestic homes, shown in Table 1. Moore suggests that '*even those [homes] run by the most enlightened staff inevitably have aspects of what Goffman called batch living*' (2002: 231). Goffman (1961) suggests that most institutions have 4 characteristics in common. First, all aspects of daily living are undertaken in the same place. They have two distinct and different social and cultural worlds, one for staff and one for residents. Residents are stripped of the roles that they might have held prior to admission and designated simply as a resident. Fourth, the various activities of the home are designed to fulfil the official objectives of the institution. Such objectives might include complying with health and safety regulation, which may be interpreted in ways that restrict individual choice and independence. Further, the application of 'batch living' may be a management expedient designed to cope with large numbers of residents whilst employing the most economic package of resources.

Institutions	**Home**
1. Public space, limitations on privacy	1. Private space, but may be some limitations on privacy
2. Living with strangers, rarely alone	2. May live alone or with relatives or friends, rarely with strangers
3. Staffed by professionals or volunteers	3. Normally no staff living there
4. Formal and lacking in intimacy	4. Informal and intimate
5. Sexual relationships discouraged	5. Sexual relationships accepted (between certain family members)
6. Owned/rented by other agencies	6. Owned/rented by inhabitants
7. Variations in size but may be large	7. Variations in size but usually small
8. Limitations on choice and on personal freedom	8. Ability to exercise choice and considerable degree of freedom
9. Strangeness (of people, place etc.)	9. Familiarity (of people, places etc.)
10. Batch or communal living	10. Individual arrangements for eating, sleeping, leisure activities which can vary according to time and place

Table 1: The key characteristics of institutions and home (source Higgins, 1989: 15)

A key feature of Table 1, also expressed in the literature, is that of *choice* and participation in the choices that determine individual lifestyle. Making choices and being treated with dignity and respect have been described as central rights of older adults, no matter how old or frail they may be (Dixon, 1991). Choice is likely to be mediated by individual and institutional considerations that arise from the relationship between resident and 'carer'.

2.5.2 Caring as an enabling and disabling concept

The care home is arguably characterised by the juxtaposition of 'home' and 'care'. The 'home' may portray institutional characteristics deriving from being a public domain oriented around batch living, however, it is the conceptualisation of 'care' that is likely to determine the residents' experience of 'home' within the residential home. Care is a broad term which has come to cover a multi-dimensional and varied remit which can be broken down into narrower categories (Bland, 2005; Holloway and Ussher, 2006). Tronto (1993: 106) differentiates between: caring about, taking care of, care-giving, and care-receiving. Caring about refers to '*the recognition in the first place that care is necessary*'. Taking care means taking the responsibility for care, whilst care-giving refers to directly meeting another person's care needs through personal contact and

physical work (1993: 107). Care-giving is the direct physical and interactional caring that one person does for another.

Historically the term *care* has been associated with 'welfare', being 'looked after', or 'protected' (Meagher and Parton, 2004). The statutory concept of *taking care* of someone or *giving care* to them might be thought of as being broadly classified into 'nursing' and 'social' care paradigms. The former is generally associated with 'professional', medical and technically oriented care which in the UK are undertaken or supervised by registered nurses whose title and competencies are prescribed by law (Clark, 2003). Nursing care might include injections, tube feeding, surgical dressings or other forms of 'complex' care. Social or personal care on the other hand is a much broader term that encompasses what any caring person would undertake in their own home. It might include helping with personal hygiene, cooking, cleaning or supporting social activities.

Thus, the broader term of 'social care' generally applies to the non-nursing context, i.e. in environments that do not engage in the 'technical' procedures associated with the nursing needs of residents. Social care instead: '*meet[s] their common human needs* [and] *give[s] quality of life*' (Social Care Association 2005, in Higham, 2005: 1). The 'residential' (as opposed to the 'nursing') care home, was defined by the 1984 Registered Homes Act as: '*any establishment which provides.....residential accommodation with both board and personal care to persons in need of personal care by reasons of old age, disablement, past or present dependence on alcohol or drugs or past or present mental illness or mental handicap*' (Sinclair, 1988: 243).

Miller and Gwynne (1972: 189) identified two distinct models of care in care homes[10]: the 'warehousing' model defined their primary task as prolonging physical life and the 'horticultural' model which saw their main function as developing the full potential of their residents. The warehousing model requires that residents remain depersonalised and dependent. Independence is discouraged and the '*ideal resident is one who accepts the staff's assessment of his or her needs and the treatment they prescribe or*

[10] The original research was undertaken in homes for physically disabled adults, however, the models have also been applied to older adults – see for example Bond (2004).

administer' (Bond, 2004: 122). The horticultural model is described by Bond as '*more aspiration than reality*' (page 123).

Youll and McCourt-Perring (1993: 172) describe six models of 'caring' identified in their evaluation of the Caring in Homes Initiative: the child care model, the kinship model, the democratic model, the hotel or catering model, the nursing or ward model and the expert or treatment model. Two sets of assumptions were identified relating to the nature of the relationship between the resident and staff which influenced the approach to care. The first assumption concerned the location of power and authority and how it was exercised. The second assumption concerned the age or circumstances in which a resident's self-responsibility was regarded as being lost or gained. Who made decisions and about what, were fundamental to the experience of residents and their ability to exercise choice. These broad ideas are further developed later on in the thesis (chapters 3 and 4) in considering the relationship between older adults, the management of risk and the conceptualisation of risk within different homes exhibiting different 'cultural' characteristics.

The kinship model of caring was highlighted as different from the other models, because it assumed relationships between staff and residents based on cultural rather than organisational norms. They gave as an example, the continued deference shown by younger workers to the residents, however frail, in a home for Asian elders. People placed great importance on shared values and beliefs between staff and fellow residents in homes run by religious organisations or minority ethnic groups. This, the authors suggested, was a model that offered a set of assumptions about how care was conducted that both residents and staff could share (Youll and McCourt-Perring, 1993: 172). The hotel or catering model was described as a '*down-to-earth approach*', based on an assumption that adults need little more than '*housekeeping services, meals and a bit of understanding company*' (1993: 173).

Meagher and Parton suggest that discussions of care within the critical social work literature '*have been remarkable only by their absence, such that it has seemed there has almost been an assumption that social work is so tainted by its associations with care that the word should be expunged both from its lexicon and rationale*' (2004: 4). In their view and in the view of Healy (2000) cited in their introduction, the critical social

work literature '*comes close to identifying care with oppression*', certainly it is seen as '*patronising, paternalist, and marginalising*' (2004: 3). While Finkelstein (1998, cited in Meagher and Parton, 2004: 22) argues that the term care should be replaced by support.

Over the last two decades there have been a number of policy and practice documents (Avebury, 1984; Avebury 1996; DoH: SSI, 1989) that have stressed the importance of allowing people in residential care to take reasonable risks, linking responsible risk-taking with independence. In 2006 the Department of Health (Lewis, DoH 2006) launched its *Dignity in Care* campaign which included the goal of enabling people to maintain the maximum possible level of independence, choice and control. The Green Paper *Independence, Well-being and Choice* (DoH, 2005) encouraged a debate about risk and consulted on the right balance between protecting individuals and enabling them to make decisions about their lives including risk. In May 2007 the English Department of Health published *Independence, Choice and Risk: a Guide to Best Practice in Supported Decision Making* (DoH, 2007), described as a best practice guide for the use of everyone involved in supporting adults [18 and over] using health and social care within any setting. Any setting includes community or residential care, in the public, independent or voluntary sectors.

Manthorpe (2007) suggests that the publication of such a risk framework highlights Government awareness of the problems of managing risk in a climate of criticism and risk aversion. Whilst the framework talks in terms of viewing risk 'proportionally and realistically', and distinguishing 'reasonable' risks from others, distinguishing between 'reasonable' risks and risks requiring management control, may prove a real challenge. Whilst Manthorpe (2007: 237) argues that this apparent turn away from the risk management of everything '*is to be welcomed*', she also acknowledges that the apparent culture of 'risk management', perhaps based upon a fear of litigation, is likely to be difficult to unseat. Indeed, Taylor arguably captures this idea in his 'wariness of lurking conflicts paradigm' where he argues that the '*consumer culture of society created more pressures for staff and less justice for service provision…….The consequence for staff, in an environment marked by increasing litigation and consumerism, was an uneasy blame culture that could inhibit practice by making practitioners overly cautious*

in the interests of being seen to do the right thing' (2006: 1423). Thus concepts of 'care' are likely to be framed in this context.

2.5.3 Dependency

The term 'care' appears to be inextricably linked to the term 'dependent'. For Dant dependency for older adults in contemporary society can be understood more fully as '*a form of relationship characterised by an unequal distribution of power*' (1988: 171, see also Biggs, 1992). A number of attempts to define dependency have stressed that it is a function of the social relationship between an individual and another or others (Booth, 1985; Willcocks et al, 1987; Dant, 1988; Qureshi and Walker, 1989). Oliver defines dependency as: '*implying an inability to do things for oneself and the consequent reliance on others to carry out some or all of the tasks of everyday life*' (1993: 50). In health and social services, the needs of older adults are generally assessed in terms of their 'dependency', based on the subjective views of someone who may lack the necessary assessment skills and awareness of alternative approaches (Taylor, 2005). Information about ability to manage daily living, continence and mobility are used to define subsequent levels of care. Bland (2005) suggests that older adults who are judged to be in need of care are also characterised as 'vulnerable' (Webb and Wistow, 1987) or 'at risk' and requiring safeguarding and protection.

A number of writers have challenged the construction of 'dependency' as an individual attribute in later life and have written about the factors or structures that bring about concepts of 'dependency' in old age. Whereas 'induced dependency' might be taken to refer to the relationship between the individual and their carers, 'structured dependency' refers to societal attitudes and institutions in their widest sense. Indeed, several authors including Walker, 1980, 1981; Townsend, 1981; Phillipson, 1982 and Hockey and James 1993, have developed a political economy approach to the experience of ageing, by demonstrating that the experience of later life as 'dependency-creating' is not accidental or irrevocable. Rather, they claimed, it was the result of deliberate social policies (Bland, 2005). Older adults living in care homes, are clearly subject to a regulatory regime that arguably characterises them as an *at risk* group. Care home and health and safety 'law' might be thought of as setting the context for the residents'

experience of 'home', where residents are treated '*more or less the same according to fixed rules and statutes*' (Engster, 2004: 7).

In considering what constitutes best practice in residential care homes, Bland (2005) suggests that it has mostly been working groups consisting of health and social care professionals, care providers, academia and family carers but rarely older adults, who have produced best practice guidance. The last decade has arguably seen a significant increase in the 'top down' definition of models of best practice. The growth of 'managerialism' often referred to as the 'new public management' (Horton and Farnham, 1999 in Meagher and Parton, 2004), has established regulatory regimes characterised by standards and systems of accountability. Such regimes are designed to assess, and regulate the performance of organisations and workers delivering public services (Meagher and Parton, 2004). The Care Standards Act 2000 and the Care Home Regulations (discussed in detail in chapter 3), might be seen as one such regime, which exerts state control over the provision and delivery of care services. Within residential homes, this framework sets *minimum* standards for services which proprietors and managers are required to apply to their homes and therefore to those who live and work in them.

Sinclair (1988 cited in Redfern and Ross, 2005), observes however that it is often difficult to get a true picture of residents' actual views because many express satisfaction with their home either through a reluctance to complain because of fear of reprisal, or because they cannot envisage an alternative. Thus it appears that debates about the nature of residential care, the application of rules and the apparent emphasis on the physical aspects of care may have been obscured perhaps by the rhetoric accumulated around residential care. It may be difficult therefore to argue with a health and safety agenda that is designed to protect those who live and work in residential care, especially where the recipients of such an agenda *appear* to be content with it.

The principal regulator for residential care homes, the Commission for Social Care Inspection, (CSCI, replaced in 2009 by the Care Quality Commission) arguably works to two distinct agendas. The first asserts the *rights* of residents, whilst the second asserts the *responsibilities* of providers. The rights based agenda is set out in a 'discussion paper' entitled *Making Choices: Taking Risks* (2006) where CSCI reiterates

the 'Government's public service reform agenda' whereby people '*should be able to exercise choice and control to help them live the kind of life they want*' (CSCI 2006: vi). The document appears to attribute oppressive practice entirely to the provider, where: '*rather than being supported to deal with personal risk in order to achieve what they want from life, older people using social care may experience a prevailing risk averse culture where risk is regarded as threatening and to be avoided wherever possible*' (2006: 8, paragraph 2.4). CSCI go on to set out in some detail a 'choice' based agenda acknowledging that: '*development of a national approach to risk in social care needs to connect with other key initiatives across Government*' (2006: 12).

Providers are invited to develop their vision for developing person-centred services and to consider whether '*efforts to minimise organisational risk are appropriately weighted against the potentially adverse risks to the overall wellbeing of people using their services*' (2006: 13). This 'rights-based' agenda contrasts with the regulator's second, and arguably principal, agenda which explicitly requires providers to comply with regulatory standards. This clearly includes the legislative framework for health and safety, which CSCI have incorporated within the National Minimum Standards (NMS) for care homes. The NMS are therefore likely to be highly influential and significant components in a care home's organisational risk management strategy. Thus, if the NMS are or *appear* to be risk averse, the home's practice is likely to reflect this. Such regulatory agendas move away from the rhetoric of rights, independence and choice towards the realities of inspecting for compliance.

The 'induction' and 'construction' of 'dependency' is an interesting and useful idea in the context of the social structures and frameworks that define and regulate care, caring and care homes. It suggests that it is not necessarily the older person's frailty or personal choice that mediates their experience of *home* rather it is the legal framework, its translation and application that determines how residents are treated and their subsequent experience of home. Whilst it is important that residents and staff within the residential care home environment are *safe*, this is not supposed to be the 'main aim' of providing residential services (Crimmens and Pitts, 2000: 25). Netten (1993, in Redfern et al, 2005) found that many staff took it for granted that their responsibility to protect residents from physical harm outweighed the right of the resident to come and go as they pleased. Tronto (1993) also suggests that 'care' can create situations where carers

see themselves as having more expertise in meeting the needs of individuals than the individuals themselves. This might lead to the development of relationships based upon profound inequality. It could be argued that the expedient for regulatory compliance enhances or amplifies this dynamic - such that 'expert' knowledge and the management of risk become the currency of care.

Whilst residents are likely to appreciate being looked after and the physical security associated with residential care, they also want a certain amount of independence and control over important aspects of their lives (Redfern et al, 2005). They want control over choosing their companions, privacy when they want it, a room of their own that can be used during the day, and being able to control their own immediate environment, such as opening or closing a window and turning the heating on or off (Redfern et al, 2005: 147). Chapter 3 will argue that the health and safety components of the National Minimum Standards appear to stress the compliance agenda and the home's subsequent 'duty of care'. In this sense the term 'care' appears to have become framed as an obligation requiring the manager and staff to adhere to those requirements stated or implied by the Minimum Standards. Thus a concept of 'enabling care' is likely to be subjugated by a perceived duty to control risk and to comply with standards.

2.5.4 Designing care homes

The World Health Organisation's Quality of Life Assessment Group (1998) recognise the physical environment in which people live as an important dimension of their quality of life alongside physical health, psychological state, level of independence and social relationships. Physical environment is therefore likely to be particularly important for older adults living in residential care settings, where good design of the communal living environment can make them places in which they feel 'at home', as opposed to 'in a home' (Marsden, 2005). Good design is also important from the perspective of care staff so that they can perform caring tasks with minimal risk to themselves.

The National Minimum Standards for Care Homes for Older People, published by the Secretary of State for Health under Section 23(1) of the Care Standards Act 2000, recognises that there are clear links between the style of home, its philosophy of care,

design and layout. Contemporary architectural design guides for care homes attempt to capture the essence of 'home' and translate the rhetoric of 'home and homeliness' into bricks and mortar. Parker et al however point out that '*in the architecture and design professions, it is rare for academic curricula to cover the needs of frail older people*' (2004: 2). Fairhurst (2000) also provides a fundamental insight into the constraints within which planners and architects must work. Older adults rely on their individual biographies to visualise the utilisation of space within a home, matters from which architects are generally excluded. This insight reinforces the individual nature of 'home' and the need for design to be sufficiently flexible (whilst being functional) to allow privacy, dignity and above all choice in the use of 'public' space. There is also said to be an overall shortage of empirical evidence on the efficacy of the physical environment in care settings (Barnes, 2002).

The National Health Service design guide (The design of residential care and nursing homes for older people, HFN 19) is one example of an architectural design guide that attempts to capture '*the inherent objectives which mankind has always aimed for when seeking shelter in which to live: good location, absence of overcrowding, physical comfort and safety, privacy of the occupants (collectively and individually) and security against intruders*' (NHS, 1998: 18). This guide briefly explores how the notion of 'home' can be translated into a 'homely environment': '*Older people….are likely to feel more at home in environments which are familiar, not too modern-looking and on a domestic scale*'. This translates into defined 'characteristics of a homely environment' which (they state) include three components: first, domestic size and scale, such as the provision of small lounges and informal seating areas. Second, ease of orientation and recognition of spaces within the building, for example, a dining room should look like a typical domestic-style dining room. The third component recognises the need to avoid 'institutional' features such as long corridors, harsh lighting and hard shiny floors in living areas. The size of care homes is however a significant factor arising from the balance between the need to provide a 'homely' environment and the expedient of the economy of scale. Whilst smaller homes can provide a more domestic environment, they still require the same basic infrastructure and proportionally the same staffing as much larger homes (Willcocks et al, 1987: Peace and Holland, 2001).

Barnes, (2002), suggests that residents express definite preferences for care arrangements which offer privacy and real freedom of choice rather than token measures of control over important aspects of their environment. This can include having control over heating and ventilation in bedrooms. The physical design attributes of the architectural framework are said to be important, only in so far that they provide the degree of autonomy and individual choice that the resident may expect from their 'own home' (Barnes, 2002). The National Service Framework for Older People (Department of Health, 2001) endorses this more general notion that older people should be able to determine levels of personal risk regarding their health and circumstances.

There may however be important gaps between the rhetoric of choice in formulating a design and the reality of the actual design when it is experienced in practice. Parker et al (2004: 17), acknowledge that '*care homes are understandably subject to many health and safety regulations. They must protect their frail residents as well as function as work places and settings for medical interventions. The perceived pressures from relatives and fear of litigation may foster a risk-averse environment, however, which our findings associate with a measurable diminution in some aspects of quality of life*'. Health and safety regulations are likely to impinge upon the most fundamental aspects of the resident's experience of their home. Heating and ventilation may be designed for safety rather than user adjustment and 'hot' water may be cooler than the resident might like in order to prevent scalding. It could however be argued that it is possible, at the design stage, to *design* 'safe' environments that offer residents' choice with respect to privacy alongside buildings that offer good lighting, heating, ventilation and access to facilities.

2.6 Conclusion

This chapter has attempted to evaluate the meaning of 'home' in order to distil out, define and understand what ideas about home are likely to mean for older adults. Such an understanding is important in order to appreciate the characteristics that differentiate the experience of being 'at home' from that of being 'in a home'. Willcocks et al (1987) conceptualise home as having three dimensions. First, home is a place of physical objects and spaces. Thus 'home' might equate with objects or treasured possessions and

the ability to exercise choice over the use of place and space. Whilst the physical characteristics of houses are important, it was argued that they are, in part at least, 'hygiene factors' that whilst having the potential to dissatisfy are not in themselves able to satisfy, and do not, on their own, constitute 'home'. The objects within houses are often however endowed with meanings that help to constitute the house as home. Such objects may include furniture and possessions which have sentimental meanings, and which, in some circumstances, may be transposable into the residential care home setting. For example, a display cabinet full of ornaments or a favourite armchair may have significant sentimental value and contribute towards meanings of home.

The second dimension relates to home as a social place involving interactions with and between people. Home is inextricably linked with relationships and with memories which in turn bestow special meanings on place, space, objects and possessions. It was argued that the domestic home can however become a very lonely place for older adults whose friends and relatives have either died or moved some distance away. Relationships are undoubtedly an important aspect of home, yet relationships are not dependent upon the house and therefore ideas about home *as a social place* may also transpose to another environment, such as the residential care home.

The third dimension of home characterises it as a 'metaphysical' place to which people ascribe their own meanings. This conceptualisation appears to recognise that home is a relative place whose meanings are personal, perspectival and temporal. Thus, different people are likely to adopt their own *very personal* meanings of 'home' and being at home according to their different perspectives at different times throughout the life-course. Family and the relationships an individual forms with them, within a particular house, are likely to change over time and with these changes ideas about 'home' are likely to change too. Once valued spaces and possessions may also become a burden to be maintained and therefore cease to be meaningful as aspects of home.

Whilst home is generally portrayed in a positive sense, it can also become a place where life is taken over by the equipment and the routines of daily care. From this perspective home can take on the characteristics of an institution where the older adult is subject to routines, surveillance and the gradual stripping away of their identity and dignity. Where relatives are directly involved in personal and intimate care, this may in turn

place stress upon family relationships and erode the features of the domestic home that once gave it special status. Under these circumstances residential care may actually improve quality of life for some older adults.

Choice is an important theme that runs through the different conceptualisations of home, for example having the choice to enjoy a hot bath, to bake a cake, to potter about in the garden or to receive visitors in privacy at any time. The chapter has argued however that whilst the published literature from Government and from providers may appear to promote independence and choice, concepts of 'care', and especially a perceived duty to manage risk, may redefine older adults as dependent, in need of care and therefore in need of protection from harm.

Within their own home however, the older adult is unlikely to encounter the discipline of health and safety law. Whilst they may no longer enjoy complete independence, they are still likely to retain autonomy to take risks in their own home without interference. For example, the older adult may choose to have a hot bath, to light a fire, to re-heat yesterday's dinner or to sleep with their bedroom window and door wide open. However, within the formal workplace that is the residential home, the older adult 'becomes' someone whose status as 'resident' places them within the protection of health and safety law. To this extent, the freedoms that they enjoyed 'at home' *may* become activities that the residential care home defines differently. Thus, the extent to which the residential care home facilitates choice in terms of possessions, pastimes and relationships and mediates these considerations within the imperatives for healthy and safety law are likely to be defining characteristics of a (care) 'home' away from (domestic) home.

Chapter 3 – Regulating risks within care homes for older adults

3.0 Introduction

Care homes for older adults operate within a mixed economy of welfare, characterised by a growing movement towards welfare pluralism involving private, voluntary and informal sectors (Powell, 2007). This represents an interesting case study of how risk is both conceptualised and regulated within the different sectors. Care homes are at once a *home* for the people who live there and also a highly regulated place of work for those who provide care. For care professionals the discernable increase in regulatory presence may have resulted in the readily available expedient of 'regulation' as a fall back when explaining or justifying risk management practices that may restrict choice.

This chapter is divided into three parts. Part one provides a brief overview of the concepts associated with the term 'risk' in order to underpin a discussion of its regulation and application within the context of the mixed economy of residential care. A discussion about 'risk' has relevance on a number of levels. It is a multidimensional phenomenon that is both highly regulated and part of the management framework that determines the residents' experience of home. The management of risk can also be applied in both enabling and disabling ways (Tanner and Harris, 2008), and as the empirical work demonstrates, the management of risk can, paradoxically, create new risks.

Part two focuses on the statutory regulation of risk within residential homes against the backdrop of a new institutional policy style in which Government's role as a regulator of risk has been developed while its role as a direct employer, property-owner and long term care provider has declined through privatisation and downsizing (Hood et al, 2004). It will trace the evolution of the new mixed economy of care showing how the role of the state has changed quite significantly over the last quarter century from a provider of public services to being a regulator of services increasingly delivered by others (Bolton, 2004).

Part three discusses the policy framework controlling health and safety, and specifically its application in residential care. It is argued that it is this often complex framework

that tends to be the focus of attention for proprietors and home managers and this has led to accusations in the care press that: '*Regulations* [are] *stripping away choice and independence for older people*' (Community Care [online] September 8th 2004). It is however argued that it is not health and safety regulation, per se, that does this. Rather it is the way that health and safety regulation has been framed in the context of residential care, specifically within the National Minimum Standards for Care homes.

3.1 Theorising risk

It has been said that the concept of risk has come to dominate the political and social landscape of the late twentieth and early twenty-first centuries (McLaughlin, 2006). For some, it has come to fiercely divide the social and natural sciences (Adams, 1995; Banks et al, 2000) representing a conflict between sociologically informed concepts of risk and what have been called the traditional, probabilistic calculations of risk (Powell and Wahidin, 2005). For Parton (1996), risk is not a set of realities waiting to happen, or to be 'unearthed', it is a way of thinking. It is therefore useful to identify not only what is meant by risk, (its semantic definition), but also how people might regard and perceive risk on a subjective level, within the different traditions of social and natural science. For some, risk only relates to potential loss or damage, while for others it has a positive side, with the possibility of gain. There is an extensive literature on risk and what has been termed the different varieties of risk (see Taylor-Gooby, 2002).

Historically the notion of risk was recognised as being either something 'good' or 'bad' which could involve loss or gain (Lupton, 1999). The shift in emphasis from 'bad luck' or 'fate' to rational thinking, systems of prevention and ways of identifying threats before they take effect, has resulted in what Castel argues is an obsession with preventing risk, built upon '*a grandiose technocratic rationalising dream of absolute control*' (1991: 289 cited in Lupton 1999: 7). Giddens (1990) also acknowledges a shift in thinking about risk as being a function of what might be termed management rather than the product of fate. Contemporary ideas about risk have replaced earlier ideas of fate or fortune with new ways of thinking concerned with human actions or inactions.

Bernstein (1996) suggests that modern thinking began when man abandoned the belief that events are due to the whim of the gods and embraced the notion that we are active,

independent agents who can manage risks. Risk, in the sense in which it is now understood, is a relatively recent concept. Before the nineteenth century *risk* was a neutral term, concerned merely with probabilities, of losses and gains (Fox, 1998). Risk simply meant that there was potential for loss or reward. The risks faced by those living in the early twentieth century were *arguably* greater than those faced today, yet the management of risk in contemporary society appears to have come to dominate the political and social landscape (McLaughlin, 2006). Indeed '*Our age is not more dangerous - not more risky - than those of earlier generations, but the balance of risks and dangers has shifted*' (Giddens, 2000: 52).

In contemporary society the meaning of risk appears to have been transformed from being seen as a neutral term into something that is entirely negative or dangerous. Douglas (1992: 40) suggests that '*from a complex attempt to reduce uncertainty*, [risk] *has become a decorative flourish on the word danger*'. Thus risk has been pre-empted to mean an '*undesirable outcome*' (1992: 24), or a state of vulnerability as the result of '*events caused by others*' (1992: 28). Indeed, within the discipline of social work, risk has been framed in negative terms as '*the relative variation in possible loss outcomes*' (Brearley, 1982: 82). Thus, when working with older adults, social carers may tend to equate risk with vulnerability (Stalker, 2003). Risk assessments are thus likely to adopt these characteristics where the 'risk assessor' feels obliged to 'protect' those in their care (or themselves) from some supposed harm. This may arise from perceived hazards within the home or from fear on the part of the home manager of litigation if they fail to fulfil their duty of care. Risk assessment therefore becomes an activity likely to pre-suppose a negative outcome and thereby some form of prohibition or constraint on freedom (Stalker, 2003).

3.2 Perspectives on risk

Whilst *risk* has been an area of considerable academic activity, Taylor-Gooby (2002) suggests that it is difficult to identify a common theme. Like home, the concept appears to be complex and many faceted. Cultural and organisational theorists have taken a particular interest in the way that risk is conceptualised within complex social worlds (Hood et al, 2004), thus, whilst the law might envisage one particular approach to understanding and applying the regulatory framework, it is likely to be done through the

socio-cultural lens of a particular world view or community of practice[11]. Douglas suggests that: '*one of the interesting questions in risk studies would be to know how consensus is reached*' (1992: 12). The next section will consider three contemporary perspectives on risk which have seen it broadly classified into *techno-scientific*, *psychometric* (Kahneman et al, 1982; Slovic 1982; Marris et al, 1997), and *socio-cultural* paradigms (Lupton 1999; Tansey and O'Riordan, 1999). Whilst there are important differences within and between these 'paradigms' or classifications, they can also be seen as complementary in many important respects.

3.2.1 The techno-scientific paradigm

The techno-scientific paradigm emerges from what might be called the numerate disciplines of engineering, statistics, actuarialism, and economics which adopt probabilistic approaches to calculating risk (Lupton, 1999). Clarke (2000: 84) suggests that there has been a 'promulgation' of the use of technical evidence which has served to perpetuate a narrow definition of risk and whilst alternative frameworks for understanding risk have been proposed, in care research, a positivist perspective has predominated (Ballinger and Payne, 2002). The techno-scientific perspective exemplifies the approach taken by UK health and safety law, which places a statutory duty upon employers to identify potentially harmful [work] activities, to assess the risk of any harm that might arise and to implement control measures to mitigate them. Such an approach is synonymous with contemporary definitions of risk which usually define risk objectively as a combination of uncertainty and damage (Kaplan and Garrick, 1981). The essence of risk that the legal framework seeks to control is not based on something that is happening but on something that might happen (Adam et al, 2000). Accounting practices might be regarded as the traditional basis for the science of risk calculation. Actuaries working for insurance companies and risk assessors in the business of health and safety risk, all use complex calculations to predict what 'might' occur (Hassler, 1993; Babcock *et al*, 1993 in Fox, 1998). Hertz and Thomas (1983) describe risk assessment as methods which seek a '*comprehensive understanding and awareness*' of the risks associated with a given setting. Risk assessment, is seen as a

[11] Community of practice - Lave and Wenger's (1991) model of situated learning framework theorises that learning involves a process of engagement in a 'community of practice' where people adopt the language of their particular cultural context and adapt to its customs and rituals – see chapter 6.

technical procedure which is to be undertaken through rational calculation of ends and means (Fox, 1998). The Health and Safety Executive suggest that: '*A risk assessment is simply a careful examination of what, in your work, could cause harm to people, so that you can weigh up whether you have taken enough precautions or should do more to prevent harm. Workers and others have a right to be protected from harm caused by a failure to take reasonable control measures*' (HSE, 2009).

Professional health and safety managers who are employed by care home providers are likely to use a techno-scientific approach to the assessment of risk. This can take the form of a numerical risk rating scale where risk is expressed mathematically as the product of the consequences of loss or damage, of a given event, having a given probability of occurrence. The resulting quantification or *quantum* of risk is then used to assign a priority for action (St John-Holt, 2005). For example, a kettle *might* be regarded as a risk to resident safety because of the potential *risk* of scalding from boiling water. The risk is a combination of the *likelihood* of being scalded and the *severity* of the scald. For most adults the risk of being severely scalded is low, however for someone who is regarded as a 'vulnerable older adult' the risk of scalding *may* be seen as significantly higher; i.e. it is deemed likely that they will spill boiling water onto themselves with the consequence of injury and subsequent 'blame' for those responsible. Thus it is possible that some professionals might apply a 'socially constructed' risk heuristic to their assessment of the risk of scalding that regards *all* kettles as intrinsically dangerous to *all* residents, regardless of their capability, personal choice or location.

This 'formula' is applied against the backdrop of what has arguably become an increasingly ageist, risk averse, litigious and regulation oriented society. The medical view of ageing as pathological retains a powerful influence, where the older adult is regarded as being at risk (Bland, 2005). For example, it is suggested that the identification of falling as a significant health problem for older adults is based on positivist (medical) perspectives of risk that prioritise the reduction of physical injury (Ballinger and Payne, 2002). Indeed across the range of health care services, Peterson and Lupton (1996) have noted that health promoters and various institutions appear to have worked together to produce the at-risk individual.

Douglas (1992) suggests the potentially important influence of our system of justice as another driving force behind the conceptualisation of risk. In this respect there have been two very significant changes to the application of the law. In 1999, Lord Justice Woolf introduced new rules (the Civil Procedure Rules) in order to improve access to justice, modernising a system that had been largely unchanged since 1875. Now anyone who is injured *at work* or *by work* can *'press for retribution and compensation where* [real or perceived] *harm has been caused by work activities'* (Walters, 2000: 8). The implication of this for the care home owner or manager is that in order to defend a legal action against them they must be able to show that they have complied with the requirements of health and safety law, which in turn may influence their approach to managing risk. The second and more significant regulatory backdrop to the management of risk can be seen in the evolution of codes of practice and social care statute. The introduction of the Care Standards Act 2000 has for example set clear *minimum* standards for care homes, requiring compliance with the framework controlling health and safety. At the same time the identification *of* and protection *from* risk are often explicit within professional codes of conduct such as those for nurses and social carers (Ballinger and Payne, 2002). The General Social Care Council's code of practice (GSCC, 2002) includes requirements to protect people from harm, and also to comply with health and safety law (McLaughlin, 2006). When faced with excessive rigidity in the form of regulatory standards and codes, services may become defensive rather than person centred and innovative (Broadhurst et al, 2009). Alaszewski and Manthorpe (1998) conclude that 'staff-centred' bureaucracies are likely to be expert oriented and will try to control their environments by anticipating and preventing risk. In contrast, organisations that are more user / resident oriented are likely to be more flexible and to value individual judgement. These ideas are further developed below and in chapter 4, the Theoretical Framework, where risk is placed within the four cultural contexts deriving from the 'Grid' and 'Group' typology (Douglas and Wildavsky, 1982).

3.2.2 The psychometric paradigm

The management of risk has evolved into a management discipline in its own right (see for example the Health and Safety Executive's extensive literature), where the 'human element' introduces what Hillison and Murray-Webster (2007: 13) suggest is an

additional layer of complexity into the process. The psychometric paradigm theorises *an individual's* perception and interpretation of risk and the mental strategies or rules that they might adopt when addressing risk. Such rules or 'heuristics' are often viewed as leading to '*large and persistent biases*' (Slovic 1987: 281; Lupton, 1999: 19). For example, the 'medical model' of ageing might be regarded as labelling older adults as vulnerable and therefore at risk (Ballinger and Payne, 2002; Bland, 2005).

The attitude of those who might wish to take a particular risk and those who perceive that they have a statutory duty to manage that risk will depend upon their attitude towards the likely degree of uncertainty. Uncertainty in a particular situation is mediated by underlying psychological influences known as *heuristics* (Greek *heuriskein* - to discover) which introduce subconscious and systematic biases into the decision process. Heuristics operate at the unconscious level and therefore represent a covert influence upon the management of risk and may be characterised by terms such as 'rule-of-thumb', 'gut-feeling', or 'intuition' (Hillison and Murray-Webster, 2007: 52).

Heuristics can operate at both the individual practitioner level influencing the decisions of managers or carers, and at organisational level, influencing shifts, entire homes or even whole organisations. The use of heuristics as a device to understand risk attitude forms part of the risk literature (see for example Kahneman et al, 1982; Reason, 1990; Cox and Tait, 1991; Cox and Cox, 1996; Kemshall et al, 1997; Hillison and Murray-Webster, 2007). The 'rule' might be regarded as the conscious manifestation of the rule makers' bias towards a perceived risk. Such biases could for example derive from professional standards or codes of conduct, subsequently adopted as 'rules' rather than aids to complex decision making (Ballinger and Payne, 2002: 307). For example, lifting and handling of people who couldn't stand or move on their own used to be heavily influenced by adherence to Royal College of Nursing guidance. This guidance advised that manual handling should be eliminated in all but exceptional or life threatening situations (RCN Code of Practice for Patient Handling, 1996). Thus, the right of an individual to choose how they might want to be assisted was apparently subordinated to a 'rule of thumb'.

Taylor (2006) recognises that addressing hazards and risks is part of professional care practice. In exploring how care professionals made decisions about the long term care

of older adults, he theorised that risk might be conceptualised and managed in terms of six distinct heuristics (which he calls paradigms), each with its own assumptions. He suggests that his paradigms appeared to be in a state of reciprocal tension, each standing alone as the '*philosophical underpinning of a heuristic to simplify decision making within a particular framework*' (2006: 1424). Each paradigm was thus a coherent way of understanding a range of issues with a 'dislocation' between working within one paradigm and another. They might also be likely to play a part in the application of 'street level bureaucracy' (Lipsky, 1980), where policies and procedures were interpreted and applied according to some preconceived 'model'.

Taylor called his first risk paradigm 'identifying and meeting needs' (IMN), which he suggests is about addressing 'risks now', but not 'risks tomorrow'. IMN is therefore a proactive or pragmatic paradigm for dealing with immediate situations, for example, admitting a person considered 'at risk' in their own home into residential care. The second paradigm is called 'protecting this individual and others' (PIO), which encompassed situations where individuals may harm others, for example a person with dementia whose mental functioning was seen as a key component in shaping their perception of 'risk'. In the PIO paradigm, the management of risk may be imposed on the individual, rather than meeting their expressed needs (IMN). Minimizing situational hazards (MSH), Taylor's third paradigm, appears to derive directly from health and safety law, which imposes a duty upon individuals to take all reasonably practicable steps to minimise risk. The health and safety requirements relating to employees were thus applied by extension to service users in order to avoid creating a double standard.

Taylor's fourth paradigm 'balancing benefits and harms' (BBH), is based on the premise that risk taking is an intrinsic part of life. The mandate for the BBH approach derives from the right to make choices regarding hazards and risks, as well as the opportunities that life presents. The fifth paradigm, accounting for resources and priorities (ARP), was said to dominate the development of policies for 'risk management' in some organisations, which might take little account of appropriate risk taking (Kemshall, 2000).

Taylor's sixth and final paradigm is wariness of lurking conflicts (WLC), which acknowledges the concerns of staff and their sense of vulnerability to legal action.

This paradigm might derive from a greater focus on accountability and public scrutiny of services (Kemshall and Pritchard, 1997) which might cause providers or their staff to act defensively. Taylor acknowledges the possible role played by a perceived 'blame culture' (Douglas, 1992; Furedi, 1997) within this paradigm. This acknowledges the role played by the socio-cultural environment within which risk is perceived, understood and acted upon.

3.2.3 The socio-cultural perspective

In discussing the techno-scientific and psychometric perspectives on risk, it appeared evident that both were inextricably linked to the environment within which they were likely to be applied. For example, the techno-scientific assessment of risk is unlikely to be completely 'objective' when it is mediated by local expectations and the perceived requirements of standards and codes. The socio-cultural perspective emphasises those aspects of risk which the techno-scientific and psychometric paradigms have been criticised for neglecting (Ballinger and Payne, 2002).

Thus, the concept of a 'hazard' or a 'risk' is seen as something that exists against a back-drop of regulatory, societal and corporate expectations. Hazards are seen as being socially constructed, i.e. created from the contingent judgements about the adverse or undesirable outcomes of choices made by human beings (Fox, 1998: 673). Clarke (2000), for example, suggests that whilst care practitioners may emphasise the physical domains of risk, the older adult may emphasise the biographical domains associated with loss of self identity. Conceptually there are two strands to the socio-cultural perspective characterised by cultural and sociological theories of risk (Shaw and Shaw, 2001). Both perspectives adopt the premise that risk is socially constructed and collectively perceived (Gabe, 1995; Shaw, 2001).

Sociological theorists focus on how material constraints and social interest impact on the perception of risk. For Giddens (1991), there has been a decline in trust for expert authority – where expert judgements are scrutinised, contested, accepted or rejected on the basis of lay people's *own* assessment of risk. Beck appears to share this view where: '*insurance experts contradict safety engineers* [and] *Politicians encounter the*

resistance of citizens' groups' (1994: 11). People appear to have become intensely aware of risk, where products once thought to be harmless have evolved into things seen as 'dangerous'. Risks become politicised as they are aligned with social, economic and political consequences, for which someone must be held to account (Beck, 1992, 1994). Annandale (1996) identifies, for example, increasing awareness of the patients' rights agenda as a factor influencing daily practice. Cultural theorists attempt to address the wider organisational, institutional and interpersonal contexts of risk which originates with the anthropological work of Douglas (1966, 1990, and 1992) and later collaborative work with Wildavsky (Douglas and Wildavsky, 1982). These authors theorise that societies are selective about the risks that they choose to address (Shaw and Shaw, 2001), where '*the perception of risk is a social process*' and not an objective reality (Douglas and Wildavsky, 1982: 6).

The idea of risk as something that is mediated by a socio-cultural perspective might be illustrated by reference to the report that followed the fire at the Fairfield residential home in 1974[12] and a later fire at Wensley Lodge in Humberside. At the time the Fairfield report concluded that '*some degree of risk from fire has to be accepted in homes*' (Robinson, 1999: 6). This arguably contrasts with the contemporary risk management of everything (Manthorpe, 2007), where risk control measures appear to have become something of a preoccupation. Certainly the risk of fire is now something that is regarded as completely unacceptable, and is therefore, very highly regulated and blame is likely to be apportioned for management failure.

The regulation of risk by institutions in different policy domains has also been explored by Hood et al, who suggest that there is no such thing as a risk society, only different risk regulation regimes (2004). The next section will develop this idea in the context of the evolving regulatory framework for care homes and how they have linked their management with the management of health and safety risk.

[12] The Fairfield home fire, inquiry, subsequent report and design considerations are discussed in more detail later on in this chapter in the context of the evolution of the 'modern' welfare state and its care home buildings.

3.3 The regulation of care homes

This section will explore the evolution of contemporary residential care and the regulatory landscape that impacts upon the management of risk within this domain. The management of risk represents a key concept at the intersection between individual rights and protection from harm (Tanner and Harris, 2008). Whilst there are legal and regulatory restrictions on what one can do in a domestic setting, home is generally not a regulated place that must be risk assessed and 'safely' managed in accordance with the law. Care homes on the other hand occupy an interesting position in society as they are at once a home and a place of paid work. Indeed many residential care homes are small or medium sized businesses, which must balance regulatory compliance with providing a 'home' for residents.

Within care homes for older adults there are two principal regulatory frameworks to consider, both concerned with risk. The principal regulator for care homes, the Commission for Social Care Inspection (CSCI), works to two distinct regulatory agendas. The first asserts the *rights* of residents, whilst the second asserts the *responsibilities* of providers to manage risk by reference to health and safety law. This regulatory process is designed to shape, motivate, monitor and modify management practice (Macrae, 2008).

3.3.1 The evolution of modern care home regulation

Modern residential care is characterised by 'care homes' and 'care homes *with* nursing', both are registered with and inspected by the same regulator. However this simple dichotomy has evolved along two completely separate historical pathways tracing the evolution of the nursing and social work professions over the late nineteenth, twentieth and early twenty-first centuries. From the 1880's onwards separate nursing homes and private (home) hospitals began to emerge for people of modest income who could not be conveniently cared for at home (Abel-Smith, 1964:150; Peace and Katz, 2003). The Nurses Registration Act of 1919 set up the General Nursing Council which maintained a register of nurses to ensure that they were properly trained. In 1927 the Nursing Homes Registration Act was introduced regulating '*any premises used or intended to be used*

for the reception of and the providing of nursing for persons suffering from any sickness, injury, or infirmity' (Nursing Homes Registration Act 1927: Section 10). This legislation remained largely intact until 1975 when powers of registration and inspection were transferred to Area (later District) Health Authorities and consolidated under the Nursing Homes Act 1975.

Care homes can arguably trace their roots to the Poor Laws and workhouses of England. For example a report of the Royal Commission on the Poor Laws published in 1909 showed that almost half of the residents living in workhouses were in old age (Peace et al, 1997). At this time however, the needs of older adults within society were not recognised in the same way that they are today (Peace and Katz, 2003), as poverty and not old age was seen as the reason why people needed state support and care. Indeed the concept of 'not working' in old age or retirement as we know it now only emerged later on largely in response to unemployment in the 1920's (Means and Smith, 1994:18).

The Local Government Act of 1929 transferred the management of workhouses from Poor Law Unions to local authorities and reclassified them as either Public Health Hospitals or Public Assistance Institutions (PAI). By the beginning of the Second World War in 1939 there were around 400 Public Assistance Institutions and the majority of their residents were older adults (Ministry of Health, 1939 cited in Peace and Katz, 2003). The advent of the Second World War brought about significant changes, specifically many old people with health problems were discharged from hospital care into overcrowded PAI's in order to make space available for the newly created Wartime Emergency Medical Service (Titmus, 1950).

3.3.2 The modern welfare state

Following the Second World War and the election of the Labour Party whose manifesto was built on social change, the National Health Service Act was introduced in 1946 providing 'free' healthcare for everyone. Two years later in 1947 and following the findings and recommendations of the Nuffield Survey Committee, the National Assistance Act of 1948 was introduced, placing a duty on local authorities to provide

'*residential accommodation for persons who, by reason of age, infirmity or any other circumstances are in need of care and attention not otherwise available to them*' (Section 21), in effect abolishing the Poor Law and introducing the idea of bespoke residential services focussed on the needs of older adults.

Section 26 of the Act gave local authorities the power to place residents in voluntary sector homes and in 1968 the Health Services and Public Health Act (Section 44) extended this provision to private sector homes. The National Assistance Act like all modern legislation was supported by an evolving regulatory framework which laid the foundations for the registration of residential care in terms of the appointment of a 'fit person' (The National Assistance Act *Registration of Homes Regulations*, 1949) to manage the home and later in 1962 to oversee the 'fit conduct' of the home (The National Assistance Act *Conduct of Homes Regulations*, 1962), (Peace and Katz, 2003).

The optimism of the post-war welfare state appears to have given way to the realities of a system famously documented by Peter Townsend in his 1962 publication *The Last Refuge*. This work examined thirty nine old workhouses, fifty three post war local authority homes, forty two private care homes and thirty nine voluntary sector care homes. Despite over a decade having passed since the introduction of the post-war reforms, Townsend was extremely critical of the institutional treatment that he found concluding that the overall standard was low and that older adults had in effect lost their right of access to equal status and independence. Concerns about care homes continued throughout the 1960's, 1970's and into the early 1980's (Townsend 1962; Miller and Gwynne, 1972; Kings Fund Centre, 1980; Booth, 1985; Willcocks et al, 1986, 87; Peace and Katz 2003), with Parliamentary and special interest groups like the Residential Working Group of the Personal Social Services Council (PSSC, 1977) pushing for reforms, a process leading to gradual changes in legislation.

One potential cause of such poor standards was the Government's focus on the building and design aspects of residential care rather than the processes such as staff training. After 1948, the Government's priority for residential care was the replacement of the old workhouses with new buildings designed to match the new philosophy of 'welfare' rather than the custodial and institutional model of care associated with the workhouses and PAI's (Bland, 2005). Thus for residential homes concepts of 'home' were almost

exclusively determined in terms of the design of buildings and space or as Bland states '*the Government put its faith in the design of new buildings in its desire to rid residential care of its stigma and unpopularity with senior citizens*' (2005: 102). Between 1969 and 1979, a series of design and good practice guidance Building Notes were issued similar to HFN 19: *The design of residential care and nursing homes for older people* (1998) discussed in Chapter 2. Amongst these designs were the very modern (modern in the very early 1970's) 'CLASP' (Consortium of Local Authorities Special Programme) buildings constructed from pre-formed concrete panels, a familiar sight in school, library and health centre designs.

The concept of home as a building appeared to mean that what happened *in the building* was left largely to chance. There was a consequent lack of attention to staff attitudes, behaviour and the management of risk through appropriate systems and levels of training. Care appears to have been viewed very much as *common sense* and in keeping with the domestic and housekeeping model: '*The notion of domesticity was adopted, to emphasise the move away from 'the institution', with staff cast in the role of 'caring' relative*' (Bland, 2005: 102). This had the unforeseen consequence that many staff perhaps 'misunderstood' what was meant by 'caring relative' and thereby adopted an overprotective and controlling regime towards the residents in their care, i.e. staff thought of *home* in terms of the control that might need to be exercised when caring for young children, rather than for their peers. Jack notes that: '*images of home, family and domesticity have obfuscated the real nature of residential institutional living for decades. The frequent refrains 'it's just like their home here' and 'we don't have rules at home' have served to confuse staff and residents alike and to undermine the benefits to be derived from shared living in certain circumstances*' (1998: 190). Whilst the Personal Social Services Council (PSSC) had recommended training for staff in1975 (Bland, 2005), it would not be until the advent of the Care Standards Act 2000 at the end of the millennium that training in social care would be required by law.

3.3.3 The new public management and the new market for care

In 1979 a Conservative Government drew what Peace et al (2003) described as a dividing line in the history of residential care for older people. Local authority

residential homes lost their dominant position, as policy makers gradually divested the public sector of its provider functions, believing that the move to a market would ultimately drive out poor quality services. This is set against a backdrop of what has been called a paradigm shift in emphasis from 'welfare' to 'consumerism' in social care (Allen et al, 1992). This trend has been especially evident in the provision of residential care where both local authorities and NHS long stay hospitals have gradually transferred provision for older adults to private sector providers (Hopkins, 2006). The Conservative's belief in the 'minimal state' where Government intervention was seen, at best, as a necessary evil, might be regarded as underpinning what has become known as the New Public Management (NPM) (McLaughlin et al, 2002). The main hypothesis behind this philosophy is that market orientation in the public sector leads to greater cost-efficiency and improved services.

The Conservative Government were attracted by the idea of private sector management techniques, in particular market based models of quality, characterised by competition, markets, flexibility, autonomy and devolution. These ideas were gradually introduced into the public sector on the basis that they '*were superior to the long established public administration principles of organisation, so the diverse approaches to quality were replicated in the public sector*' (Waine, 2004: 46). The Government encouraged a policy of closing long-stay hospital beds for older adults (Means et al, 2002) adding to the numbers of potential clients and in effect opening up a completely new market for residential and nursing care. Amendments to supplementary benefit regulations in 1980 and 1983 extended benefits to cover the cost of residential care, effectively removing state control on funding and allocating residential accommodation. From November 1983 until 1993, older adults with limited savings automatically qualified to receive full state benefits which paid care home fees without assessment and or means testing (Andrews and Kendall, 2000). This enabled people who normally could not afford it, the right to choose private or voluntary sector care, creating at the same time significant increases in public spending on care home support. Between 1978 and 1984 expenditure increased from £6 million to £190 million (Bartlett and Phillips, 1996).

The Audit Commission, established under the Local Government Finance Act (1982), as an arms length inspectorate, was arguably a key component in driving forward the Government's new agenda. The commission was tasked to secure compliance with the

law, by helping local authorities to achieve better value for money, whilst strengthening local accountability (Audit Commission, 1986: 1). These objectives were to be achieved by monitoring the three E's of *economy*, *efficiency* and *effectiveness*. In 1986, the Commission published '*Making a Reality of Community Care*' which endorsed community care as the major alternative to institutional forms of provision for adults. The National Health Service and Community Care Act (1990), which followed the Griffiths report (1988), was arguably influenced by the Audit Commission[13] and introduced three significant changes. First, the previously open budget for residential care was finally 'capped' in April 1994 (Bartlett and Phillips, 1996). Budgets were subsequently relocated back to local authorities and eligibility for residential care became subject to an assessment of need. Second, the role of local authorities was redefined; they were to become purchasers rather than providers of care. Third, any homes the local authority continued to manage were brought under the same regulatory umbrella as all other homes. This heralded the introduction of 'arms length' inspection units, although in practice they were still under the direction of the local authority.

These changes to the way that residential care was funded and allocated resulted in the rapid growth of private and voluntary sector care home provision thus creating a perception of greater choice for those contemplating residential care. The dual guarantees of state funding and a pool of residents acted as a catalyst for a boom in private homes (Andrews and Kendall, 2000), with the number of private residential homes in the UK rising from 2,255 in 1979 to 7,240 in 1986 (Phillips et al, 1988) and by 1990, the independent sector (voluntary/charitable and private/for profit organisations) accounted for more than 59% of all residential home places compared to 35% in 1981 (Central Statistical Office, 1992: 142). By 2001, the independent sector provided 90% of residential care homes for older adults (Wright, 2005: 1095).

The new market for care homes has however succumbed to what might be argued as the inevitability of market forces, or what Scourfield (2007: 156) has termed, a trend towards 'caretelisation'. In this respect the 'market' may become saturated by a smaller number of large corporate providers. Indeed, whilst the demand for residential care has increased, the supply of new care home beds has actually fallen since the early 1990's

[13] See for example Hansard *18 January 1991 volume 183 cc1166-74* 1166 discussing the Audit Commission in the context of the Community care Act

(Banks et al, 2006; Hanson, 2007). The potential resident may therefore have an ever more limited choice of provider within the shrinking market (Office of Fair Trading, 2005). Since the Millennium, a substantial proportion of independent sector care homes have closed. Such closures and the resulting relocation of displaced residents are likely to continue as long as there is a care home market (Williams et al, 2007). As the marketplace is consolidated with closures and mergers, 'new' care homes may not necessarily be located where they are most needed. Local authority fee levels, considered too low by some operators, may mean that homes are increasingly located in more affluent areas which can sustain privately funded residents, or those who can afford to 'top-up' the local authority payments (Banks et al, 2006; Hanson, 2007).

3.2.4 Registration and inspection of the new market

The question arises why *regulate* care homes at all when their very remit is to emulate the unregulated environment of home? Market failure is one likely explanation resulting in concerns about poor quality care, neglect and abuse that the market does not adequately control (BRT, 2004). Such neglect and abuse was documented by an inspector of residential care homes in the 1990's, which illustrates the standards which were evidently deemed 'acceptable' at this time: '*It is impossible to say the number of occasions when I observed staff handling residents roughly, almost dragging [them] out of chairs……Some homes stink of urine and faeces; can you imagine how you would feel, eating your meals in a room that stinks……many older peoples homes [also] have locked doors for most of the day and night*' (Griffin, 1999: 118-19). The evolution of a new market place for care and evidence of possible failures in quality resulted in political demands for an increasingly rigorous form of public scrutiny characterised by a blurring of regulation, inspection and audit (Waine, 2004). Regulation therefore evolved to show how inputs (especially financial resources) were being used to achieve stated objectives for quality and value for money. Regulation was also seen as protecting the public interest, the interests of individual consumers (residents) whilst ensuring the delivery of cost effective services (Bolton, 2004). Rather than an enlightened and self regulating system of residential care, based on a vision of hotel like freedoms, the legislative and regulatory frameworks gradually became stronger and more prescriptive.

The Registered Homes Act was introduced in1984 to ensure the regulation of standards within the new market, *primarily* in private and voluntary residential care homes. The Act built upon the evaluative principles used by the Audit Commission and required homes with more than three residents to register with their local authority. Local authorities were in turn required to set up and to administer an inspection programme to provide independent supervision and protection for people living in private homes. This included ensuring that good material standards existed within homes, for example in the provision of facilities and the identification of weaknesses with a view to improving standards of care. The Registered Homes (Amendment) Regulations 1991, removed the exclusion of small homes from the provisions of the Act so that homes of any size could be registered, regulated and inspected. Whilst the Registered Homes Act introduced a regulatory framework, the system to administer it became the subject of much criticism, mainly due to the differences in the way local authority inspection units were organised and operated. Different local authorities created, in effect, 107 regulatory regimes with various interpretations of the same Regulations (Day et al, 1996). Both homes and inspection units were guided by a code of practice developed in 1984 called *Home Life* (Centre for Policy on Ageing, 1984), whilst nursing homes followed a set of model guidelines issued by the National Association of Health Authorities (1985). In 1989 this guidance was consolidated by a Department of Health publication called *Homes are for Living in* (DoH, 1989), which was intended to be used as a manual for evaluating both the quality of care provided and the quality of life experienced. Its assumptions were that good quality care and life experience group naturally around six basic values of privacy, dignity, independence, choice, rights and fulfilment.

Despite the guidance and regulations the system of registration and inspection allowed inspectors to set their own local standards. For example some inspectors insisted that all rooms should be single occupancy, while others required only 20 percent single rooms. Inspection even varied in the same unit where inspectors interpreted the same rules differently (SCR, 1996). Even the inspection reports produced by local authorities on the basis of their interpretation of this guidance varied in both detail and length (Redmayne, 1995; Worden and Challis, 2006). The approach of inspectors can be seen as an example of *street-level bureaucracy*, a term coined by Lipsky (1980) to describe how policy might be translated into action at the discretion of those who actually

implement it. The relevance of this idea for the thesis is considered in detail in Chapter 4, the Theoretical Framework.

The Registered Homes Act 1984 was like all subsequent legislation designed to protect vulnerable people from (inter alia) poor practice and abuse, however, evidence from both the nursing and social care sectors appeared to demonstrate that this was not the case. Since 1985, there have been a number of well-publicised scandals in both public and private sector homes (for example 'Cold Comfort' – Granada TV, 1987 cited in Allen et al, 1992). Indeed the early 1990s saw an increase in the number of disciplinary cases brought before the professional body responsible for regulating nurses in the UK[14], many of whom worked in care homes. This prompted the damning conclusion that: '*whilst the complaints reveal serious professional misconduct such as physical and verbal abuse, they also identify wholly inadequate systems of drug administration, ineffective management systems, lack of systematic care planning or effective record keeping and almost non-existent induction or in service training….Financial controls and audit procedures designed to safeguard residents' appear to be woefully inadequate*' (UKCC, 1994: 7 in Redfern and Ross, 2005: 258). Health and safety was also identified as an issue, but surprisingly not in the same high profile manner as abuse, but rather in official statistics highlighted in an academic thesis stating that: '*The national picture for notification* [of accidents] *holds little for encouragement. The Health and Safety Executive recently published the notified statistics for 1987/8…. identified residential accommodation as being the Local Authority enforced sector with the greatest number of notified deaths*' (Thrale, 1990: 23).

3.3.5 Regulation of care homes into the Millennium

In 1988 the Wagner Committee was given a remit to review the role of residential care in relation to other personal social services. Letters from residential workers to the Committee revealed the lack of training and ignorance about the philosophy of residential work or of what constituted 'good' or 'bad' practice (Bland, 2005). Reports from industry professionals including Clough (1988) concluded that there were a

[14] Until the advent of the Care Standards Act there was no equivalent professional body for residential social workers.

number of warning signs of abuse occurring in communal settings that were being missed, in part by a failure to share information. Wagner's conclusions were to try and raise the profile of residential care. However the Government took '*a characteristically low key*' response to her proposals (Bland, 2005: 115) and commissioned the Caring in Homes Initiative to take forward the recommendations. This did little more than publish an evaluation of the various initiatives looked at by Wagner and suggested that best practice was being thwarted by three barriers. The first barrier was a lack of clarity about the objectives of individual homes. The second was the tendency of management, professionals and care staff to see their role as protective. The third, and arguably the most significant, was the failure to recognise what mattered to residents. In short, the structures and cultural shift needed to enable residents to voice their opinions and influence their care were '*hardly in place*' (Youll and McCourt-Perring, 1993: 194).

It took nearly a decade and a new Government before any definitive action was taken to improve the regulation of residential care services. In September 1995 it launched a review of regulation and inspection in social services with the publication of the consultation document '*Moving Forward*' which asked a series of questions on the future operation of regulatory arrangements. At the time the Conservative Government had been actively considering deregulation (Waine, 2004). The Burgner report *The Regulation and Inspection of Social Services* (1996) proposed, however, the development of a more rigorous system of regulation and inspection with a greater degree of '*national input into standard setting'* (Burgner, 1996: section 3).

Since 1997 the New Labour Government has introduced a series of regulatory reforms which build upon and implement the recommendations of the Burgner report. In 1998 the Government's White Paper '*Modernising Social Services*' proposed an improved inspection and regulatory regime acknowledging the shortcomings of the 1984 Registered Homes Act. The Care Standards Act 2000 and supporting Care Homes Regulations 2001, established three new structures. The first applied Burgner's (1996) recommendations, by establishing minimum standards designed to '*guarantee the public interest, even while ownership remains outside the public sector*' (Drakeford, 2006: 936). To this end all care homes are now assessed against National Minimum Standards, published by the Secretary of Health under section 23(1) of the Care Standards Act. The second structure established the General Social Care Council, which

is equivalent to the regulatory body for nurses, having a remit to register and regulate social care staff. Third, the Act created an independent public body taking over the work carried out by local and health authority inspection units, with a national remit to regulate care services in England.

The newly created regulator has seen three incarnations since inception. The first, the short lived National Care Standards Commission, was replaced in April 2004 by the Commission for Social Care Inspection (CSCI). The third and latest regulator, the Care Quality Commission, came into force in April 2009 and postdates the empirical stage of the thesis. For five years, CSCI have been the principal regulator, registering and inspecting all care homes and nursing homes, re-designated by the 2000 Act as care homes *with nursing*. CSCI are completely independent of local authorities, with their primary function to focus on the service user and the levels of care delivered by providers in accordance with the new minimum standards.

From inception the minimum standards have also proved problematic in terms of what providers have found to be practicable. In August 2002 for example, in response to apparent difficulties in meeting minimum physical standards for accommodation (the size of resident rooms), the Secretary of State for Health in England issued a consultation document on an amended set of environmental standards for care homes (DoH, 2002). At the time, Age Concern stated that they were '*extremely disappointed…*' (2002: 1) at this apparent dilution of the standards and indeed such changes were not implemented in either Wales or Scotland. The standards are central to the thesis as they bridge the regulation of care homes with health and safety law. The framing of the statutory instruments and secondary legislation for care homes was a '*closed process with little or no involvement of the voluntary sector*' (Kerrison and Pollock, 2001: 491). This implies that the standards were written by industry professionals, some of whom have possibly worked within the industry they now regulate (Makkai and Braithwaite, 1992). This raises the possibility of what Makkai and Braithwaite (1992) have called 'reverse capture effects' which might imply that the standards indeed reflect a particular 'industry' conception or perspective on health and safety regulation.

3.4 Regulation and inspection in practice

Inspectors carry out a range of inspection activities in order to evaluate compliance with the National Minimum Standards. At present there are 38 standards which form the basis of judgements made regarding the conduct of homes. Standard 38 deals specifically with 'Safe Working Practice' with the outcome that: '*The health, safety and welfare of service users and staff are promoted and protected*'. Homes are explicitly required by standard 38.4 to comply with relevant health and safety legislation which includes the Health and Safety at Work etc Act 1974.

Inspection as a process has been said to involve the three core elements of 'direction', 'detection' and 'effect' (Furness, 2009: 490). The director element involves checking the home's compliance with the minimum standards and encouraging improvements. Inspectors must be absolutely clear about the standards that they are inspecting for this element to be effective[15]. Detection involves a comprehensive system of checking the home's systems by announced and unannounced inspections and audit methodologies. For example, care home inspection reports frequently cite 'case tracking' as a means of tracing how resident care is documented and implemented in the context of the standards. Even where inspection and detection methods work well, they may be insufficient to influence practice on their own. Boyne et al (2002: 1203) argue that technical, managerial and relationship factors have a strong bearing on an inspector's ability to effect change. Their expertise and relationship with the inspected home may, for example, influence the degree to which providers accept regulatory findings and the efficacy of their response (Furness, 2009).

This conceptualisation suggests two important considerations. Firstly the 'director' element of the inspection process relies upon the National Minimum Standards and inspector guidance logs being unambiguous in order to reduce street level bureaucracy. Concern about the reliability of quality based judgments has been identified as problematic, as it relies on the inspector to assess the degree to which a standard has been met. An ambiguous standard may for example lead to an ambiguous outcome (Furness, 2009). Secondly, a potentially significant implication of the effecter dynamic

[15] Inspectors are provided with guidance logs which summarise the requirements of the national minimum standards.

is that of 'regulatory capture' (see Schwartz, 2007-8), where the inspector and inspected become '*too close*' so that independent judgment is compromised (Furness, 2009: 490). It has been suggested that *capture* is more likely where residents or their representatives have no voice in the regulatory process (Kerrison and Pollock, 2001). Regulatory capture theorises that regulators go through a lifecycle that sees public interests gradually subordinated to those of the regulated industry (Makkai and Braithwaite, 1992). In practical terms regulators are generally drawn from the regulated industry. Thus many inspectors have been home managers and may therefore identify with the concerns of those regulated and '*lack toughness in dealing with problematic aspects highlighted in inspections*' (Wright, 2005: 1096).

The concept of regulatory capture was said to be influential in driving forward the Conservative Government's 1991 Citizen's Charter initiative, designed to open up inspectorates to the outside world. This was to be accomplished by encouraging 'lay assessors' to become involved in statutory inspections (Wright, 2005). The Department of Health (1994), for example, suggested that lay assessors should be involved in full inspections of residential care homes. The Burgner report (1996), indeed considered lay assessors to be an important development in the inspection process (Wright, 2005). Care home inspections were generally conducted at least twice per year with one announced *full* inspection followed up by a less rigorous unannounced inspection. Each announced and unannounced inspection results in a written report, copies of which are freely available in the public domain. Each report represents a detailed source of information about the home. It is this mechanism that forms one of the measuring instruments and subsequent data sets for this thesis.

Generally, the inspection process consisted of an evaluation of documentary evidence by the professional inspector, whilst the lay assessor toured the home and interacted with residents (Wright, 2005). Evidence from the literature (Wright, 2005; Simmill-Binning et al, 2007; Furness, 2009) would suggest however that the original idea behind including lay assessors in full inspections has not necessarily been realised. They appear to have been cut back or dropped altogether in line with changes to the nature and frequency of care home inspections (Simmill-Binning et al, 2007).

From April 2007, CSCI changed its inspection methodology from two annual inspections to one based primarily upon 'self assessment'. Care homes are required instead to provide Annual Quality Assurance Assessment (AQAA) reports based on seven key outcomes agreed by the Department of Health. The required outcomes include: quality of life; exercising choice and control; making a positive contribution; personal dignity and respect; freedom from discrimination and harassment; improved health and emotional well-being; economic well-being and leadership and management (CSCI, 2006). From 2008/9 homes were allocated a 'star rating' based on inspection data and the perceived quality of their assessment. The new rating includes 3-stars for excellent homes through to zero stars for a poorly performing home. This rating will effectively determine the frequency of future inspections. To some extent this new regime might be seen as encouraging self regulation. Poorly performing homes might be incentivised to improve standards in order to promote their star rating.

In summary, the first part of this chapter discussed how risk is theorised in terms of technical, social and psychological paradigms. Whilst each paradigm is underpinned by its own epistemology and academic discipline, there would appear to be considerable common ground between them in respect of their relevance to this thesis. For example, whilst the techno-scientific paradigm appears to be dominant when considering health and safety risk, hazards and risks are integral to particular cultural contexts and are interpreted through the psychological lens of social actors.

The second part of the chapter showed how the state has made the transition from being a major provider of residential care to a regulator of homes. Residential care is now part of an innovative mixed economy comprising primarily private, corporate and voluntary sector providers. This highly regulated marketplace introduces the interesting paradox of environments, which whilst called 'home', appear also to be regarded as risk laden places of work. The New Public Management of the Conservative Government appears to have intended to deregulate the care home market. However, the Burgner report and the advent of the New Labour administration have seen a significant increase in regulation. This has included an explicit link to the techno-scientific domain of health and safety law which is explored in more detail in the next section.

3.5 Health and Safety in care homes

This section will look at the framework of health and safety law and how it is linked to care homes by Standard 38 of the National Minimum Standards for care homes. The objective is to understand how the national minimum standards manage the interface between the techno-scientific discipline of safety law and values of independence and choice.

The basic framework of health and safety law comprises a relatively large and complex body of regulations; however, the components of the framework are based upon a three stage process requiring employers (those charged with the management of care homes) to:

- Identify the hazards that are associated with work activities **- a Hazard** is something that has the *potential* to cause harm
- Assess the risk - **Risk** (in techno-scientific terms) is the *chance* or *probability* (high or low), that a hazard will actually cause harm
- Identify control measures – **Control measures** should be designed to reduce the risks to the lowest level that is reasonably practicable under the circumstances

As workplaces in their own right, care homes are subject to the provisions of the Health and Safety at Work etc Act 1974 and associated regulatory framework. This means that regardless of the Care Standards Act 2000, care homes have been required to comply with health and safety law since 1974. Health and safety has been portrayed in the media as a very time consuming and institutionalising discipline. In this respect it is seen as taking time away from core business activities and has been reported in at least one professional care journal as stripping away choice and independence for older people (Community Care, 2004). Indeed the literature often appears to cite safety as a reason why older adults' choice might be denied (Youll and McCourt-Perring, 1993; Burton, 1998; Ballinger and Payne, 2002; Help the Aged, 2002; Bland, 2005). The diligent management of risk can therefore be at odds with promoting independence (Ballinger and Payne, 2002). This is a major theme of the thesis where care homes are subject to Minimum Standards that may, at times, appear contradictory. For example, valuing privacy, dignity, choice, rights and independence may conflict with the

expedient to manage risk. It does not however follow that the management of risk arises exclusively from the requirements of health and safety law. It will be argued that health and safety law was not necessarily designed or intended to 'interfere' with the activities of older adults living in residential care homes. However, when health and safety law is mandated within such an environment, it *may* be interpreted in a particular way, which emphasises controlling aspects of the law.

Whereas the evolution of residential care can be traced back over four hundred years, the interface between residential care and health and safety legislation is relatively recent. Health and safety law, however, can trace its roots to the industrial manufacturing context of the factory. In order to understand how the technical discipline of safety law has become linked to the service oriented environment of residential care, it is necessary to briefly trace its evolution and standpoint.

3.5.1 Early health and safety legislation

Health and safety law has evolved over the last three centuries in a fragmented and piecemeal way, often driven by public opinion and political expedience (Stranks, 2006). The Industrial Revolution of the late eighteenth and early nineteenth centuries, for example, saw factory owners employing children in their mills as apprentices. The Health and Morals of Apprentices Act 1802 was in effect the first 'Factories Act' designed to protect young workers from hazards associated with their workplace. Later Factories Acts continued the tradition of protecting industrial manufacturing sites, whilst the equivalent Offices Shops and Railway Premises Act 1963 provided protection for those working in the non-industrial sector. Prior to 1974 an estimated 8 million workers including those employed in the state and welfare sectors, such as care homes, had no protection at all (Barrett et al 2000; Beck and Woolfson, 2000). The residents themselves were however afforded a little protection from fire and accident by virtue of a single paragraph in the National Assistance Act 1948 which stated: '*The manager of every Nursing Home/Home shall take adequate precautions against the risk of fire and accident, having regard in particular to the mental and physical condition of such persons as are received there*' (Robinson, 1999: 1).

3.5.2 The dawn of modern safety regulation

By the end of the 1960's there were 9 statutes, 500 statutory instruments, 7 different inspectorates and 5 separate Government departments all dealing with health and safety (Beck and Woolfson, 2000). Little if any of this infrastructure was seen as delivering an effective standard of protection, prosecution of law breakers being their apparent remit (Beaumont, 1983). In May 1970 a Government Committee was appointed under the chairmanship of Lord Robens with a very open remit to: '*review the provision made for health and safety of persons in the course of their employment ..... and to consider whether any major changes are needed...*' (Robens, 1972 in Smith undated: 3). An important feature of the committee's remit was to look into whether or not further steps were needed to safeguard members of the public against hazards arising out of work activities. It is this aspect of the law that impacts on residents in care homes and indeed children at school (for the purposes of the Act the residents of care homes are defined as members of the public). In June 1972 the Robens Committee submitted its report: '*The legislation is badly structured and the attempt to cover contingency after contingency has resulted in a degree of elaboration, detail and complexity that deters even the most determined reader. It is written in a language and style that renders it largely unintelligible to those whose actions it is intended to influence…*'(Robens, 1972 cited in Smith, undated: 16).

Robens' recommendations met with the approval of the Conservative Government of the day (Nichols, 1997 in Beck and Woolfson, 2000) and the Health and Safety at Work etc. Act (HASWA) was given Royal Assent in late 1974. Whilst the Act conceptually predated the New Public Management it arguably shared many of the characteristics of this philosophy. The key aim of the Robens committee for example had been to replace complex, detailed and prescriptive regulation with a flexible and goal-setting framework. The principal contention behind this approach was that *there was too much law*. '*Voluntary self-regulation was at the core of the regulatory approach which industry representatives advocated and which the Act was eventually to embody*' (Beck and Woolfson, 2000: 39/40).

An enabling Act[16](in four parts) it promoted self-regulation and moved away from the old system of prescribing how safety was to be managed, it created a framework for goal-setting regulations supported by approved codes of practice and guidance. It gave employers a range of options based upon the assessment of risk and formalised the concept of 'reasonable practicability' where the person in control can take into account the cost of providing safe systems and set this against the benefits. Reasonable practicability was designed to ensure a fair and consistent approach to health and safety across all industries. Even though the employer held ultimate responsibility for their undertaking, for the first time health and safety was deemed to be the concern of everyone who created risk at work (Beck and Woolfson, 2000). The new Act streamlined policy making and enforcement providing the legal basis for the appointment and powers of inspectors, penalties for offences etc. and created two statutory bodies (merged in 2008). The Health and Safety Commission (HSC) originally comprised representatives from industry, consumers and local government and was effectively a forum for policy. The Health and Safety Executive (HSE), was a distinct statutory body advising and assisting the Commission. The Legislative and Regulatory Reform Act 2006 facilitated the merger of the HSC and HSE in April 2008. The *new* Health and Safety Executive has responsibility for strategy and enforcing health and safety legislation. Equivalent enforcement powers are delegated to local authority Environmental Health Officers (EHO) under the Health & Safety (Enforcing Authority) Regulations 1977 (Freeman, 1997).

3.5.3 The influence of the European Union

The UK's membership of the European Union (EU) has profoundly influenced the development and application of health and safety law. In 1987 Article 118A of the Single European Act allowed the European Council of Ministers to adopt (by a qualified majority) *Directives* setting down minimum requirements concerning health and safety at work. As an 'enabling Act' HASWA provides for these Directives to be introduced into UK law as subordinate legislation or Regulations. The opt-out of the UK Conservative Government from the social provisions of the Maastricht Treaty of 1992

[16] An enabling act establishes Government agencies to carry out specific functions, in this case the HSC and the HSE.

did not prevent the transposition of Directives into UK law (Beck and Woolfson, 2000). Thus, much outdated or inadequate UK legislation has been replaced or updated by new regulations, approved codes of practice, and guidance. Arguably, the doctrine of Parliamentary sovereignty was considerably qualified by membership of the Union, creating in effect a 'new legal order' whereby Community law has supremacy over national law (Deards and Hargreaves, 1998: 43). The most obvious consequence of this has been the proliferation of Directives and subsequent Regulations that are most keenly felt in the small business or operational environment such as a care home: '……*instead of being less prescriptive, it's probably come round full circle to being more prescriptive than it was before*' (John Shattock, Croner publications quoted in the Telegraph October, 2004). The first major impact was felt in 1993 with the introduction of what has become known as the 'six pack'[17]. This implemented the European Union Health and Safety Directive ensuring that Member States had the same standards to allow for fair competition between businesses working within the Union. This included regulations covering: the Management of Health and Safety at Work, Manual Handling Operations, Display Screen Equipment, Workplace (Health, Safety and Welfare), Provision and Use of Work Equipment and Personal Protective Equipment (Dalton, 1998).

The new Regulations have made the assessment of risk and other requirements that were implied by the Health and Safety at Work Act 1974 completely *explicit*. The Management of Health and Safety at Work Regulations (updated in 1999) for example oblige care home owners and more specifically their managers to undertake certain defined actions and interventions. These include the identification of hazards, the assessment of risk and the development of appropriate control measures and training. Indeed the assessment of risk is now the mainstay of modern safety management, but here again, the EU approach has not met with universal acclaim: '*…the bolting on of European legislation demands a very bureaucratic approach to risk assessment…..*' (Janet Asherson from the Confederation of British Industry quoted in the Telegraph October 2004). Such sentiments may explain why some employers choose risk avoidance in preference to risk assessment and management.

[17] The 'six-pack' is the name given to the 6 most widely quoted health and safety Regulations. The HSE use the term 6 pack, as do many safety texts, although the origin of the term is difficult to reference.

In a whole variety of care settings care staff routinely use mechanical aides to move residents, whereas they might previously have provided more personalised assistance. However, the presumed expedients of health and safety law to act 'safely' do not necessarily override the 'rights' based agenda of those affected. A good example arises from a Judicial Review in the High Court in the case of disabled sisters, A and B, against Sussex County Council. In this case the local authority had operated a 'no manual handling policy' on the grounds of health and safety. The Court ruled however that any risk assessment must take into account the individual needs of the person, their dignity and independence (Disability Rights Commission, 2003). Thus decisions should be taken in the context of individual rights and '*not simply health and safety legislation*' or blanket policies (Mandelstam, 2002: 36).

3.5.4 The interface of disciplines

The Registered Homes Act 1984, the Care Homes Regulations 1984 and Codes of Practice were introduced by a Conservative Government as a means of ensuring good standards of practice within the evolving market for residential care. Regulation 10 of the Residential Care Homes Regulations (1984) included the requirement for the person registered to consider the factors that might affect the general welfare of residents. Like the Health and Safety at Work Act, these provisions were goal setting, with clauses often preceded by the term 'adequate'. For example, keeping the home clean and in good repair, having suitable numbers of adequately trained staff, adequate equipment, furniture, lighting and heating, kitchen facilities and adequate precautions against fire and the risk of accidents (Paraphrased from items A-R Regulation 10 of the Care Homes Regulations, 1984). The influential Code of Practice supporting the Registered Homes Act 'Home Life' referred to by Thrale as the '*bible of residential care*' (1990: 31), tended to emphasise the residents' right to take risk, rather than an agenda of managing risk. This resonates with Alaszewski and Manthorpe's (1998) contention that until the 1980's little attention was paid to the way welfare organisations managed risk.

Indeed 'Home Life' warned against excessive paternalism. For example, responsible risk taking was regarded as normal, and the guide stated that residents should not be discouraged from undertaking certain activities solely on the grounds that there was an

element of risk (Avebury, 1984). Thus it can be argued that the framework for managing health and safety was implied rather than stated as it was closely aligned with maintaining 'adequate' hotel services and preserving residents' right to choose. Indeed the Health and Safety Executive appeared to acknowledge a 'light touch', providing advice for their inspectors that acknowledged the perspective taken by 'Home Life'. Inspectors were advised that they should not '*insist on a standard package of safeguards*' for every home (HSE, SIM 07/2000/08, 2000: 3).

3.5.5 Health and Safety and the Care Standards Act 2000

The advent and implementation of the Care Standards Act 2000 has arguably seen a significant change at the interface of care and safety law. Whilst care home regulation prior to 2000 was not explicit about the implementation of health and safety law[18], contemporary regulation mandates it. This section will explore this contention by reference to the literature published by the separate regulators of safety and care. In practical terms there are two distinct interfaces: the *service delivery* interface in the form of the National Minimum Standards which prescribe how homes must broadly comply with the Care Standards Act and the *regulatory interface* which prescribes how the different regulators (CSCI, HSE and local authority EHO) will interface with care homes when applying health and safety law.

3.5.6 The regulatory interface

The Health and Safety Executive / Local Authorities Enforcement Liaison Committee (HELA) was set up in 1975 to provide effective liaison between the HSE, who as a general rule enforce health and safety in nursing homes, and local authority EHO's who are generally responsible for residential homes. In many ways the progressive stance taken by the Care Standards Act 2000 in removing the distinction between residential and nursing care should eventually erode away the differentiation used in the enforcement of health and safety law. With the advent of the Care Standards Act HELA

[18] This does not imply that health and safety law was not being enforced. Indeed the Health and Safety Executive and Local Authority EHO have continued to enforce health and safety law within care homes throughout this period. However, health and safety law was not an explicit part of care home regulation until the advent of the Care Standards Act 2000.

devised a memorandum of understanding (MoU) between the regulators of health and safety and the newly created regulator for care homes and care services. The purpose of the MoU was to facilitate cooperation and co-ordination between the different enforcing authorities.

An *Enforcement Matrix* accompanied the MoU setting out the distribution of lead responsibilities between the CSCI, HSE and the local authority EHO. The matrix showed that CSCI was expected to take the lead on service user safety, whilst the HSE and local authorities would lead on all other aspects of safety management. The MoU was withdrawn from the internet in June 2007 as new working arrangements had rendered it obsolete. The MoU was replaced by a 'Working Arrangements Protocol' in July 2009 reflecting the agreed operational policy with respect to work related accident investigations. The new enforcement matrix (Annex B of the new protocol) covers the following three broad areas: first, the HSE and local authority are designated as taking lead responsibility for employee safety, general safety management and building/facilities management within the home. Second, the Commission for Social Care Inspection were designated to take the lead on risks to residents arising from their identified care needs. The third area is jointly enforced by both regulators and covers risks affecting residents and employees. For example moving and handling, aggression and facilities issues such as scalding (HSE, 2008, Annex B Working Arrangements Protocol).

3.5.7 The service delivery interface

The National Minimum Standards (NMS) are the point of interface between health and safety law and the delivery of care services to residents. They derive from Section 23 of the Care Standards Act 2000 and are published as 38 separate standards directed at the proprietors and managers of care homes in order to guide them in how to provide legally compliant services. Safe working practices are covered by standard 38. The NMS are supported by 'Guidance Logs' that are used by CSCI inspectors to help them decide the extent to which a particular care home complies or fails to comply with the standards (these logs are written by the CSCI – *Quality, Performance and Methods*

Directorate). Table 2 identifies the NMS that relate directly to health and safety provisions within the home.

Standard	Application	Briefly
38 **Safe Working Practice**	The registered manager ensures so far as is reasonably practicable the health, safety and welfare of service users and staff.	▪ Compliance with legislation ▪ Safe working practices ▪ Health and safety of staff and residents
25 **Services: Heating & Lighting**	The heating, lighting, water supply and ventilation of service users' accommodation meet the relevant environmental health and safety requirements and the needs of individual service users.	▪ Ventilation ▪ Central heating ▪ Prevention of burns and scalds ▪ Adequate lighting ▪ Prevention of Legionnaires disease
26 **Services: Hygiene & Control of Infection**	The premises are kept clean, hygienic and free from offensive odours throughout and systems are in place to control the spread of infection, in accordance with relevant legislation and published professional guidance.	▪ Laundry and sluicing facilities ▪ Hand washing ▪ Clinical waste ▪ Policies for infection control
33 **Quality Assurance**	Effective quality assurance and quality monitoring systems, based on seeking the views of service users, are in place to measure success in meeting the aims, objectives and statement of purpose of the home.	▪ Quality assurance mechanisms might be seen as the key to planning healthy and safe care
37 **Record Keeping**	Records required by regulation for the protection of service users and for the effective and efficient running of the business are maintained, up to date and accurate.	▪ Record keeping is both a legal requirement and a mechanism for ensuring the provision of quality services ▪

Table 2: Health, Safety and the National Minimum Standards

In order to better appreciate the impact of the health and safety specific standards the next section will critically evaluate the standards listed in Table 2 and contained in the most up to date version of the NMS for older persons care homes.

3.5.8 Coherence and relevance of the national minimum standards

The NMS reviewed here was the *Third Impression* dated 2006, which was the most up to date version available from the Care Quality Commission in late 2009. This section identifies areas within the NMS that appear to show an apparent lack of coherence within and between the standards. It is argued that this lack of coherence may reflect an underlying uncertainty about the purpose of the NMS and may also be confusing to providers and inspectors. Regulations listed in Standard 38 (shown in Table 2) and also reproduced in the Inspectors' Guidance Logs, appeared to be out of date, for example the Reporting of Injuries Diseases and Dangerous Occurrences Regulations were dated

1985 whereas the up to date version was 1995. The Control of Substances Hazardous to Health Regulations was dated *1988* (revised in 2002) and the Provision and Use of Work Equipment Regulations was dated *1992* (revised in 1998). It is suggested that the accuracy of dates and versions are important in two main respects. First and most obviously updated Regulations contain important changes or requirements (e.g. RIDDOR changed quite significantly). Second, CSCI themselves emphasise quality assurance, for example, Standard 33 requires the home to have a 'recognised quality assurance system', a requirement of which is the control of documentation to ensure that information is up to date and valid.

Some scholars have suggested that compliance with a particular regulation may be linked to the particular 'regulatory domain' that it occupies (Amodu, 2008). Thus it could be argued that the grouping of particular initiatives or requirements might influence their regulatory significance. For example, Standard 38 mixes the requirements of health and safety law with those of food hygiene legislation. Whilst there are obvious overlaps between the two disciplines, food hygiene is clearly a separate and specialist area. A similar potential source of confusion is the alignment and the apparent lack of cross referencing between different standards. Standard 25 'Services' requires that windows conform to '*recognised standards*'. This recognised standard is arguably set by the Workplace Health Safety and Welfare Regulations 1992[19], listed in standard 38.4, yet this connection is not made.

Standard 26 requires that: '*Services and facilities comply with the Water Supply (Water Fittings) Regulations 1999*' (Std. 26.9). Whilst these Regulations might be relevant to manufacturers, designers and installers, it is difficult to understand their direct relevance for home managers. Nonetheless, there was evidence in CSCI inspection reports that care home managers were being asked to spend time and resources providing evidence that their home met this Standard[20]. Care homes have a statutory responsibility to maintain the records required or implied by the national minimum standards and by

[19] The regulation states that: '*Where there is a risk of falling from a height, devices should be placed to prevent the window opening too far'*

[20] The inspection report examined shows that the home had been required to commission a 'specialist contractor' to undertake a survey of the home to ensure compliance with the *Water Supply (Water Fittings) Regulations 1999.*

health and safety law. However, Furness (2009) suggests that where such records detract from contact time with residents, this may not be a sensible course to follow.

The review of Standard 38 also showed that it provides no additional guidance to the reader that directs them as to how compliance might be achieved in practice. There is for example no debate about the management dilemmas that might arise in balancing 'freedom of choice' against risk management. Whilst *guidance* may not be the intended role of the NMS, it does not appear to cite suitable published texts such as the Health and Safety Executive's own guidance '*Health and Safety in Care Homes*' (HSG 220, 2001) written specifically to provide authoritative advice on compliance with safety law. Standard 26, Hygiene and Control of Infection provides a further relevant example. The requirement to comply '*with relevant legislation and published professional guidance*' (Standard 26.1) is not supported with reference to the Department of Health publication '*Guidelines on the Control of Infection in Residential and Nursing Homes*' originally published in 1996 and updated in 2006.

3.5.9 The Health and Safety Executive guidance

The Health and Safety Executive has a long tradition of producing industry relevant guidance, some of which is highly specific and technical and some more general. A good example of specific guidance includes that on Controlling Legionella in nursing and residential care homes (INDG 253, 2009). This publication provides guidance on managing the risks associated with Legionella bacteria in the water systems and the susceptibility of some people to infection. More general advice and guidance to care homes on a whole range of topics is available in the form of the HSE publication Health and Safety in Care Homes (HSG 220), published in 2001. HSG 220 acknowledges that: '*Care homes differ from other workplaces because they are not only a place of work but they are also a home. While meeting legal duties and providing a safe and healthy environment, they need to be maintained as pleasant places to live*' (HSG 220, 2001: 3).

Arguably HSG 220 is not a panacea that home managers can rely upon to guide them through the (implicit) requirements of standard 38. It appears to be written from the techno-scientific perspective of the HSE and therefore lacks the narratives associated

with the socio-cultural perspective of independence and choice. For example whilst it acknowledges the need for proper risk assessment it fails to clearly differentiate resident related risk and premises related risk that form the basis of the enforcement split identified in the MoU. An important opportunity appears, therefore, to have been missed to convey some clear and authoritative guidance that puts the concept of risk assessment into the context of residential care. There is a brief example of a risk assessment looking at the use of 'cot sides' (also called 'bed rails'). This is perhaps a poor choice of example as there is a significant body of opinion that actively discourages their use. For example, cot sides can potentiate, rather than prevent, injuries (Govier et al, 2000) and the Royal College of Nursing (1992; 2004) argue for the alteration of the environment and meeting the comfort needs of residents instead of using cot sides. Indeed the HSE and CSCI have recently (February 2007) prosecuted BUPA Care Homes under section 3 of the Health and Safety at Work etc Act 1974 (*protecting people who are not at work*) and Regulation 4 of the Provision and Use of Work Equipment Regulations 1998 (*providing and using suitable equipment*), following injuries and the subsequent death of an eighty year old resident who became trapped in the cot sides fitted to her bed (HSE v BUPA Care Homes, Frome Magistrates Court, 2nd February 2007).

Smoking is another area largely ignored and covered by the simple statement: '*Some service users may wish to smoke in their bedrooms. Individual risk assessments should be completed before seeking the views of the Fire Prevention Officer*' (HSG 220, 2001: 38). In July 2007, the Smoke-free (Premises and Enforcement) Regulations 2006 came into effect, making virtually all enclosed public places and workplaces in England cigarette smoke free. The Smoke-free (Exemptions and Vehicles) Regulations 2007, however permit limited exemptions to the smoke free law, which includes designated rooms, including residents bedrooms, within residential care homes. HSG 220 is also silent on the requirements of the Fire Precautions (Workplace) Regulations 1997, amended 1999 and recently replaced altogether with the Regulatory Reform (Fire Safety) Order 2005.

The section on the Control of Substances Hazardous to Health (pg. 16) and infection control (pg.18 & 19) is brief and to the point but in common with standard 38 makes no attempt to cross reference the more detailed Joint publication by the Department of

Health and the Public Health Medicine Environmental Group '*Guidelines on the Control of Infection in Residential and Nursing Homes*' (1996 and updated in 2006). The actions to be taken in the event of a reportable accident or incident (pg. 11 - 13), makes reference to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (cited as *1985* in Standard 38), but ignores the roughly equivalent reporting requirement found in Regulation 37 of the Care Homes Regulations 2001. Such similar requirement for reporting to different enforcing authorities may give rise to possible confusion, having the potential to lead to underreporting (Kelly, 2006).

3.6 Conclusion

A key concept at the interface of individual rights and protection from harm is 'risk' (Tanner and Harris, 2008). The first part of the chapter discussed the different conceptualisations or paradigms of risk, each with its own distinct epistemology and academic following. Whilst the techno-scientific paradigm may be regarded as having a dominant position with respect to health and safety law, it was argued that risk is not assessed from a 'sterile' perspective within a 'sterile' context. Risks are perceived by actors who bring their own experiences to the assessment which takes place within a defined social context influenced by custom, practice and expedience.

The second part of the chapter considered the evolution of contemporary residential care in England from public sector provision through to a new position as part of a mixed economy of welfare. The early market formed by a Conservative Government was a product of the new public management that emphasised a 'light touch' with respect to regulatory intervention. This historical perspective is relevant within the thesis as it shows the cultural origins of contemporary residential care. Homes were encouraged to open by relatively generous funding and relatively relaxed regulation. Whilst health and safety law was a part of the regulatory framework, it appeared not to have been emphasised to any significant extent prior to the Millennium. The new market for care established during the 1980's has since evolved into a highly regulated domain under the administration of New Labour. New Labour has in the words of Newman (2001 in Scourfield, 2007a) emerged as one of the more *regulating and centralising administrations* with the extensive use of performance indicators and targets which are

overseen by regulators who are able to exert more influence on service delivery than ever before.

The contemporary regulation of care homes has seen them subject to National *Minimum* Standards enforced by a new and evolving regulator. The regulator has been empowered to audit and inspect homes against the newly created Standards and to assign a 'star rating' indicating different levels of 'compliance'. The standards require, amongst other things, the application of health and safety law, which at times may sit uncomfortably with concepts of independence and choice. Home managers must therefore balance the stated or implied needs of their residents with the imperatives of meeting standards and managing risk.

The final part of the chapter argued that the technical standards expressed in health and safety regulations and required by the new Standards may appear at times to be complex and confusing. The standards, specifically standard 38, did not convey a clear, concise and seamless interpretation of safety regulation in a workplace that is also a home. Furness suggests that '*clearer and more explicit descriptors of met and unmet outcomes*' (2009: 500) may improve the reliability and validity of the quality judgements made about a home. Clarity of purpose with respect to the standards may therefore reduce time spent on compliance demonstrating initiatives that may have little apparent relevance to residents within the home.

In summary, the residents' experience of their home is mediated by the provider, manager and care staff's perception and management of risk, understood within a highly regulated social context. The next chapter will consider these ideas in terms of a conceptual and theoretical framework thought to have the potential to capture such complexity. It recognises the interrelatedness and interactions of the components and actors that comprise and interface with the different homes comprising the mixed economy of residential care.

Chapter 4 – The theoretical framework

4.0 Introduction

Residential care homes are complex places that operate within a highly regulated mixed economy of welfare (Knapp, 1986). This mixed economy involves 'meso' level public, private and voluntary sector providers, who have evolved from different disciplines, interests and social perspectives. The providers are accountable to both the purchasers and regulators of their service. Purchasers for example are likely to include local authorities who fund large numbers of residents, whilst regulators will include CSCI, the HSE and the local authority EHO who inspect individual homes for regulatory compliance. Each of the care homes operated by a particular provider will in turn comprise a mix of different interests, facilities and processes that constitute what might be thought of as a complex 'micro' system. The home manager for example, is likely to be a powerful mediator within their own home. Whilst they are *theoretically* constrained to operating within the provider's and regulator's policies and procedures, each home manager is likely to bring their own perspective to its interpretation and therefore to the 'street-level' (Lipsky, 1980) management of the home.

This chapter will consider these different dimensions in terms of complex socio-technical systems comprising the varied and interlinked interests of regulators, providers, managers, staff and residents. In conceptualising the home as part of such a complex 'system', this gives rise to ideas of its mediation by the local culture deriving from the provider, home manager, staff and residents. Thus the culture of an individual provider and care home is thought to be an important consideration and will be considered in the context of Cultural Theory (Douglas and Wildavsky, 1982). Cultural Theory may be considered as the lens through which the local socio-technical system is understood and perpetuated. Whilst the regulator and provider might create policies with particular intentions in mind, such policies are not enacted within a vacuum. Rather they are interpreted and translated into action through the lens of 'street-level' actors who may include inspectors and managers. Social phenomena are complex and can be difficult to understand and elucidate. The concepts presented in this chapter thus represent a framework within which the phenomenon of health and safety law within

care homes might be structured and understood. Towards the end of the chapter the idea of systems operating within a culture are consolidated into a model that was found to be helpful in terms of understanding the theoretical ideas and some of the findings. The use of such a model represents an interpretation and understanding of a particular situation, it is neither true nor false, but is more or less useful (Benko and Sarvimäki, 2000). The chapter is divided into three sections. The first section will examine the concept of systems and systems theory including processes and activities. The second section will discuss the consequences of system complexity in terms of outcomes, emergence and what has been termed metastability. The third and final section of the chapter will examine the relationship between systems and 'culture'. The use of the 'grid' and 'group' structure will be discussed as a framework for understanding the likely orientation of a particular care home. A series of tentative propositions is included hypothesising how a care home might appear and present when located within one of the four possible cultural orientations.

4.1 Conceptualising the home as a complex system

Residential care homes are complex social organisations that comprise different actors interacting within highly regulated, multidimensional and culturally mediated environments. Such complexity might suggest a number of different theoretical approaches to help develop insights and understanding into how actors might behave within the regulated workplace and home. For example, critical realism has made an important contribution to the understanding of organisational complexity, in terms of a context-mechanism-outcome model (Pawson and Tilley, 1997; see also Bryman, 2004 for a methodological discussion). This section will however discuss a systems based perspective that appeared to provide a productive way of conceptualising residential care.

It might be theorised that an understanding of a system can be derived from an understanding of its individual parts. Whilst such a reductionist approach apparently simplifies the task, organisations are generally recognised as being '*vast, complex, fragmented, elusive and multidimensional*' (Weick and Daft, 1983: 72). It is therefore unlikely that system components or processes work in isolation or in a linear fashion. On the contrary, components are likely to interact in often complex, non-linear and

unpredictable ways (Checkland, 1981; Bednar, 2009[21]). Thus from the systems perspective, assumptions about reality are built on synergy effects, i.e. that the whole is likely to be greater than the sum of its parts. The idea of conceptualising complex systems in this way was first proposed by Ludwig Von Bertalanffy (1968) in his General Systems Theory. Complex systems can be characterised in several different ways (Johnson, undated), for example, they may be living biological systems or completely 'mechanical' or 'chemical' systems. Systems also include those that can be characterised as 'socio-technical' where people interact with technology and hardware. Cox and Cox define systems as '*interacting sets of components forming hierarchies and networks for the purpose of fulfilling systems related objectives*' (1996: 57). Systems thinking is holistic and not reductionist. Since the whole is always greater than the sum of the parts, systems based approaches have been adopted across a range of disciplines, including health and social care and health and safety (Atherton, 1989; Van Raak and Paulus, 2001; Gausdal, 2005).

Care homes are examples of socio-technical systems where residents and staff (as actors within the system), interface with the equipment, technology and services designed to fulfil numerous functions. Kendall et al (2002) argue that residential care needs to be understood as part of a social care *system* in which there are: micro; meso; and macro-level considerations. At the *macro level* the local and national political economies in which care provision is embedded, shape what is possible in local care markets. Macro level regulators include the Commission for Social Care Inspection (CSCI); and the Local Authority Environmental Health Department who are likely to adopt a particular *cultural* perspective in undertaking their work. At the *meso level* the institutions created by public purchasers as they design contracting regimes, mediate resource flows and create the environment for feedback, recognition and trust. At this level, homes may also be part of a larger group of care homes with a defined corporate identity, philosophy and culture, with regional management functions that form a 'corporate culture'.

At the *micro level* providers must adapt to the demands of the regulatory framework and the requirements of local authority funders in addition to meeting the needs of residents.

[21] Bednar argues for critical *systemic* rather than *reductionist* thinking which embraces 'complexification' within organisations.

At this level the care home is entrusted to one registered manager who brings certain personal and professional qualities to their role. The home manager, the residents and their relatives, the administrative function, care, domestic and maintenance personnel all represent parts of the local system. Even the home's written documentation (Penchas, 2004), the building, furniture and equipment that make up the home can be considered as part of the 'system' (Chalmers, 2002).

Within organisations there are cultural concerns that are expressed as '*less visible*' components such as values, beliefs and attitudes, and '*more visible*' components such as technologies, means of co-ordination, systems, policy and practice. The *less visible* components represented by beliefs and attitudes are expressed in the *more visible* aspects of organisations such as the different technologies and means of coordination employed (Simmons et al, 2006: 14). These aspects of an organisation are shown in Table 3 and include: operating systems, information systems, communications systems, maintenance systems and reward systems (Handy, 1993). Simmons et al (2006: 15) explain that the 'reach' of such systems within an organisation is extensive, making them important cultural 'transmitters'. In this respect policies 'codify principal goals, work methods and behaviour', and prescribe work practices, and the behaviours expected of staff (Simmons et al, 2006: 15). For example, health and safety practices may direct staff to act in particular ways under particular circumstances which in turn 'transmit' a particular cultural ethos. The 'no lift' policies discussed in chapter 3, might be one such example, where the 'rule' to use mechanical aids precludes any notion of choice.

Example system	**Activity and application**
Operating systems	Daily routines of care planning, service delivery and safe premises management
Information systems	Monitoring and evaluation of safety, management and care practices
Communications systems	Systems for communicating and implementing packages of care
Maintenance systems	Systems for ensuring the management of healthy and safe premises
Reward systems	Systems for monitoring staff performance and encouraging best practice

Table 3: The more visible components of a care home

Donabedian (1966, 1988), is often credited for his contribution to healthcare in terms of understanding it as a *system* comprising resources, activities and outcomes. He developed a conceptual framework for quality healthcare comprising the three dimensions of *structure*, *process*, and *outcome*. *Structure* is important because it relates to the resources that are available to and for service delivery. Large providers for example, might arguably be in a position to afford better facilities for the provision of care. *Process*, relates to the way that facilities are used by staff in accordance with their training and the organisation's procedures to deliver an outcome. Figure 2 shows the four considerations that constitute a process. First the home manager should understand and apply the required regulatory and good practice standards. Second the home should posses the right facilities for the activity. Third, the staff should be trained in how to carry out the activity, and the fourth consideration is possession of a written procedure that sets out how the activity is to be done properly and safely. This 'process model' is useful because it suggests a general range of variables that are likely to be important in determining the outcome for any activity.

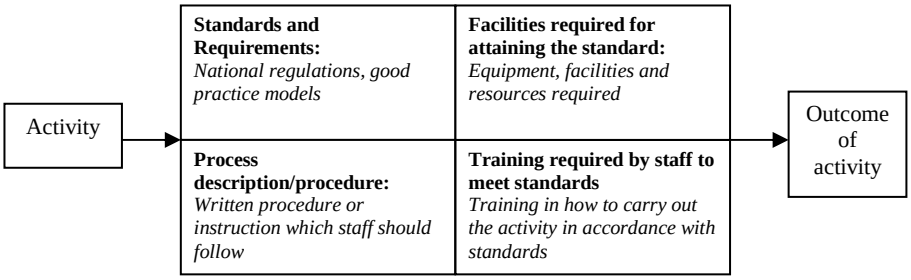


Figure 2: 'Process model'

It is at this level that the relationship between provider of care and residents of care homes becomes more tangible. Facilities, policies and staff training provide the means of communicating what is important to an organisation. Indeed, these ideas provide potentially important research variables in terms of understanding how regulations and important initiatives are translated into practical activities within particular social contexts. For example, how do proprietors conceptualise a particular National Standard, what policies, procedures, facilities and training are subsequently made available to staff?

4.1.1 The consequence of systems complexity: outcomes, emergence and metastability

The interaction between the different actors or systems of state regulator, organisational provider and local care home arguably determine the experience of those who live and work in residential care homes. For example, the regulatory system attempts to control how providers manage their services, whilst providers, in turn, control how local services are delivered. These regulated and planned activities help to determine the outcomes that are experienced by residents. It could be argued that where the regulator's and provider's systems are aligned with the needs and expectations of residents, the outcomes will be as planned. Systems theorists call such planned and expected outcomes the *functional* emergent properties that appear when all the parts of a system work together to achieve some stated, or implied, policy objective.

New Labour has emerged as one of the more regulating and centralising administrations with the extensive use of performance indicators, targets and regulators who are able to exert more influence on service delivery than ever before (Scourfield, 2007). The interrelationships and interaction between the different system functions of regulation and service delivery are however complex and *not always* predictable. Moran observes, for example, that there may be potential problems trying to regulate complex social systems, where 'a*ttempts to extend modes of command law beyond the legal system to other social systems produce pathological consequences which manifest themselves as implementation failure*' (2002: 401).

The nature of the English health and safety regulatory framework (see chapter 3) is, also 'goal setting' (HSE, 2003), which arguably leaves lots of opportunity for local interpretation of its various requirements by regulators and managers. Lipsky's (1980) concept of 'street level bureaucracy' theorises that those in front line practice (such as EHO's, CSCI inspectors and regional or local managers) respond to individual need according to humanistic ideology, but within a bureaucratic structure orientated towards needs defined for the majority. Lipsky argues that front-line workers such as social workers are in a perpetual state of conflict with their supervisors (bureau managers). This situation arises where those in front line practice are obliged to *choose* from conflicting objectives and adapt them to meet local need. Whilst bureau managers constantly seek to apply organisational policy, front line practitioners try to maintain

their autonomy and act in accordance with local knowledge and circumstances (Moore, 1987). These 'local' ways of doing things in turn become policy, or as Lipsky articulates: '*the decisions of street-level bureaucrats, the routines they establish and the devices they invent to cope with uncertainty and work pressures, effectively become the public policies they carry out*' (1980: xii). He identifies discretion, by those in front line decision making roles, as an inevitable and significant part of the implementation of policy within the public services (Evans, 2009). This situation was arguably evident under the old Registered Homes Act 1984 (replaced by the Care Standards Act 2000), where the system to administer it became the subject of much criticism as the result of widely differing interpretations of the law by different local authority inspectors (see Department of Health, 1998). Whilst the Care Standards Act is now administered by one principal regulator and supported by much tighter, national, standards, it remains likely that those who must interpret public policy will continue to exercise discretion where this is available to them.

Evans (2009: 5) argues that Lipsky's approach, however, gives insufficient attention to the role of occupational status and professionalism in structuring and informing discretionary practices. The idea that managers, at the 'bureau' level are disinterested 'servants' of public policy, is, perhaps, unrealistic. A shared, professional, perspective on what constitutes the 'correct' interpretation of public policy may, for example, be a powerful mediating factor. It could then be argued that the interpretation of policy might have wider impact in terms of a 'macro level' version of street level bureaucracy. This may for example have been evidenced in the influential Royal College of Nursing 'Code of Practice for Patient Handling' (RCN, 1996). These guidelines were based upon what the Disabilities Rights Commission saw as an overly restrictive interpretation of the Manual Handling Operations Regulations 1992 and the Management of Health and Safety at Work Regulations 1999. The result was that many care providers insisted that their staff used hoists or other aids, regardless of their suitability or the choice of the person involved (Disability Rights Commission, 2003). In this example, there appears to have been broad alignment of the policy guidance within the different levels of management, inspection through to practitioner. Perhaps more importantly this policy context arose from the interpretation of health and safety law within the professional, cultural, context of nursing care and patient welfare. It was not European or UK health and safety regulation that dictated the use of mechanical handling aids, but the

interpretation of the law within a particular cultural context. The subsequent adoption of these guidelines by social care agencies and their application and interpretation at local level resulted in what appears to have been a one dimensional, restrictive, approach to client handling practices (Disability Rights Commission, 2003).

Thus, on occasion the systems set out within the regulatory or management framework may give rise to outcomes that were not, or could not, necessarily have been anticipated. System theorists call these outcomes *non-functional* emergent properties (Checkland, 1981). Examples might include reliability, performance, safety, and security issues (Sommerville, 2004), i.e. a whole range of practical things that impact directly on resident and staff welfare and service delivery. Indeed despite the apparent intensity of the regulatory system, a number of providers have occasionally failed to meet the necessary regulatory standard despite having apparently robust written systems in place (HSE, 2009a).

These *emergent properties* cannot be attributed to any specific part of the regulatory or care home systems. Rather, they only emerge once the system components have been integrated. Thus, again using the example of the Royal College of Nursing's (1996) policy on manual handling, whilst the document was not designed to remove client choice, it apparently did so when applied within certain contexts. The term 'emergence' is associated with the 19th century philosopher George Henry Lewes, who attempted to distinguish between *resultants* and *emergents*. In the former, the sequence of steps producing an outcome is traceable. Emergents are, however, not traceable (Ali, Zimmer and Elstob, 1998; Winder, 2007). An event might therefore be deemed emergent if it appears to arise spontaneously and without any apparent, or predictable, connection to the elements of the system with which it is connected.

This conception of *unpredictable emergence* implies that events such as accidents or incidents *could* on occasion, be deemed as the emergent properties of a complex system, and arguably, could not therefore have been predicted. This idea is arguably the antithesis of risk assessment methodologies which are designed to 'predict' when harm is likely to arise. It is also perhaps too simplistic to suggest that an incident, for example an accident might arise *spontaneously* and *unpredictably* as the result of the complexities of the home. However, there is one theoretical idea that would appear to

provide some form of explanatory framework for incidents that have no apparent or immediate explanation that has been termed meta-balance or meta-stability.

4.1.2 The concept of the metastable state

The concept of the metastable state describes a transition state that is said to exist in 'delicate equilibrium'. Such a state has much in common with social systems like care homes which might also be seen as existing in a state of delicate cultural equilibrium. The diagram, Figure 3 is adapted from Cox and Cox (1996: 58 Figure 3.7) and shows: '*the importance of the metastable state….which follows a departure from 'normal' operation, [which] may exist over quite a lengthy period*'. During the metastable phase the system, in this case an aspect of the day to day routines of the care home, continues to operate 'normally', but at an increased level of risk. On one level the system appears to be ordered whilst on another it contains 'unstable' elements.

A system that is in meta-balance can thus be viewed from two different perspectives. From the perspective of the home's proprietor, management and staff, the system seems to be *stable and ordered*. The system *appears* to deliver the outcomes that are expected, for example, an activity is completed without apparent harm to anyone. On the level of detail however, the system is *out of balance* because it contains elements that, on closer scrutiny, are potentially unsafe or unstable under particular circumstances. This idea is discussed in chapter 8, the experience of regulation and risk**,** with reference to a number of examples drawn from the fieldwork.

A system is in a metastable state when some action or inaction makes it *potentially* unstable in a way that is not immediately obvious. Thus, whilst appearing stable over some period of time, the system might actually be in a state of very delicate equilibrium or balance which could, if not recognised result in damage. Equilibrium in this context might refer to the balance of 'normal' rights, risks and responsibilities that can exist within a social system. Rights afforded to an individual might for example be finely balanced within a regulatory regime. The arbitrary removal or restriction of these rights takes the system out of balance. What is perhaps most significant about the adapted diagram (Figure 3), is the second box labelled '*Predisposing conditions in wider*

environment'. This might be theorised as the '*culture*' of the organisation or care home, which arguably contributes to the management of risk. The metastable state may be considered the period between a hazard being created and that hazard either causing an accident or being recognised.

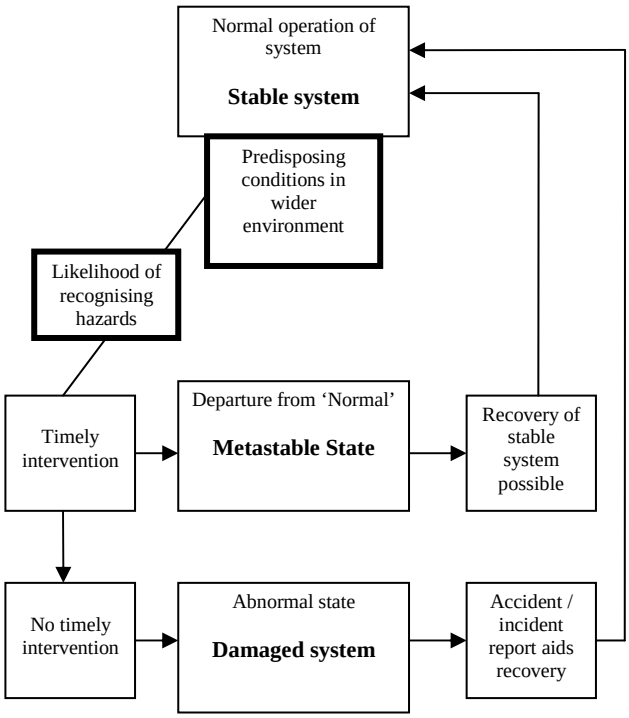


***Figure 3*: Metastable State Diagram** – Adapted from Figure 3.7 Systemic accident sequence model in Cox and Cox (1996), Safety Systems and People

4.1.3 Emergence, metastability, rituals and rules

In an 'ideal' world an organisation will operate with complete congruence between and within the different components and systems of which it is comprised. It might therefore be expected that the greater the alignment between the different components of organisational culture, the lower the conflict within the system (Quinn and Hall, 1983 in Simmons et al, 2006). This idea might, for example, be particularly relevant within larger provider organisations which must manage and attempt to align the different policy interests of their organisation.

In reality however, the imperatives associated with legal compliance, might sometimes, leave organisations and individual care homes with little room within which to manoeuvre. Van Meter and Horn (1975: 447 cited in Bergen and While 2004: 2) define

policy implementation as encompassing '*those actions by public and private individuals (or groups) that are directed at the achievement of objectives set forth in prior policy decisions*'. They theorise that the degree of compliance is affected by two major dimensions. First, the amount of organisational *change* involved and, secondly, the degree of consensus over its goals and objectives. Thus at the *micro* or care home level, policies that are not seen as appropriate or that absorb a disproportionate level of resources are less likely to succeed. Indeed Handy (1993: 180) suggests that many of the '*ills of organisations*' stem from imposing inappropriate regulatory structures or systems on a particular culture and then expecting it to thrive. The question then arises how do organisations respond to potential incongruity between their philosophies and the expedient for regulatory compliance?

Compliance is arguably demonstrated in two ways, through documented systems and through physical evidence. Both the National Minimum Standards for Care Homes and health and safety law require homes to have documented systems, for example, written plans of care or records of risk assessments. Health and safety based systems *might* however be written in isolation from those relating to day to day care. The home can 'prove' that it has a system, however, in reality, the system has little or nothing to do with the day to day management of the home. This idea can be illustrated with reference to two real examples. In the first, a resident died (later in hospital) following a fall at her care home. Although the home had undertaken a risk assessment on the resident, the care home staff had not linked it to any risks present within her room. In other words, the home had not correlated the resident and the premises related risk assessments (Chapman, 2006). In the second example, staff at a care home had not been involved in, or told about, the findings of a fire risk assessment on their boiler room. A fire risk assessment had been undertaken in all of the care homes belonging to a large national provider in order to demonstrate compliance with the Regulatory Reform (Fire Safety) Order 2005. This risk assessment had identified the boiler room as a high risk area that should not be used for storage. The home staff, however, having not been told about or appreciating the risk, used the boiler room as a convenient general store, resulting in a large and damaging fire (National Association for Safety in Care Services, 2009). Both of these examples illustrate how the respective providers, whilst having written systems in place to demonstrate legal compliance, had not correlated or integrated these systems with the working and care practices of the homes. Research undertaken for the Health

and Safety Executive around a decade ago appears to support this contention. Osborne and Zairi (1997) investigated the link between total quality management systems and the integration of health and safety in the business community, suggesting two main conclusions. First, health and safety management was driven by issues of compliance, rather than being integrated into the core business. Second, organisations tended to view the different facets of health and safety separately and the safety needs of stakeholders tended to be assumed or implied.

These conclusions might imply that Health and Safety had not been considered as an integral part of the business, it was viewed separately as a *compliance issue*, rather than in the context of what was actually done. Thus, the way that national policy is translated into local policy depends upon the translator's worldview and as Burton (2005: 18), suggests although '*essentially progressive and supportive in intent, legislation, regulation and guidance usually appears negative and controlling in implementation and effect*'. Organisations therefore appear to have the 'choice' whether they operationalise the regulatory system as part of their day to day processes, to ignore them altogether or to deal entirely separately with those that are not regarded as integral to the core business. Evans (2007), observes that 'management' (which could include the executives within large provider organisations and arguably also advisors, legislators or regulators) might create systems that whilst appearing logical in their own eyes, might be in, or create, conflict with those who are supposed to follow them. Evans uses the phrase 'fatal conceit' (Evans, 2007: 18) to illustrate how organisational management can sometimes 'pre-assume' levels of knowledge that may not be available to local managers. He quotes Boulding (1966) to illustrate this dissonance: '*There is a great deal of evidence that almost all organisational structures tend to produce false images in decision-makers, and that the larger and more authoritarian the organization, the better the chance that its top decision-makers will be operating in purely imaginary worlds*' (Boulding, 1966: 8 cited in Evans, 2007: 18).

Braithwaite (1993, 2007) provides another insight that would appear to explain why some providers may apparently have systems, yet, experience safety critical failures. He applies Robert Merton's (1968) typology of modes of adaptation to understanding why there might be a dissonance between what is '*said*' (or shown) in terms of policies and procedures and what is '*done*' in terms of practice in care homes. The theory

derives from (amongst others) the work of Emile Durkheim, who used the term *anomie* to describe the apparent lack of norms and values or social regulation in modern society (Akers, 2000: 143, 161). Sometimes called '*means-ends*' theory, it suggests that whenever there is a disjuncture between culturally defined goals and the socially approved means to realise them, there are four logically possible responses available. Innovation involves breaking the rules, retreatism, involves opting out, whilst rebellion involves seeking to change the system. The fourth response, and the basis for Braithwaite's principal observation, is *ritualism*. This involves going through the motions of pursuing approved means without actually achieving those means. Ritualism is arguably a likely outcome in many organisations, resonating as it does with Newman's (1994: 59-64 cited in Simmons et al, 2006: 16) contention that it is common for organisations to '*espouse particular sets of values in rhetoric, but not follow through by putting them into practice or, conversely, to 'go through the motions' of creating new policies and practice, but [with little or] no value to them*'.

Thus Braithwaite's (1993), account of the role that ritualism might play within the care home industry, is insightful and may indeed be thought of as a form of system metastability. Ritualism is a mechanism whereby the proprietor / home manager writes policies and procedures that *suggest* good levels of legal compliance, whilst the reality is that their systems are not in fact applied as intended. Thus from the global perspective the system seems to be *stable, ordered* and *compliant*. At the level of detail however, the system is *out of balance* because the policies and procedures designed to ensure systems safety are not being implemented. A possible example of this phenomenon was highlighted following the serious injury of a resident in a care home belonging to a large corporate provider. The provider was able to evidence written safety procedures; however, these were not actually used / followed by staff (SHP, 2009: 14). Such examples might arise either because the organisational culture regards the policy as 'window dressing' i.e. part of a *ritual* of 'compliance' or that there has been a failure to communicate the policy to front line staff. This could itself suggest that policy dissemination and training have become an organisational 'ritual'. *Ritualism* implies that the organisation *has* policies and procedures, although they exist more as part of a *ritual of compliance*; whilst performing little or no front line function.

An alternative perspective is associated with the (over) rigorous implementation of health and safety law, whereby it might be the primary consideration of a particular care home. Here again, Braithwaite's (2007: 7) use of the term ritualism is useful as it suggests the home's '*acceptance of institutional means for securing regulatory goals while losing all focus on achieving the goals or outcomes themselves*'. Instead of accepting that risk is an inevitable part of everyday life - an emphasis on healthy and safe care might regard risk as something to be eliminated. This may be driven by the perception of accountability, either at the corporate level or at the local level. At local level this may be driven by a community of practice (Lave and Wenger, 1991) whereby the home manager and staff feel uneasy about accepting and managing risk as a normal part of home life, and therefore apply a literal application of health and safety law.

4.2 The influence of 'culture'

The previous sections discussed the idea that the care home is a complex system that is also part of a wider system comprising providers, purchasers and regulators. These systems, their related processes and human actors are mediated within particular social contexts. The cultural context is arguably the 'lens' through which the different parts of the system are viewed. Indeed 'culture' is much more than a lens; it is an active component or catalyst within the system. According to Hatch (1997, in Scott et al, 2003), organisational culture has been described as perhaps the most difficult of organisational concepts to define. Schein defines it as:

'*The pattern of basic assumptions that a given group have invented, discovered or developed in learning to cope with its problems of external adaptation and internal integration, and that has worked well enough in the past to be considered valid, and, therefore to be taught to new members as the correct way to perceive, think and feel in relation to those problems*' (1984: 3).

Culture thus consists of the values members of a given group hold, the norms they follow and the social constructs they create. Whilst 'culture' can be conceptually distinguished from 'society' there is a very close connection (Giddens, 1989). Bland (2005) and Youll and McCourt-Perring (1993) for example, describe how some models of best social care practice might derive from the wider cultural contexts that exist

within some faith based groups. Such 'kinship' models are successful because they promote cultures of friendliness and mutual respect that is owned and shared by most residents and staff. Thus the processes and systems that constitute the home are interpreted and translated into activities through a 'lens' that sees dignity and respect as important.

Handy (1993), identifies six principal factors that he suggests influence an organisation's culture, these are the history and ownership, size, technology, goals and objectives, environment and people. The history and ownership of an organisation is significant in terms of the location of power where, centralised ownership tends towards a power culture. Size is often the single most important variable influencing structure and culture, large organisations tend to be formalised and adopt a 'role culture'. The use of technology can have a profound influence on an organisation, for example, communications technologies may reduce personal contact between managers. Goals and objectives are seldom clear cut, homes must provide a service within the limits of the resources available, yet profit may also be an objective for providers. Goals not only influence cultures they are influenced by them. The organisations environment includes the economic climate, local competition, from, for example, other care homes and the social environment, which might include the perspective of the local community of practice. Finally, the individual orientations of key people within an organisation will play a significant role in determining its culture. This is perhaps especially true of the home manager who has the authority to influence how regulatory and organisational policies are translated into local practice.

Scott et al (2003), suggests that culture can be divided into three broad streams. It can be seen as an *attribute* that an organisation possesses in much the same way that it has a structure and strategies. Alternatively culture might be seen as an expression of the whole character and experience of the organisation, it is a metaphor, indeed it is the very essence of what the organisation *is*. The third concept is described by Scott as treading a middle path between these ideas by viewing culture as an *emergent property*.

Thus, culture is the result of the interaction and interrelationships between the different elements of the system. This idea might at first appear to be counterintuitive. If systems exist within a particular culture, how then can 'culture' be an emergent property of the

same system? On closer reflection however, the idea would appear to have much to commend it - if it is considered in terms of a feedback loop. This idea is implicit in item four of Handy's six principal factors: '*goals not only influence cultures they are influenced by them*' (1996: 195). Certain features of a system are likely to give rise to environments that favour particular cultural attributes. In turn, these *cultural* attributes are likely to favour some systems configurations and ways of doing things. Thus '*the way we do things around here*' will be framed in accordance with the local context where its members become 'enculturated' into a local 'community of practice' (Lave and Wenger, 1991, Brown and Duguid, 1991; Horton, 2006). This idea of joining and becoming part of a local community of practice and learning to become a resident or a member of staff is further explored in chapter 7.

Culture is thus *unique* within organisations; it does not exist in ready-made structures to be classified superficially. It is situated within specific local contexts and negotiated by actors within that context (Weisinger and Trauth, 2002). Care homes are not, for example, one homogenous group comprising similar older adults, living in similar buildings being cared for by similar staff. They represent a range of different perspectives, processes and system orientations operating within a framework of written and un-written practices and rules set down by their members. Bland (2005: 46-47) consequently acknowledges the role played by 'organisational culture' in determining quality of residential life: '*the local culture of the resident group and the culture of care within the home as well as staffing, resources and the distribution of public and private space*' all impact upon the front line experience of life within the home. From the perspective of health and social care, a positive culture has been characterised as one where the ethos of care becomes and remains '*person-centred, evidence-based and continually effective within a changing health and social care context*' (Dewar, 2007: 142).

Culture might also be thought of as mediating how people from different cultural orientations view and perceive specific images, messages and systems (Sheridan, 2001: online in Jagne et al, 2004). A lack of attention to understanding such complexities and social biases within organisations is often cited as an important reason for *change failure* when implementing new policies and systems (Johnson, 1987; 1990; Hackney and McBride, 1995). Hafford-Letchfield, suggests that increasingly, organisational

culture is recognised as important in contributing to the effectiveness of any organisation, yet it is an area that is often overlooked. She illustrates this with reference to the numerous high-profile inquiries into public service failures that have taken place over the years. These have tended to feed a culture of blame, accompanied by '*a constant stream of new structures, legislation and organisational policies and procedures*' to try to put things right (2006: 1). Yet, at the same time, the Government has perhaps failed to recognise the cultural and structural factors that stigmatise older adults (Bland, 2005). These factors arguably create the conditions within which progressive policy initiatives may ultimately fail. Thus, attempts to impose models of 'best practice' in the form of National Minimum Standards are unlikely to be met with a uniform and predictable response. Instead the response is likely to be mediated by the local community of practice and its *predisposition* to the message.

4.2.1 Cultural Theory

The next section will discuss the theoretical framework around which the different ideas discussed in this chapter begin to converge. Cultural Theory (Douglas and Wildavsky, 1982) develops the idea of culture as a function of attitudes, beliefs and group dynamics interacting within a framework of 'social rules'. The interaction of these different functions provides for different cultural orientations within which systems are likely to behave in subtly different ways.

Grid and Group or Cultural Theory (CT) derives from the anthropological tradition and the interpretation of social solidarity within groups and wider society. It is a tool that can be used to help in understanding the cultural diversity that exists within society. It has become important in the disciplines of political science, public policy and management because it presents at least the possibility of being able to identify and understand the cultural dimension behind institutions. CT has its roots in Durkheim's (1951 [1897]) two dimensions of forms of social organisation, specifically social regulation and social integration. Maesschalck, describes him as the '*intellectual grandfather of grid-group theory*', sometimes referred to as the neo-Durkheimian approach (2004-5: 34). Grid and group as we know it today was introduced by Douglas in the first edition of her book *Natural Symbols* (Douglas, 1970). The theory has since

been developed and applied in different variations by Douglas (1992) and later by Douglas and Wildavsky (1982) and Thompson et al (1990). Indeed Douglas (2005) acknowledges this *happy convergence* of interests that transformed grid and group analysis from a modest method into a new theory.

A major strength of Cultural Theory is its intuitive simplicity, based upon its notion of 'types' which have been variously described as 'cultural biases', interaction patterns' and 'cosmologies' (Maesschalck, 2004-5). This versatility means that different authors have at different times adopted and adapted the framework to explore specific cultural situations. Hood (1998), for example has used the grid and group typology / heuristic to describe four ideal cultural types of public service '*production*', whilst 6 et al (2007) have applied it to the problem of interagency information exchange. Douglas suggests that to use this framework for empirical research, you must first choose a specific 'world' where other things are more or less equal, clearly defined and stable. Whilst the 'worlds' anticipated by this approach are generally at the macro or meso levels (see Hood, 1998, Stoker, 2002; and 6 et al, 2002, 2007), residential care homes are clearly well defined cultural entities in their own right. Whilst Cultural Theory has been applied to public administration and public policy debates, it has seen much less application to '*in-depth case studies of real organisations*' (Maesschalck, 2004: 377).

Cultural Theory exposes what Douglas calls the machinery of cultural transmission: '*where sets of values and expectations are transferred along the lines of the social structure*' (2005: 4). The theory explores the often dissimilar cognitive lenses through which people interpret different phenomena including risk and regulation. The theory recognises the importance of social construction, and the possibility of distinguishing particular patterns of commonality that help in illuminating the human construction of meaning, particularly the interpretation of risk. The management of risk is central to the implementation of health and safety law and the subsequent experience of those who live and work in care homes.

4.2.2 The grid and group typology

The grid and group typology of CT envisages that an individual's behaviour, perception, attitudes, beliefs, and values are shaped by constraints defined by two principal axes. *Grid* (corresponds with Durkheim's *social regulation*) is the degree to which choice is constrained by laws, regulations, rules and control i.e. '*the cross-hatch of rules to which individuals are subject in the course of their interaction*' (Douglas,1978: 8 in Oltedal et al, 2004: 18). *Group* (corresponds with Durkheim's *social integration*) determines the affiliations and limitations exerted by membership of social groups. Thus in a basic form, 'group' determines who you are within a particular culture, whilst 'grid' dictates what you are able and not able to do within that culture (Maesschalck, 2004-5).

On the horizontal axis 'High Group' orientation favours group loyalty and teamwork where individuals interact frequently in a range of activities and depend on each other. 'Low Group' favours those who prefer to fend for themselves or perform on their own initiative (Kahan et al, 2006). On the vertical axis, 'High grid' cultures favour a systems orientation or bureaucracy whereas 'Low grid' cultures favour trust and mutuality. The horizontal and vertical axes shown in Figure 4 represent a *range* of affiliations and orientations extending from low or weak to high or strong, i.e. there is a continuum within the dimensions. Professional affiliations are likely to be quite strong; indeed there might be disciplinary consequences for those who fail to meet their professional obligations. A random shock such as a serious incident may shift a particular worldview along the continuum such that weak grid affiliations make a shift towards a stronger grid position as an expedient to comply with previously neglected regulatory requirements.

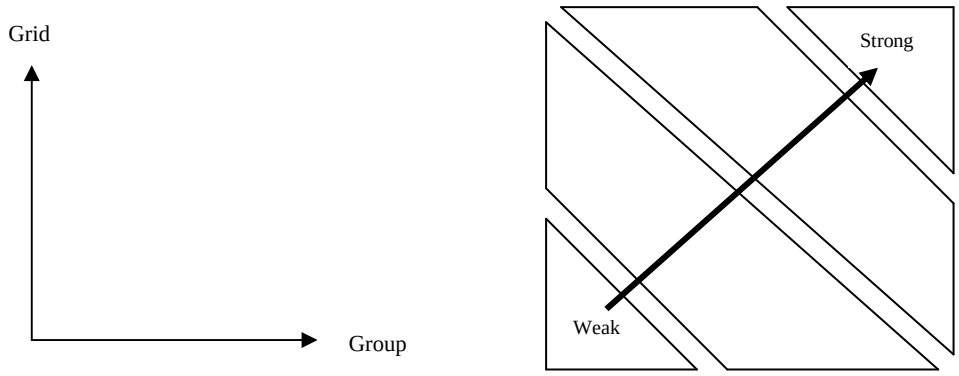


Figure 4: Grid / Group – adapted from Douglas, 2005

The two axes of 'grid and 'group' give rise to 4 four cultural dimensions: *weak grid* and *weak group*; *strong grid* and *weak group*; *strong grid* and *group*; *weak grid* and *strong group*. Each combination of characteristics suggest differing systemic biases with regards to ideas of blame when things go wrong, attitudes towards power and authority, risk taking, trust, loyalty, commitment, motivation, the coordination and use of knowledge, communication and participation. Each cultural bias thus has inbuilt strengths and weaknesses. Arguably, a combination of traits is most likely to be found in well balanced organisations. Indeed, Cultural Theory suggests that social relations and biases are reciprocal, interacting and mutually reinforcing and that '*those regimes that have largely excluded a cultural bias lose the wisdom attached to that bias*' (Thompson et al, 1990: 96). Hence, in line with the 'compatibility condition' of grid-group theory, each of the cultural biases has something to offer each of the others, in addition to also representing a potential threat. Care homes are therefore likely to share and to exhibit a range or a mix of cultural characteristics, suggesting a 'balance' of cultural types within any particular home, although one particular bias may dominate. The terminology used in defining the four cultural biases varies slightly between different authors and so the most commonly used terms have been included in each quadrant (Figure 5), although they have essentially the same meanings.

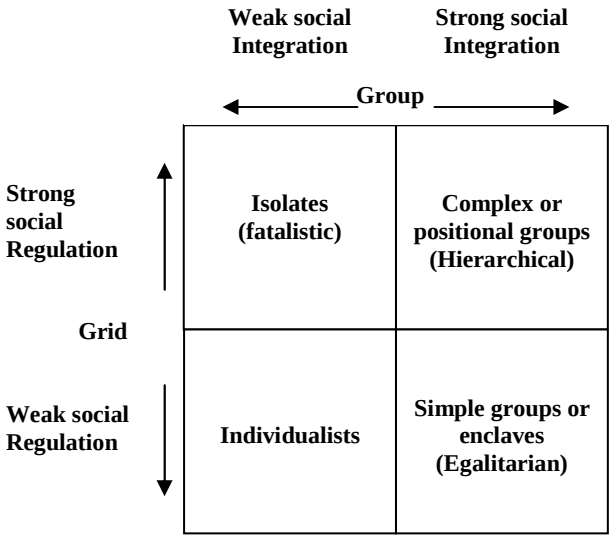


Figure 5: Four cultures

For the purposes of this thesis, the following descriptions will be applied to the four cultural dimensions: Individual, Isolate, Hierarchy, and Egalitarian.

4.2.3 Broad characteristics of the four biases

The term individualist goes beyond the assumption of 'self-interest' to suggest other characteristics. Weak grid and weak group orientations favour low levels of communal involvement and are intolerant of restrictions on freedom of choice. Those in this cultural orientation will tend to emphasise autonomy, freedom and experimentation, character traits that are arguably associated with the private owner managed sector. The individualist culture represents a social context dominated by strongly competitive conditions and autonomy which allows maximum options for negotiating contracts or choosing allies. Individualists are responsible for themselves and for anyone else they choose (Altman and Baruch, 1998). Hood (1998) suggests that the dimension is represented by a market-based relationship in which service users are seen as customers of an organisation that has contracted to provide a service. The 'contract' is awarded within a competitive market in which there is a strict separation between the purchaser and the provider of services. Service users' influence on the service depends mainly on their ability to affect the price and to choose between suppliers. Managers see risk as an opportunity as long as it does not limit their freedom. The social care value base is likely to be well articulated, but may not be realised in practice where the manager

perceives a threat. Bland's (2005) example of the 'hotel model' of care would appear to (loosely) fit with this particular worldview.

The Isolate dimension is characterised by a strong grid and weak group orientation, which is inextricably linked to following orders from above. Individuals within the organisation respond to instructions and directives in isolation to a group identity. This type of culture reinforces 'insulation' where individuals will react to change in unpredictable ways characterised by frustration, despair and distrust. Indeed Evans (2007: 10) suggests that in its extreme form such an organisation would be consumed by apathy. Isolates can have important effects on user-provider relationships within the service system. As Hood (1998: 9) observes, '*a fatalist approach to public management will arise in conditions where co-operation is rejected, distrust widespread, and apathy reigns – a state of affairs which will be far from unfamiliar to many readers*'. This orientation is *not likely* to be a 'major' characteristic of care homes as a whole system, as it is not generally considered conducive to organisational structures, although it could apply to the managers and staff of large provider organisations who feel that they have no control over the bureaucracy that 'controls' them.

Within the Hierarchical dimensions, the strong grid and group orientation favours clearly defined parameters of action and a commitment to the institutions that created them. The fundamental concern of these organisations is to preserve order defined by well defined systems. Within this culture individuals will tend to encourage clear role definition, pragmatic decision making and 'rule' oriented management. Policies, procedures and rules are said to be defining characteristics as they demonstrate order. Hierarchical care homes are therefore likely to favour detailed policies and procedures providing codification, structure and order. Within the hierarchical environment service users (residents) may have little or no say in what services they receive or how they are delivered, although the home may outwardly espouse the values of participation.

Managers emphasise the natural order of society and place their trust in expert knowledge, management is by rule, role and given fact. The legislative framework (where clearly understood) is likely to be applied in preference to the less tangible social care value base. Bland (2005) describes traditional local authority care homes in these

terms, a situation which might equally apply to any large provider whose systems discourage local choice and discretion.

The Egalitarian dimension derives from a weak grid and strong group orientation which combines low levels of hierarchy with a high degree of solidarity. Another term for this cultural dimension is 'the sect' since there is a clear boundary that differentiates members from non-members. This type of culture thrives on reciprocity, with a commitment to other people, social harmony and strong social bonds within the dimension. There is little real formality or structure in terms of clearly defined, systems and explicit leadership. Arguably, as an 'egalitarian' organisation grows, it will of necessity begin to adopt hierarchical values. Managers dislike inequalities amongst people and tend to be sceptical of institutions and authority. Management is therefore by shared mutual commitment within the bounded group. The social care value base will take precedence over (bureaucratic) legislative considerations. Bland's (2005) example of Methodist Homes would appear to fit with this worldview where the shared values of those involved set the management agenda for the homes. The four dimensions are summarised in the cultural matrix Figure 6 which shows the principal characteristics associated with each cultural type:

Isolationist Surprise, frustration and ambiguity Apathy and passivity Lack of motivation Distrust and general disharmony	**Hierarchy** Symbols of authority; distance and control Trust is placed in authority and professional expertise Communication is formalised Policies and procedures are unquestioned Formal atmosphere / dress codes
Individualist Lack of authority and power Trust is placed in individual competence Communication is frequent Relaxed and informal atmosphere / dress code Individuals are encouraged to experiment	**Egalitarian** Blame expertise and excessive power Atmosphere of harmony and cooperation Reciprocal communication Sensitive to others feelings and opinions Sociable behaviour within group

Figure 6: Grid and Group cultural theory and managing change: adapted from figure 4: Jackson et al (2005).

Evans (2007: 1) has proposed an 'adaptation' to the Grid and Group nomenclature (Figure 7) to reflect the systems based nature of the *corporate* or *business* environment. Here 'Low Grid' is relabelled as 'experimentation' and 'High Grid' as 'procedural'. Experimentation is said to be the driving force behind innovation where an organisation is enabled to adapt, evolve and renew itself. These factors are driven by a coalition of the individualist characteristics of trial-and-error, discovery, and entrepreneurialism; and the egalitarian ability for critique, dialogue and sharing. By contrast, hierarchy and isolation prefer well defined systems characterised by documented policies, procedures and processes.

The degree to which the organisation values solidarity above liability shows how inclusive it is and how much commitment is required to participate within it. A strong corporate culture of procedures creates committees, regulation and rigid control of time and space. An emphasis on experimentation and discovery however, will generate greater freedom to innovate. The more employees (and residents) control their working and living conditions, the greater that experimentation is valued over process.

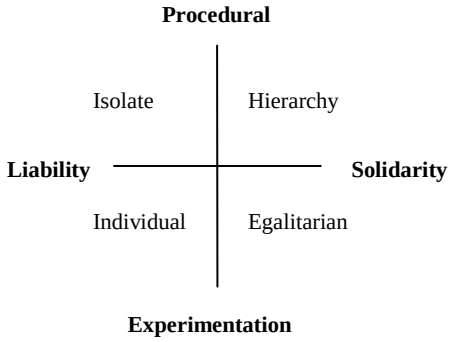


Figure 7: Corporate Cultural theory applied to grid and group. Adapted from figure 2 Evans 2007: 6

4.2.4 Mobility between and within cultures

Evans suggests that Cultural Theory: '*is a lens to understand organisational culture, rather than a full description of reality*' (2007: 7). For this reason organisations cannot be neatly categorised as belonging to one of the four cultural typologies. For example, there is no such thing as an 'egalitarian' organisation, merely organisations that differ in the degree to which the concept of 'egalitarianism' applies. For this reason the 'unit of

analysis' needs careful consideration because there is no clear definition about what it should be, not least because the concepts generally apply to the sociological concept of culture, rather than to the individual.

Two different perspectives of cultural theory appear to exist. The first named the 'stability' view envisages individuals as consistent both temporally and regardless of social context, i.e. they are consistent within and across cultural biases. The second 'mobility' perspective, suggests that it is possible for individuals to move between social structures with different types of cultural bias, at different times and in different areas of their lives, i.e. individuals conform to different cultural biases according to specific social contexts (Tsohou, 2006). Bellaby (1989: 481) whilst arguing that the grid-group model favours 'comparative statics', and lacks a basis for showing how organisations might change from one risk culture to another, appears to support the mobility view. Individuals may, for example, move between cultures within an organisation as part of what he calls 'life course transitions', exemplified perhaps by moving from a frontline (care) role to a position of management responsibility.
The mobility view would appear to have far more explanatory power in the context of the care home environment and might, for example, explain why regulators, relatives, management and care staff are able to rationalise their own home and family situation with the 'home life' that they may permit, design and implement for residents.
However, the principal cultural type of the organisation itself is likely to be quite stable. As Hendry (1999: 563) points out, '*once established, the cultural type is self-reinforcing in very much the same way as described in Gidden's (1979), theory of structuration, as structures of power, legitimation, and domination are both constituted by and, at the same time, constrain, the practices of individuals*'. Thus even though *individuals* may demonstrate some degree of cultural mobility, the 'host' culture is likely to remain *relatively* stable. These ideas are further explored in chapter 7.

4.2.5 Enabling and disabling characteristics of the four cultural types

Jackson et al (2005: 7), suggest that each cultural bias has inbuilt strengths and weaknesses that are complementary across cultures. No one characteristic is necessarily 'better' or 'worse' than another, each is merely better or worse suited to a particular

cultural context. This section will provide a brief overview of some of the disabling and enabling characteristics to be found across the four cultural biases and will identify their potential strengths and weaknesses in that particular context. These considerations might be useful when analysing the management characteristics of the case study homes.

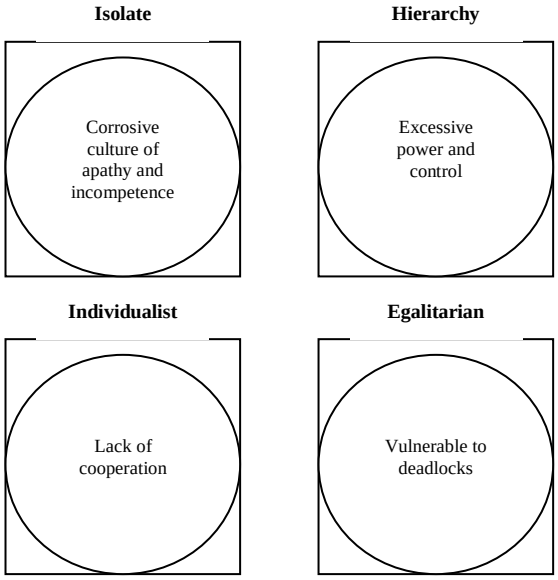


Figure 8: Constraining characteristics of each cultural type, adapted from figure 5, Jackson et al (2005)

4.2.6 Disabling characteristics

Figure 8 shows the main disabling characteristics of the four cultural types. Hierarchical cultures can create environments where authority and obedience to systems dominate all aspects of the home. Individuals are encouraged to place trust in authority and expertise, particularly as these are expressed in procedures that must be followed to the letter and without question. Individuals will have an over reliance on 'technological fixes' (Hood, 1998), arguably characterised by a myriad of risk management technology within the home which staff 'trust' and subsequent rely on. Examples include thermostatic mixer valves on hot water taps to prevent scalding, window locks to prevent falls and programmes of preventive maintenance and testing designed to ensure systems safety.

By placing so much trust in leadership, expertise and systems, the organisation is likely to suffer from the inability to learn from experience leading to errors in judgment and recurring failures that may manifest as 'unexpected' accidents and incidents. Alder (2001) noted that a domination of hierarchical values can smother vision, foster dissatisfaction and demotivate staff, leading to a sluggish, impassive and unresponsive culture. This is potentially a very important observation in terms of the creation of 'metastable states' where local trust in management systems and technological solutions may lead to unexpected outcomes at local level.

The egalitarian culture can be disabling in terms of an overall lack of leadership, authoritative values and strategic direction, leading to internal disagreement and rivalry. This may lead to ineffective management decisions and the creation of internal factions (Jackson et al, 2005). Because of their low grid orientation and thus a lack of strategic direction, relations within these groups can become confusing as no one appears to take control. A possible consequence of such a cultural orientation is the likely absence of any delegated responsibility for setting up or managing safety critical systems within the home. Dissenting *factions* within the home may exert a number of destabilising influences that undermine whatever management there is.

Excessive individualism may create a culture lacking in co-operation and some staff may theoretically take advantage of their independence to pursue their own, rather than the organisation's agenda. Homes may be unwilling to co-operate with others in relation to sharing vital (safety) information and tacit knowledge (Hood, 1998), and may experience problems with team working and participation (Thompson et al, 1990). These circumstances are likely to lead to an absence of safety critical management resulting from unwillingness to invest time or financial resources in systems.

The disabling characteristics of the isolate culture can be equated to the factory production line. The residents are seen as a commodity and staff as operatives whose role is to comply with company policy. The combination of high grid and low group results in a high degree of social isolation between all of those who live and work in the home, whilst at the same time these individuals are subject to a high degree of regulatory constraint. No one is enabled to use their discretion or judgement; they must comply without question with the 'rules' that are imposed upon them. Such an

orientation might exist in an organisation that has experienced some form of extreme management trauma, where the proprietor imposes oppressive rules and the bonds between staff are too weak to assert any real influence.

4.2.7 Enabling characteristics

In the enabling form, hierarchical cultures can provide internal competence, synchronisation of resources and appraisal of outcomes, shown in Figure 9. Hierarchical managers can make people appreciate the connections between the different organisational systems and mobilise new ideas. Schein (1993) highlights that hierarchical cultures provide steadiness, support and psychological defences to reduce stress and enable experimentation, vision and long term change. Alder and Bory (1996) suggest that hierarchy provides direction, reduces role stress and helps people to feel more effective.

An egalitarian culture can provide a high trust environment that reinforces mutuality, group norms and knowledge sharing (Alder, 2001). Excessive power and authority are kept to a minimum, so that commonality and shared experiences dominate creating an environment of belonging and recognition. Fukuyama (1996) suggests that a high trust culture can more effectively lead to innovation and permits a wide range of social relations to emerge. The views of residents are likely to be held in high regard.

An individualist culture is oriented towards innovation, noticing new things, making fresh distinctions and encouraging ideas to emerge and to be implemented. It enables a climate of stimulation and creativity in managing a service. Arguably, the innovative management of the service, often without elaborate systems, will lead to fewer 'institutional' or risk averse management practices. The isolate dimension is arguably associated with a requirement to *comply* with little control or discretion. For example, care staff and residents may be required to comply with organisational policy that constrains choice on various dimensions. From this perspective it has no real enabling qualities and has therefore been omitted from Figure 9.

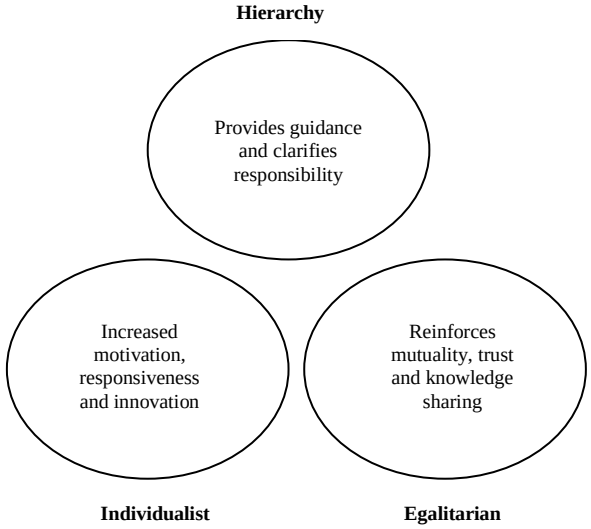


Figure 9: Enabling characteristics of cultural types, adapted from figure 6, Jackson et al (undated)

4.2.8 Influences within or upon cultural perspectives

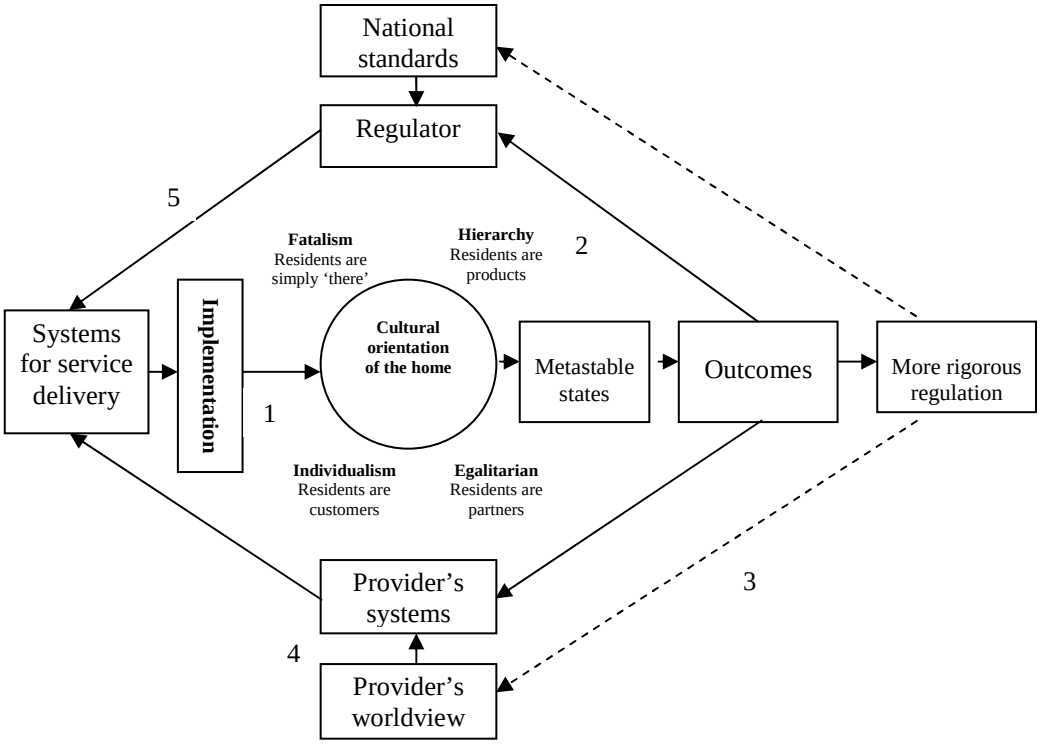
Cultural theory exists alongside other theories and disciplines which explore and try to understand and explain the perception of risk (see Lupton, 1999). From a psychological perspective for example, it is the individual who uses information that is available or *unavailable* to them as a mental guide or 'heuristic' that determines how they will act when confronted with perceived risk. Prominent authors within this 'psychometric paradigm' (Kahan and Slovic cited in Kahan et al, 2006) appear to agree and to support the fact that: '*the impact of cultural worldviews is not an alternative to, but rather a vital component of, the various psychological and social mechanisms that determine perceptions of risk……..risk perceptions depend on individuals' cultural values*' (Kahan et al, 2006: 1084).

The contribution that an emphasis on the individual's or group's perception of risk makes is the use of heuristic devices to interpret and to act upon the complexities of the care home environment. Douglas herself acknowledges the contribution of heuristics defining them as: '*simplifying procedures for teaching or learning devised in order to facilitate rapid treatment of complex problems – heuristics work by simplification*' (1985: 79). She also suggests that they are potential sources of distortion and can be used as conventions: '*by being shared by community they resolve problems in*

coordination – in this capacity they are the essential element of the cultural process' (Douglas, 1985: 79). The availability or unavailability of information about past or recent hazards or risks is likely to mediate the decisions of those who work in care homes and also those who enforce the law, arguably as part of a process of 'street level bureaucracy' (Lipsky, 1980). These ideas are further explored and given explanatory value in the context of the empirical data discussed in chapter 8 The Experience of Regulation and Risk.

4.3 Building a theoretical model

The theoretical concepts discussed so far have attempted to conceptualise the factors likely to relate to the translation of regulatory requirements into front line management practice. The idea that systems operate within a cultural context, indeed that culture and systems may be related by feedback mechanisms, suggests that the concepts lend themselves to a diagrammatic representation oriented around the four cultural biases (Figure 10). The culture of the home mediates the translation of the regulatory framework into local systems and subsequently the degree to which the systems are applied in practice. The application of these systems produces predictable and unpredictable outcomes that may be characterised as either the result of emergence or metastability. The model allows for the idea that the culture of the home might indeed be an emergent property of the whole system, i.e. the culture is the product of the regulations, the regulators, providers and local management systems. The logic of this theory relates to the feedback that is represented by the outcome arrows on the right hand side of the model. The model's 'feedback loop' also applies to the local regulator where their experience of the service providers that they regulate establishes preconceptions about the standards of service that they provide. Such preconceptions may in turn colour the regulatory relationship and subsequent expectations about written systems.



1: Services for residents are implemented within a culturally mediated context giving rise to planned and unplanned outcomes. The outcomes may arise as the result of actions or inactions that cause an imbalance within the system.
2. Outcomes result in feedback loops influencing the provider's systems and regulatory intervention.
3. Detrimental outcomes such as a serious accident might result in more rigorous regulatory intervention which impacts on the application of national standards, the 'worldview' of the provider and the approach taken by the regulator.
4. Regulators may be required to tighten their controls and providers may have to improve their systems.
5. Changes to the provider's systems and regulatory requirements determine systems for service delivery

Figure 10: Conceptual model

In its most simple form, the model shows the idea that the cultural perspectives of those responsible for implementing care, health and safety law impacts on the front line experience of home and work. Cultural theory suggests four *lenses* through which services might be viewed and implemented, although the 'strength' of the lenses is likely to vary significantly between different providers. The experiences of those living and working within the home are not however isolated from the wider society. There is a 'feedback loop' that observes the home through society's broader value base which in turn determines how they should be regulated.

4.3.1 Theoretical propositions for the case study homes

The theoretical perspectives discussed in this chapter allow for a number of propositions regarding how health and safety law might be interpreted, implemented and experienced within each of the four cultural orientations. Table 4 shows some of the organisational factors that may, hypothetically, be associated with each of the four cultural orientations.

4.3.2 Hierarchical homes

Within hierarchical homes there will be clear policies, procedures and rules of conduct that effectively constrain the homes decision making powers. Boundaries are very clear and based on systems of authority. The home manager and staff are likely to understand that they are expected to comply with the provider's systems and will demonstrate alignment to these systems, regardless of how they might restrict autonomy and choice.

Street level bureaucracy is likely to be limited due to clear management policies and systems of audit and training. Those who work in hierarchical homes will usually follow systems or 'rules' with little discretion. There will be tasks to complete according to well defined protocols and within defined hierarchies of manager, senior care staff and carers. The apparent rigidity of the systems and the failure to involve those who apply them may lead to localised custom and practice that 'circumvents' some of the organisation's procedures leading to the possibility of rituals of compliance without compliance in fact. Whilst residents are the stated focus of the organisation's values and activities, it is the systems for meeting regulatory compliance that drive the organisation's procedures. Residents are well cared for and safe, yet, their experience might be equated more with protection than with freedom to pursue a lifestyle of their choice.

4.3.3 Individualistic homes

The individualistic home is characterised by practices that are primarily determined at local level, allowing for the exercise of significant discretion. The home is likely to be

owned and probably managed by the same person. Rigid policies and procedures constraining management practice are unlikely, whilst personal local management is likely to be strong. Street level bureaucracy may be a factor as regulators and purchasers exert influence upon the development of the home's systems. The degree to which documented systems are applied ritualistically will depend on how and why they were created. Systems designed to support home staff are more likely to be 'owned' than those created to satisfy what might be seen as 'bureaucratic' expedients.

Home managers will be focussed on all aspects of the success of the home and will take a direct and personal interest in its practical day to day running, spending less time on documented audits and checklists. Those who work in individualistic homes will be involved in a variety of tasks that are undertaken in response to the needs of residents. Whilst written systems may exist, carers are more likely to be flexible, thus, some areas of 'choice' may depend upon the discretion of the member of staff on duty at the time. Residents' experience is therefore determined locally and may indeed emulate the characteristics of a domestic home in terms of informality, access to facilities and relationships.

4.3.4 Egalitarian homes

Egalitarian homes might be characterised by a shared commitment to the values and principles of the managing organisation. Policies, procedures and rules will be framed within this value base, and are likely to be flexible, and supported by the manager and staff team. The degree to which health and safety law is applied is likely to depend upon the local community of practice rather than systems imposed by the provider.

Street level bureaucracy and rituals of compliance will probably vary according to how well the home is bound to the provider organisation by systems and protocols. The provider is unlikely to exert significant direct regulatory control upon the home, preferring instead to allow local discretion and to cultivate the support of the manager and staff. Residents are clearly the focus of the home as they are often the sole reason for its existence, with mechanisms in place to involve residents in the management decision making process. The value base of the provider is likely to resonate with those

who choose to live or work in the home and therefore a resident's expectations of the home and its systems are more likely to be aligned. In general, the local community of practice will determine the extent to which care services are formalised, although care is thought more likely to be person centred and will therefore facilitate lifestyle choice.

4.3.5 Isolate homes

The isolate home might be characterised by short term coping strategies, because they are subject to tight regulatory constraints and the staff team do not work as a cohesive and empowered team. They are instead groups of individuals whose role is to follow 'rules' without question. The isolate home might belong to a provider organisation with centrally driven systems that may be seen as risk averse and constraining. Homes belonging to small providers that have been the subject of a management take over or 'buy-out' by a larger, systems oriented, provider may fall within the isolate category. The isolate home is thought unlikely to exist in the long term, as its dysfunctional characteristics will quickly bring it to the attention of both the provider and regulator.

Management areas	Hierarchy, strong grid, strong group	Egalitarian, weak grid, strong group	Individual, weak grid, weak group	Isolate, strong grid, weak group
Management structure	Clearly defined by staff grades and reporting structures	Relatively flat with few clearly defined grades	Owner likely to manage the home. Flat staffing structure	Presence of a 'personality' manager. 'Silo' management
Risk assessment	Clearly set out within 'rules' (policies and procedures).	Adaptable according to perceived need and concern	Locally determined. Revenue is likely to be important	Little forward planning & characterised by 'fire fighting'
Risk management - Residents	Prescribed by 'rules'. Risk taking is unlikely	Needs and consultation based. Risk taking is possible	Relaxed approach, however likely 'blame' is a factor	May be procedural yet erratic, crisis driven implementation
Risk management - Premises	Prescribed by 'Rules' and managed by specialists	Adaptable to local circumstances & concerns	Relaxed attitude to premises risk. It is 'home'.	Procedural yet erratic, crisis driven implementation
Training	Set by organisational policy	Adaptable to need, staff encouraged to share skills	Adaptable to local need according to resources	Ad hoc unless prescribed by owner
Staff involvement in management of the home	Set by policy and procedure. Home manager leads within parameters set by proprietor	Staff are involved at all levels	Instructions to staff are general rather than specific and at owners discretion	Staff tend to operate in 'silos' according to management 'rules'
Resident involvement	Set by policy in order to demonstrate 'compliance'	Residents views are respected	In accordance with local expedience	Set by policy but erratic and ritualistic
Key working	Set by policy in order to demonstrate 'compliance'	Residents are seen as important 'partners'	Key working may not be seen as viable in small homes	Set by policy but erratic and ritualistic
Care planning	Proceduralised & compliance oriented	Continuum of informal to formal	Informal	Set by policy but erratic and ritualistic
Likelihood of uniform	Corporate identity with uniform	Informal without uniform	Likely to be informal. Simple tabard	Uniform possible, but 'hit and miss'

Table 4: Cultural biases and expected organisational factors

4.4 Conclusion

This chapter has considered a range of concepts and theories that contribute towards a theoretical framework that has informed the empirical and analytical phases of the thesis. The chapter has conceptualised residential care homes as complex and dynamic environments operating within a highly regulated mixed economy of welfare (Knapp, 1986). At the macro level providers are subject to Government orchestrated regimes of regulation and inspection. At the 'meso' level, providers within the mixed economy

must ensure that they have policies and procedures in place that satisfy purchasers and regulators. At the 'micro' level services are delivered to residents in accordance with the regulator's and provider's policy framework. It was argued that these interlinked, interrelated and interdependent components form a system whose relationships result in predictable and sometimes unpredictable service outcomes. Each care home in turn comprises a mix of different interests, facilities and processes that constitute a complex social system in their own right. It is at this level that individual home managers and inspectors are likely to bring their own perspective to the interpretation and application of the regulatory framework and therefore to the delivery of services within each home. The chapter has argued that individuals, particularly those in positions of authority and influence might use culturally mediated *heuristics* or rules of thumb when making decisions about what constitutes risk. Such perspectives may in turn influence the interpretation of health and safety law as part of what was described as a process of street level bureaucracy (Lipsky, 1980). It was further argued that local policies may sometimes exist as 'rituals' of regulatory compliance rather than as tools for service delivery.

A key explanatory component of the theoretical framework is the idea that these complex social systems do not operate within a vacuum, rather they are mediated by an organisation's or care home's local culture. Cultural Theory (Douglas and Wildavsky, 1982) is one useful and well tested means for appreciating this cultural dimension. Cultural theory postulates that there are two key dimensions that determine how an organisation is likely to respond under particular circumstances. The first dimension is that of constraint by the regulatory framework (grid) whilst the second is the level of social integration and cohesion of those who live and work within each home (group). These two dimensions give rise to four cultural types that mediate the translation of national, organisational and local policy into front line practice. Each dimension is likely to favour particular perspectives, for example, trust in regulatory expertise and a strong mutual loyalty, teamwork and the commitment of staff and residents might be associated with a high grid and group 'hierarchical' oriented culture. Conversely, a lack of trust in regulatory expertise and an independently oriented staff and resident group might equate with the low grid and group orientation of an 'individualist' cultural type. These different perspectives have been used to construct a set of tentative propositions thought likely to characterise care homes occupying each of the four cultural types.

Chapter 5 - Methodology and Methods

5.0 Introduction

This chapter is in two main parts. Section 1 outlines the chosen methodology and discuses the scientific basis, rationale and philosophical considerations that underpin the research. It will briefly consider the widely used positivist paradigm, specifically the use of survey questionnaires popular with management and technical disciplines, before moving on to argue for a qualitative case study approach. The theoretical stance underpinning the case study is perhaps best described as social constructionist, which '*regards experience as an active process of interpretation rather than a passive material apprehension of an external physical world*'. Manager, care staff, residents and researcher '*do not merely provide descriptions of events, but are themselves constitutive of wider policy discourses and conflicts*' (Jacobs and Manzi, 2000: 36). The case study is therefore designed to explore the ways in which individuals and groups *participate* in the creation of 'social reality' within their particular home. The second part of the chapter outlines the methods chosen to generate data relevant to the research questions and explores the management and analysis of the data collected during the empirical phase of the project.

5.1 The argument for a qualitative methodology

Early social sciences and health services researchers appeared to favour quantitative methods, assuming that numerical information was objective and scientific, and thus, offered more valid and reliable findings (Maykut and Morehouse, 1994). Research into health, safety and housing related issues is often characterised by large scale surveys, for example the MORI survey '*Attitudes towards health and safety: a quantitative survey of stakeholder opinion*' (2004) commissioned by the Health and Safety Executive. Jacobs and Manzi (2000: 35 - 36), suggest that mainstream housing research '*relies primarily upon a positivist epistemology*' whose roots can be traced to the '*influential Fabian agenda that has dominated the study of social research in the UK*'. Qualitative research in the social sciences, the social and health services has however developed as a means of studying people in their natural social context. It is particularly used by anthropologists and in healthcare, for example, to study people's experience of illness (Bowling, 1997).

Handy (1993: 181) states that '*in organisations there are deep-set beliefs about the way work should be organised, the way authority should be exercised, people rewarded, people controlled*' i.e. the organisational culture is at the heart of 'the way things are done around here[22].' Is it realistic to think that these cultural complexities can be elucidated using questionnaires and numbers - are meaningful conclusions to be derived from questions that are asked outside the temporal and socio-cultural context of the care setting? Patton and Appelbaum (2003), express a wide felt criticism of the 'natural science' approach to management, whereby activities and behaviours are regarded as variables that can be broken down into quantifiable units. The human dimension is regarded almost as an afterthought and the uniqueness of a case is regularly treated as 'error'. Reducing a complex social situation to a number of discrete and clearly defined variables that are then evaluated by analysing the mathematical relationships between them completely disregards the dynamic process of interpretation that takes place between individuals in a social situation i.e. the subjective world is squeezed into an objective measurement that represents a monochrome and completely static view of what is in reality a colourful moving picture. '*By dealing with brief survey questions and large numbers of disconnected respondents, the flesh and bones of everyday life is removed from the substance of the research itself, which diminishes the usefulness of the research*' (Patton and Appelbaum, 2003: 62). Perhaps for these reasons research in the area of residential care often employs the techniques of ethnography[23] and case studies such as Williams, Netten and Ware's (2003) study into the experiences of those involved in the closure of residential homes.

5.2 A qualitative case study approach

Draper (2004) defines a qualitative study as an inquiry process that explores a social problem by building a holistic picture within a natural setting. According to Maykut and Morehouse (1994) qualitative approaches are designed so that sampling of participants gives variation within a particular social context, are concerned with words

[22] The phrase '*the way things are done around here*' appears in a number of texts and contexts across different disciplines, for example its use can be found in management studies (Evans, 2007), nursing studies (Trimmer, 2006) and educational theory (O'Neil et al, 2005).

[23] A number of 'fly on the wall' documentaries including the BBC Panorama documentary 'A Carer's Story' and Channel Five's 'Who Cares for Granny?' have employed ethnographic techniques to demonstrate a perceived 'reality'. Such techniques may however be questionable on ethical grounds.

rather than numbers, are descriptive and interpretive, and often use a case study approach.

Residential care homes are highly complex communities comprising many interdependent components, representing a 'colourful moving picture' of highly contextual and interrelated data. The different components which comprise the home thus represent a culture based social *system* that is far greater than the sum of the different parts. A case study therefore has much to recommend it in that the research questions are investigated in the context of the direct experiences of those whose social actions are of interest. The case study also uses multiple sources of evidence that represent different cultural interfaces that comprise the social system. The case study's unique strength is its ability to deal with a wide range of evidence (Yin, 1994). It allows for multiple perspectives to be studied within the context that the question is being asked. Stake (1995) identifies three types of case study: *intrinsic,* the study of the case itself; *instrumental*, to understand a more general issue or theory and; *collective*, the study of several, individual cases, again to understand a more general issue or theory. Bryman (2004: 53) talks about the comparative design which entails using more or less identical methods to investigate two or more contrasting cases, where the resulting data can be compared to identify different *cultural* perspectives. The collective and comparative designs fit well with the idea of exploring the experience of health and safety regulation across a range of homes deriving from the mixed economy of residential care. A case study uses a variety of sources in deriving a holistic picture of each home. Yin (1994: 80) suggests six potential sources of evidence for data collection in the case study protocol: documentation, archival records, interviews, direct observation, participant observation, and physical artefacts. All of these sources were used within the present research design. For example, the use and efficacy of care plans was examined from multiple perspectives using documentation, physical evidence and interview. The written plan of care was often restricted on the basis of confidentiality, however, reviewing the home's CSCI inspection reports[24] helped to derive further and deeper understanding.

[24] The Commission for Social Care Inspection have a legal right to inspect all documentation held by the home. Whilst their reports do not cite 'confidential' material, they do include critical feedback on key activities like care planning.

This process of *triangulation* highlights points of agreement and disagreement in the data. In this context triangulation is a process that serves to corroborate the data gathered from different sources, thereby increasing its internal validity. Thus data generated by interview, observation and content analysis can be aggregated to present a single unitary picture of events. Individual points of view are neither 'right' nor 'wrong', they merely represent a perspective on the phenomenon.

5.2.1 Qualitative interviews as part of a case study

Interviews can be a significant source of case study information; they are however a complicated, dynamic, social process between two people which cannot be easily replicated (Seal, 2004). The ontological standpoint for the qualitative interview derives from a belief that knowledge, views, understandings, interpretations, experiences and interactions are meaningful properties of social reality (Mason, 2006). Interviews are unlikely to uncover some *objective* truth about a particular phenomenon as the parties to the interview will have differing ideas and perspectives about the subject being discussed. Maykut & Morehouse (1994: 124) use the word '*perspectival*' rather than subjective because they believe that subjectivity has come to be associated with research that is less than real. By using the word perspectival, they are clearly trying to signal that qualitative research has the added advantage of being inclusive i.e., inclusive of a variety of perspectives, including those of both the participant and the researcher. This is an important acknowledgement as in the arena of qualitative interviews '*it is the researcher themselves* [who] *is the research instrument par excellence*' (Hammersley and Atkinson, 1995: 19). Interviews can be structured or semi-structured. Rice and Ezzy (1999: 53) prefer the terminology of in-depth interview because they believe describing qualitative interviews as *semi-structured* infers that they are a watered-down version of a *structured* interview. The qualitative or semi-structured interview is however described as a method 'having its own character' with some core common characteristics deriving from the principle that knowledge is situated and contextual. These include a relatively informal style, a theme or topic based approach, and the interactional exchange of dialogue. This allows for discussion and for the participant's stories to develop (Mason, 2006). Thus, the semi-structured interview is a valid and

flexible tool that is suited to a dynamic and culturally rich environment such as the residential care home.

5.2.2 Validity, reliability and generalisability in case study research

Flyvbjerg (2006: 220) suggests that there are a number of misunderstandings about the role and use of case study designs. These misunderstandings or oversimplifications challenged the reliability, validity and theoretical basis of the case study approach. Flyvbjerg spends considerable time unpicking each criticism, however his main points are summarised in Table 5.

	Misunderstanding	**Flyvbjerg's correction**
1	*Context-independent knowledge is more valuable than context-dependent knowledge*	Predictive theories are not found in social situations. Context dependent knowledge is therefore more useful
2	*Cannot generalise from an individual case; therefore, the case study cannot contribute to scientific development*	One can often generalise, specifically in terms of the use of examples
3	*The case study is most useful for generating hypotheses*	The case study is useful for both generating and testing hypotheses
4	*The case study contains a bias toward verification* (circularity)	The case study contains no greater bias than any other method. Indeed experience suggests a greater bias towards falsification of preconceived ideas
5	*Difficult to summarise and develop general propositions and theories on the basis of specific case studies*	Case studies should be read as narratives in their entirety.

Table 5: Flyvbjerg's corrections

The main message that Flyvbjerg and others appear to convey about qualitative approaches like the case study is that the means for ensuring validity and reliability are different from those used in quantitative research, although the principles are often regarded as the same. Others, for example Yin (1994), appear to apply the general criteria for assessing scientific validity that are detailed in many methodological texts. Likewise, Bryman (2004) identifies the four sub-types of *external*, *internal*, *measurement* and *ecological* validity. External validity refers to the generalisability of findings to other settings; internal validity refers to the degree to which a stated cause withstands scientific challenge; measurement validity defines the relationship between a concept and its unit of measurement; and ecological validity relates to the degree to which the findings withstand a reality check i.e. do the findings apply to a *real* situation. Reliability relates to the consistency of the measuring instrument or measurement i.e.

the *repeatability* of the measurements, for example, the instrument and outcome are consistent when used over time (Bowling, 1997). This consideration was important in terms of designing the methods to consistently gather data from the different participants in the different case study homes.

There are alternative criteria which can be used to reflect the underlying assumptions involved in much qualitative research. Guba and Lincoln (1985) and Marshall and Rossman (1995), for example, talk about credibility, dependability, transferability and conformability. *Credibility* is synonymous with internal validity, *dependability*, with external reliability, *transferability*, with external validity, and *conformability* is synonymous with objectivity and refers to the degree to which the results can be confirmed or corroborated.

5.2.3 Generalisability of the research findings

It has been said that it is not possible to generalise from single case studies, as single members or small samples are often poor representations of whole populations (Bowling, 1997). Guba and Lincoln (1981: 62 in Hammersley, 2004: 206) write, for example, that it is '*virtually impossible to imagine any human behaviour that is not heavily mediated by the context in which it occurs. One can easily conclude that generalisations that are intended to be context free will have little that is useful to say about human behaviour*'. Gomm (2000) argues however that we all engage in naturalistic generalisations at one time or another and indeed this may take the form of empirical generalisation or even theoretical inference. Thus, in principle at least, there is no reason why case studies should not provide a basis for empirical generalisations. Stake (1995 in Patton and Appelbaum, 2003: 66) suggests that we can however learn much that is general from a single case as we are all familiar with other 'similar' cases and as we add new cases there are new opportunities to strengthen, modify or reject old generalisations.

A number of authors emphasise the importance of clear and detailed descriptions that ultimately help the reader to determine comparisons between the researched case and other cases of interest. Patton and Appelbaum assert that '*if you have a good*

descriptive or analytic language by means of which you can truly grasp the interaction between various parts of a system and the important parts of a system, the possibilities to generalise from very few cases, or even one single case , may be reasonably good' (2003: 65). Goetz and LeCompte (1984: 228) introduce the concepts of *comparability* and *translatability*, where comparability refers to the degree to which the components of a study, including the characteristics of the population and setting are sufficiently well described that they can be used for comparison. Translatability refers to the clarity of the descriptions and theoretical ideas in order to facilitate scientific comparison.

It has also been suggested that the burden of *proof* in terms of generalisability is the responsibility of the user of the research rather than the researcher's (Gomm, 2000: 100). However, the researcher can facilitate the possibility of future generalisability by giving adequate voice to participants and sufficient description of their procedures, within a narrative context that successfully merges these different components in a coherent way (Ponterotto, 2006).

5.3 Sampling strategy

The goal of case study research is not *necessarily* to produce a standardised set of results from which generalisations can be made (Feagin et al, 1991; Yin, 1994; Stake, 1995). Rather the intention is to produce a coherent and illuminating description of social experiences, derived from a study of those experiences within the context that shapes them. Denzin (1983: 133) writes: '*the interpretivist rejects generalisation as a goal and never aims to draw randomly selected samples of human experience. For the interpretivist every instance of social interaction, if thickly described represents a slice from the life world that is the proper subject matter for interactive inquiry….Every topic…must be seen as carrying its own logic, sense of order and meaning*'.

Gomm (2000) however asserts that *it is* possible for case study researchers to try to take into account probable and relevant heterogeneity[25] within the population of interest in two complementary ways. First this is done by using theoretical ideas and information about the case and the population. Second, cases are selected for study on the basis of

[25] That is the differences, dissimilar elements or parts of care homes, locally and as a consequence of them belonging to different providers.

this information. One sampling strategy, information oriented sampling (Yin, 2009), selects a case study sample that as far as possible is typical in relevant respects or extremes of those in the population. For example, very small care homes which represent a minority of the sampling frame. Flyvbjerg (2006: 229) appears to favour this approach to sampling whereby: '*the objective is to achieve the greatest possible amount of information on a given problem or phenomenon….. A representative case or a random sample may not be the most appropriate strategy*'.

In practical terms an information oriented sample of care homes was derived by making use of the data that was available within the Commission for Social Care Inspections (CSCI) report data set. These reports are compiled by inspectors who audit homes against National Minimum Standards; reports therefore detail wide ranging variables about every care home in England. This method for case selection also afforded the compilation of a summary profile of the entire sampling frame, detailed in Appendix 1.

5.4 Methods

Bryman (2004: 27) describes a research method simply as a technique for collecting data; however, this perhaps belies the complexity of this process. This section describes the methods that that were used for translating the theoretical considerations into data and how that data was subsequently analysed.

5.4.1 Deriving the case study sample and overview of the sampling frame

The Commission for Social Care Inspection (CSCI) maintain electronic copies of care home inspection reports which are available in the public domain for download in Portable Document Format. CSCI reports provide a valuable source of original data detailing what inspectors found during their visits to the home. Inspectors are legally entitled to inspect all aspects of management and care practice and these insights are recorded as evidence of compliance with the National Minimum Standards. The availability of this inspection report data provided an illuminating backdrop to the case study supporting its internal validity.

The inspection reports can be accessed by entering a postcode in the search page of the CSCI database and specifying a 5, 10 or 15 mile radius within which to search. The database then provides a list of all of the homes in that area. This method was chosen to derive the names and contact details for all of the adult care homes within a 5 mile radius of an 'NG' postcode[26]. The CSCI database identified 163 adult care homes in this location, which are shown in Table 6. The distribution of providers against service type suggests that a range of registered providers were represented within the sample that closely approximated the national distribution of care home beds shown in Appendix C of the CSCI publication *The State of Social care in England* (2006). The table shows that there were 100 small, medium and large homes designated 'old age' distributed across a range of providers.

Proprietor	**Learning disability**	**Mental disorder**	**Old age**	**Physical disability**	**Totals**
Local authority	2	-	9	-	11
Private provider	7	9	41	1	58
Corporate provider	10	4	42	6	62
Voluntary sector	20	3	8	1	32
Totals	39	16	**100**	8	163 homes

Table 6: proprietor and service types within sampling frame in 2007/08 (n=163)

These 100 homes formed the basis of the sampling frame and a database comprising a copy of the latest CSCI inspection reports downloaded from the CSCI website. These reports were used to derive an overview of the sampling frame and to derive the information oriented case study sample. In order to derive a range of useful and interesting data from the reports, content analysis was used (Bryman, 2004). This involved the allocation of codes to the data, making it relatively easy to sift through a large volume of data in a systematic fashion. The United States General Accounting Office provide a compelling reason for using content analysis in that it enables the researcher to sift through a large volumes of data with relative ease in a systematic fashion (General Accounting Office, 1996). Content analysis breaks texts into recordable units, such as words, themes, characters, items and temporal measures (Berelson, 1958). The process of applying a numerical code to the text does not

[26] The actual postcode has not been given as this would identify all of the care homes within the sampling frame.

necessarily seek to derive the deeper meaning within that text, simply to identify and quantify its 'meaningful' components. In this case, meaningful units included the category of home, ownership, size, and coded variables detailing such parameters as any shortfalls identified by inspectors. The benefits associated with content analysis are that the objectivity and reliability of the research instrument can be clearly defined and tested by setting out 'rules' that are to be applied to the data and establish the reliability of the coding tool. Reliability here refers to the reproducibility or consistency of the analysis such that different researchers code the same data in similar ways. The 'rules' for numerically coding specific elements of the text were set out in a code book, designed to ensure some consistency of coding.

The process of devising and developing these codes was recursive i.e. the categories, coding scale and rules evolved as they were tested and used. The basic framework was based on that advocated by Bryman (2004), and as new categories were identified (that did not fit existing codes) the coding scale was updated. Management of the data derived from the analysis of inspection reports was undertaken using the Statistical Package for the Social Sciences (SPSS) a software based system that allowed data to be stored and manipulated with relative ease. SPSS was used, not as a statistical device, but because it helped with the creation of a suitable data collection instrument and provided a facility to store, collate and present the data in different ways. The data captured in this way was used in two distinct ways. First, to provide an overview of the sampling frame (Appendix 1); and second, to inform the information oriented selection of eight homes for the qualitative case study. This selection involved laying down 'markers' within the data base that denoted significant characteristics used to derive an initial shortlist of 40 homes distributed across a range of service sizes and providers within the mixed economy of residential care.

5.4.2 The case study sample

The shortlisted care homes derived from the content analysis of the sampling frame were initially contacted by letter. This included an enclosed project booklet setting out the background to the research and a stamped addressed envelope (SAE). For the larger providers, such as the local authority, larger housing associations or corporate

providers, the responsible manager from the home's managing organisation was identified and contacted to seek their permission and to approve subsequent contact with the sample home. Homes were invited to return a card expressing their interest in participating in the research or requesting further details using the SAE provided. Only one home actually replied using the SAE, so it was necessary to contact the remaining homes by telephone, working slowly down the shortlist. One of the larger corporate providers required a detailed submission to their own internal ethics committee before they would consider taking part in the study.

Following numerous telephone calls and e-mails eight care homes were recruited. These homes represented a cross section of the characteristics discussed within the theoretical framework. These included variations in the size of home, a cross section of providers from across the mixed economy of care with either local or regional governance. A ninth home (home 'A') owned by a small private provider, was unable to participate due to closure in the early stages of the research. A summary of the case study sample is shown below in Table 7. A more detailed overview of all of the case study homes is provided in Appendix 2.

Home name	**Number of beds**	**Home type**	**Home's CSCI 'star' rating**	**Comment**
B	19	Voluntary sector	2 Good	National provider
C	4	Private / independent sector	2 Good	Owner manager home
D	12	Private / independent sector	2 Good	Owner manager home
E	40	Voluntary sector	1 Adequate	National provider
F	16	Local authority	3 Excellent	Council provider
G	19	Voluntary sector	2 Good	Local housing association
H	22	Voluntary sector	1 Adequate	Local housing association
I	54	Private / corporate sector	2 Good	Very large national provider

Table 7: the case study sample showing 'star rating'

5.4.3 Qualitative question frames

Bryman (2004) suggests that three 'rules of thumb' can be used as a starting point for designing questions. First, they must derive from the research question discussed in the introduction to the thesis. Second, the questions must elicit information required to answer the research question, and third, they must be asked in a way that avoids ambiguities and contradictions. These rules provided a basic framework within which the research aims, questions and concepts were operationalised. Figure 11 shows the

sequence of steps that informed the decisions whereby concepts were translated into the actual questions that were used in the fieldwork.

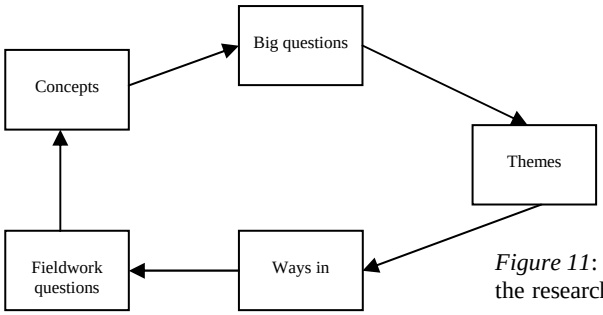


Figure 11: Operationalising the research

Table 8 shows this process in practice starting with the 14 big questions that the research originally set out to address. These 14 questions have since been consolidated / summarised into the six primary research questions discussed in the introductory chapter. The table shows the themes deriving from the questions, the ways in, i.e. the person or data source best suited to answering the question and reference to the question instrument / schedules that were actually used (Appendix 3).

Original big questions	**Themes / concepts / operational definitions**	**Ways in**	**Fieldwork questions**
1. Why are care homes apparently dangerous places?	Natural consequence of a 'homely' environment or the failure to assess hazards, assess risks and apply safe systems	National statistics, Health and Safety Executive and Local Authority	National statistics and evidence from case study participants
2. What mechanisms drive health and safety within residential homes?	Intrinsic to the principles of good care practice; an imperative to comply with the law; or a fear of civil litigation	Resident Manager	R1 (R = Resident) M1(M = Manager
3. Is the framework controlling health and safety appropriate for the needs of residential care homes?	Complex regulations and guidance might be confusing and therefore open to misinterpretation or misapplication	Literature review Manager Documents	What do the regulations and standards actually say. Are the messages coherent and consistent M2
4. Are there inherent contradictions within the regulatory framework that confuse managers and lead to the paradox of risk averse practice whilst failing to apply important control measures?	Tensions between different regulatory frames / contradiction between home and work Confusing duplication of advice, guidance and documentation e.g. Regulation 37 and RIDDOR 95	Literature review Manager Documents	What do the regulations and standards actually say. Are the messages coherent and consistent M3 D1 (D = document)
5. What role do care practices / management arrangements play in delivering healthy and safe premises and care?	Role of key workers etc in the assessment of risk and the implementation of safe working practices	Manager Staff Resident	M4 S1 (S = staff member) R2
6. Are there inherent contradictions in the philosophies of privacy, dignity, choice and the regulatory framework?	Whilst residents have theoretical rights, their responsibility is to the wider care home community and its rules	Manager Resident Staff	M5 R3 S2
7. What mechanisms drive the interpretation and implementation of the regulatory framework?	The planning and management of care determines the balance between risk and choice (rights and responsibilities)	Like question 2	
8. What role does organisational and professional culture play in the interpretation and management of risk?	Organisations influence systems and management practice. Professional affiliations may influence systems and management practice	Manager Staff	M6 S3

Table 8: Developing interview schedules

Original big questions	Themes / concepts / operational definitions	Ways in	Fieldwork questions
9. Is the process of risk assessment appropriate?	Hazards identified, real risks identified and sensibly managed. Relevant people are involved	Manager Staff Resident Documents	M7 S4 R3 Documented risk assessments
10. To what extent might health and safety influence the institutional aspects of residential care?	Health and safety is emphasised before or to the detriment of privacy, dignity and choice	Manager Staff Resident	M8 S2 R4
11. How are residents empowered to influence the management of the home and its safe working practices? (Passive clients or discriminating consumers?)	Empowerment: a residents committee, plans of care that involve the resident, staff who follow this plan, evidence of real choice, access to facilities and evidence of individual respect	Manager Staff Resident Documents and physical evidence	M9 S5 and 6 (care planning) R1 and 5 Minutes of resident meetings, plans of care, evidence of access to facilities and choice
12. To what extent is the regulatory framework used to explain risk averse practices?	Care practices are designed to meet the needs of older adults as a group in ways perceived to eliminate harm but which also restrict choice	Manager Staff Resident Documents and physical evidence	M8 and 9 S7 R6 Notices restricting access, locked doors etc.
13. What role does 'quality' play in the management of health and safety and its integration with the stated or implied needs of residents?	Management systems and practices that meet resident need whilst ensuring legal compliance	Manager Staff Documents	M10 S3 Documented procedures that show integration of the homes management systems
14. What role does training and written guidance play in the management of health and safety?	Type and level of training and guidance and the degree to which it is integrated with care management.	Manager Staff Documentation	M11 S8 Training materials, schedules and records

Table 8: Developing interview schedules

5.4.4 Qualitative interviews

Semi-structured qualitative interviews were held with the home managers, care staff and residents from each of the case study homes, during multiple visits made between the early spring and autumn of 2008. The interviews were generally conducted with two residents and two members of staff as shown in the schedule of participants, Table 9. Whilst the selection of home manager as a participant was dictated by the choice of home, there was some choice with respect to other participants. The availability of staff was, to some extent, dependent upon who was on duty on a particular day and was

always at the discretion of the home manager in terms of allowing time away from their other duties. Residents were generally chosen or 'self selected' following introductions from the home manager and time spent with groups of residents in the communal lounge. This process was designed in order to include any resident who wanted to share their experiences about their home. Whilst residents' wishes were always respected, if they chose not to participate, time was always made available for those who had a story to tell or an experience to relate.

Kvale (1996 in Bryman, 2004: 325) suggests a number of techniques that may be used to guide the interview process. The interviewer must be 'knowledgeable' by becoming thoroughly familiar with the focus of their interview, by understanding the subject matter in sufficient depth and detail to be able to ask questions in different ways and interpret answers appropriately. Time was taken to structure and to explain the purpose of the interview; clarifying the participant's understanding and expectations by being clear**,** asking simple, easy, short questions without using jargon. The interviews were designed so that they could be used flexibly whilst keeping a clear focus on the principles deriving from the original research questions. The interview questions were not necessarily asked in any fixed order and the same wording was not always used. They were instead 'tailored' to the participant and to the context within which they were being asked. This allowed flexibility and for a greater in-depth examination of the participants views under particular circumstances. The interviews were always conducted with sensitivity towards the participants allowing them to finish; giving them time to think and by respecting digressions from the original interview schedule. However, it was occasionally necessary to steer the participant back to the discussions at hand and where necessary to question inconsistent replies or to clarify the meaning of the participant's statements without changing their meaning.

The aim was to capture as much as possible of the participant's thinking about a particular topic, and to exploit any opportunities that arose where the participant mentioned something of relevance or interest. Residents and staff were frequently located in the main lounge of the home, a busy and dynamic place which frequently facilitated a discussion about something happening at the time. A few interviews were held in the resident's own room, which gave the resident the opportunity to talk about

their possessions and perhaps more personal topics. Home managers often preferred their own office, as this meant that they remained accessible.

The interview timetable and times were largely dictated by the limits placed upon them by the participants. Their time was valuable and often limited by their health, their busy schedule or shift pattern. For example, whilst a time was always agreed with the home manager, there were occasions when participants were unavailable due to illness or pressure of work. Interviews in general lasted an average of one hour; however, those undertaken with residents frequently lasted much longer, as time was spent talking generally about their experiences and observations. Whilst home managers were often very busy, the managers of the private sector homes were generous with their time resulting in interviews lasting two or more hours. All interviews were recorded on audio tape and later transcribed verbatim, by a process of listening, typing the words and capturing the context and re-listening to ensure that what had been said was accurately reproduced. Transcripts were completely anonymised by allocating each participant a code number and a pseudonym to give them voice within the thesis (Table 9). The secure key to the coded data will be destroyed upon conclusion of the thesis.

5.4.5 Observation within the case study homes

Observation as a research method involved being open to what was happening within the case study environment. Bowling (1997: 316) explains that within the social sciences the definition of 'observation' is not limited to 'watching' but extends to the direct gathering of information via the senses. Observation was used to elicit information about how different parts of the care home were accessed, or where access might be denied for reasons of health and safety. It was also used to observe the different physical features of the home that also existed for reasons of health and safety, such as window restrictors and door closers that will be discussed in the empirical chapters of the thesis. Access to different parts of the care home was controlled by the home manager who facilitated the act of observation by introducing the researcher to different areas of their home. Thus the observations were not generally spontaneous, but were, in effect controlled by the home manager and staff. Bryman (2004) describes this as a reactive effect. The measurement itself acts as a change agent and impacts on

what was done or not done. Webb et al (1966 cited in Bryman, 2004: 175 Box 8.10), talk about 'role selection' whereby participants are tempted to adjust what they say and do in line with how they perceive the researcher's aims. Reactive effects are an inevitable part of participant observation; however they were unlikely to impact significantly on physical evidence such as locked doors or windows that were often explained as necessary for resident safety.

Home	**Home code**	**Participant** (pseudonym)	**Designation**	**Participant number**	**Transcript code**
B	14	Rose	Manager	1	141M
	14	Ann	Deputy	2	142D
	14	Matt	Care assistant	3	143CA
	14	Betty	Resident	4	144R
	14	Hilda	Resident	5	145R
C	51	Julie	Manager	6	516M
	51	Zara	Care assistant	7	517CA
	51	George	Resident	8	518R
D	65	Cath	Manager	9	659M
	65	Martha	Care assistant	10	6510CA
	65	Marie	Care assistant	11	6511CA
	65	Jim	Resident	12	6512R
	65	Fran & Jean	Residents	13	6513R
E	27	Bob	Manager	14	2714M
	27	Ruth	Administrator	15	2715A
	27	Karen	Care assistant	16	2716CA
	27	Mo	Resident	17	2717R
	27	Joyce	Resident	18	2718R
F	22	Mike	Manager	19	2219M
	22	Marie	Senior Care Assistant	20	2220SCA
	22	Janet	Care assistant	21	2221CA
	22	John	Resident	22	2222R
	22	Edna	Resident	23	2223R
G	45	Lisa	Manager	24	4524M
	45	Zoe	Deputy	25	4525D
	45	Maria	Senior Care assistant	26	4526SCA
	45	Arthur	Resident	27	4527R
	45	Hugh	Resident	28	4528R
H	6	Rachael	Manager	29	629M
	6	Helen	Resident	30	630R
	6	Mandy	Care assistant	31	631CA
	6	Tom	Resident	32	632R
	6	Maria	Care assistant	33	633CA
	6	Andrew	Resident	37	637R
I	72	Jack	Resident	34	7234R
	72	Jane	Resident	35	7235R
	72	Penny	Activities coordinator	36	7236AC
	72	Hazel	Staff nurse / care assistant	38	7238SN/CA
	72	Jill	Manager	39	7239M

Table 9: Participant Code Log showing homes and participants

Note: The transcript code comprises the 'Home code' the 'Participant number' and a letter designating their position within the home. Thus Home 72, Resident 35 = Transcript code 7235R

5.5 Ethical considerations

Three basic principles underpinned the fieldwork: informed consent, anonymity and sensitivity. Participants were fully briefed on the nature of the research both at the point that providers or home managers were asked to participate and prior to each interview. Participants were given the opportunity to refuse involvement and to withdraw their participation at any time. The resident participants were considered in the context of their possible frailty and vulnerability. Bland (2005: 156) for example makes the point that '*the [participant] needs to be understood in terms of the broader context of ageing generally and wider social processes*', of what Davies (1985: 181) calls 'marginal individuals'. This suggests that whilst the scientific principles underpinning the research interview remain the same as they would for any participant group, the researcher needed to be aware of and consider the unique position of older adults in residential care. In practical terms this meant having awareness and understanding of any particular physical or sensory impairment. For example checking the participant's ability to hear or extending a handshake to someone with impaired sight and letting them choose the seating arrangement. It was also important to be sensitive to the emotional context within which the interview was being conducted and the likelihood that the process might elicit particularly upsetting feelings or memories. In all circumstances the resident was shown respect and the interview location was treated in much the same way as might have been anticipated if it had been the resident's own home.

The anonymity of the participants and their homes was an important ethical consideration. Individual homes were allocated a unique code number in order to track the data and tape recordings and transcriptions were stored securely. Whilst inspection reports were freely available, the conclusions drawn from them are from the perspective of the researcher and therefore the names of the homes were coded to protect them from the possibility of a negative interpretation of their management practices. A secure *non-electronic* register of home names and their codes was constructed in order to ensure that no care home names or addresses could be linked with data analysed electronically or discussed in this thesis. Homes were anonymised using a number and letter code that is used to identify a particular case study home within the thesis. None of the names used in the thesis are the real names of any of the participants and every care has been taken to remove anything within the transcripts that might link it to a particular home.

Two participant information sheets were constructed and used. One for home managers and providers gave a detailed overview of the project and what each stage would involve for the home. The other, for home staff and residents, gave an outline of the project, stated the value placed on their contribution and how their data would be anonymised and protected. It also emphasised the absolute right to refuse participation or to withdraw consent at any time. A statement about the role of the Commission for Social Care Inspection was also included should the participant express concerns about any aspect of home management during the interview. These forms were accompanied by a consent form designed in a tick box format to ensure that participants had read and understood the information sheet and were giving their informed consent, to participation, tape recording, document sharing and use of data in the thesis and subsequent publications.

5.6 Managing the qualitative data

The data recorded after each phase of the fieldwork is extremely 'fragile', it is most relevant in terms of its context. As time passes the *meaning* may be difficult to reconstruct, therefore a daily interpretive analysis (DIA) was used to capture those 'flashes of insight' that might otherwise have been lost. This was particularly the case with any observations made during the fieldwork visits or during interviews before they were transcribed. In practical terms this DIA was undertaken in diary format by making general notes about each visit, and recording any significant observations about the home, its record keeping or specific items highlighted during the interviews. Where the interviews contained an item of particular relevance to subsequent visits, these were replayed and appropriate diary notes made.

5.6.1 Analysis of the qualitative data

Draper (2004: 644) describes data analysis as sorting out the structures of significance. Data can be read literally or interpretively, however, it has been suggested that a purely 'literal' interpretation is not possible. This is because what we see is shaped by how we see it, and the social world we seek to 'read' has already been interpreted by our participants (Mason, 2006). An interpretive reading on the other hand involves making

a judgement about what the data might mean or infer. For example, parts of the interview transcript may provide insights into the implicit norms or rules within which the participant is operating (Mason, 2006). In practical terms both approaches have been used in presenting the data within the empirical chapters. This process is given transparency within the discussion that either precedes or accompanies the data presented as evidence.

The first part of analysing the interview transcripts was a process of reading and re-reading transcripts, making notes from them and constantly referring back to the aims, research questions and themes emerging from the literature and the home's CSCI reports. This was an important part of the analysis because as, Bowling notes, it '*has the advantage of the researcher maintaining a close relationship with the data*' (1997: 345).

The contents of the interview transcripts were subsequently coded by labelling sections of the text with reference to the theoretical framework and according to interesting and emerging themes. The themes included, for example, the broad categories of, home, activities and interests, keeping residents safe, care, care planning and key working, the impact of the workplace, risks, hazards and blame, examples of street level bureaucracy and rituals of compliance. As Bryman (2004) notes, coding *is not* the same as analysis, it is a process of managing and reducing large amounts of text. Thus, key data contained within the different interview transcripts were managed by tagging or identifying them according to the chosen themes and sub-themes. This ultimately facilitated their recovery for use as evidence within the empirical chapters of the thesis. Coding has been criticised for fragmenting text, chopping it up and thereby losing or disregarding the stories and social context that might be contained within the narrative. However, the coding process used was designed to take into account the coherence and sequence of the account and connect it with the context within which the narrative had taken place. An Nvivo 8 software package was used to support the process of data analysis, although much of it included referring back to the original transcripts to derive contextual information and by copying quotations with similar themes into word documents for comparison with narratives deriving from CSCI reports. These differently themed word documents were placed into folders labelled with the broad categories. Thus, for

example, the 'home' folder contained themes including: 'chosen lifestyle ', 'privacy', 'my room ', 'domestic activities' or 'living with spouse' etc.

Zucker (2001) advocates Miles and Huberman's (1994: 245-246) thirteen tactics for generating meaning from qualitative data which were found to be useful. The first three tactics tell us '*what goes with what*' the next two tell us '*what's there*' followed by '*sharpening our understanding*' before helping us to '*see things and their relationships more abstractly*' and finally to '*assembling a coherent understanding of the data*'. Zucker explains that it is not always necessary to use all of these tactics in any one case study.

The theoretical ideas explored prior to the fieldwork were part of a deductive approach to the research, allowing for speculation on some of the possible consequences of the research problem. These included possible conceptualisations of key themes such home, hazards and risk. However, whilst the analysis described here is not categorised in any way as *Grounded Theory* (Glaser and Strauss, 1967) it inevitably borrowed from its basic concepts and ideas. The analysis and coding was, for example, iterative and recursive whereby the researcher moved between the data and the literature as theory began to emerge. Assumptions made at the stage of drafting the theoretical framework were subsequently challenged by the data, and the literature was used to develop general conclusions from the findings. This necessitated seeking more data on some occasions in order to further explore new and emerging issues that did not appear to be explained by the theoretical model.

5.6.2 Elucidating the likely cultural orientation of the case study homes

Chapter 4 discussed the theoretical framework that conceptualised organisations in terms of two principal axes, 'grid' and 'group' which give rise to four possible 'cultural biases' or 'ways of life'. The final section of chapter 4 set out a series of summary propositions theorising what an individualist, egalitarian, hierarchist, or isolate residential home might look like.

As part of the analysis, the general 'characteristics' of each case study home were compared with each of these propositions in turn. These 'characteristics' were derived from participant data, CSCI inspection reports and empirical observation. The analysis is shown in Appendix 4 which comprises four tables per home, each representing one cultural type. It was found helpful to allocate a score of 1 where there was evidence that the home met a particular criterion and zero where it did not. A score of 0.5 was used where there was incomplete or inconclusive evidence. These scores represent a purely *qualitative* judgement and have no 'quantitative' significance at all. By adding all of the scores within each table it was then possible to see which home appeared to have most in common with a particular cultural orientation. The results are shown in Table 10.

Home	**Hierarchical**	**Individualistic**	**Egalitarian**	**Isolate**
I	6	0	1	2
H	3	3.5	4.5	1.5
C	0	6	4.5	0
E	4	1.5	3	1
G	0	3	6	0
B	4.5	0	3	1
D	0.5	5.5	3	0
F	5.5	0	3	0

Table 10: Enumerated grid and group

The tables shows that home I 'scores' 6 for hierarchy, but only 1 for egalitarian and 2 for its isolate characteristics. Thus home I was *qualitatively* deemed to exhibit predominantly hierarchical characteristics. These findings are discussed in more detail in Chapter 6.

5.7 Conclusion

This chapter has outlined why a qualitative case study design was considered better able to answer the research questions than a larger scale survey based approach. The chapter has justified the choice of a case study on the basis that it was able to take into account the rich cultural context within which health and safety law was interpreted and applied by using multiple sources of evidence. The idea of cultural context was integral to the theoretical framework and thus it was important that the research design was sensitive to the nature of the home and the provider's culture.

The methods comprised evidence drawn from those who lived, worked and inspected the case study homes. The CSCI inspection reports were initially used to compile an overview of the sampling frame (Appendix 1) and to select a suitable cross section of care homes deemed suitable for case study. The study subsequently utilised a combination of interviews, the narratives contained within the CSCI inspection reports, documentary sources and observation within the homes.

The interviews were conducted with residents, home staff and managers and transcribed verbatim so that the transcripts could be read from both a literal and interpretive perspective in order to identify key themes. Narratives derived from the home's inspection reports and fieldwork observations were subsequently used to support the interview data in a process of triangulation. The anonymity of each care home and provider has been preserved throughout by allocating number codes and a pseudonym to each participant in order to give them voice within the thesis.

The theoretical framework discussed in chapter 4 suggested that different homes belonging to the different providers might exhibit particular characteristics according to the dimensions of 'grid' and 'group'. The data and impressions deriving from the analysis of the data were subsequently 'compared' with the propositions within chapter 4 in order to place each case study home within its most likely 'cultural' orientation. This information is discussed in chapter 6, where the particular characteristics of the case study homes are explored, in order to provide a foundation upon which the key themes of 'home' and 'health and safety risk' are discussed in chapters 7 and 8.

Chapter 6 - Cultural characteristics of the case study homes

6.0 Introduction

This chapter will explore the broad management characteristics of the eight case study homes in terms of their relationship with the theoretical framework discussed in Chapter 4. It will attempt to tease out the similarities and differences between the homes, between their managers and between the different styles of management as they were perceived during the fieldwork. In doing so the chapter will begin to address the first research aim and the first three research questions.

The chapter is divided into three broad sections which will examine the characteristics of the case study homes within the context of the four theoretical grid and group typologies discussed in chapter 4. The chapter draws on the analysis of empirical data which included comparing each home with the propositions set out in chapter 4 (see Appendix 4). Whilst none of the case study homes could be said to 'neatly' and completely occupy a single discreet cultural orientation, there was generally evidence that appeared to bias each of them towards one more 'dominant' orientation. The first section discusses the private sector homes which appeared to occupy an 'individualistic' orientation characterised by few systems and an emphasis on self sufficiency. Section 2 looks at the smaller faith based voluntary sector homes which appeared to occupy a predominantly 'egalitarian' orientation characterised by locally derived systems and staff who worked to achieve the provider's objectives. The final section discusses the homes that appeared to show a predominantly 'hierarchical' orientation, characterised by clearly defined systems of authority. The sections comprising this chapter will be structured in accordance with the broad themes of organisation and systems of authority, discretion in the design, interpretation and use of systems, street level bureaucracy and ritualism. The provider's broad conceptualisation of 'home' and 'risk' are developed in chapters 7 and 8 as these are principal themes of the thesis.

6.1 The 'individualistic' private sector homes

6.1.1 Overview

The two private sector case study homes were both managed by their owners. Home C was the smallest in the sample with just four beds, one of which was for short term, respite care. It was owned and managed by a retired nurse, Julie, and her husband who also occupied a first floor flat within the home. The property had been partially adapted to accommodate older adults in ground floor bedrooms. Home D was a large converted 1930's family house with a 1980's extension comprising 12 bedrooms, which had also been the owner's home until she and her growing family had relocated. It had been opened at a time of considerable growth in the numbers of private care homes, and relaxed policies towards care home governance (Andrews and Kendall, 1999). This was arguably demonstrated by the fact that the owner, Cath, had been registered as the manager at the age of only 21 without qualifications, training or experience in care or care homes:

> "……..*I mean they wouldn't register you now at 21 for a manager, because I mean I hadn't got any experience, I'd never worked in the caring business, we brought a property that had got eight elderly people; we lived in for ten years*" (Cath, manager home D – 559M).

Cath had since undertaken both the NVQ level 4 in care and the Registered Managers Award (RMA) which appeared to have been very influential in terms of the systems and support structures that had subsequently been developed within the home. Julie was however a qualified and experienced retired nurse and had not been required to do either the NVQ or RMA[27].

6.1.2 Organisation and systems of authority

Cath and Julie were both company directors as well as home managers, which enabled them to determine the strategic direction of their business and the systems that underpinned it. They had no close ties to any provider organisation and therefore had

[27] As a senior nurse Julie had undertaken management training which CSCI apparently accepted in lieu of the RMA.

complete and full responsibility for, amongst other things, recruitment, training, maintaining premises in good condition, buying goods and services and balancing income and expenditure. Systems were devised and implemented by their owners and staff without the support of any affiliated organisation, professional advisors or consultants. Typically, the supporting infrastructures were needs driven, informal and opportunistic. For example, whilst health and safety maintenance and checks had become an increasingly important consideration, neither home appeared to have formal arrangements in place. Within home C, Julie's husband, had been active in undertaking basic maintenance and safety checks, whilst Cath at home D, used contractors on an ad hoc basis. Cath had however developed a 'wider' system of support than Julie at home C, although this too was largely informal and made use of the home's bank, local college and the internet for gathering health and safety information:

> "*Well, I think that the main people are who I subscribe to like RBS*[28] *and you know the private business forum that they constantly send you out information making you aware of things. So I do get support, I don't feel totally on my own, and obviously because I've done an NVQ*[29] *as well and doing the Registered Managers Award, they, the course has made you aware to get on the web sites, you know, and look up what's happening with health and safety, you know*" (Cath, manager home D - 659M).

Support with implementing the regulatory framework was however an issue for the smallest case study home, home C. Julie had not been required to undertake an NVQ qualification, and therefore did not appear to have developed a support network beyond contact with the CSCI inspector or the local EHO:

> "*Nobody, nobody, no, not a soul; the environmental health officer (pause) did give me a couple of labels to put on my health and safety poster (pause and laughs), that I'd already got, and she did give us a few leaflets, but no, no-one else has given us support at that level*" (Julie, manager home C - 516M).

[28] The Royal Bank of Scotland provided updates and information relating to the regulation of small businesses.

[29] A National Vocational Qualification (NVQ) in care and management are now required for home managers who do not posses an equivalent approved qualification.

6.1.3 The interpretation and use of systems

A characteristic of the smaller private care homes was the apparent informality associated with the flat management structure and narrow lines of communication between owner and staff. 'Work' appeared to be undertaken largely in accordance with principles of 'common sense' based on an understanding that *social care* was derived from what any caring relative might deliver in their own homes. Neither home appeared to formalise care planning or operate a keyworker system because the small size of both the resident and staff groups was felt to make this impractical:

> "*No, we don't have keyworkers here, no, because we're only small so we feel that we get time to spend really with all of them*" (Marie, care assistant home D – 6511CA).

Both owners and managers were described by their staff as 'very hands on' however, it appeared that there was also a heavy emphasis placed on the need for carers themselves to be self reliant. This was generally accomplished by requiring staff to read any guidance provided by inspectors and by asking them to pay attention to safety and care related issues recorded in residents' personal documentation.

> "……*she explained everything, or you've got leaflets and things and all of the manuals in the rooms to read up on. She said to make yourself aware of these things, plus it's up to yourself as well to look after your own personal safety and whatever*" (Martha, care assistant home D – 6510CA).

Home C usually operated with only one carer on duty at any one time, whilst home D sometimes had two, with on-call support from the home manager. Thus, those on duty were effectively delegated a relatively wide range of responsibilities and autonomy and were expected to 'know their job':

> "…….*Everybody knows what roles they play basically*" (Cath, manager home D – 659M).

Generally both homes appeared to exhibit the enabling characteristics of an individualistic cultural orientation without elaborate systems, and arguably with few risk averse management practices. However, there was some evidence of issues with team working and participation within home D. For example, Cath explained that she would have to do regular safety inspections of the home herself, because carers were not

always proactive about issues such as lights that were not working and were not prepared to replace a faulty light-bulb. This was arguably one possible example of a disabling characteristic associated with a low-grid and group individualistic culture, where group members, at times, lack cooperation (Thompson et al, 1990):

> "*I check everything and it even irritates me when a light bulb is out and the staff won't put one in because they won't walk up any ladders; because it's not part of their job description, so the house is in darkness on a landing until I'm aware of it*" (Cath, manager home D – 659M).

6.1.4 Street level bureaucracy and ritualism

The creation of policy was arguably integral to the combined role of home owner and manager, and this meant that both Julie and Cath were susceptible to direct influence by local regulators. Cath at home C, for example, was very clear that she recognised her wide ranging responsibilities and was therefore likely to respond expediently to any request that impacted on her business.

> "*I'm quite conscientious really, I'm a bit of a perfectionist, I like things in place, and I'm not one of these people where I constantly want to be looking over my shoulder because I've not done it. And then I think to myself well, I've been told enough times what I'm responsible for, so that really makes me sit up and take notice. So now being in the company of people who've been at tribunals, and I think to myself, well I don't really want to be going down that road*" (Cath, manager home D – 659M).

Julie also indicated that she was likely to act expediently towards the suggestions and requirements of inspectors; however, she was not always a willing participant:

> "*For some of the things you think: oh for goodness sake, but you know that it's something they're going to want to make an issue of if you don't*" (Julie, manager home C – 516M).

Both homes operated within a competitive marketplace for care, and demonstrated a high level of self reliance. This meant that they were likely to innovate and to develop informal, unwritten and relatively simple systems that were embedded within an ethos of local control. The homes therefore appeared more likely to be in a position to respond to the demands placed upon them by purchasers than might be expected of homes that

were constrained by strict protocols. Thus, the informal and locally derived systems of the smaller homes did not always sit comfortably with local CSCI inspectors who required written systems and written *evidence* of compliance with the standards they enforced:

> "*Improved record keeping and advice from the Environmental Health Officer and Fire Officer are needed to ensure the home is fully compliant with Regulation and Standards. Good practice recommendations are set in relation to reviewing of care plans, medication management, adult protection protocols, training in health and safety, quality monitoring and some areas around health and safety*" (CSCI inspection report for home C - 51206I).

The inspection reports would, however, suggest that the home had not engaged in rituals of compliance, what you saw was largely what you got. As such the reports were arguably seen by the homes as a criticism of what they regarded as positive achievements, i.e. whilst the home appeared to deliver care that met the needs of residents, the CSCI inspectors were nonetheless critical of their efforts:

> "*Criticised, come in and criticise, pull everything apart and then go away and you never see them again. But you get a report that reflects that, which is unfair……..…It doesn't matter so much when they do the visit: about the resident. It's about the paperwork and it's about the documentation and the recording. And whether you've got your risk, your assessments done and your reviews done and your quality assurance, making sure that you have sent out questionnaires to see what your service is like, what the families think, you know. And it's, well, you know, the care plans, making sure that it's all documented*" (Cath, manager home D – 659M).

Burton (2006) has been critical of what he sees as an often 'superficial' inspection process where the CSCI inspector arrives at the home to examine documentation, whilst perhaps missing the real 'workings' of the home. He suggests that inspectors should be able to determine when standards are indeed 'good enough'. The smaller case study homes were characterised by informality in their general approach to management and to systems, but were able to demonstrate that they had their own, *usually informal*, and simplified way of managing health and safety. According to Penchas (2004: 155): '*there is definitely ample evidence that simple systems do not 'suffer' from emergent properties, and stay stable, with predictable outcomes for lengthy periods of time*'.

Despite their apparent informality, the individualistic care homes were competing within a competitive marketplace and as such were acutely aware of the need to manage risks:

> "*….my livelihood would suffer so much through it [a serious accident], these people who live here would suffer through it, you know, we initially could close through a claim*" (Cath, manager home D – 659M).

Chapters 7 and 8 will develop this theme in terms of how the concept of risk impacted on the residents' experience of their home.

6.2 The 'egalitarian' voluntary sector homes

6.2.1 Overview

Homes G and H, were faith based voluntary sector residential homes located in converted town houses with 1980's extensions and large established gardens. Both homes were registered as housing associations, which are independent bodies established for the purpose of providing social housing on a *non-profit* basis. Any surplus generated is therefore used for the benefit of the association and not paid to shareholders as a dividend. The associations were also registered charities and as such had access to additional funding not necessarily available to private sector homes (Kendall, 2003). Governance for each home was provided by a local voluntary committee who in turn had delegated much of the day to day running of the undertaking to the registered manager. This arguably meant that this role carried a great deal more autonomy, authority and responsibility than might be found in some larger provider organisations.

Home G was registered for 19 beds and was managed by Lisa who had worked there for over 20 years, having started as a care assistant, and had recently undertaken both the NVQ 4 in care and the RMA. Home H, comprised 22 beds and had a relatively new manager, Rachael, who had also undertaken the NVQ and RMA. Her appointment followed the retirement of the previous and long standing post holder, a qualified nurse, who had managed the home with a very 'relaxed' attitude to formal systems. Rachael had thus inherited a cultural legacy that had seen the home manager in a 'hands on,

front of house' role, whereas the committee's emphasis had now shifted to expect a pro-active and systems oriented management style:

> "*……they called her the Matron; she was here 18 years…… She didn't have a lot of management reports and things to do so she used to have chats and tea and bath people and hands on; they don't see me like that and I don't have the time to be like that, so there's two completely different people running the home: there's matron who was the hands on, but none of this (points to files & documentation) was in place, and there's me who's got all of this in place, who would dearly love to be hands on like the other Matron was, but can't*" (Rachael, manager home H – 629M).

6.2.2 Organisation and systems of authority

According to Harris et al (2003), voluntary sector board members often contribute a significant amount to their role and recruiting members can be difficult due to the likely commitment required. Within the case study homes, however, the local voluntary committee's role appeared to be strategic rather than 'managerial' and did not include the scrutiny or practical support of the home's day to day management. The committee therefore vested a great deal more trust, autonomy and reliance in their respective home managers than the post holders apparently felt comfortable with:

> "*……..my issue has always been that I'm it here, the committee are …..…retired people, residents' families, residents' children; we've got quite a few on the committee. So as far as knowledge of this particular environment: it's me is it; so I can't go to somebody else if I'm stuck with anything or, you know, and because they have, they come from different fields; I get a lot of things: now well you sort that out, you sort that out…*" (Lisa, manager home G – 4524M).

After the departure of the long standing manager from home H, the committee had evidently decided to introduce a more formalised management model comprising a 'business manager' and a 'care manager'. This appears to be in line with what Harris et al (2003) calls a drive for professionalism within the voluntary sector, deriving from the influence of business management principles. However, the model had apparently failed and the business manager had left the home. The committee thus gave Rachael what she described as a '*free hand*' with the management of the home:

> "*……you've got a free hand whatever you think, you know, just e-mail me and let me know, keep me abreast of things*" (Rachael, manager home H – 629M).

Thus both Lisa and Rachael found that they were increasingly taking the lead, interpreting the regulatory framework and translating it into local systems. Whilst this had generally worked within the long established culture of home G, the apparent lack of strategic management within home H meant that, arguably, the home was beginning to exhibit the disabling characteristics of the egalitarian culture. These included a *perceived* lack of direction and leadership, internal disagreement and a possible 'anti-manager' enclave, some evidence for which could be found in the home's inspection reports:

> "*Some staff and residents told us that the manager has gaps in her knowledge and we think she needs to make sure she works on the areas of concern we have found on our inspection so people live in a safe and well run home*" (Inspection report, home H – 6103Q).

The 'poor' management outcomes evident within such highly influential inspection reports arguably contributed towards a 'negative feedback loop' as suggested by the theoretical model Figure 10 in Chapter 4. This in turn created a climate where the provider and regulator were calling for increasingly rigorous systems in order to guarantee improved standards.

6.2.3 The interpretation and use of systems

The informal character of both homes G and H was a product of their longstanding informal management style that had resulted from many years of custom and a particular community of practice. This was arguably characterised by the 'low grid' and 'high group' orientation of an egalitarian culture that reflected the informal value base of the provider. However, the advent of the Care Standards Act 2000 and the creation of a 'new' regulatory climate required what might be called a more 'evidential' approach to management. For example, the written plans of care for the residents living in home G were highlighted as needing more specific detail:

> "*The care plans lack the specifics of the support that the service user requires. Information was also missing from some care plans examined* [and] *did not have the date or signature to indicate when completed*" (Inspection report home G - 45107Rr).

There was also reference in the report to a 'significant incident' that had been dealt with internally rather than in accordance with regulatory requirements. The inspection

reports appear to make similar observations regarding the organisation and management of systems within home H, for example:

> "*…….the information staff have about minimising risks could be much better and could offer clearer guidance……..……the manager and owners are not clear about the local safeguarding procedures and have not followed these when incidents have occurred.……..……..*" (Inspection report, home H – 6103Q).

The comments contained within these reports suggest that there were pressures for the homes to improve their approach to systems based management. However, the changing management and regulatory climate has not necessarily been matched by the required support for smaller providers, including perhaps the availability of clearly written guidance and supporting documentation (See chapter 3; Manson-Smith et al, 2006; Scourfield, 2007). At the time of the fieldwork, Lisa had, for example, experienced a significant change in her relationship with CSCI, which had previously been characterised as supportive. It was evident that both she and her deputy Zoe were now experiencing considerable difficulties trying to get advice and guidance from the regulator's local office:

> "*……. a few years ago we had a named inspector and I used to ring her up and say right: I've got this, I've got this, what's the best way to you know, treat it, what should I do, am I doing this right; and she'd just tell me and that was the end of that. And she'd pop in, because she lived locally, see if everything was alright and it was great*" (Lisa, manager home G - 4524M).

The inspection regime, and arguably the relationship between the local inspector and home manager, had recently shifted towards encouraging increasing self reliance and assessment though the use of the Annual Quality Assurance Assessment (AQAA). These considerations appeared to be one of the factors that contributed towards the voluntary committees[30] within both homes considering alternative forms of professional support for their home managers. Within home H the decision was taken to commission a large national housing association provider to undertake some of the management and systems based functions. This included the gradual introduction of the full range of policies, procedures and systems that the larger organisation had implemented in its own homes. A similar arrangement had been proposed within home G, however, using a private sector health, safety and human resources consultancy instead of another

[30] The chair of the voluntary committee for home G had personal experience of trying to arrange a meeting with a CSCI representative to discuss the Regulation 26 visits. On one occasion he was reported to have arrived at the local CSCI office for an appointment, but was told that he was not expected.

provider. These arrangements were at a relatively early stage of implementation during the fieldwork.

6.2.4 Street level bureaucracy and ritualism

There was evidence that street level bureaucracy had played a role in the management of both homes G and H, in a similar way to homes C and D. This arose from the fact that the home managers were expected to develop systems that complied with the expectations of the regulator. Lisa, at home G, for example, had spent many years translating regulatory requirements into systems that she thought were right for the home:

> "*I got to the stage where I could interpret it, interpret like the health and safety etc, etc. and do what I thought.……*" (Lisa, manager home G – 4524M).

Lisa, also provided some evidence of what might be seen as street level bureaucracy from local inspectors, perhaps evidenced by the different approaches sometimes taken to the management of risk by the home's CSCI inspector and by the local EHO. For example, whilst the EHO would generally suggest that health and safety decisions should be based upon a risk assessment, the CSCI inspector would tend to resort to a directive. At the time of the fieldwork, however, the homes were beginning to introduce the consultant's policies and procedures, which arguably left less room for inspector level intervention. A disciplinary issue at home H illustrated this shifting dynamic and showed how the new policies might have conflicted with the CSCI inspector's own view of how the process should have been conducted:

> "*CSCI came in and they weren't happy with how the investigation was conducted and they actually said that they find it confusing with the [consultant] link and me being the registered manager and the responsible person…*" (Rachael, manager home H – 629M).

Thus, in areas of policy that had once been influenced, decided or interpreted at local level, there was evidence of a shift towards the involvement of the more systems oriented consultancy. The homes were therefore increasingly characterised by a developing dichotomy of management systems created and introduced locally and those deriving from their respective consultant. Such a dichotomy and the managing

committee's apparent arms-length emphasis on the introduction of robust systems and improved accountability appeared to be shifting the culture of both homes from a traditionally low-grid, egalitarian, culture towards what appeared to be a high-grid, hierarchical, orientation. With careful and thoughtful management this shift could be steered towards the more enabling characteristics of a hierarchical culture in terms of the availability of useful systems. However, the introduction of new and 'alien' systems into a well established culture could also cause problems including *emergence* and ritualism in terms of the changing culture and character of the homes.

6.3 The 'hierarchical' homes

6.3.1 Overview

This section will consider the remaining case study homes which the analysis suggests were predominantly 'high-grid' and 'high-group' in their cultural orientation. These homes include two further voluntary sector properties, homes B and E, belonging to large national housing associations, the local authority home, home F, and the corporate sector home, home I, which was also the largest in the sample.

Home E was the largest voluntary sector home in the sample at 40 beds, belonging to a national provider of housing and care services including a modest number of registered care homes for older adults. The home was located within a refurbished, 1950's complex with enclosed courtyard garden and large windows giving the home a light and airy feel. The home manager, Bob, had worked for the provider for a number of years. During this time he had undertaken both the NVQ level 4 in care and the RMA. Home B was half the size of home E at 19 beds; however, it was similar in other respects, belonging to another national housing association providing over 200 care homes. The home was, like homes G and H, located in a large converted townhouse with a modern extension. The manager, Rose, had also worked there for a number of years having originally been recruited as a senior care assistant in the late 1990's. Since then she had undertaken both the NVQ level 4 in care and the RMA.

Home F was a 22 bed local authority home located within a modernised, purpose built 1960's building with a range of up to date facilities including an ancillary kitchen that

could be used by residents. The home manager, Mike, had worked for the local authority for a number of years in various capacities in different homes, starting as a care assistant and working his way through the local authority grade structure. He had undertaken a range of training courses including the NVQ level 4 in care, RMA and at the time of the fieldwork was completing a part time social work course. The final case study home, home I, comprised 54 beds and belonged to one of the very large corporate 'for profit' providers. The home, built in the 1990's for a smaller private provider, comprised a two storey spacious building with a modest garden. It had been acquired by the present owner as part of its growing national portfolio of care homes. Both the home and provider appeared to exemplify the evolving trend of larger homes whose ownership is increasingly concentrated within a smaller pool of private equity funded corporations (Holden, 2002).

6.3.2 Organisation and systems of authority

All of the care homes discussed in this section were characterised by a clearly delineated management structure which included specialist, standard setting, management functions. These functions were often located away from the home but their staff visited homes in order to check compliance or to provide support. Unlike the previous case study homes (Homes C, D, G and H), the actions of the managers in the 'hierarchical' homes was constrained within this clearly defined management infrastructure, where management autonomy and discretion were set out in policy and procedures. Whereas Julie at home C or even Lisa at home G were, empowered to make quite wide ranging decisions, the providers of homes B, E, F and I exerted what Rose the manager of home B summarised as "*A big influence*":

> "*Obviously they are the proprietors so we (pause), it's through their guidelines that I run the home; I am answerable to them*" (manager home B – 141M).

A significant benefit to be derived from the provider systems oriented model was the availability of professional support. Each of the providers employed a specialist health and safety manager who, in addition to developing and advising on suitable systems, was available to undertake training and to support home managers where advice or guidance was needed. This might include guidance on implementing initiatives such as

premises fire risk assessments or dealing with regulators. The maintenance function was also controlled by a surveyor or manager who would make all of the necessary arrangements for significant repairs or refurbishment on behalf of the homes. Jill at home I summarised the situation for the 'hierarchical' homes. Whilst the home manager was responsible for the management of their home, they were able to call upon a number of departments for support when needed:

> "……..*the buck will always stop with us in a sense because we are responsible for the home, but, because we work for a large company, we do have support systems in place. You know, it's not like we have to deal with all of this individually because there are health and safety Directors and Managers, whole teams of people really…..*…" (Jill, manager home I – 7239M).

The size of the provider organisations generally meant that they were divided into areas or regions which were overseen by a line manager. These managers provided support to the local manager and undertook the statutory monthly visits. Whilst the provider set the standard in terms of the interpretation of the law, the implementation of their systems was placed squarely with the home manager. Adherence to the provider's standards was theoretically ensured by a process of checking and auditing. For example, a health and safety audit of home I was observed during the fieldwork which comprised physical checks on the building and an examination of documentation. Within the local authority home the manager was expected to undertake risk assessments which were then checked and audited:

> "……..*they require us to do risk assessments, and because there are certain risk assessments that get checked by my line manager in supervision…..and we have the audits as well for example tomorrow we have got nine o'clock until five the health and safety officer for this section will be here all day going through every single bit of paperwork that we have and checking it all, so from the basis of that then we've got a structure to work with: so the products for us to do it with, the expectation of what we do, the training that's mandatory, the observation and checking through supervision and then the audits*……." (Mike, manager home F – 2219M).

A consequence of the strong corporate governance exhibited within the homes was arguably an increasing emphasis on demonstrating regulatory compliance. The expedient to 'document compliance' for subsequent audit, had evidently shifted the manager's role towards more of an 'administrative' function which Rose felt was taking her away from the job that she had originally been employed to do:

> "*Because of the paperwork that is coming in, it's taking me away from the job that I originally had*" (Rose, manager home B – 141M).

This had also been the situation that Rachael at home H had faced whereby the 'hands-on' management of 'matron' had given way to the systems based management of a large provider. Home E however appeared to exhibit a slight variation on the theme of governance deriving entirely from a remote regional office, due to the fact that the provider encouraged some localised governance. A local advisory panel, that innovatively included two residents, were empowered to scrutinise the home and report their findings directly to the home manager:

> "*……..they will go through the building and address things as they see it……it's whatever they view on the day, so that may well pick up on a lot of issues*".

This offered home E the *theoretical* benefits of a large provider's systems supported by local knowledge and some resident involvement in the management scrutiny of their home. These arrangements might theoretically remove any *capture* effects by giving residents and their representatives a voice as 'lay assessors' and advisors in the inspection and regulatory process (Kerrison and Pollock, 2001; Wright, 2005). In some respects this pointed towards a low-grid orientation, such as that found in homes G and H, whereby policy was decided locally. However, the provider's comprehensive systems and supporting infrastructure would generally tend to bias the home towards high-grid.

6.3.3 The interpretation and use of systems

A characteristic of the 'hierarchical' case study homes was the availability of written policies and procedures that covered the full range of regulatory standards, often held in large well labelled folders. These folders mirrored the separation of disciplines within the organisation, for example, health and safety, human resources and the management of care were generally documented as completely separate policies and procedures. Health and safety was arguably compliance oriented and was itself 'chopped-up' into the different compliance areas, for example, procedures dealing with the 'control of substances hazardous to health' (COSHH), 'manual handling' or 'risk assessment' etc. This would tend to support Osborne and Zairi's (1997) contention that health and safety

might be regarded as a separate, compliance oriented, discipline and not necessarily integral to the organisations mainstream procedures. An illustration of this can be given from Home I where the home was given access to a 'health and safety intranet'. During the fieldwork one of the provider's facility managers was observed undertaking a safety audit of the home. This included checking that the home manager had downloaded and printed the most up to date procedures and checking other physical evidence. The safety related aspects of the home appeared to be considered entirely separately and arguably in isolation from the home's other systems.

Within the local authority home there was evidence that carers regularly used and treated their procedures as *working* documents: "*Yes, it's like a bible*" (Janet, care assistant home F – 2221CA). There also appeared to be a close relationship between the written documentation, training and practice within the home: "…….*yes, it all falls into the same category, one corresponds with the other*" (Home F - 2220SCA). Of particular note was the apparent appreciation that training and written procedures were seen by staff as *enablers* and of direct benefit in terms of clarifying expectations between different carers undertaking the same task. This was described by one care assistant in the context of her experiences within smaller private sector homes, where she had worked before joining the local authority, and where different carers did the same job differently. Within home F however, carers were expected to do the *same job*, the *same way*. This arguably reflected the enabling characteristics of their hierarchical cultural orientation, promoting internal competence, synchronisation of resources and appraisal of outcomes (Jackson et al, 2005).

Whilst the use of aligned policies and procedures appeared to work within home F, this was not necessarily the case in the other 'hierarchical' homes. Within home I for example, the apparent domination of policy could arguably foster task oriented values, for example, one inspection report for the home described carers as: "*task orientated, with no evidence of team work*" (103JK). One inspector also noted concerns about the priorities of carers who were: "……*making beds whilst service users were waiting to be provided with assistance for feeding*" (Inspection report, home I - 204J). Such disabling characteristics of the hierarchical culture can create environments where authority and obedience to systems dominate all aspects of the home. A domination of hierarchical values can smother vision, foster dissatisfaction and demotivate staff,

leading to a sluggish, impassive and unresponsive culture (Alder, 2001). Throughout the fieldwork home I also appeared to suffer shortages of staff, which were reflected in earlier inspection reports suggesting that there had been a history of staffing difficulties within the home:

> "*The acting manager was informed that service users and relatives spoken with by the inspectors stated how they are aware of the high turnover of staff and the lack of their experience*" (CSCI inspection report, home I - 104JL).

According to Kerrison and Pollock (2001: 567), research in the United States and Australia has shown that having low numbers of staff is associated with poor quality care. Because the hierarchical culture tends to create clearly defined roles for staff, this also meant that significant policy areas such as keyworking had not been fully implemented. These are potentially significant observations in terms of the creation of 'metastable states' (see chapter 4 the theoretical framework) where trust in apparently robust management systems, by the senior managers who create them, may in fact lead to unsafe outcomes at local level (Evans, 2007).

The interpretation and use of management systems appeared to be organised slightly differently within home E where the home manager had delegated some key responsibilities and functions to 'teams' within his home. For example there were 'quality assurance', 'housekeeping' and a 'health and safety team' that appeared to involve staff at all levels and reinforced the high-group orientation of the home. Thus, health and safety related matters might be passed onto the health and safety team for attention and action:

> "…….*I might delegate that to one of the health and safety team to do…..so it depends on what it is and what is delegated out to the appropriate person to do*" (Bob, manager home E - 2714M).

The role of this health and safety team was described by one of its members, Karen (2716CA), as 'new' and from her perspective at least, its role was safety oriented, whereby "*anything we see we report*". This might suggest that health and safety was seen as a separate, compliance oriented discipline based upon observing, checking and reporting perceived hazards and risks.

6.3.4 Street level bureaucracy and ritualism

As part of large provider organisations, the hierarchical homes could evidence comprehensive policy, procedures and checking mechanisms designed to ensure a corporate systems framework. This framework was not open to change by the home manager, even at the request of the CSCI inspector. Thus localised interpretations of the law by individual inspectors were deflected and challenged by the provider as part of a programme of negotiating national protocols with the regulator:

> "*Although we come under the local area for CSCI inspection, we have a corporate CSCI manager which allows us if we've got something in a particular area that we have concerns about, interpretation or whatever, we can take it up with the corporate provider management, just to see if that's a national, or make sure that it is a national understanding. Because we can't have something where a CSCI inspector from Scotland says this is what I'm looking for and the CSCI inspector down in Cornwall saying something totally different on the same subject, that wouldn't work*" (Bob, manager home E – 2714M).

What was however interesting was that whilst a framework defining the limits of the manager's autonomy existed, it did not always define how that autonomy was to be exercised. Some policy areas might, for example, reflect an organisation's concept of Government policy which when framed more in terms of 'performance' rather than actual 'practice', left room for local interpretation:

> "……*sometimes what they are wanting us to do as a service area is not really about people, it's more about performance and so we've got to try and rise above that and do our best with the situation that we've got.*……" (Home F – 2219M).

There was also ample evidence that the home manager was able to exercise a form of localised 'street level bureaucracy' with respect to the provider's policies and procedures. This might arise, for example, where the home manager's concept of 'care' differed in some way from the intention behind the provider's policy towards enabling lifestyle choice. These issues were discussed in chapter 2 where it was theorised that older adults who are judged to be in need of 'care' may also be characterised by their carers as 'vulnerable' or 'at risk' and therefore requiring safeguarding and protection (Webb and Wistow, 1987; Bland, 2005). Thus, the home manager's *perspective* or *biases* towards the management of care within his or her home may be a significant mediating factor:

> "*You've got your own way of running the home; you've got a basic procedure, that's your policy and that's your procedure. How you implement it, you know, you've got your procedure there, but everybody will handle things differently; each manager runs a home differently to the next manager*" (Rose, manager home B – 141M).

This was an important theme and might arguably be illustrated in the context of home B's keyworker system. The manager's idea was that at some point after the resident's admission he or she might develop an affinity for a particular member of staff. Thus anyone working within the home could potentially act as a *key-worker*:

> "*I mean it's not just the care staff who are key workers either, Rose is trying with the domestics as well because obviously; like Mary the domestic, she sees the residents daily, she goes in their rooms, she knows who she clicks with, she knows who she can have fun with and that resident will have fun back, you know. So it's not just the care staff*" (Ann, deputy manager home B - 142D).

Whilst this seemed an innovative approach, it appeared to vary from CSCI's guidance and from the provider's own procedure. For example, CSCI state: '*when you first meet your care workers, they should spend time getting to know you and then agree a care plan that you are happy with*' (CSCI, 2007). The approach advocated by Home B, however, separated the duties of keyworker and writing the resident's care plan. Within home I only the senior care staff documented resident care and risk.

During the fieldwork there was also evidence to support the argument that there might have been a dissonance between *practice* and the provider's written systems. The CSCI inspection reports for home E, for example, appeared to suggest a degree of *irritation* with the apparent ritual of having a policy document without the substance of its application:

> "*Staff need to become more familiar with these manuals and may need further guidance*" (Inspection report home E - 104E).

A notable and very topical example of this related to infection control, where home E's proprietor had introduced a '*new Healthcare manual*'. This manual was seen to contain guidance on the cleaning and storage of equipment, however, another inspection report still observed that:

"*Staff need to be reminded not to leave items such as urinal bottles in communal facilities*" (Inspection report home E - 204C).

6.4 Conclusion

The fieldwork examined a variety of ownership and management models each demonstrating characteristics that placed it at a different point within the grid / group continuum. It should be appreciated that this 'continuum' is dynamic and not static and homes therefore make subtle shifts within and between cultural orientations according to the prevailing circumstances. Perhaps for this reason, one cultural orientation alone did not always appear to explain the 'practice' that arose. The owner managers of homes C and D were seen as being 'individualistic' and arguably had the most autonomy. The role of home manager was enhanced by the complete 'ownership' of home and business which meant that decisions were made quickly and locally (Matosevic et al, 2006; Franco, Bennett and Kanfer, 2002). Homes G and H were characterised by 'high-group' where the staff and managers were employed by the same faith oriented provider and worked mutually together. The managers were also afforded significant autonomy within what had been 'low-grid' orientations suggesting a predominantly egalitarian cultural orientation.

The managers working within the remaining homes: B, E, F and I, were all subject to working within the high-grid orientations of larger organisations and were therefore *less likely* to be afforded a significant level of discretion and independence in terms of how they employed policy. Their staff shared a corporate identity but had defined roles and responsibilities within the homes. This high-grid, group orientation was therefore consistent with a hierarchical culture. Despite the apparent constraints of their high-grid orientation, the fieldwork suggested that the home managers were however still able to influence local practice by their attitude to care, acts or omissions. For example, by emphasising or ignoring the proprietor's procedures, or by emphasising or ignoring particular risks or aspects of individual choice, the manager was in a position to set the priorities of the home.

The local authority home arguably exemplified many of the enabling characteristics of a hierarchy in terms of providing clear guidance, high levels of internal competence, targeted resources and an appreciation of the connections and linkages between various

systems. There appeared, however, to be something of a management paradox within home E, evidenced by an apparent dissonance between the provider's 'theoretical' application of systems and the home's actual relationship with them. This meant that whilst home E generally demonstrated the characteristics of a 'high-grid' provider, it also exhibited some of the characteristics of an egalitarian cultural orientation. Home B and I also exhibited the general characteristics of a hierarchical cultural orientation. However, home I was arguably more compliance oriented than the others, and this appeared to be reflected in the disabling characteristics of a hierarchy, creating what might be seen as a very slight 'isolate' dimension to the home.

Chapter 7 – Living in the regulated home

7.0 Introduction

This chapter draws on evidence derived from the perspective of residents, staff, CSCI inspection reports and fieldwork observation to consider what it might be like to actually live within the case study homes discussed in chapter 6. The chapter is divided into three distinct parts which address the first and second research aims and questions one, three, five and six. The first part will build on the discussions in Chapter 3 that suggest health and safety law is now a highly influential aspect of the regulatory framework for residential homes. It will look at the mechanisms used by care home providers and home managers to consult with residents about how the health and safety regulatory framework is applied in practice.

The second part of the chapter will consider the residents' experience of the care home, both as a 'home' and as a safe place offering the potential for social contact and meaningful interaction. It examines the choices, facilities and social resources that appeared to be available to residents within their homes, and considers the extent to which health and safety regulations enable or restrict lifestyle choice. The final part of the chapter will consider some of the findings from parts one and two in the context of the cultural orientation of the homes and of the residents. It is argued that despite, the apparent *egalitarian*, *hierarchical* or *individualist* orientation of the home, the residents generally appeared to occupy a discrete *isolate* culture in their own right. It is also theorised that residents and staff 'learn' their particular role within the home in a process of enculturation that appears to be separate from provider's written systems.

7.1 Consultation with Residents about Health and Safety

The key mechanism for involving residents in the decisions that impact upon policies, practices and choice within their home appeared to be through formal residents' meetings usually held with the home manager. Specifically this meeting could be seen as a potential means to influence the translation of health and safety law into operational policy. Residents' meetings can be thought of as a function of the interface between 'management' and 'client'. The degree to which the interface is permeable to the views

of residents and to new ideas might therefore be seen as a measure of management control. A very permeable interface might, for example, be expected in a 'high-group' environment characterised by significant alignment between decision makers (managers), decision implementers (staff), and decision recipients (residents and staff). The 'high-group' orientation is associated with the hierarchical and egalitarian cultures, and thus homes oriented towards these quadrants *might* be expected to exhibit advanced and effective mechanisms for consulting with residents. Table 11 summarises the likely cultural orientations of the case study homes discussed in chapter 6. A tick (✓**)** next to the home shows that the home demonstrates a high-group orientation, thus homes B, E, F, G, H and I might all be expected to have mechanisms in place for meaningful consultation with their residents. It should also be acknowledged that consultation with residents generally occurs at two different levels: the communal level, affecting everyone in the home and covered here, and the specific level, designated as the individual plan of care. This individual negotiation of choice and risk is considered in the next chapter.

Home	**Likely general cultural orientation**
B ✓Voluntary sector home	Generally a high grid and high group orientation suggesting a hierarchical culture.
C Very small private home	Generally a low grid and low group orientation suggesting an individualistic culture
D Small private home	Generally a low grid and low group orientation suggesting an individualistic culture
E ✓ Large voluntary sector home	A mixed picture, however the 'rule' based management impacted upon the residents' freedom of choice in some areas and therefore arguably emulated a predominantly hierarchical culture.
F ✓ Local authority home	Generally a high grid and high group orientation suggesting a hierarchical culture.
G ✓Voluntary sector home – local managing committee	Generally the low grid and high group characteristics of an egalitarian culture, however, the adoption of formal systems was arguably shifting the home towards a high grid, hierarchical orientation.
H ✓Voluntary sector home – local managing committee	The low grid and high group orientation contributed to a predominately egalitarian culture. The introduction of formal systems was shifting the home towards a high grid and thus a hierarchical cultural orientation.
I ✓Large corporate provider	Generally the high grid and high group orientation of a predominately hierarchical culture. There was however some evidence of a 'low-group' orientation and thus the characteristics of an 'isolate' culture.

Table 11: Likely cultural orientations of the case study homes (see chapter 6)

What is perhaps interesting here is that the two smaller private homes (homes C and D) were not designated as 'high-group' due to their predominately individualistic cultures. This is because whilst the high-group orientation exhibits a high degree of collective control, the 'low- group' private homes emphasised individual self-sufficiency within

the staff team. Their managers and staff were required to work within a framework of limited support, and often on their own, using their own initiative.

The proposition that a high-group orientation might lend itself to a culture of consultation was arguably a necessary condition, but not, by itself, a sufficient condition for effective consultation. The potential to influence management decisions was also likely to be determined to some degree by the residents' proximity to the decision maker. For example resident involvement in the management of their home might be a function of the degree to which the home manager was empowered, by the provider organisation, to make local health and safety policy decisions. This suggested a dichotomy of two broad groups: those with close contact with decision makers, including homes C, D, (F), G and H; and those without close contact, homes B, E and I.

Home F, the local authority home, was included in the first group because *theoretically* the decision makers were located relatively close to the home. Residents could access the local councillor and subsequently the authority managing the home (Scourfield, 2007). This direct influence was arguably denied to residents in those homes where the real decision makers and budget holders were located well away from the day to day management of the home. Scourfield (2007: 169) talks about '*a remoteness*' - a sense that the physical distance between decision maker and recipient severs the links between the local people who go to live in care homes and those who control the running of those homes. Certainly all of the case study homes could demonstrate that they had forums for consultation in place, some of which were formal, whilst others, especially in the smaller case study home (Home C), were clearly informal. The residents' meeting generally appeared to have two primary functions. Firstly meetings were a means of *imparting* information to residents about proposed changes, i.e. about management decisions that had already been made. Secondly they were a public mechanism to receive general feedback on services. This observation would appear to resonate with Abbott et al (2000), who suggest that residents were not generally *consulted* about things that were decided in management committee meetings.

The following discussion will explore the perceived reality of resident consultation, and the degree to which homes actually consulted with and involved residents in the decision making process. The discussion is split according to the broad dichotomy of

local and remote governance. 'Governance' in this context refers to the system by which the care home is directed and controlled by the proprietor. It is distinct from 'management' which can be thought of as the regular day-to-day decisions and actions required to run the home. Governance refers to the higher level processes by which managers are held to account and through which the broadest strategic decisions are taken (Acona, 2006).

7.1.1 Consultation in homes with local governance (homes C, D, G, H and F)

Typically the managers of the smaller independent private homes had considerable management autonomy and therefore the authority to make decisions directly. The smallest case study home (home C) did not however have any regular or formal consultation or feedback meetings with residents, arguably because there was already very close day to day contact between the small number of residents, staff and the owner / manager, facilitating an almost 'family like' dialogue:

> "*……..we do have meetings with them……..but it's informal, so that wouldn't do for CSCI, I mean very often we're sat with them……., either in the lounge, or whilst they're having a meal……and over the general sort of conversation lots and lots of decisions can be ironed out or rules set, you know things like mealtimes, purely by talking to them, when do they want the, on average, you know*" (Julie, manager home C - 516M).

From George's perspective, a long term resident of home C, the home manager was clearly responsive: "*Oh yes and she listens, and she'll take advice – she listens to you*" (George, resident home C - 518R).

Home C was unique in many respects, the very small number of residents and the intimacy of the home's environment had allowed something of a 'guest-house' atmosphere to develop where residents were regarded almost as friends, if not as part of the family. That said there was little doubt that Julie, the owner, had implemented many health and safety initiatives in much the same way that her colleagues had done in the larger homes, arguably in response to regulatory requirements. The other small private home (home D), did however hold 'regular' and more formal meetings. Although Cath the manager suggested that encouraging residents to actually participate was challenging and health and safety related items were rarely discussed. This appeared to

be a theme in most homes where some participants reported a degree of 'apathy' with respect to attending or participating in the meetings and health and safety was rarely reported to be an agenda item. Scourfield (2007: 170 – 171) points out that the resident is often not even a 'customer' of the care home provider, this role is reserved for the local authority purchaser who must be satisfied that the home meets the necessary 'legal' requirements. The consequence of this is that the home will, arguably, consult with the purchaser, who they may regard as their 'client', rather than the resident, who is the actual recipient of their service.

Thus, whilst the residents were theoretically close to the home's decision maker, decisions relating directly to their health, safety and welfare were apparently taken *without* consultation. This scenario might have arisen because many health and safety controls were regarded as mandatory by CSCI, by purchasers and by providers and were consequently seen as being in the *best interests* of the residents. The implementation of such 'mandatory' health and safety risk control measures is discussed in more detail in Chapter 8.

The local authority home (Home F) also appeared to offer what appeared to be a relatively informal system of meetings. The manager Mike had adopted a very relaxed and informal style of consultation where he would sit down with the residents and talk with them on a fairly frequent basis about the day to day issues that affected them. What was interesting about home F was the juxtaposition of bureaucracy afforded by the home being managed by the local authority, and the informality of consultation process adopted by Mike the home manager:

> "*We'll sit with service users and just, well I used to do it, and double check - are there any issues. I've got key headings like: food, furnishing, rehabilitation plan, your rights and your choices, all things like that. And then we'll talk generically about those subjects and if people bring up things one to one, then I'll probably sit with them on their own to chat*" (Mike, manager home F – 2219M).

Thus it was likely that the home made an effort to consult with the residents frequently, yet informally in an environment that was arguably more likely to engage their support. However, in common with many of the other case study homes, home F was still well equipped with safety related features such as thermostatic mixer valves and self closing fire doors. There can be little doubt that such features were mandated, without

consultation, by the local authority in line with their considerable risk management portfolio. Indeed Mike made the point that he did not always feel it appropriate to discuss many of the '*back-room*' activities such as health and safety with the residents, as they were part and parcel of the home and what it did:

> "*…… and there's no real mention of the operational side of the building to the service users on admission, I mean we go through the fire policy and things like that, but we won't say oh staff might be doing this or staff might be doing that ….*" (Mike, manager home F – 2219M).

7.1.2 Voluntary sector homes with local governance

Homes G and H had local voluntary committees who delegated considerable authority and autonomy to their home managers. Meetings with residents were clearly evidenced within the home's CSCI inspection reports, for example the reports for home H evidenced 'regular' formal meetings:

> "*residents meetings are held quarterly and when we looked at the minutes there was clear evidence of consultation taking place with the residents*" (Inspection report for home H - 6108Q).

Quarterly formal meetings are relatively infrequent, and in this respect the CSCI report adds some weight to an argument that *might* suggest a degree of *ritualism* in the consultation process. Whilst residents had been consulted on one level, they were also being 'informed' of pre-determined outcomes on another. From a theoretical perspective, these homes could have allowed the residents to exercise considerable decision making authority, either as part of the managing committee, or directly via the committee or manager. This did not however appear to have been the case. Neither home's committee included residents (there were some relatives), nor was there an obvious mechanism for the committee members to consult directly with the residents, although it is appreciated that committee members with relatives living within the home might do this. Thus, the managers of homes G and H, in keeping with their other wide ranging responsibilities, were empowered to consult with residents more or less as they saw fit. Lisa, the manager of home G was very clear that she did indeed consult and used the example of purchasing furniture to illustrate this:

> "*We do, we absolutely consult; I always ask them their opinion, like with the dining room chairs, you know, in the front room with all of the residents: Do you like this, come on, come and have a sit on this, what do you think to that*" (4524M).

This assertion is interesting, and certainly demonstrates that, in some circumstances, residents were asked to give an opinion. However, in other respects there was evidence that the residents' involvement was passive, the meetings were designed to inform them of a decision that had arguably already been made. Hugh, one of the more recently admitted residents in home G arguably alluded to this idea when he described a meeting that was to be held to discuss the fitting of new carpets:

> "*I mean for example there is a meeting at 3 o'clock this afternoon because they want to put a new floor in the dining room, so what does that mean, it means that residents are going to get together and discuss this. But I mean the thing is already laid on: they will do this and when they do, the dining room will be empty and we will eat in our rooms. Is that alright? Yes, fine, that's it*" (Hugh, resident home H - 4528R).

Home H presented a very similar picture with Rachael, the manager, talking in terms of '*what I wanted*' and the fact that "*you have to juggle the budget, what you've got to spend, what you're told to spend and what you can do*" (Rachael, manager home H - 629M). At no point was there reference to the involvement of the residents in the decision making process. Indeed from Tom's perspective, one of the home's longer term residents, he was a relatively passive recipient of the home's decisions and 'rules':

> "*No, everyday they bring out new rules, it can affect us, but, for example the new chairs in the dining room, the other ones were getting a bit rickety, I think, the new chairs are quite heavy as it happens; that's the only innovation that we've recently had*" (Tom, resident home H - 632R).

7.1.3 Consultation in homes with 'remote' governance (homes: B, E and I)

The other two voluntary sector homes, home B and E, belonged to larger voluntary sector groups, with a large number of social housing schemes located around the UK. These homes were characterised by systems of governance that derived from specialist managers working within a centralised management function, although home E did have a lot of local autonomy.

Home B and E held quarterly resident meetings, which one of the residents, Hilda from home B, suggested were not necessarily *inclusive*, as some of the residents were either unable or unwilling to attend. Here again the meetings were described as 'informative' i.e. the meetings were primarily about *informing* the residents about what the organisation or the home was 'planning to do':

> "*…….they do have, they used to have residents meetings; we had one last year I know, Rose called it and some of the staff were there and as many in-mates sort of thing as they can muster. And that's usually very interesting: Rose says what they are planning to do; if we can think of anything different, please tell me, or anything you want to do, just as you said, and if that's possible they will accommodate you if they can. We're not completely at their beck and call; they do encourage you to ask*" (Hilda, resident at home E - 145R).

Home E also had an innovative local advisory group, which included two residents. Whilst this group certainly appeared to offer the potential for management consultation, and scrutiny, its primary role appeared to cover the Regulation 26 monthly visits[31] which the manager appeared to regard as a mechanism to support his role:

> "*Happens once a quarter; we also have an advisory group which really potentially is people who are here to support me, to give me advice in the running of the establishment, which will include or does include two resident representatives as well, so that's another thing where a health and safety issue may well come up. And particularly where they also do what is called a visitor's report, where members of that advisory group will come in unannounced and make a visitor's report on what they find*" (2714M).

From the perspective of Karen, one of the staff participants, the residents' meetings appeared to be viewed as a forum for complaints, some of which might relate to what were seen as health and safety issues such as keeping fire doors closed:

> "*……..That might well include health and safety reasons, some of them for instance like the doors open in the summer, but they are fire doors and they have to be kept shut, so they might have a complaint, you know. They go there to make complaints basically.……*" (Karen, care assistant at home E - 2716CA).

The ability to complain about health and safety related matters could be seen as a positive sign that the residents felt, and were able to challenge a practice that impacted on their comfort and wellbeing. However, as Karen suggests, certain health and safety 'rules' were not amenable to challenge and thus the residents' ability to influence their

[31] If the registered provider is an individual, who is not in day-to-day charge of the care home, that individual must undertake a monthly visit to their care home and make a record of their findings

environment, appeared in real terms, to be very limited. This is an important finding that characterised many of the case study homes. Certain 'rules' were derived from what were believed to be health and safety requirements, and as such were beyond question. The likely consequence of blind obedience to such rules was, on occasion, the introduction of additional risks and hazards. In the case of locked doors and windows this would certainly include a hot and uncomfortable environment with predictable mental and physical consequences. What was interesting about these narratives was that 'rules' appeared to be regarded as unquestionable, perhaps because they were seen to represent the health, safety and welfare of the residents. At no time did the 'rules' appear to have been tested in terms of alternative technical solutions. Such solutions might for example have included fitting automatic door closers that would close the door in the event of a fire alarm.

7.1.4 The large corporate home (home I)

There was evidence that the cycle of formal residents meetings in home I was a relatively recent event as there had been some management instability within the recent past. The actual frequency and format of the meetings was at times a little difficult to elucidate, perhaps because of the management changes that had apparently taken place. One of the home's CSCI reports suggested that the meetings were being held monthly "*for residents and relatives who wish to attend*" (inspection report, home I - 72106N), whereas a subsequent report suggested that the manager held 'weekly surgeries' and three monthly meetings for relatives:

> "*The manager holds regular weekly surgeries, where relatives know that they can come and meet the manager and raise any particular issues. In addition there are three monthly relatives' meetings*" (inspection report, home I - 72107O).

From the home manager's perspective the residents were indeed involved in the management of the home, primarily through *monthly* meetings:

> "*There is a residents' meeting every month, we have relatives' meetings, yes we do, we do involve them a great deal really, as much as we possibly can*"(Jill, manager home I - 7239M).

Whilst the home manager arguably played a key role in the meeting *process*, it was the home's activities coordinator, who appeared to have taken the real lead in organising and conducting the actual meeting:

> "*And we have monthly residents' meetings for that purpose which they've really cottoned onto and they attend those well now and like the first meeting, there was about a paragraph about the discussion, the last meeting they had; two pages long, you know, they're really coming forth now, yes*" (Penny, activities coordinator home I -7236AC).

The key role of the activities coordinator in organising these meetings was reflected in the participant transcripts, where the 'committee', as one resident termed it, was seen as a forum to "*air your views*" (Jane, resident home I - 7235R). The degree to which the residents' meetings were actually able to influence the management decision making process was however open to question. Indeed it could be argued that even the home manager was able to exercise little, if any, influence upon strategic health and safety decisions made centrally by the provider. As the home was part of a very large 'for profit' organisation, the Directors must ultimately answer to their shareholders for the 'safe' conduct of the business. Indeed Argyle et al (2000: 71) have expressed concern that:

> "*Stock market rules demand consultation with shareholders, but not with end users, so residents may find that the place they call home is owned by a different group of people who appoint different staff, and introduce different policies and procedures*".

During the fieldwork it had been possible to spend some time with the home's handyperson and with one of the provider's facilities managers. This gave an insight into how health and safety based decisions made at the centre were mandated to homes as policy. Practical safety measures such as window restrictors, door closers or security measures were often installed and implemented without necessarily consulting locally with the home. For example, door closers had been imposed upon the home and the residents by an executive decision which was then implemented by the handyperson. This example is further discussed in Chapter 8.

7.2 Experiencing the care home as home

This section will build on chapter 2 in terms of considering the residents' experience of their care home, both as a 'home' and as a safe place that offered the potential for social contact and meaningful interaction. The idea of choice and social contact with family and friends is used as a useful framework to describe and to illuminate the discussion. The concept of 'home' is generally accepted to be much more than just the physical dwelling. It includes, for example, a sense of dignity, independence, choice and fulfillment (Mallett, 2004). Whilst 'home' may have many diverse characteristics, including memories (see Chapter 2), it is generally a place where people are able to exercise control and influence over their lifestyle. For the older adult moving into a care home, their experience of being at 'home' may therefore be determined by the degree to which they can maintain lifestyle choices. Such choices are likely to be mediated by access to familiar objects and practices that linked their present experience to their past. For example, sitting in a favourite armchair in a room full of familiar objects with access to family and friends would arguably go a long way towards emulating a basic sense of being at 'home'.

Whilst there was ample evidence that many of the case study residents had well established ties with family and friends outside the home, access to familiar objects and other lifestyle choice was often subject to 'rules'. Indeed, whilst choice was an important mediating factor in the experience of 'home', it was also a function of the local community of practice that is discussed towards the end of this chapter. Choice in this context might be thought of as including the choice to have furniture and possessions that provide continuity with the resident's past life, or the choice of personal activities, risk taking and other *resources* that mediated a sense of control over the domestic environment. It is useful to think about social resources in terms of how the residents' relationships with staff and friends inside and outside the home, provided access to, or mediated resources in terms of objects or social contact that contributed to a sense of home.

7.2.1 Negotiating resources within an unequal social relationship

Within the case study context it will be argued that a resident might occupy a 'low-group' social orientation and is thus subject to the limits imposed by the 'high-grid' 'rule' oriented environment or local community of practice operating within the care home. Inevitably the juxtaposition of 'work' and 'home' must be managed in order to demonstrate compliance with the regulatory framework. Thus whilst the manager and staff participant transcripts often suggested that 'choice' was an important aspect of making residents feel at home, in reality 'choice' was usually constrained or highly *qualified* by concepts of regulation and risk. When discussing choice for example, staff participants would often use terms like: "*as much as possible*" (142D), "*within reason*" (141M), or "*as much as we need to keep them safe*" (4524M).

Constrained or 'qualified' choice was arguably one of the significant factors that differentiated the resident's own 'home' from the care home. In the care home the regulated routines, 'structure' and 'considering other people', dictated or impinged upon 'real' choice. From a theoretical perspective, whilst the smallest case study home, home C, was most likely to emulate 'home', the need for 'structure' and considering others remained qualifying factors when discussing 'choice':

> "*Yes, if they were at home they'd be able to do whatever they wanted, when they wanted, I mean obviously there are still structure, because there has to be when you've got other people to think about, but with lots…… it is their choice, if they don't want to come down, they don't come down, if they don't want pie and chips for dinner, they don't get pie and chips for dinner*" (care assistant home C - 517CA).

As might have been anticipated, the 'high-grid' local authority home also qualified 'choice' in terms of what was possible within a regulated environment:

> "……*But still, you know, understanding that there are restrictions, because it is a community living environment, but as much as absolutely possible, whatever they want to do and whatever choices they are going to be upheld by us, and by emphasising their rights as individuals I think we make it homely for them, and that's the most important thing that has to come through to them*" (Mike, manager home F - 2219M).

Both participants appear to make an important distinction here between the *community* and the *individual*. This distinction resonates with the findings discussed in the previous

sections where the residents were arguably unable to influence the *communal* management of the home. Interestingly, Mike the manager of the local authority home, home F, uses the term "*as much as absolutely possible*", which is arguably similar to the health and safety term '*as is reasonably practicable*', suggesting the rights of the individual resident were weighed against the risks posed to others. The communal aspects of the home include the range of choices affecting the health, safety and welfare of the residents as a group. For example, access to 'unsafe' parts of home, were likely to be regarded as 'regulated' and therefore completely non-negotiable. Choice that related to the individual and their immediate space might however be regarded as something that *was* negotiable. There was ample evidence for example that residents could agree individual lifestyle choices as part of their care plan[32] and certainly the resident's room was generally regarded as a private space that might be theorised as their 'home' within the care home.

7.2.2 Room, possessions and autonomous space

Social resources and choice might be thought of as the degree to which the resident was able to influence the resources that were available to them. This is likely to include resources such as open access to their own room, access to important possessions and the ability to influence risk based decisions such as going out and about without supervision. Having your own space and possessions are an important ingredient of 'home'. A home has been described as an environment of physical objects (Fairhurst and Vilkko, 2005). Such objects carry biographical meanings, expressed through memorabilia, furnishings and other effects. These can have sentimental attachment through the feelings bestowed on displayed objects that keep alive the memories of work, leisure and family, or through personalising the spaces that enable interests to be continued or developed (Percival, 2002; Rowles, 1993). For example, in common with a number of other participants, Mo who lived at home E described how, whilst she sometimes wished she 'was back at home', had now identified her room as her home:

> "*Well I've got used to it now, I mean always there are little minutes when you think, you know, I wish I was back at home, but it just can't, so you make the best*

[32] The care plan implies a 'formalised' written plan; however, it might also be regarded, and indeed, was often found to be more of an 'informal' understanding between residents and staff.

> *of it and it is a good home, yes, it is, oh yes it's a very good home; I've made this into my room*" (Mo, resident home E - 2717R).

The significance and importance of the resident's room in terms of their experience of 'home' was an interesting and evolving finding. Typically the general environs of the home were highly regulated and access was often denied to key areas such as the laundry. Even within the very small private home, home C, health and safety considerations and the fact that the owner lived within the home meant that there were clear 'rules' about what residents could do and where they could go. The resident's room was however respected as personal space, which was frequently reflected in the CSCI inspection reports. For example, one report for home B gave an insight into the importance attached to the resident's own space:

> "*Residents' rooms contained personal possessions. One resident said: 'my room is lovely; I have a great view outside and have everything I need inside*"'
> (Inspection report home B - 14107T).

That is not to say that this space was unregulated, indeed, the resident's room was often subject to risk assessment, and safety 'rules' that included windows that could not be fully opened and doors that were 'mechanically' kept closed. The 'rules' *theoretically*, meant that the choice of furniture was highly controlled, meaning that it had to meet 'fire safety standards' and any other risk assessment criteria that might apply at the time. However, the resident's room was still regarded as their own personal space and in this respect it was their own piece of 'home' that could be customised to reflect their taste and personality.

A number of residents commented positively on the size of their rooms and were proud to invite visitors into their own piece of space: *"Oh yes, my room is the biggest room……I could show it to you*" (Helen, resident at home H - 630R). Whilst most residents had some of their own furniture, space and health and safety considerations were often a limiting factor. For some residents space was an important personal consideration in terms of their mobility, where 'clutter' was unwelcome. Jane at Home I, for example, was typical of the residents who had taken the opportunity to 'de-clutter':

> "*You couldn't get anything else in and it isn't worth being* [cluttered] [33] *up with it, you know……..… you don't want a lot of stuff in the room where you can't get around, if you can't walk*" (Jane, resident at home I - 7235R).

In effect, some residents had undertaken their own risk assessment and decided to strictly limit the furniture they had in their room. From a theoretical perspective, the resident's experience of 'home' was likely to be mediated by access to familiar objects and practices linking past and present. It was, however, evident in the resident transcripts that the *quantity* of possessions was secondary to their *quality* in terms of sentimental value. Mo at home E exemplified this point:

> "*I've still got things that are perhaps not money expensive, but they are years of sentimental value, like my grandson has been to China working, it's only ordinary common things that he's brought, I mean he wouldn't (laughs), but it's little bits of things isn't it, and, but in the bottom half there is a big box full of photographs and things like that which you couldn't have had if you just had a china cabinet, you couldn't do with two cabinets in here, not really*" (Mo, resident home E - 2717R).

An important feature of the resident's own room was their ability to withdraw and to watch a television programme of their choice. At least one resident, Arthur (home G), had been able to install Sky television in his room; however the installation had still required approval from the housing association committee before he could actually buy the equipment:

> "…..*And there was no problem about having that in the room, it had to go to the committee but there was no problem from me having Sky television, so long as I paid for it and had the aerial put up……..but I like the sport*" (Arthur, resident home G - 4527R).

Whilst the communal television was found to be an omnipresent feature of all of the case study homes, many of the participants valued the opportunity to withdraw to the privacy of their own room and relax whilst watching their own television, on a channel and at a volume of their choice:

> "*Well, I'm often upstairs in my bedroom watching telly, and I like to nod off to sleep and watch telly*" (Jim, resident home D - 6512R).

Using a computer, video recorder, reading or listening to the radio were other activities that residents typically said they were able to do in their own room:

[33] Participant used the word '*clumbered*', but it was in the context of a 'cluttered' room.

> "*I've got a television in my room, it's my own television and I did have a computer, but I couldn't get on with it, it's bad reception here , so and I've got a video player and I read a lot; I've got a library only half a mile down the road*" (Tom, resident home H -632R).

Closely related to the idea of one's own space and the importance of personal possessions, was the resident's attachment to their own clothing, since clothing could help residents to maintain their personal identity. The Social Care Institute for Excellence suggests that particular care should be taken in residential settings, to ensure that personal laundry is treated with respect, and not mixed up or damaged (Cass et al, 2008).

Hygiene and personal appearance were also highlighted in a Department of Health online survey (DH, 2006 cited in Cass et al, 2008) as important factors in maintaining the dignity of older adults. An analysis of UK data (Woolhead et al., 2004) from the Dignity in Older Europeans study (Cardiff University, 2001 - 2004) found that the self-respect of older people could be undermined by neglecting their appearance and clothing. This was another theme that came across very clearly within the residents' transcripts, where laundry was typically done on a communal basis, completely outside the residents' control. It appeared that the regulatory framework was driving homes to offer their residents a completely one dimensional service where the resident was afforded little or no choice about the arrangements for their laundry. A CSCI inspection report for home D perhaps helps to illustrate how the laundry room was considered a *high risk* area:

> "*There was a security policy in place which was specific about some action needed to reduce risks such as the laundry door must be kept locked*" (CSCI inspection report home D - 65106C).

This again would appear to suggest a level of street level bureaucracy, where the laundry was *automatically* assumed to be a dangerous place[34]. This frequently had the effect of denying residents access to a utility that had been a significant part of their lives at 'home'. From a practical perspective, the communal laundry arrangements in place in some case study homes meant that personal items would often go missing. For

[34] The risk assessment was likely to reflect the hazards associated with the equipment and chemicals used and stored in the laundry. It may also have highlighted the infection control risks associated with soiled laundry.

Betty living in home B, this had been a significant and frustrating issue over which she could exercise no apparent control:

> "*Eight petticoats; I missed every one of my nighties before Christmas; and I'd got lots of nighties. And the family bought me nighties, so I'd got seventeen when I came back; they found them in somebody's case*" (Betty, resident home B - 144R).

7.2.3 Constrained or qualified choice within the resident's own space

Two important areas of choice relating to the resident's *own personal space* were however highly qualified on the basis of perceived health and safety regulation or local rules. First, none of the case study homes permitted residents to smoke in their own room. Smoking was regarded by most home staff as a significant fire hazard and the Smoke Free (Premises and Enforcement) Regulations 2006, had effectively supported home managers in eliminating or reducing residents' choice to smoke within their room.

From a legal perspective, care homes were exempt from the general smoking ban, meaning that residents were *legally* allowed smoke in their own rooms. Indeed English civil case law had previously upheld residents' right to smoke in 'their own home' (Sylvia Sparrow - v - St Andrew's Homes Limited, May 1998 in White and Beswick, 2005). However, there was evidence that street level bureaucracy had been applied by home managers, in effect prohibiting private smoking. Whilst this 'rule' offered a safer working and living environment for non-smokers, some authors have questioned whether it would lead to social isolation for others (Dean-Osgood, 2007). In at least three case study homes, homes D, H and I, residents were actually required to smoke outside the home – regardless of the weather. In other homes a designated smoking room was made available, and this was interestingly observed to encourage social contact for the small numbers of residents who wanted to share a cigarette together. It might thus be argued that prohibiting smoking in the resident's room had the effect of actually promoting some social contact.

The second area of highly qualified choice relating to fire safety was that of the furniture that the resident was allowed to bring into the home. Whilst residents were theoretically encouraged to bring their own furniture into the homes, this was always

qualified by safety rules to the extent that, in reality, the older 'favourite armchair' was unlikely to be suitable. Thus, whilst the resident's room was highlighted as an autonomous space, the reality was often somewhat different. Lisa, the manager of home G, exemplified the situation that was common to all of the case study homes:

> "*Feel at home; by giving them freedom to make their own choices, in as much as we possibly can (pause), we only run the home; it's hard to explain, it is their home, everything we aim to do is to keep it as their home and we only do the health and safety aspect in as much as we need to keep them safe. So everything, again you have to weigh, to weigh up between safety and home, safety and home, safety and home; so that's how you look at everything. So, they bring their own furniture in, so obviously there are going to be issues with that, because some people; not now but a few years ago we had people who used to bring their old chairs that they've had like twenty years which they might love, but it wasn't fire proof. So you have to offset what you do, I mean now they have to bring fire proof stuff in, but then it was like: well it is a chair, it's in the house, it wasn't as strict then as it is now so they could bring it, I mean now they can't*" (Lisa, manager home G - 4524M).

Julie the owner and manager of the smallest case study home, home C, suggested that the idea of such qualified choice arose from the Commission for Social Care Inspection who stipulated that furniture must meet defined standards and criteria. This provides some evidence of a form of 'institutionalised' street level bureaucracy whereby actions, *not strictly imposed by health and safety law*, were nonetheless imposed by CSCI inspectors with the effect of limiting or qualifying resident choice:

> "*The bit about making them feel welcome, we try to do that from the time they come and look around initially, when we explain, about, you are welcome to bring in some of your own items of furniture, but again CSCI would say it has to be this, it has to be that, it has to be the other. Because they'll want it fire proof and all the other things, and that's difficult, because if you've got an older person that's got a particular chair that they're very comfy in and had for years and love it, it's very difficult again. If we were a bigger home, we probably wouldn't get away with that*" (Julie, manager home C - 516M).

In fact the National Minimum Standards would appear, on this occasion, to *encourage* homes to allow residents to bring their own furniture into the home, although this is qualified in terms of what is *practicable*: 16 (d) '*permit service users, so far as it is practicable to do so, to bring their own furniture and furnishings into the rooms they occupy*'. In practice however, it is likely that fire safety considerations are given precedence, by CSCI inspectors, proprietors and home managers. It is important to note

here that none of the residents made reference to an item of furniture having been prohibited by their home.

7.2.4 Negotiating personal resources

Whilst some residents may have made observations about not being permitted to go into the laundry, the kitchen or perhaps the garden without supervision, they appeared generally satisfied with the levels of 'choice' afforded them. This may have been because, on an individual basis, the case study home residents were able to negotiate a level of personal resource that, in its most basic form, provided at least the illusion of real choice. Helen for example, who presented as a particularly independent and assertive resident suggested that: "*You can do what you like in your own room*" (Helen, resident at home H - 630R).

Helen's idea of doing 'what she liked' was however still highly qualified by the same general health and safety considerations that applied to the entire home. For many people, the choice to make a hot drink in their own room might be regarded as a very basic feature of life 'at home', and not something that you might have to negotiate. For the case study residents living in home G, however, the choice to have a kettle in their room was subject to a risk assessment. This was based upon the perception that the use of an electric kettle might be harmful - and potentially harmful things were 'regulated'. In other case study homes (homes B, E, and I) the residents were not given the choice and kettles were not generally permitted. In the following example however, the resident was able to exert influence upon her keyworker to keep her kettle, although the implication here is that she was not really *supposed* to use it herself:

> "*I mean one of my ladies who I'm a key worker for, she's got a kettle in her room, but she, when I went and I said: well for the kettle we've got to do a risk assessment, she said, but I don't use the kettle, it's just for my relatives when they come, to make tea in their room. But you've still got to do a risk assessment just in case she does touch the kettle and burns herself*" (Senior care assistant, home G - 4526SCA).

7.2.5 Enhanced quality of care home life

Only a minority of participants had *actually chosen* to move into their care home as a positive lifestyle option. For most residents the move into a care home followed what might be described as a complete breakdown in their ability to function independently in a domestic setting. Rose, the manager of home B, along with most other home managers, was very clear about the fact that a care home could never really be home, however, it could offer resources that simply were not available to the resident in their own home:

> "*How do you make it feel like their home, you don't you never do: because all of them miss home, the only thing that you can do is to make it comfortable for them. If you ask any one of them, they'll tell you that it's not like home but it's the next best thing that you can do; it's their choice, their rights, their privacy*" (Rose, resident home B - 141M).

Arthur, living in home G exemplified this point. Whilst he would not have chosen life in residential care, the benefits of the home, appeared to have enhanced his general quality of life:

> "*I wouldn't have left my own home if I wasn't feeling, if I felt up to it, I don't think anybody would go into a home, no matter how good it was……..I can go out here if I say to them that I'm going out, they know that I'm, I can do it, so I don't think anybody in a home is delighted about it, but I realise that I'm very fortunate in here because it's so nice, I like it so much, so I don't worry so much about the fact that there are certain things that I can't do*" (Arthur, resident home G - 4527R).

Joyce at home E also exemplified the situation where loneliness, multiple hospital admissions and the need for basic physical care had arguably put pressure upon her family and therefore her relationship with them:

> "*Oh yes, the best place I came to, because I was on my own, you know living alone. And then my son and daughter in law said would I like to come and I said yes and I came. They wanted their lives and I was getting on. I've been very satisfied, very satisfied, they've been very good to me, because I've had a lot of illness and they've been very patient*" (Joyce, home E -2718R).

The practical resources that were available to Joyce and the fact that she no longer felt a burden upon her family had clearly enhanced her quality of life. The availability of specialist equipment and care had, as Oldman and Quilgars (1999), suggest increased her feelings of independence:

> "*I've got an electric bed, I've got a machine for my oxygen, so it really is, what could I do if I were at home, I couldn't do anything. They are wonderful places for old people, they are and I advise anybody, you can't cope when you're getting old, can you…*" (Joyce, resident home E - 2718R).

Arthur living at home G also described a practical example of the resources that he derived from the home, especially when he was feeling unwell. He provides a vivid description of being ill in hospital, where staff were busy and dismissive, which he contrasts with his experience of being ill in the care home, where staff treated him with dignity and respect:

> "……*The other year I had a rotten head cold, like a flu feeling, and they gave me all of my meals in the room as well. And it's pleasurable, I never hear anybody say anything in a nasty way: wait a minute, which I got in hospital: wait a minute, I've only got one pair of hands, here they say I won't be a moment, I've got so and so, which is reasonable then, and so I think they're great*" (Arthur, resident home G - 4527R).

Within all of the case study homes there was evidence that most participants were deriving such positive benefits from their care home. This was likely to be the result of how they had cultivated the resources that were available to them. Hilda at home B, for example, articulated how she was able to pursue a 'way of life' that suited her:

> "*Yes, I do actually, yes you can do, you can have a way of life and you tell them and they are as obliging as possible*" (Hilda, resident home B - 145R).

7.2.6 Relationships within and outside the case study homes

For some residents their room was a place where they could keep in touch with their relatives and friends. Many of the case study residents, like Mo at home E and Arthur at home G had telephones in their rooms which they used to maintain contact. Perhaps the best example of the ability to maintain relationships in a home was found within home H where Tom (632R) and his wife had both moved into the home together – as a couple. Both, however, occupied separate rooms within the home, primarily because Tom's wife required intensive levels of care, and it had been felt that this could only be delivered safely on an individual basis. Tom's situation also exemplified the differentiation of what could be negotiated within his 'personal space' and the limitations imposed within the 'communal space' of the home. At 'home' Tom had

been used to cooking for his wife. However, health, safety and food hygiene rules had prevented him from doing this within the home:

> "*Well I used to cook at home for my wife when she became ill, and there are certain things that I like that you can't get here, well there are certain things that if I wanted to cook myself, because I find that there are a lot of things they don't have here. The cooks are sort of limited to what they do, they're not (pause), four star Michelin, but that's about the only thing*" (Tom, resident home H - 632R).

The smallest home in the case study sample (home C) and the local authority home (home F) were the only homes to offer basic kitchen facilities for their residents to use. The second small home in the sample (home D), did allow access to the main kitchen, although there was evidence that this was on a case by case basis, i.e. it was based on the resident's ability to influence access to this resource. All of the other case study homes, without exception, had strict no access rules.

There was abundant evidence during the fieldwork of contact and interaction between the resident, their family and friends. Edna at home F for example had regular visits from different members of her family: "…..*three of them come, my daughter, her husband, and they brought, picked my brother, and my grandson*" (Edna home F - 2223R). This was a fairly typical example of maintaining relationships that occurred within all of the case study homes and was arguably at a similar level and frequency as might have been expected in the resident's own 'home'.

Friendship with those who worked in the homes was also observed. One of the kitchen staff working in home I, had for example, known Jane before she moved into the home. Consequently she had maintained her friendship and actively engaged with Jane, even taking her shopping on her day off. The extended role of 'non-care' staff in meeting the social needs of residents had been recognised and harnessed by some of the case study home managers. For example, Rose the manager of home B had encouraged all grades of staff to act as 'key workers' for her residents (see Chapter 6). Mike, the manager at home F suggested that staff engaging in 'homely' tasks such as cleaning, were creating a common ground where the resident was able to relate to the task and subsequently to the person undertaking it:

> "…..*it's interesting really that a lot of the domestic staff and auxiliary staff within the building have some of the most profound conversations with the service users*

> *because they might be in there cleaning the room……just doing a bit of polishing, it's something you might be able to relate to because you've done it yourself and you might be helping them as well*" (Mike, manager home F - 2219M).

7.2.7 Wider social networks

Access to wider social resources was readily available to most of the case study participants who were physically and mentally able to engage with social activities both inside and outside their home. As Oldman and Quilgars (1999) suggest, quality of life might be seen as a function of the resident's independence, which in part derives from not feeling dependent. It was arguably this social resource that the case study homes were best at enabling for many of their mentally able residents. In this respect the homes were able to meet the basic physical care needs of the residents so that they did not feel dependent on relatives and friends. This in turn facilitated or provided a bridge for those who wished, and were able to participate in their wider community without feeling too reliant upon the help of others.

Relations with distant friends, associates and colleagues might, for example, be facilitated allowing continued membership of a church or other social group. There was ample evidence of such relationships within a number of the case study homes, where residents were able to travel out of the home to their local church. In the case of Hugh (4528R) living at home G, this also provided him with the opportunity to engage with his passion for music. Hugh's sense of personal responsibility meant that he had felt unable to play his violin in his own room, because he didn't want to make too much noise; however, by going to church he was able to indulge his passion:

> "*Well I mean I play the violin. I would imagine that if I started playing it in the evening, it might upset a few people, so I don't do it; if I want to play with my friends down at the church, I can take it down there and play down there*" (4528R).

These social resources and choices were nonetheless qualified in some important respects. For those residents with any form of mental impairment, leaving the home unaccompanied was often discouraged or prevented on the grounds of safety. For those residents with a significant physical impairment, leaving the home might be qualified by

their mobility needs and legal considerations around what is considered safe practice for staff. Indeed a notice in the main entrance of home H clearly announced that: '*Due to health and safety reasons, care staff will no longer be able to assist residents into and out of relative's cars. If such assistance is required arrangements will need to be made with a disabled taxi*'.

7.3 The residents as isolates within their home

Although residents may reside in a care home characterised as *egalitarian, hierarchical* or *individualist*, the data would tend to suggest that the residents themselves comprise a distinct culture. Residents in the case study homes, for example, appeared to be groups of individuals whose circumstances included a lack of cohesive bonds between members of the general resident group. Scourfield cites Bauman's (1998: 38) expression, whereby older adults are '*flawed and inadequate consumers*'. Thus for those residents who might be publicly funded, they may not be regarded as 'customers' of their own home, as this role, is arguably reserved for the local authority who meet their costs. As Scourfield (2007:170) suggests: '*the resident is a service user of the local authority and therefore does not have recourse to consumer legislation in the same way as a 'normal' customer*'. These characteristics would suggest that, regardless of the predominant cultural orientation of the home, the residents themselves occupy a 'low-group' position.

Residents were also routinely constrained by the timetables, rules and regulatory culture of the home, i.e. they were subject to 'high-grid' regimes that would arguably have been unacceptable to them before moving into a care home. The combination of *low group* and *high grid* suggests that residents *may* therefore occupy an isolate cultural orientation within their own homes. The question then arises how do outgoing and independent minded adults, used to exercising significant choice over their daily lives make the transition to a culture characterised by risk control with little or no choice about how such controls are implemented. This section will examine the empirical evidence and theory and discuss how residents might make the transition from being an *enabled* adult to an 'isolate' resident and the role that health and safety regulation might play in this process.

Apart from hospitals for chronic illness, prisons and some secure psychiatric institutions, care homes for older adults are among the few examples of long term residential institutions that still exist today. For older adults who need more care than can be provided to them in their own home, admission to a care home may therefore represent their first experience of living in an institution. The newly admitted resident must therefore adjust to their new circumstances in a process that involves learning to 'become' a care home resident, i.e. 'becoming' part of a community with its own practices and rituals.

7.3.1 Institutions and the process of 'becoming' a resident

Social scientists have considered institutions in terms of certain common qualities which affect those in them. For example, living within an institution is fundamentally different from normal life in the community. Table 1 in chapter 2 compared the characteristics of 'homes' and 'institutions'. Moore (2002: 231), suggests that '*even those [homes] run by the most enlightened staff inevitably have aspects of what Goffman called batch living*'. Goffman (1961) suggests that most institutions have four characteristics in common. First, all aspects of daily living are undertaken in the same place. Second, they have two distinct and different social and cultural worlds, one for staff and one for residents. Third, residents are stripped of the roles that they might have held prior to admission and designated simply as a resident. Fourth, the various activities of the home are designed to fulfil the official objectives of the institution.

While it is a 'normal' arrangement for most individuals to sleep, work and play in different places, with different people, and without an overall rational plan, the central feature of the institution is a breakdown of the barriers separating these features of life (Barton, 1959; Goffman, 1961; King et al, 1968, 1971). Further, the application of 'batch living' is likely to be a management expedient designed to cope with large numbers of residents whilst employing fewer staff. Such a situation was exemplified in the large corporate case study home (home I), where one of the staff readily explained that the domestic activities of the home were usually 'timetabled' rather than 'chosen':

> "*Usually we have to do certain things at certain times because it is quite a big home, I mean we have to organise because if everybody has got a different way*

> *we cannot cope. The [chefs] need to do the cooking and they need to serve the food whilst it's hot*" (Hazel, senior care assistant home I - 7238SNCA).

Thus, despite Government and organisational rhetoric, in these terms many older adults living in such care homes occupy what might be termed traditional institutions, living their lives entirely in one place with little or no separation between time, place and space. It could be argued that, for the majority of residents, at few if any time in their lives will they have been so meticulously categorised, documented and monitored as they will have been within the highly regulated environment of the care home. The process of 'institutionalisation' usually begins with a multi-agency, bureaucratic assessment process. Ken, a resident in a voluntary sector home illustrated his own experiences of admission to residential care. The process was described as being entirely bureaucratic and invasive at a time when he had felt most vulnerable:

> "*Oh yes, everyone starts by asking: what is your date of birth, what is your Christian name, where do you live, da, da, da; that's page one done. Turnover that's page two: what's the state of your health, why are you here? Because I've had a fall; oh yes; how has that affected you? But it's all part of their form filling, I wonder if it's not just jobs for the boys or ladies as the case may be; it was always the same and in the end I used to get fed up with people coming and asking: now what was your date of birth, and what is your Christian name and why are you here; it just went on and on*" (Ken, resident, home G - 4528R).

In this new culture the individual is required to reveal their most intimate and personal details to complete strangers, and is then introduced into an environment where the social bonds between peers may well be weak. Within the dominant culture of the care home, the resident *must* 'fit in'. Arthur, who lived in the same home as Ken, and was indeed very happy with his life there, appears to capture the basic idea that, for most residents, the care home is really a last resort and a function of their particular level of frailty and life circumstances. Ken suggests that both frailty and perhaps the home itself could have an institutionalising or imprisoning effect:

> "*I don't think anybody would go into a home, no matter how good it was. I'm sure that you'd agree; for example, you're certainly, to a certain degree in prison aren't you because of your physical difficulties and well, what you are doing…*" (Ken, resident, home G - 4527R)

The workplace can thus be seen to impose a strict regulatory regime upon the residents that includes round-the-clock supervision and control over the most basic and intimate of their activities. In most care homes residents' toileting, bathing and meals are

completely controlled by home staff, often affording little choice to the resident. The existence of such regimes was clearly recognised by some of the staff, who readily acknowledged that the 'restrictions' that they routinely imposed upon residents' were not what they would want for themselves:

> "*From my point of view, I think the fact that I wouldn't be able to go and make myself a drink, the fact that things are in a set routine, I know things have got to be like that for things to, you know. That's what I find difficult (pause); I suppose it is difficult you know you've got to have some sort of a routine for it to work. I find that hard personally, because in your own home you just get up and you can have your lunch at whatever time that you want; here its set times for your meals and you know*" (Mandy, care assistant home H - 631CA).

A further apparent erosion of the residents' choice and dignity was the practice, in at least one of the case study homes, of separating those residents who required extra support at mealtimes, and concentrating them as a distinct group. Thus some residents were isolated from their peers on a 'special table' in order to support and *protect* them:

> "*Right, well, we've never, say in the dining room then for instance, we've got a special table in the middle for people that need feeding, that can't reach for the teapot or anything like that, so the carers do all of that for them, they pour the tea and help to feed them, you know so they're not in any harm in that way*" (Karen, care assistant, home E - 2716CA).

Another example of institutional and protective care that would probably be completely unacceptable to many adults was the practice of restricted and supervised bathing. Most of the residents interviewed appeared to have been allocated a designated day for having a bath or a shower. The reason for this was twofold. First, because of the logistics of ensuring that all residents had access to the facilities and, second, there appeared to be an expectation that the activity would be supervised by staff:

> "*When they're having baths, obviously it's with a carer, we'd never allow them to have a bath or a shower on their own, you know, and if the resident is a bit immobile you'll have two carers*" (Karen, care assistant home E - 2716CA)

A direct consequence of the balance between the availability of staff and the dependency of the resident meant that, on occasion, a resident might even have to forego their usual weekly assisted bath:

> "*It's every Tuesday my bath time, but they're short staffed today – which is usual, they're always short staffed; so I didn't get one*" (Jane, resident home I - 7235R).

This situation was a recurrent theme in many of the case study homes, however, it was interesting that the residents were generally philosophical about the arrangements in place and did not seem to mind if they missed their bath, even though it might mean waiting a week for their next opportunity. Checking residents at night was also regarded in a 'matter of fact' way rather than being seen as an intrusion or a disturbance:

> "*And the lady in the night keeps coming to see if you're alright, if you're asleep, all night*……..." (Edna, resident home F - 2223R)

For some residents their independence, sense of empowerment and possibly even their dignity in terms of being able to 'pay their own way' were further eroded by the arrangements that were in place for managing their money. It was not uncommon for residents' money to be looked after entirely by their family, with 'pocket money' being allocated during visits. This was certainly the case for Jane living in home I, who clearly felt embarrassed by the arrangements in place:

> "*I've got a son-in-law, but he's got my bank books to look after, and I always send messages to tell him to bring me some money; he might bring me £10.00, he might not. Because when I first had some he brought me £50.00 and I lost it, so he just brings me £10.00, but not very often and I feel lost when I want some money you see; I've got to scratch about to pay for something*" (Jane, resident home I - 7235R).

Whilst asking relatives to look after a resident's money might be a convenient expedient, the impact on the resident's dignity and sense of independence is likely to be negative and isolating. Thus a resident who has been a wife or husband, a mother or father, indeed an active citizen who has exercised control over their life, appears to 'learn' a new set of rules and a new role as part of a process of *becoming* a resident. Indeed their new role is perhaps just that, to accept the new 'rules'.

7.3.2 Cultural pluralism and communities of practice

The idea of multiple cultures operating within a dominant cultural orientation is compatible with the theoretical idea of Grid and Group. Organisational culture cannot *in general* be separated from culture of the society in which the organisation operates (Hofstede, 1980; Hendry, 1999), i.e. care homes operate within a society that has become increasing risk averse and ageist (see for example Ray and Sharp, 2006). This

idea is also compatible with the concept of *cultural pluralism*, where groups exist within another culture whilst maintaining their own unique cultural identity. One example of cultural pluralism is the dynamic by which minority groups participate in a dominant society, yet remain within a defined community. This idea would appear to resonate with the situation in most if not all care homes where an apparently isolate culture existed within a home that might otherwise have been characterised as egalitarian, hierarchical or individualist. Kerr et al (2008) have observed these types of sub-cultures with night staff working in care homes. Such temporal isolation might cause such groups to experience a sense of separation from the main culture of the home, and therefore of being less valued by the organisation. These perceptions are likely to be compounded by limited contact with managers and other staff and lead to distinct communities of practice. For some residents, their sense of loneliness and isolation was arguably twofold; on the one hand they might be 'isolated' within their own care home whilst at the same time they were often isolated from members of their own family too:

> "*I've got a sister and she's gone up North, somewhere, in a home, it's just an ordinary place like; like a home. I've not seen her, I don't like to think about it or else I'll cry. You get very lonely sitting here thinking about your past*" (Fran, resident home D - 6513R).

Some residents appeared to be both isolated in terms of having few other residents to communicate with and at the same time they were apparently afraid of the likelihood of their own mental deterioration. Betty for example had been quite distressed about the fact that many of her personal belongings, nightdresses and underclothes, were going missing. She was quick to point out that the 'blame' for these losses did not rest with the staff, but with some of her other more confused peers, who she did not get on with. In acknowledging the confusion of her peers, Betty also expressed her own fear of becoming '*just like them*':

> *"I know I can't blame other people for not having them, because I might be like that one day. If I get like that I'm frightened you see; if I have another stroke and I'm just like them. That's my only hurtful thing; I can't have a conversation with many of the people, you know*" (Betty, resident home B -144R).

Figure 12 shows a conceptual representation of the idea of different cultural groups existing within the home, where individuals (shown in circles) interact with and within

their 'group' and develop a group 'identity', where identity refers to the *identity* of being a resident or a carer. The bonds between these individuals and their 'group' determine the *strength* of the group orientation.

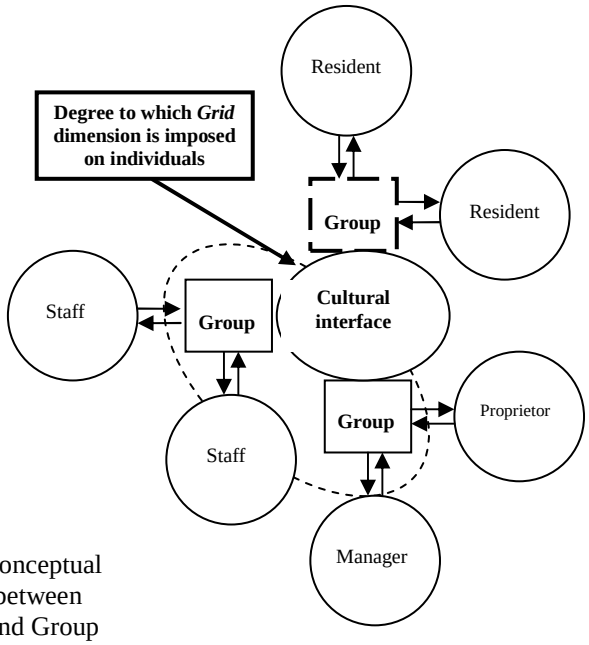


Figure 12: Conceptual relationship between individuals and Group

For the proprietor, manager and staff, whilst they might occupy their own 'sub-groups' of managers and managed, they are nonetheless part of the larger *corporate* 'group' of employer and employees shown by the dotted ellipse on the diagram. The residents however, are generally not (unless they actually own the home) part of the 'ellipse', they are a distinct group in their own right. Despite the rhetoric of choice and empowerment, residents do not however appear to represent an *empowered* group in their own right. Indeed as argued, they appear to occupy an isolate dimension aptly summarised by Douglas (2005: 8) as '*being alone, [having] little or no influence, no close friends, no one has a reason to consult them; their support is hardly worth having*'.

Mars (1982) proposes four tests for the strength of the group component: frequency, degree of mutuality, scope of interpersonal interactions and the strength of the group's boundary in terms of the inclusion and exclusion of members. Group strength is *low* when people negotiate their way through life on their own behalf as individuals, a situation that is perhaps synonymous with becoming a resident in residential care. The frequency, degree of mutuality and scope of interpersonal interactions appeared, in most homes, to be low. The group's boundary was generally beyond the control of the

residents. Inclusion or exclusion was decided and imposed by those who were external to the 'group' and the environments that they created and permitted. For example, mealtimes could be a matter of rules and routines that were a function of the home's timetables and shift patterns. This routinisation of the home was perceived by one resident as a function of the staff's shift patterns:

> "*On the whole I help myself, but there are occasions, especially those dictated to by the mealtimes, when you need to speed up your toilet, speed up your washing so that you get your dinner in time, your food in time and so do not upset the staff; because some of them leave after one meal and some of them start after one meal from what I can see*" (Andrew, resident home H - 637R).

For some residents, their social lives were clearly constrained by the abilities or disabilities of their peers and their social lives were thus largely a function of being able to interact with staff. Tom for example, was independent in many respects, yet appeared to rely on staff for his 'social stimulation':

> "*they're all incapacitated really, there's only one, well there's [names a recently admitted resident] there……...None of them can do much talking so the only pleasure we get is talking to the staff actually*" (Tom, resident home H - 632R).

One fieldwork observation common to all of the case study homes was that the residents often did not appear to identify with their more physically or mentally impaired peers. There was rarely a sense of a truly shared identity and solidarity and no residents appeared to be part of a 'powerful' resident group. Indeed some residents, whilst acknowledging that they all lived together, appeared to distance themselves from their more dependent peers and lead *relatively* independent lives:

> "……..*they don't go into the garden half of them, don't talk very much; I'm determined not to be like that, yet……..a lot of them don't; don't come out of their rooms or can't come out of their rooms and they usually come from this area; and they have relations who will help out with shopping or whatever. Well I don't have that, but I'm moveable so I can get out and do my own*" (Hilda, resident home B - 145R).

The 'individualised independence' of some residents was discussed earlier on in this chapter where it was shown that some residents were able to negotiate *individualised* resources that contributed positively to their quality of life. However, for those residents with increasing mental or physical frailty there seemed to be an increase in loneliness, both to the frail resident and to those who live with them. For example, those

participants who were profoundly deaf were isolated as the result of their inability to communicate. Jack had lived in home I for around six years. He was able to communicate on a one to one basis; however, in the noisy environment of the day room, it had been very difficult for him to engage with anyone:

> "*I tend to sit quite a lot with not being able to hear very well. You don't hear conversations much, so you really don't know what's happening unless someone like you is speaking to me one to one*" (Jack, resident home H - 7234R).

It could therefore be argued that the 'omni-present' television set that occupied a prominent place in the communal lounges of many case study homes, was a barrier to communication and interaction. The practice of having communal televisions whose volume was often turned to the highest level arguably promoted isolation. In most homes the television appeared to be the focal point of the communal areas where its loud volume dominated the environment. As one of the residents in home H pointed out, this effectively put certain spaces 'out of bounds' for those who wanted a quiet space, or a place for conversation:

> "*I think because it must be known that I haven't got the right to speak with authority about how the place is run, but I do think that people who are very, very deaf, ought not to be so dominant, like for instance this room is out of bounds to those people who don't want to go deaf*" (Andrew, resident home H - 637R).

In two case study homes (B and F), even the 'quiet room' had a television set switched on. For some residents there was therefore little choice about where they could spend their time. Physical frailty, immobility and limited communal space, meant that the resident's choice was limited to either the main lounge or sitting alone in their own room.

Occupying and sustaining a particular cultural perspective is not a passive process. It is likely to be active and involve learning a defined role as part of becoming part of the community in which you live or work. The idea of *learning* to become a resident or a carer resonates with the concept that learning is a social activity and comes largely from our experience of participating in daily life. Such ideas formed the basis of a significant rethinking of learning theory in the late 1980's and early 1990's by two researchers - Jean Lave and Etienne Wenger. Their model of situated learning proposed that learning involved a process of engagement in a 'community of practice' (Lave and Wenger,

1991). Their basic argument was that communities of practice are everywhere and that we are generally involved in a number of them. Learning in this context is a process of adopting the language of the community and adapting to its customs, practices and rituals. In care homes learning the process of 'becoming' a resident (or a carer) involved constructing an understanding of the respective roles of resident and carer as they were played out within the institutional context. What is learned is profoundly connected with the conditions within which it is learned, thus the learning materials are likely to include ambient social and physical circumstances and the histories and social relations of those involved (Brown and Duguid, 1991: 11). As the transcript from one of the carers suggests, staff in her cultural environment appeared to conceptualise residents as being 'just happy to sit around':

> "……*at the end of the day there's not a lot that they do want to do, they're quite happy to just sit, you know, interact with each other, day dream, watch the seasons talking, they're quite happy with that*" (Karen, senior care home E - 2716CA).

There was also evidence to suggest that in fact, staff did not always have time to spend with residents on these basic 'quality of life' measures. It could be argued that, in some homes, they had 'learned' that undertaking the practical, safety oriented, tasks set out on the provider's procedures was regarded as more important than interacting with residents. Chapter 6, for example, suggests that some of the 'hierarchical' homes were more likely to be task oriented. The resident was arguably well cared for, physically, but socially quite isolated. Jane, a resident in home I explained on a number of occasions that '*the girls*' were very busy, and as a consequence it was unlikely that they would spend quality social time with the residents:

> "*No, they haven't got time I tell you, they haven't got time to sit and talk to you*" (Jane, resident home I - 7235R).

This statement was in no way a direct or implied criticism of '*the girls*', it was a simple statement of fact. The carers were indeed too busy undertaking the tasks, that they had been told were important, to be in a position to spend time sitting down and talking. This was indeed observed to be the case during the fieldwork, the home was very busy. The dependency levels of some of the residents and the relatively low numbers of staff on duty meant that carers spent a lot of their time engaged in practical activities. From

the staff perspective, their role was practical, and in the words of one of the staff in home I:

> "……*I haven't got a lot of time; I mean you can see me here and there, I don't have enough time to sit down there for half an hour*" (Hazel, home I - 7238SN/CA).

Home I, did however have a very popular activities coordinator who was observed to spend quality time with a number of residents when she was on duty. This dissonance between basic care and social interaction was occasionally reflected in a care home's CSCI inspection report. For example the report for the larger voluntary sector case study home, home E, indicated the realities of balancing the basic care of residents with their social needs, highlighting the shortfall in staff availability and meeting the social needs of the residents:

> "*There is no specific person responsible for activities and staff said they do not have the time they would like to spend organising activities as they have to prioritise care needs*" (Inspection report voluntary sector home E: 27107I).
>
> "*Staff members said they felt that no one was neglected but they do have to prioritise care needs and don't have the time to spend quality time with service users*" (Inspection report voluntary sector home E: 27107I).

Thus residents and carers were immersed into a culture or community of practice that did not necessarily anticipate activity or social interaction as an important function of the home. The residents and staff in this environment learned how to function within their community – they learned their place within the system, they learned the rules of the home. Lave and Wenger (1991), argue that learning, understanding and interpretation involve much that is not explicit or explicable. What is learned is framed within the communal context where the resident and staff acquire the language and 'customs' of their community, indeed they are '*enculturated*' (Brown and Duguid, 1991: 12).

7.3.3 Learning to live and work in a care home

Wenger's diagram (1999: 5, Figure 13) suggests that whilst carers learn to adopt practices by 'doing', residents adopt identities by 'becoming'. Residents, staff and indeed managers may all learn that *meaning* is a relative term. The provider's policy

might, for example, require that carers work in one way, whilst their local community of practice may have adopted its own custom and practice. Clough (2000: 4) illustrates this by painting a vivid picture of how such different meanings might co-exist within a care home:

> '*Staff were insistent that residents could call on staff at any time during the night. Staff then commented on the nuisance of some residents who had kept pressing the call bell. Residents who heard these comments would learn that the formal statement 'call us at any time' had to be interpreted in the light of the informal labelling of some residents as a nuisance*'.

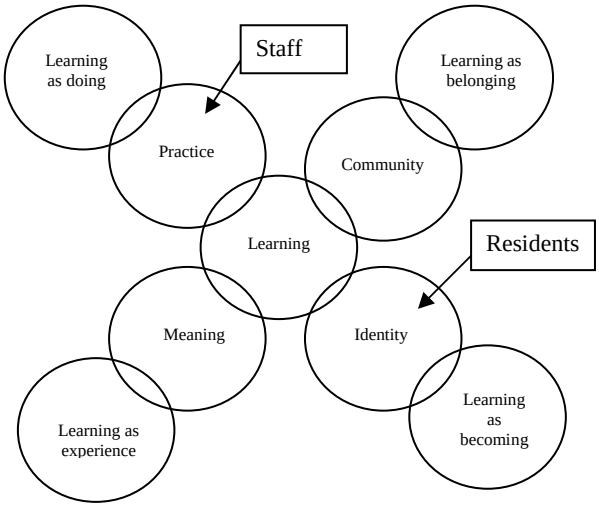


Figure 13: Adapted from Figure 0.1 pg. 5, Components of a social theory of learning: an initial inventory, Wenger, 1999

Wenger (1999: 6) explains that for staff: '*no matter what their official job description may be, they create a practice to do what needs to be done*'. Thus even whilst the regulator, the regulatory framework and the provider undoubtedly exert a significant influence on the way that care homes are managed, the carer's local community of practice may impose or tolerate a different regime within which actors define their identity. It is arguably the home manager and staff who establish the culture and community identity within which the regulatory framework is applied. These ideas were briefly explored in Chapter 6 where it was suggested that the home manager often appeared to exhibit the characteristics of a *street level bureaucrat*, interpreting policy in accordance with their own perception of practice.

One of the most interesting and potentially significant findings of the empirical research was an insight into how home managers conceptualise *care* (which might on occasion be argued as synonymous with control measures) in terms of 'rules' that were designed to 'prevent' harm to *vulnerable* residents. Arguably the expedient to prevent harm was done at the expense of *choice*. Whilst carers emphasised the physical domain of risk management, they ignored the biographical domains of risk such as loss of self-identity (Clarke, 2000). For example, on few occasions were 'rules' supported by a collaborative, suitable and sufficient assessment of the risks designed to balance the quantum of risk. Indeed the manager of home F reflected that where risk assessments did take place, they rarely involved the resident. The role of care planning and the management of risk will be further explored in chapter 8 where it will be argued that there is an apparent lack of resident involvement in the planning of their care.

Further examples of the apparent dissonance between organisational rhetoric and local reality were evident within some of the case study home's CSCI reports. Home E, was particularly noteworthy in this respect. During a discussion with one of the care staff, Kath (2716CA), she retrieved a policy folder which she explained, '*all staff should read, sign and date*'. Whilst there were a number of relevant documents dealing with equality, stress etc., there were no bathing or lifting policy / procedure documents in the file. After some flicking through the manual and looking in the cupboard to find these documents, the participant proceeded to explain that bathing and handling were individual procedures that would be recorded in the care plan. Another care assistant in the staff room at the same time added that safe bathing was '*common sense*'. Both carers couldn't remember having actually received formal training in bathing related activities – however, both were obviously experienced and aware of the issues involved. The administrator for home E, who maintained many of the home's documented systems (2715A), was asked about the bathing and lifting care related policies and procedures that the carers had not been able to locate; she also had no knowledge of their existence. The significance of this finding is not that the home, *apparently*, doesn't possess bathing and handling policies – it may indeed have them as part of the provider's systems, however, key staff were unaware of them and so adopted a '*common sense*' approach to safety critical care activities that they had 'learned' within the home.

Wenger (1999: 6) explains this likely dissonance in the following terms: '*although workers may be contractually employed by a large institution, in day-to-day practice they work with - and in a sense for - a much smaller set of people and communities*'. New staff joining the home will thus 'learn' the pre-existing practices of their peers rather than the approved best practice of the proprietor and residents will learn the 'rules' emanating from these practices.

This section has argued that the case study residents were not a homogenous cultural group who could be counted as belonging to the same cultural orientation that characterised their respective homes. Thus, when talking about the 'egalitarian' or the 'individualistic' characteristics of a case study home, this does not imply that the residents enjoyed the same 'low grid' orientation. On the contrary, it has been argued that the residents of both egalitarian and individualist homes were likely to be subject to a 'high grid' orientation characterised by a 'rule' oriented interpretation or application of the regulatory framework. At the same time residents were seen to occupy an apparently 'low group' orientation characterised by weak social bonds unlikely to encourage them to assert their rights as clients or consumers of the service.

Such customs and practices were subsequently maintained as 'communities of practice' whose new members were expected to 'learn' the rules of the community regardless of Government or organisational rhetoric about choice. Thus the new residents and carers could be said to have adopted the customs, practices and vocabulary of their home and adapted to its rules in a process of 'enculturation'. Such enculturation perhaps serves to explain why *all* of the case study residents appeared to accept, apparently without question, the regimes of the homes within which they lived. This *acceptance* included care and risk management practices that would arguably be unacceptable to an adult living independently in their own home. Examples included weekly baths or showers, hot water temperatures limited to 43°C, windows that couldn't be fully opened, restricted access to parts of the home, and supervision.

7.4 Conclusion

This chapter has considered what it was like to live and work within the regulated care home. The first part of the chapter discussed the degree to which residents were

involved with the decision making processes that determined the broad interpretation and application of health and safety law within their home. It was proposed that the cultural orientation of the home and the proximity of the resident to decision makers were likely to be factors in this process.

It was theorised that a very permeable interface between management and residents might have been expected in those homes characterised as 'high-group' resulting in significant alignment between decision makers (providers), decision implementers (staff), and decision recipients (residents and staff). However, even within the clearly 'egalitarian' culture of home G, there was little if any evidence that residents were encouraged to take an active role in health and safety based decision making.

It was also theorised that the proximity of the resident to the provider's system of governance was likely to determine the residents' ability to influence key decisions. For example, those residents in homes with local governance, exemplified by the smaller owner, managed care homes, were more likely to be able to influence 'executive' decisions. The fieldwork however suggested that health and safety decisions were often taken pragmatically and with little real consultation with those affected. This situation appeared to apply equally to the small homes and to the larger providers. It was suggested that the answer to why this might have been the case is likely to derive from the fact that many of the health and safety requirements appeared to be mandated by the National Minimum Standards (see Chapter 3) and stipulated by CSCI inspectors and even local authority purchasers. It was therefore argued that providers felt that they had little option but to comply with health and safety requirements required in the 'best interests' of residents. There was also little or no evidence to support the proposition that a 'high-group' cultural orientation within the home encouraged participative management. These were interesting findings that suggested that residents were not necessarily involved in the process of making decisions about how health and safety law was implemented within their own home.

The second part of the chapter considered the idea of being at 'home' within the care home, acknowledging that 'home' is generally accepted to be much more than just the physical dwelling. Whilst 'home' may have many diverse characteristics, generally, it can be thought of as a place where people are able to exercise control and influence over

their lives. The evidence from the case study homes would, however, suggest that constrained or 'qualified' choice was arguably one of the significant factors that differentiated the resident's own 'home' from the care home. In the care home the regulated routines, 'structure' and 'considering other people', dictated or impinged upon 'real' choice. It was shown that the residents' day was generally subject to routines and restrictions that often had their origins, in health and safety law. For example, residents were frequently excluded from the laundry, kitchen or even the garden. Whilst the resident might have their own room, these too were subject to risk assessment, and safety 'rules' that included windows that could not be fully opened and doors that were 'mechanically' kept closed. The 'rules' meant that the choice of furniture had to meet 'fire safety standards' and any other risk assessment criteria that might apply at the time. Within all of the case study homes there was, however, evidence that most participants were deriving positive benefits in terms of access to social resources such as family, friends, trips out of the home and security.

The final part of the chapter explored what might be described as the apparent contradictions that had arisen with respect to the grid and group conceptualisation of the case study homes. Despite the rhetoric of the care home being 'their home' and the theoretical idea that a home might exhibit a 'high-group' cultural orientation, residents arguably exercised considerably less control than they might have expected to in their own 'home'. This suggests that rather than belonging to an empowered 'high-group' cultural orientation, the residents might, in fact, occupy a generally 'low-group' orientation within a 'high-grid' regime characterised by rules. This low group high grid orientation is synonymous with an isolate culture, which appears to co-exist within the predominant cultural orientation of the care home.

In some respects this was a surprising finding, however, the theory suggests that the idea of 'multiple cultures' operating within a predominant cultural orientation is compatible with grid and group. For example, organisational culture cannot *in general* be separated from culture of the society in which the organisation operates (Hofstede, 1980; Hendry, 1999). Chapters 2 and 3 would appear to support this view in terms of the suggestion made by Bland (2005) that older adults may occupy a less equitable position within society and in this respect are often characterised as vulnerable and dependent.

Chapter 6 also identified the phenomenon whereby the home manager, who whilst theoretically constrained to operating within the provider's systems, appeared able to exert an influence upon their application. Thus, home managers were able to exert an influence upon the home by the way that they applied and didn't apply policy, by their rituals of compliance and by their 'rules'. It was argued that those who lived and worked in care homes did so as part of an active process that involved learning a defined 'role' within their home. The idea of *learning* to become a resident or a carer resonates with the concept that learning is a social activity and comes largely from our experience of participating in daily life. No matter what the job description or tenancy agreement might say, it is the accepted custom and practice that drives what happens (Wenger, 1999). Thus even whilst the provider, the regulator and the regulatory framework undoubtedly exerted a significant influence upon the homes, it was the local community of practice that defined their real identity.

Chapter 8 - The experience of regulation and risk

8.0 Introduction

The previous chapter considered the resident's experience of home, and the conceptualisation of 'home' by home managers and staff. It was shown that the choices an older adult may make in their own home were viewed differently in the residential care home. Within the care home choice was almost always *qualified* by perceived risk or legal requirements. The choice to have a kettle in one's room or to have a bedside rug might for example be conditional upon a risk assessment. The resident's ability to influence the health and safety management culture of their home was shown to be limited by their apparent *isolate* orientation, which 'disempowered' them as a group. This chapter is principally concerned with the way that risk and regulation are conceptualised and managed at a *practical* level, how local culture and the attitudes of managers and carers mediate the application of regulation in terms of the assessment and management of health and safety risk. The chapter touches upon all three research aims and addresses questions one to four.

The assessment and management of hazards and risks within care homes takes place on two levels. First, the identification of hazards associated with the premises, which will include all aspects of the building, substances and work practices. Second, the individual management of risk associated with the care of each individual resident which should include how that resident's choices correlate with the management of risk within the premises. This suggested a general dichotomy of systems that appeared to differentiate health and safety from other key areas of home management. It will be shown, for example, that 'hierarchical' providers may introduce systems into their homes that are not always fully understood or accepted by local staff. The chapter is divided into four broad sections. First the conceptualisation of risk is discussed in the context of the theory explored in chapters 2, 3 and 4. Second, a number of practical examples of premises related hazard and risk management are drawn from the fieldwork and used to illustrate the theory. Third, the individual management of resident related risk is discussed in the context of care planning. The fourth and final section explores the data in relation to the theoretical ideas suggested in Chapter 4. The systems perspective is then developed in order to suggest an explanation for the apparent

paradox highlighted in sections 2 and 3, whereby the management of health and safety risk, appears, on occasion, to give rise to new and unexpected risk.

8.1 Conceptualising and managing health and safety risk

The Health and Safety at Work etc Act 1974, discussed in detail in Chapter 3, is supported by a (large) number of subordinate regulations, each designed to address particular work based scenarios. Principal amongst these is the Management of Health and Safety at Work Regulations 1999, which places a duty on the proprietors and managers of care homes, to *assess* and to *manage* hazards and risks to their employees and to anyone else affected by their work activities. The Health and Safety Executive publication: Health and Safety in Care Homes (2001: 5), defines a hazard as anything that can cause harm, and a risk as the chance, high or low, that somebody will be harmed by the hazard. A risk assessment in the context of health and safety law requires managers to follow five basic steps. First, to look for any hazards associated with a particular activity, second, to decide who might be harmed and how by that activity, third, to evaluate the risks and decide whether the existing precautions are adequate or whether more should be done, fourth, to record their findings. Finally managers should review their risk assessment from time to time and revise it if necessary.

Within the case study homes there was generally evidence that the 'principal' premises related risks, including: the control of Legionella from hot water systems[35]; servicing gas and electrical systems; preventing scalding and burning; preventing falls from high windows; and managing cleaning and other chemicals, were being controlled. Generally within the hierarchical homes such as homes E and I, the provider had established robust systems. This included making the handyperson responsible for undertaking a number of the checks associated with these risk areas, specifically: testing and recording water temperatures; visually checking electrical appliances; or checking window restrictors. The provider of home I had elaborated these checks to include a formalised 'register' that had to be signed off by the home and regional managers. It could, however, be argued that all of the control measures seen related to the 'high-profile', highly publicised risk areas, such as falls, scalding and Legionella, that were mandated

[35] Legionnaires' disease is a type of pneumonia that can be contracted from breathing in water droplets contaminated with bacteria living in water tanks, pipe-work and showers.

by Standard 38. There was generally little evidence seen, at local level, of a consistent, documented approach to the general risks associated with the premises. For example, whilst there was widespread use of window restrictors, none of the case study homes could confirm that the glass itself was safety glass or indeed if a risk assessment had been undertaken. When this was raised with home managers it was generally acknowledged as "*a good point*" (Bob, manager home E – 2714M).

The management of risks, arguably, entails a degree of professional risk for the provider and for the home manager. According to Taylor (2006), managers are likely to assess risk with reference to, what they *believe* the law requires of them, specifically the duty to *minimise* risk. In Taylor's research, the term '*minimise*' was commonly used by participants, yet, he suggests that its use left much unsaid. This situation might be seen as synonymous with that of conceptualising 'choice', discussed in Chapter 7, where 'choice' was almost always highly *qualified* by concepts of minimising risk.
The rigour of a formal health and safety investigation following a serious accident, probing questions about control measures, the disapproval of relatives, the threat of being sued or held to account for some action or inaction, are likely to represent powerful mediating forces when assessing and making risk decisions (Taylor, 2006). Most home managers were for example aware of the so called 'where there's blame, there's a claim' culture that has become so prevalent in the media. Cath, the manager of home D gave an interesting insight into how such anxieties framed her management of risk within the individualistic culture of a small private home:

> "*…..you are just so aware of like the where there's blame there's a claim, you're just so aware of it; it's like you see it so much, I've even had friends in situations who work in nursing homes make claims: Fell on a floor and broke her wrist and got £7000, and although she was signed off sick, it wasn't as bad as she said. Because it was a friend, but to the company, it's not a nice situation to be in, and through that knowledge, makes me more aware, that you know, how easy people can claim. You know, and to me I think to myself; you know my livelihood would suffer so much through it, these people who live here would suffer through it; you know, we initially could close through a claim, you know*" (Cath, manager home D – 659M)

This situation might also be exacerbated by the increased focus on accountability and the public scrutiny of services (Kemshall and Pritchard, 1997), and on the requirements of purchasers and regulators, particularly CSCI. This may ultimately lead to conflict over rights and risks within the context of a 'blame culture' (Douglas, 1992; Furedi,

1997). Robinson et al (2007) suggest, for example, that for care professionals a fear of litigation tipped the balance in favour of risk management. This observation resonates with this research and was reflected in the transcripts of managers from all of the different cultural orientations, but most vociferously from the individualistic and hierarchical homes. For example, Bob the manager of home E (a 'hierarchical' home), clearly articulated his concerns about a perceived culture of apportioning blame:

> "*We have a culture of attaching blame to somebody, you know, I've often said the word accident should no longer be in the dictionary, because you cannot have an accident anymore, you've got to find somebody that's responsible and put them up as a scapegoat almost……...there is a very severe cultural factor to apportion blame to somebody or some organisation, and obviously riding on the back of that there's a lot of litigation going on, and therefore companies and organisations become terrified of being litigated against*" (Bob, manager, home E – 2714M).

Despite the written rhetoric of privacy, dignity and choice espoused in Government publications and care home literature, a very practical example, and arguably one cause of these fears, can be readily demonstrated in prosecutions following accidents and incidents in care homes for older adults with their subsequent press attention. For example, when in 2006 an 81 year old resident fell from her bedroom window, the home owner was prosecuted for 'failing to secure the health and safety of residents' (the HSE prosecution database details all such prosecutions). The prosecuting District Council claimed that the risk had been '*brought to the proprietor's attention as early as 2000, but that he had felt a 'home from home' environment was important to residents*' (Mid Devon Star, first published Friday 23rd June 2006).

Such headlines with their accompanying fear of censure are perhaps more likely to promote 'risk averse' practices by care home proprietors, managers and staff at the expense of individual residents' freedoms. Figure 14 illustrates how Robinson et al (2007) conceptualised the factors that determine how carers are likely to weigh the balance between the rights of the individual and the application of risk reduction measures.

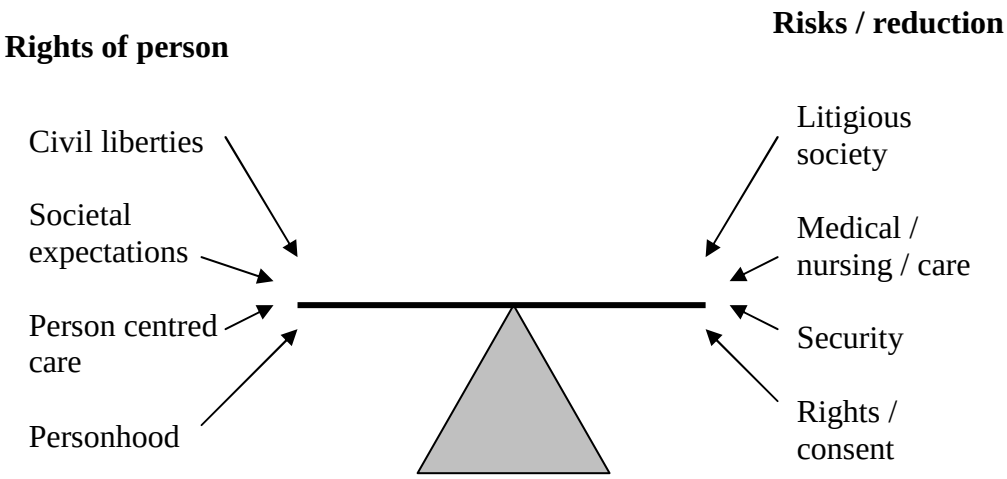


Figure 14: Factors affecting the balance between rights and risks (Diagram adapted from Robinson et al 2007:395)

For residents, the balance is likely to be tipped in favour of quality of life and independence. The values of liberty, personhood and society's expectations of equality and the *rights* of the individual to person centred care are likely to outweigh *risks*. However, for professional carers where their perceived duty to *care* is a significant factor, the balance is likely to be tipped the other way. Professional expectations and the likelihood of litigation may be more likely to outweigh the rights and freedoms of the individual (Robinson et al, 2007: 395). The role of the resident's relatives is also likely to be a factor. There was evidence during the fieldwork (discussed a little later on) that suggests that whilst relatives, theoretically, support choice and risk taking, they in fact, adopt a more conservative attitude to risk in practice. The home manager and staff within the case study homes sometimes appeared to be faced with situations where they must balance residents' rights with a perceived responsibility to comply with the law, '*workers [were led] into scenarios of conflicting purposes, principles, rights and duties*' (Taylor, 2006: 1420). This was perhaps again exemplified by the manager of home E who tried to articulate the tensions that derive from balancing best practice in terms of being 'homely' with what are perceived to be the regulatory requirements of health and safety law:

> "*Ok, here's a good one, a typical example is dealing with a dementia aspect, you know, the people that study and understand dementia they say: what sort of things do you apply within your establishment; and they like to see you have things left around so that it feels very much relaxed, so if someone is knitting or something like that you don't need to put it away every five minutes. But per se what happens is you suddenly find someone walking around with the knitting needle*

> *that is immediately a risk. They've got, as they did have the other day, they've got the ball of wool, that somebody else had been knitting and was on the floor wrapped around their ankles, you know, to trip over, ok. So, on one aspect you see that the desire to make it a home and have it as homely as you can, but you have to take an interpretation as though the experts that say that you are dealing with this condition, this group of people; and these are the ideal scenarios, don't fit very comfortably with health and safety. So you have to make a judgement, do I follow the guidance because this range of people have dementia and therefore this is the environment that makes them feel at home and comfortable; or do I take the fact that well it is health and safety and the risk is there*" (Bob, manager home E - 2714M).

This example provides an interesting insight into how Bob had rationalised the best practice guidance around making his home 'homely' with his perceived duty to manage risk within a predominantly hierarchical cultural orientation. It could be argued that Bob had applied the 'availability or representativeness heuristic' where his perspective on the likely risk derives either from his own experience of a recent event or a stereotype that characterises all residents as being vulnerable. For example, Bob related in his narrative the recent example of someone who had: "*got the ball of wool that somebody else had been knitting and was on the floor wrapped around their ankles*" (Bob, manager home E - 2714M). This scenario begins to illuminate how home managers responded to perceived risks. The following discussion will develop this theme by examining some other risk scenarios that derive from the case study homes by using three broad examples. First, the management of walking frames, prevalent in all of the case study homes, and regarded as a risk by some of the home managers and their staff. Second, doors within the case study homes were often closed or locked either to prevent the spread of fire or the passage of unaccompanied residents into 'unsafe areas'. Third, the choice to have a 'hot' bath within any of the case study homes is now largely constrained by the use of thermostatic mixer valves.

8.1.1 Walking frames

The walking or 'Zimmer' frame is perhaps most closely associated with mobility in residential homes for older adults. Whilst these walking aids undoubtedly provide significant independence to those who use them, they may also be, or be seen as, a 'hazard'. Residents may for example leave their frames where they could be tripped over by others. Rachael, the manager of home H, a voluntary sector home, with a

predominantly 'egalitarian' orientation explained how she had encountered the risks associated with walking frames and her subsequent actions:

> "*There was an incident before Christmas when somebody had their Zimmer frame out and their feet up, and somebody was walking past and tripped over and dislocated their hip, so now no frames or walkers are allowed in the dining room; there's a complete clear space now and all of the frames are stacked outside near to the front door……. ……..…..And when they've finished we'll get the frame and bring it to them and bring them out*" (Rachael, manager home H - 629M).

Bob the manager of home E, had chosen to address the risk from walking frames in the same way that he had done with the knitting wool, by removing them. From a health and safety management perspective removing the hazard can be a very efficient risk management strategy as it is at the top of the hierarchy of controls[36]. Remove the hazard and thus eliminate the risk. In a practical sense this involved removing the walking frame from the resident whilst they were in communal areas, such as the dining room:

> "*……..…..now Zimmer frames are always an issue because of, in the dining room where you are sitting people down, I make an instruction that risk is to take all of those Zimmer frames out of that area when they are not in use, and store them outside the dining room; and when the resident wants to move, they will be taken through by a member of staff and given back to the resident. So, a certain resident isn't very happy about that, but you know, I sort of say: I'm sorry but that is a rule, that is non-negotiable in effect; because I see the overall factor, is the most important driving point, the overall wellbeing of people, overrides his personal independence*" (Bob, manager home E - 2714M).

The idea that the 'overall wellbeing' of people can override their independence is somewhat incompatible with the idea of 'home' as a place of choice, and also ignores the biographical risk to the individual (Chapter 2). There may be psychological consequences, in terms of a loss of self esteem, as the result of being placed in a dependent situation. Additionally, the removal of the choice to leave the table without first having to ask for the walking frame may also introduce the likelihood of an accident where the resident chooses to leave the table without first asking for the return of their walking frame. Indeed Healy and Scobie (2007: 47) suggest that '*walking frames should be within reach*'.

[36] Eliminate the hazard is the 'gold standard' followed by substitution with something less hazardous, using barriers etc. The use of personal protective equipment is at the bottom of the hierarchy.

An example of an alternative and choice based solution was observed in home G, a home also operating within an 'egalitarian' cultural frame and of a similar size and management structure to home H. The home manager appeared to have recognised the apparent paradox and rather than acting by imposing a 'rule' appeared to have undertaken a risk assessment of the problem. This had suggested that the home adopt a strategy that did not require removal of the walking frames:

> "*This meant making sure that when they go in and out to move all of the little tables to the side to give the residents more access with their frames*" (Zoe, deputy manager, home G - 4525M).

The other case study homes did not appear to have adopted any one particular approach or 'rule' to managing walking frames. Instead there appeared to be a mixture of frames left with residents, and on occasion removed to one side to facilitate free movement. The question arises what might have differentiated the responses to the same apparent risk. On reflection the difference might relate more to the homes' respective experience of serious injury from the walking frames than from their predominant cultural perspective. The response might be an example of what has been termed the 'availability' heuristic (Hillison et al, 2007). Availability refers to the extent to which the memory of an event is *available* in your memory or experience of some event. For example, the manager of home H had arguably based her evaluation of the risk on the 'availability' of the serious accident where the resident had tripped over a frame and dislocated their hip. Conversely, the manager of home G may have demonstrated what Sunstein (2004: 16) terms the '*un*availability bias' where the home's *inexperience* of such an accident or event frames their subsequent actions. The extent, to which homes E and H subjugate the rights of the individual in preference to the avoidance of risk in this way, whilst questionable, was potentially a part of the contemporary risk management landscape. This proposition would also appear to fit with the idea of residents as an 'isolate' culture who were subjected to 'rules' designed to protect them from 'harm'.

8.1.2 Closed doors and fire precautions

A significant departure from the philosophy of the home as 'home' (Chapter 2) was perhaps the fact that in most of the case study homes the doors to different rooms, including the resident's own flat or bedroom were closed shut. The closure of doors

and windows was often stated as a matter of regulation or policy and was deemed non-negotiable. Parsloe (1999: 203) for example explains that: '*within residential care, the issue of risk is ever present; it may loom larger in day-to-day anxieties of workers and managers because of their responsibility to provide a 'safe' environment……...Fire doors.…..are an obvious example*'. The impact of closed fire doors might be experienced on two levels. First, they close the resident into a room or space, an experience that the older adult may not have been used to in their own home. Second, the doors themselves were usually heavy and difficult to negotiate.

Closed doors have long been a feature of institutions and the basis for this has often arisen from the need to divide a building into fire tight compartments in order to prevent the spread of smoke and flame. The fire at Rose Park Care Home in 2004 perhaps exemplifies the rationale behind the policy and explains why fire doors are an important safety feature: '*The deaths of 10 elderly people in the worst fire in Scotland for decades were last night blamed on the fact many of the victims were sleeping with their bedroom doors open*' (The Scotsman, February 2004).

The Fire Safety Reform Order 2006 makes care home providers responsible for completing a fire risk assessment of their premises. This includes identifying fire hazards, implementing suitable control measures and carrying out fire safety training for their staff. The implication of these regulations and subsequent responsibilities was most graphically illustrated in home D, a predominately individualistic home, where the home manager, Cath, had previously adopted an apparently 'laid back' attitude to the issue of leaving residents room doors open:

> "…….*a lot of the doors, well a few of the doors, during the night were propped open; because they didn't want the light on in the room, but they didn't want to be in the dark. So by having the door ajar at night would leave the landing light filtering into the room.*…." (Cath, manager home D - 659M).

The requirement to coldly identify the likely hazards and to evaluate the risk of fire appears, however, to have 'galvanised' Cath's attention. At once the implications of an enlightened policy of 'choice' were apparently relegated in favour of a policy of fire risk management where the 'choice' was taken away in favour of 'regulatory compliance':

> "……..*but when we did the fire, it's a no, no: that door has got to be shut, so when we had the residents' meeting, they all signed the risk assessment, that the doors were propped open during the night, and the families signed it to say that they agreed and to say that they were happy with that. But then I thought, that's not good enough now; it's got to stop, I'm responsible, if that fire goes through that zone those doors are open and I'm responsible for those people in those rooms. So we had to have a meeting and say, you can't have that door open any longer, you know, I've taken that choice away from them……..*" (Cath, manager home D - 659M).

Thus the option to have the bedroom door open was theoretically removed, and this was indeed the case in *all* of the case study homes, whether individual, egalitarian or hierarchical. The complexity and magnitude of closing 'bedroom doors' was obviously appreciated by many of the staff participants who readily acknowledged the practices of a lifetime, being balanced against what was seen as the safety of everyone. The right of the individual to have their bedroom door open was seen within the hierarchical home, home F, to be limited, by the 'rights' of the wider care home community to be protected from potential harm:

> "……..*when people have been used to living at home they leave their bedroom doors wide open; it's just the thing isn't it. It's getting past that and seeing the security for all of the other service users and getting a happy medium that suits everybody*" (Marie, senior care assistant home F - 2220SCA).

Most of the case study residents also appeared to accept that fire doors should be kept shut. There was, however, some evidence that such blanket policies were sometimes 'ignored' in favour of the resident's individually and informally negotiated choice, or perhaps their insistence that their room door be left open at night. During one interview Jane, a resident of home I, the largest corporate case study home confided that the night staff did allow her to have her door propped open at night:

> "*I do have my bedroom door open, they prop it open at night, but they're not supposed to*" (Jane, resident home I - 7235R).

Home I clearly occupied a hierarchical cultural frame, with an emphasis on regulatory compliance, and to this end it might be thought unusual that home staff disregarded company policy in this way. It could be argued that the provider, whilst having undertaken the risk assessment, had not informed the staff of the risk. Such a situation was identified and discussed in Chapter 4, where an investigation by the enforcement authorities found that local staff in a home, very similar to home I, had not been

instructed in the findings of the risk assessment (National Association for Safety in Care Services, 2009). From another perspective, however, the practice of leaving fire doors open might have related to the particular community of practice and local culture within the home. Hillison and Murray-Webster (2007: 66) suggest for example that '*in the arena of approaches to risk, it seems clear that a group can adopt a distinct risk attitude or chosen response to significant uncertainty*'.

Thus, it was possible that some staff had adopted the group risk heuristic, known as the '*risky-shift*'[37] (Hillison and Murray-Webster 2007: 67) where, despite regulatory protocols, the shift adopted their own guidelines. In effect they had decided that, in their experience, open doors were not hazardous, and importantly, there were no consequences for ignoring company policy. There was evidence from the home manager, Jill, to support this latter proposition, where despite her acknowledgment that fire doors should be closed, she nonetheless appeared reluctant to acknowledge this as a mandatory policy. Instead having the doors closed was described as an *ideal*:

> "……..*if they are insistent on not having it closed then we have to have it open, perhaps. But you know, you can't sort of say: well you're having it closed; you know you can't be that sort of authoritarian, but, ideally obviously bedroom doors should be closed*" (Jill, manager home I - 7239M).

This dissonance between written and 'agreed' corporate policy and local practice was arguably matched by the way that home based fire safety training was actually delivered. Fire safety training for all home based staff was undertaken by one of the visiting facilities managers rather than anyone who actually worked within the home. This dichotomy of health and safety and 'care' management could be seen as contrary to the spirit of the regulatory framework that seeks to engage managers at local level in making decisions that are appropriate to the local situation. It is possible to speculate that the apparent splitting of responsibilities in this way *might arguably* have allowed Jill to (perhaps unconsciously) regard the practical implementation of the training as falling outside her remit. Within the individualistic and egalitarian homes there was no

[37] The risky shift is likely to be mediated by Sunstein's (2004) '*un*availability bias' where those who take risks have no experience of the likely consequences of their actions.

such professional dichotomy and the home manager, generally, made, implemented and policed their own control measures[38].

From a corporate safety policy perspective the proprietor of home I had taken steps to try to ensure that resident bedroom doors would be kept closed by adopting what might be thought of as a typically hierarchical expedient. This had been achieved by instructing the home's handyperson to fit mechanical 'door-closers' onto every bedroom door. The fitting of these had however presented an additional potential for serious risk to individual residents within the home. Frail older adults could easily be knocked off-balance trying to open their door, or indeed as the door closed suddenly. It is interesting to reflect here that most of the communal doors within the home were actually held *open* electrically to facilitate the passage of residents with their frames. Such doors were fitted with special door closers[39] that automatically shut all of the fire doors upon activation of the fire alarm. The bedroom doors, of which there were many more, were however only fitted with a relatively inexpensive device to hold the doors *closed*. During one of the fieldwork visits to home I, the handyperson explained that he had personally received a lot of negative feedback from many residents and their relatives who disagreed with the policy. His response to them had been that he had carried out the work because it was a 'legal duty'. This situation again raises questions about the apparent risk management dichotomy that appeared to exist between proprietor and home manager within the hierarchical homes. Here decisions about safety were taken by senior managers who were remote from their implications. The availability of such professional health and safety support within these homes evidenced both a positive and negative influence upon their management of health and safety. It would also support Osborne and Zairi's (1997) contention that health and safety management was viewed as a *separate* issue of compliance, rather than being regarded as something that needed to be integrated into operational policies and procedures. The imposition of safety 'rules' by managers who are 'remote' from the home may prove unpopular and paradoxically may even create risk at local level:

> "*The bedroom doors, yes, one lady has objected to the way it springs shut on her, because if she's trying to go through with her Zimmer frame, the spring on the*

[38] Within home G and H this dynamic was likely to change with the introduction of a consultant's systems.

[39] Either an electro-magnetic device that holds the doors open or a device integral to the door closer that closes the door when the fire alarm sounds.

> *door is stronger than she is and she's said to me a couple of times: I can't open it, and I've gone with her, you know, to help her open the door. But I could see that being a real problem because she could be half way through one of these days and if she's not standing firmly and securely; if that door springs onto her, it could knock her off her feet I think. It is such a strong and heavy spring on that door, yes, that is one, I was thinking about that just the other day; that is one of the health and safety issues that are getting in the way of the residents actually. For the idea of protecting all of them in the case of a fire, in fact it is making daily life a lot worse for the ones that are mobile and can get to their own room and back*" (Penny, activities coordinator, home I - 7236AC).

8.1.3 Locked doors – protection or restraint

It could be argued that, under certain circumstances, the very independence or mobility of some residents may be regarded as a risk factor by managers and staff. Mobility combined with mental impairment is likely to increase the risk where the resident might have access to areas of the home deemed hazardous. Such concerns were indeed expressed across the spectrum of case study homes, where the frailty of some residents was felt to put them at risk if they were allowed to leave the confines of the home unaccompanied. It was generally apparent that movements out of the home and around the home were often monitored, especially within the larger hierarchical homes. Access to the kitchen, laundry and even the dining room and upper floors of the home might all be restricted on the grounds of health and safety. The management of such risk within some of the case study homes made use of locked or alarmed doors as a means of 'containing' residents in what were deemed to be safe, supervised areas of the home. Within the hierarchical homes, E and I, for example some of the doors were either locked or alarmed:

> "*So the first thing that we have is that we have to make sure that all of our doors are alarmed so that they cannot then go from the premises without us knowing that they have gone, especially in the early days when they are not quite sure about their environment*" (Ruth, administrator, home E - 2715A).

Home E and I also used keypad locks[40] to control access and egress to different parts of the home. A CSCI inspection report for home E highlighted this particular practice and the consequent denial of resident choice:

> "*Access for service users to various parts of the building and the grounds is limited, as doors are kept locked with a keypad system. The manager reported*

[40] The keypad lock was opened by entering the appropriate combination onto a keypad.

> *that those service users who are able to access these areas without supervision know the keypad number. It is recommended that details about access and the level of supervision required are recorded on the care plans*" (Inspection report home E - 103AB).

Access to parts of the building regarded as unsafe within home I was controlled or restricted by the use of 'combination' door locks to various areas. This included the main (front and back) doors, corridors and stair wells. Whilst this initiative reduced the likelihood of a confused resident being placed 'at risk' from accessing an area deemed to be hazardous, it also had the effect of preventing egress in the event of an emergency. This fact was amply demonstrated during a fieldwork visit to the home in the company of one of the facilities managers. The home's laundry was located on the first floor adjacent to a stair way that acted as an emergency exit in the event of a fire. The handyperson in accordance with the provider's guidance and with the approval of the home manager had fitted a 'combination' keypad to this door; the keypad was not however linked to the fire alarm system[41]. Theoretically all staff should have known the combination to the door. However, the laundry assistant on duty on the day of the visit expressed concern that, in the event of a fire, she might become trapped if she forgot the combination.

The case study participant transcripts provide an interesting insight into the contradictions that were associated with such a regime. Locking doors was acknowledged as an '*issue*', but it appears to be deemed justifiable because it was 'a *safety issue*', that relatives apparently approved of. Indeed the role of relatives in mediating the care home's approach to risk should not be underestimated (see for example Parsloe, 1999 and Kemshall et al, 1997). All residents were apparently included in home E's assessment, such that *all* residents were equally affected by it:

> "*Well you know, it, we've often thought is it an issue, but it's a safety issue really and I think the relatives are quite happy with it, I mean it's not happened, you know, because we're watching everything, you know, if the alarm sounds. I think if we were to think, well it's a nice day let's leave the door open, they'd wander out into the garden, think I wonder what's out there and they'd be gone. So that is a big safety thing, you know. And it's a case of well do you leave it open and let them have the rights that they are allowed to go out; or do you or do you close it and keep them completely safe; so in that event we close it and we take them out*

[41] If the keypad had been linked to the fire alarm system – the door would have opened in the event of a fire thus presenting no 'physical' risk.

> *ourselves for a little walk if they want to go*" (Karen, care assistant home E - 2716CA).

Evidence derived from both CSCI inspection reports and from Mo and Jane (residents at home E and I respectively) would suggest that staffing levels might actually preclude such supervised trips out of the home. Thus residents *may* find that they were kept within the confines of the building, unless staff could be spared to supervise them, even within the home's relatively enclosed garden:

> "*As I say, we can't leave residents outside with nobody there, yes; you just don't know what they are doing outside; it's quite dangerous and if there is a resident out there in the garden we always have somebody out there to supervise*" (Hazel, senior care assistant, home I - 7238SNCA).

Such practices inevitably restricted freedom of movement and choice for some residents, which moved away from Bland's (2005) 'hotel' model where the residents' enjoy the privileges of guests with free movement in communal areas whilst enjoying privacy and security in their own rooms.

> "……. *I mean we've never let a resident intentionally go upstairs or anything like that, so we know the steps to take to prevent things like that*" (Karen, care assistant home E - 2716CA).

Cath, the manager of the predominately individualistic home D, however, regarded 'locking' doors, in particular the front door, as a form of restraint. Indeed she went further by suggesting that such practice, rather than being implemented as part of the home's legal responsibility to manage risk, was 'against the law'. Cath was also the only home manager to acknowledge the Mental Capacity Act 2005, with its associated Deprivation of Liberty safeguards, introduced through the Mental Health Act in July 2007. These safeguards were designed to ensure people can be given the care they need in the least restrictive regimes. At the same time however, Cath acknowledged that leaving the home was a *big risk*:

> "……*So it's like, the biggest risk is how do you stop them going out on their own when the door is unlocked, because you can't lock the door, because it's against the law, because it's a form of restraint*" (Cath, manager home D – 659M).

It could be argued that the size and layout of home D made it easier for staff to 'supervise' the movement of the residents. There was, however, some evidence within

one of the resident transcripts (Jim – 6512R) that going out unaccompanied was still discouraged by home D. Kemshall and Pritchard (1997: 98), point out that according to Counsel and Care (1992) and others: '*physical restraint to circulate within and beyond buildings*' and '*supervision and observation*' might indeed be regarded as forms of restraint. For residents who were able to negotiate personal resources in line with the findings discussed in Chapter 7, they were 'allowed' to leave the home unaccompanied, provided that they informed staff before they did so.

8.1.4 The choice of bathwater temperature

The control of bathwater temperatures was a feature within all of the case study homes. This arguably follows guidance from the Health and Safety Executive that 'hot' water, exceeding a temperature 43°C is a scalding hazard and the National Minimum Standards requirement to fit thermostatic mixer valves. It is interesting to note here that in 2004, the year that CSCI began to regulate care homes, Brindle and Carvel (2004) reported in the Guardian that '*the Commission for Social Care Inspection says that it is committed to involving users of services and to taking a 'proportionate' approach*'. A spokeswoman for CSCI was reported to have said that: '*while care homes were advised to keep bath water no hotter than 43°C, to avoid scalding, they were urged to accommodate resident wishes to vary this*'. Indeed, the Chairman of the Better Regulation Task Force suggested in 2004 that: '*Prescriptive regulation is taking away people's choices; even the temperature of bath water is not a personal choice for someone who lives in a care home*' (Arculus, 2004). In fact it is the Care Home Regulations 2001 and associated National Minimum Standards (2006) that appear to have prescribed the temperature of the bathwater, specifically Standard 25.8 on page 26: '*To prevent risks from scalding, pre-set valves of a type unaffected by changes in water pressure and which have fail safe devices are fitted locally to provide water close to 43°C*'.

However, Brindle and Carvel were quick to highlight that '*following previous scalding incidents, the Commission was under pressure to enforce a strict maximum temperature*' (2004). Thus, despite the rhetoric of choice, involvement and '*accommodating resident wishes*' all of the case study homes had, either by choice or

pressure from their local CSCI inspector, fitted mixer valves. Cath the manager of the small private home (home D), illustrates the impact of this decision on her home:

> "*Oh it is a nightmare that was when that happened……I mean, the amount of sort of backlash from it, from the staff, from the service users, from the families, it was like I was cutting back; and I said you know, there's nothing that I can do, you know, at the end of the day it's a regulation, it's part and parcel of what is in the home*" (Manager of home D - 659M).

Strictly speaking, Cath's only legal obligation under health and safety law, with respect to any of the hazards discussed so far in this Chapter, was to undertake a *suitable and sufficient* assessment of the risks. Only then, and where the risk assessment suggests that engineering controls are required, should they be used (HSE guidance, LAC 79/5). From a theoretical perspective the 'risk assessment' should involve those affected by decisions made about the use of control measures. However, as suggested in Chapter 7, this did not appear to have been the case. The perception that control measures were mandatory appeared to transcend any notion of choice or consultation. It could be argued that in this respect the National Minimum Standards are an example of 'institutional street level bureaucracy' where standards were drafted in response to perceived hazards and perceived legal requirements.

8.2 The management of risk at the individual level – the care plan

Regulation 15 of the Care Homes Regulations 2001, stipulates that the care home manager (the 'registered person') must consult with the resident or their representative and prepare a written plan as to how their health and welfare needs are to be met. The management of hazards and risks is arguably *part* of such professional care practice (Taylor, 2006), and in this respect the written 'care plan' also provides a vehicle to document the management of individual risk.

The care plan might thus be thought of as the individual risk assessment, examining all of the risks that are perceived to be associated with meeting the resident's wants and needs safely. The word '*safely*' in this context includes the safety of both the resident and others who are affected by their care plan. This issue will be touched upon later in this section, where the importance of involving *all staff* in the management of individual risk will be discussed. All of the case study homes were able to evidence risk oriented

care plans, for example, Julie the owner and manager of home C suggests that the process of risk assessment was integral to her own care plan documentation:

> "*When the service user first comes we have quite a few risk assessments to do with them and a lot are around moving and handling and that's sort of thing…….and if there is a problem, then we put it into a care plan scenario*" (Julie, manager home C – 516M).

Cath at home D indicated that her care plans were afforded a relatively high priority as part of the CSCI inspection process whereby inspectors checked: "*whether you've got your risk, your assessments done and your reviews done*" (Cath, manager home D – 659M).

One of the enabling aspects of a 'hierarchical' orientation is the likely existence of clear procedural guidelines and documentation for staff to follow. To that end homes B, E, F and I could demonstrate comprehensive documented care planning systems. However, there was also evidence within the CSCI inspection reports for home 'E' and 'I' to suggest that care plans were not always completed in accordance with the required standard, and may not be 'working' documents, agreed by residents and used by staff. Within home I for example the inspector identifies the importance of the care plan as a *working tool* for risk management, whose efficacy depends on the plan being kept up to date and being used by carers as intended:

> **"***The company has produced a comprehensive care-planning framework to comply with the standards. Care plans examined by the inspectors provide valuable recorded information on how to meet the needs of the individual service user. However care staff spoken with by the inspector was unaware of the content recorded in service users' plans of care and were also unable to report to the inspector specific needs of service users chosen for case tracking*" (CSCI inspection report, home I - 304JM).

Whilst home B could also evidence comprehensive, care plans with documented risk assessments and reviews, there was evidence within one of the CSCI inspection reports that the assessed needs of residents were arguably not always aligned with the organised activities of the home:

> "*The lack of attendance at [some planned activities] indicates a possible mismatch between what is provided and what the residents are able to do*" (Inspection report home B – 107T).

These finding are arguably significant in the context of an apparent dissonance between the written plans of care and the practical activities of the home. This may be particularly significant with respect to the home's legal obligation to protect 'those at work or who may be affected by work' from hazards. In addition to meeting the resident's individual needs, the plan of care is effectively the tool that the home uses to identify any hazards that the resident may indeed present to others. Typical examples might include the safe moving and handling or infection control measures. There was further evidence to support the assertion that not everyone was fully aware of the safety critical contents of the care plans. For example, the activities coordinator, at home I, Penny, was actively engaged with residents within the home, however, she had not been made aware of the infection control precautions that should have been communicated to everyone coming into contact with the resident concerned:

> "*C. Diff. yes, I mean I did go to visit a resident in his room and it was one of the cleaners that just by and by said to me: [Penny], put gloves on when you go in there, but I hadn't been told that this resident had C. Diff.*" (Penny, activities coordinator, home I - 7236AC).

The inspection report data also supported evidence from the fieldwork that residents were often not necessarily aware of their care plan and their right of ownership. This was a general theme deriving from most of the case study homes, where the residents appeared to have little or no knowledge and no expectations about their written plan of care. The managers in some of the case study homes had evidently tried to address the issue of holding evidence of resident involvement in care planning by devising a pro-forma. However, according to one CSCI report for home I, the inspector was subsequently unable to confirm the *actual* involvement of residents in the process:

> "*The inspector evidenced a pro-forma that has been devised by the home to obtain service users or relatives signature to confirm they have been included in the care planning process but the inspector was unable to evidence there[sic] subsequent involvement*" (CSCI inspection report, home I - 104JL).

Mike the manager of the local authority home, home F, appeared to sum up the situation for all of the case study homes when he reflected that where risk assessments did take place, they rarely involved the resident: "……..*risk assessing is something you* ***do*** *to somebody, not something you do* ***with*** *somebody, and that's where it needs to change I think*" (Mike, manager home F – 2219M).

Thus it could be argued that the regulatory expedient to evidence signed documentation sits alongside or apart from the actual, day to day, and practical process of service delivery and 'care'. At the time of the fieldwork the predominantly egalitarian home H and the predominantly hierarchical home E, had both introduced new documented care planning systems. Within home E this was apparently as the result of pressure from CSCI who had been critical of the home's original system. Whilst the new documentation provided a detailed biographical picture of the residents and their presenting circumstances, their agreed care needs and how they were to be met were not always apparent. This appeared to have been CSCI's criticism of the home's 'old' care planning system where it was not always apparent what the resident actually required from their plan. Instead 'care' appeared to be delivered in accordance with a doctrine of '*common sense*' and '*rules*'. The documentation was arguably a 'ritual' of compliance rather than a working 'plan'. An insight into the apparent 'practice' of care planning derived from the interview transcript for one of the keyworkers at home E. Karen, a care assistant and keyworker appeared to regard herself as the *owner* of the care plan rather than the resident. Instead of describing a process of negotiation with the resident, she describes *her* actions and *her* decisions:

> "*….you might decide that you're not going to use soap..... on this resident anymore, I want to use Diprobase or something like that because of the dry skin and I'll put a little story in there and I'll put refer to care plan*" (Karen, care assistant, home E - 2716CA).

This would appear to support Mike's (2219M) contention that the process of 'risk assessment' is something that is 'done to you' where the resident is regarded as a passive recipient of 'care'. One CSCI inspector, for example, provided an insight into the apparent degree to which resident's 'choice' with respect to their medical care was respected within home E: "*On one occasion the manager failed to respond to the request of a service user to see a doctor following a fall*" (CSCI inspection report, home E - 104E). These findings support Mallinson's (1996) view that the practice of care planning is quite different from the theory and supports the argument (Chapter 7) that the residents occupy an isolate cultural orientation. From the perspective of health and safety risk, the care plan provides a vehicle for the identification of individual risk, however, the findings might also suggest that 'plans' were not always translated into practice and may not always correlate with the wider (safety) activities of the home.

8.3 'Mapping' regulation and risk onto the grid and group typology

The theoretical considerations discussed in chapter 4 suggest that there may be a direct correlation between the home's predominant cultural orientation and its approach to regulation and managing risk. For example a predominantly 'high grid' and 'high group' orientation might be theorised as showing compliance with the regulatory framework by the adoption and implementation of good systems for the management of health and safety risk. Conversely, a predominantly low grid and group care home might be expected to place more emphasis on resident choice and less on regulatory compliance and risk oriented systems. Chapter 6 suggested that the case study homes were, very broadly, differentiated along these lines and discussed the macroscopic 'cultural' differences that allowed the application of the grid, group typology. The 'hierarchical' homes were for example characterised by management infrastructures that included dedicated in-house health and safety managers and bespoke, demonstrable, written safety oriented policies, procedures and systems. The smaller 'individualistic' and 'egalitarian' homes with localised, non-specialist, management, were however expected to develop their own systems. Under these circumstances the resulting approaches to risk were generally less formal and relied upon the home manager's expertise and motivation to devise the necessary policies, procedures and training.

At the level of detail however, these very broad characterisations do not appear to explain the full range of empirical observations and how they map onto the grid and group orientation of each case study home. The transcripts from the case study home managers suggest, for example, that all were equally aware of the regulatory framework and its implications for their practice. All had responded to it by adopting or implementing broadly similar control measures. Table 12 shows how some of these risk control measures map across the range of case study homes. What is immediately obvious from the table is the broad similarity between the different homes in terms of their use of control measures. These broad similarities in approach arguably correlate with the discussion in Chapter 7 that the residents were likely to occupy an 'isolate' cultural orientation as a result of such regulatory restrictions. Even the very small case study home, home C, which most closely approximated a 'domestic' setting, demonstrated awareness of the regulatory framework and had adopted a range of risk oriented policies. This perhaps resonates with Peace and Holland's observations

whereby: *'Falling as they do somewhere between domestic homes and formal care settings, small homes are nevertheless in danger of replicating the controlling environment of those larger residential settings where authentic autonomy may be lost. They are in many ways a hybrid with the potential for the best and worst of both worlds*' (2001: 408).

Thus, the grid and group typology does not appear, in this instance, to offer a complete 'explanation' of how regulated health and safety risk is managed across the range of case study homes. It does, however offer a useful 'lens' through which to observe the homes (Evans, 2007, Chapter 4) and suggests a useful classification that subsequently highlights the differences and the similarities in approach. What is apparent, however, is the management of health and safety risk appears to contribute towards the loss of '*authentic autonomy*'.

Home	**Window locks**	**Closed bedroom doors**	**Restricted access & egress**	**Control of hot water**	**Safety 'rules'**	**Risk based care plans**
B **Hierarchical**	Yes to all windows	Yes	Locked front door	Yes, via mixer taps	Yes, e.g. no rugs	Yes, corporate system
C **Individual**	Generally no. Some windows screwed shut	Yes, although doors were seen to be open	Locked front door and gate	Yes, via mixer taps	Yes, e.g. no access to kitchen, no smoking	Yes, own system devised by manager
D **Individual**	Yes to all upstairs windows	Yes	Front door generally unlocked	Yes, via mixer taps	Yes, e.g. can't go outside gate, no smoking	Yes, own system devised by manager
E **Hierarchical**	Yes to all windows	Yes	Yes via keypad control	Yes, via mixer taps	Yes, e.g. walking frames	Yes, new corporate system
F **Hierarchical**	Yes to all windows	Yes	Locked doors	Yes, via mixer taps	Yes, e.g. no smoking, supervised activities	Yes, local authority system
G **Egalitarian**	Yes to all windows	Yes	Locked front door	Yes, via mixer taps	Yes, e.g. kettles in bedrooms	Yes, in transition to consultant system
H **Egalitarian**	Yes to all upstairs windows	Yes	Locked front door	Yes, via mixer taps	Yes, e.g. walking frames	Yes, system imposed by consultancy
I **Hierarchical**	Yes to all windows	Yes	Yes via keypad control	Yes, via mixer taps	Yes, e.g. resident supervised in garden	Yes, corporate system

Table 12: *Mapping risk management across the case study homes*

The next section will look at the wider 'systemic' aspects of the conceptual model Figure 10, Chapter 4, in an attempt to develop an explanation for some of the risk based findings discussed earlier on in this chapter.

8.4 The risk management paradox – resources, emergence and metastability

One of the most interesting and potentially significant findings of the empirical research has been insights into how home managers conceptualise *care* (which might on occasion be argued as synonymous with *control*) in terms of 'rules' that were designed to 'prevent' harm to *vulnerable* residents. As discussed, such 'rules' may derive from heuristics that influence the home's interpretation and application of health and safety law. Thus heuristics might be thought of as interacting with the 'Grid' component of the home's cultural orientation to bring about a particular 'rule' based community of practice.

These 'rules' or controls form part of a wider debate about how the perceived legal expedient to prevent harm is done at the expense of *choice*. Thus choice becomes a qualified concept where choice is defined within the limits of the 'law'. Indeed whilst carers might emphasise the physical and legal domains of risk management, they may tend to ignore the biographical domains of risk such as loss of self-identity (Clarke, 2000). How for example might the older adult begin to perceive themselves in the context of a regime that constantly treats them as vulnerable and apparently unable to make a decision? This chapter has also shown that some of the case study homes were seen to adopt risk control measures or 'rules' that, *paradoxically*, appeared to introduce the possibility for other, sometimes potentially more serious risks that home staff did not *appear* to recognise or appreciate. The question then arises – is there indeed such a paradox and why might it exist?

8.4.1 A systems perspective

Care homes represent complex systems comprising a large number of parts. These include the residents and their relatives, the management function, care, domestic and maintenance staff. Even the home's written documentation (Penchas, 2004), the

building, furniture and equipment that make up the home can be considered as part of the 'system' (Chalmers, 2002). Homes like homes B, E, F and I were also part of a larger organisational system that includes regional and area management functions that form an even more complex hierarchical cultural system.

The interaction between these different parts can be thought of as resulting in the predictable emergence of service outcomes. Within home I for example, the facilities management function was designed to ensure suitable and safe premises where domestic and hotel services contributed to meeting the needs of older and often frail residents. Systems theorists call these the *functional* emergent properties that appear when all the parts of a system work together to achieve some objective. The interrelationships and interaction between these different functions is however complex and *not always predictable*. On occasion the system might give rise to outcomes that were not, or could not, necessarily have been anticipated by looking at one particular function in isolation. For example, the facilities management function within home I might be thought of as applying a 'legal-compliance' model to premises management. However, as discussed in chapter 4, the theoretical framework, the application of command law within the complex social world of the care home may give rise to implementation failure (Moran, 2002). Thus, 'compliance' decisions made by 'head-office' to implement particular health and safety control measures may not be successful at 'street level'. System theorists call these outcomes *non-functional* emergent properties.

These *emergent properties* (Checkland, 1981) cannot be attributed to any specific part of the care home system. Rather, they only emerge once the system components have been integrated. An event might therefore be deemed emergent if it appears to arise spontaneously and without any apparent, or predictable, connection to the elements of the system with which it is connected. This chapter cannot claim to show any real examples of emergence within the case study homes. It could however be argued that the regulatory system itself, which is clearly part of the system, did demonstrate examples of emergence. For example, the Woolf civil justice reforms have given rise to the '*where there's blame there's a claim*' 'compensation' culture (SHP, 2010) that appeared to be linked with much of the risk averse practice displayed by proprietors, home managers and regulators. This was particularly evidenced within the transcripts

of Cath, the owner and manager of home D and Bob the manager of home E. A further such example that was discussed in Chapter 3, The Regulatory Framework, might include the very way that the National Minimum Standards, particularly Standard 38, have interpreted and translated (into 'minimum standards'), the requirements of health and safety law. This has arguably resulted in significant 'street level bureaucracy' in terms of how health and safety law has been applied in a risk averse manner. The expedient to demonstrate regulatory compliance has also resulted in a proliferation of documentation, such as policies, procedures and well written plans of care. Some of these documents were shown to exist as 'rituals' of compliance (Braithwaite, 1993, Chapter 4) which may not have delivered the anticipated 'safe' outcomes. The fieldwork nonetheless identified examples where decision makers were apparently 'unaware' of situations where the interaction between different elements within (or outside) the home had given rise to the *potential* for an accident. The next section will briefly discuss a theoretical idea that might help to illustrate this finding.

8.4.2 The apparent paradox of risk control and risk creation

A significant finding of the empirical research that has been discussed in this chapter was that some of the risk management strategies that the homes employed appeared to themselves to give rise to the potential for harm. A situation that appears to give rise to the potential for harm, yet is apparently unrecognised, might be explained by applying the theoretical idea of meta-balance or meta-stability[42] discussed in chapter 4. Meta-balance is not an example of emergence, but it is part of a process that on one level appears to be an ordered system whilst on another contains 'unstable' elements. A system that is in meta-balance can thus be viewed from two different perspectives. From the global perspective of the home's proprietor, management and staff, the system seems to be *stable and ordered*. The system *appears* to deliver the outcomes that are expected, for example, an activity is completed without apparent harm to anyone. On the level of detail however, the system is *out of balance* because it contains elements that, on closer scrutiny, are potentially unsafe under particular circumstances. This idea can be illustrated with reference to one of the examples discussed earlier on. In this

[42] 'Meta' derives from the Greek meaning *beyond*, *after*, or *adjacent* to, it is a prefix indicating an abstraction or another concept. Meta-stability is therefore literally *beyond* or *adjacent* to a *stable* state.

example from homes H and I, the residents sat down to eat and their walking frames were then removed by staff to prevent other residents from tripping over them. Residents completed their meal, their walking frames were returned and they left the dining room. As a result of these measures no-one had an accident relating to tripping over a walking frame – the hazard had been removed.

A system is in a metastable state when it is not changing with time, yet is *potentially* unstable, i.e. it is the ability of a situation that is not in equilibrium to persist for some period of time. Equilibrium in this context refers to the balance of rights, risks and responsibilities that might be thought to exist within any social situation. Within a social system rights afforded to an individual are finely balanced within a regulatory regime. The arbitrary removal or restriction of rights takes the system out of balance. Returning then to the walking frames, the act of removing them also removed the resident's right to determine exactly when they wanted to leave the table. They must first ask for their frame to be returned, if they choose not to wait, they are placed at an increased risk of falling because they do not have their frames for support. Thus at the level of detail the system is likely to be out of balance or *metastable*. Even though the system *appears* to operate normally over quite some time – on the balance of probabilities one resident, one day, will choose to leave the table without their walking frame and will fall as a result.

Thus, in a 'rule' based culture, the rule transcends any concepts of rights and obfuscates any consideration that the rule itself, might, cause harm. The hazard or risk is therefore unlikely to be recognised. The metastable state may be considered the period between a hazard being created and that hazard either causing an accident, being recognised by staff or both. In addition to the examples discussed in this chapter, there were other examples of potential 'metastable states' discussed within other chapters. One notable example derived from measures designed to prevent residents from falling out of their bedroom window.

Generally some providers and regulators appeared to apply a 'ritual' or 'rule' that all windows were fitted with a restrictor to prevent the window from opening more than 10cm. Indeed all but one of the case study homes had either fitted window restrictors or planned to do so. Such controls are not in themselves a *regulatory* requirement whereas

undertaking an assessment of the risk is. However, guiding standards have effectively persuaded regulators and providers to adopt these control measures *irrespective* of any assessment or local choice. The choice in this case relates to the resident's ability to choose to safely open their window on a hot day. For this reason the owner and manager of the small case study home had decided not to fit window restrictors despite having been told by CSCI that the home *must* do so:

> "……..*But for instance I haven't got window restrainers on, which CSCI told me I had to have on, but I said I wasn't going to do that*" (Julie, manager home C – 516M).

What is interesting about the apparent 'rule' to fit restrictors is that it appeared to ignore the closely related risk posed by the integrity of the glazing itself. It could be argued that the windows in many of the older case study homes were 'unsafe' in terms of the panes of glass that were frequently in evidence. For example, the glass in some of the older homes was sometimes already cracked or of leaded stained glass construction. In one of the homes, for example, the CSCI inspector had noted that: "*the stained glass window at the top of the stairs has not been fitted with a restrictor*". Whilst this 'advice' was clearly *relevant*, it ignored the equally significant hazard posed by the leaded / stained glass itself, and indeed apparently did not question the home's legal responsibility to undertake an assessment of the risks posed by this glass[43]. Thus, the application of a window restrictor would not entirely remove the risk of someone falling through the fragile pane. It could for example be argued that, given the 'rule' requiring residents to keep their bedroom shut, someone may try hard to open their window, and in doing so may indeed fall. Whilst there might be a belief that an officially sanctioned control measure was in place, the reality was that the hazard and subsequent risk remained present in a *dormant* or *metastable* state. A resident might just as easily fall through a pane of 'flimsy' glass as through a fully open window. A key informant who worked for a large provider organisation (not one of the case study homes) actually related a similar incident. In her example, a resident had fallen downstairs and in doing so had tumbled through a 'Georgian' wired glass door panel sustaining serious injury. This example is not intended as a critique of the *reasonableness* of protecting vulnerable people from falls by using restrictors. However, it is intended to highlight

[43] Regulation 14 of the Workplace Health Safety and Welfare Regulations 1992: Regulation 14(a): Every window (as deemed necessary by an assessment of the risk)……*shall be of safety material or be protected against breakage of the transparent or translucent material*.

that the *ritualistic* use of control measures in the absence of a suitable and sufficient assessment of the risks, will not necessarily afford protection.

8.5 Conclusion

This chapter does not set out to argue that proper risk control measures are in any way inappropriate. Indeed vulnerable older adults do need to be protected from the identifiable hazards that exist in care homes by means that afford real protection without unreasonably compromising rights or introducing additional risks. Gilbert (2002: 189 in Scourfield 2007: 117) suggests: '*policies devoted entirely to cultivating independence and private responsibility leave little ground for a life of honourable dependence*'.

The example scenarios discussed in this chapter all have at least three common characteristics. *First*, they relate to 'rituals or rules' designed to control the perceived risk of harm arising from within the home; *second*, there was often little evidence that a suitable and sufficient assessment of the risks had taken place in order to inform subsequent control measures; and *third*, the measures taken appeared to give rise to the possibility of consequences that had not necessarily been predicted in the form of additional 'hidden' risks.

Within the homes there appeared to be a management dichotomy that differentiated person and premises related risk and thus techno-scientific and socio-cultural perspectives on risk. Ideally the assessment of risk should consider the *interaction* between person and premises i.e. how the person behaves *within* the premises and how the premises, which include the fabric of the building, furniture, fixtures and fittings within it, impact upon the resident. In other words risks and their assessment must be integrated and correlated (Chapman, 2006). Within the case study homes the 'premises' aspects of the home's management were perceived to be the least well integrated into the local management function. This was especially evident where strategic decisions were taken by managers who were external to the home, for example by professionals within larger provider organisations. Homes were often expected to work within a techno-scientific paradigm, comprising laws and control measures, viewed through a localised socio-cultural lens. It was therefore evident that controls employed 'ritualistically' by proprietors were not necessarily applied appropriately at local level.

The chapter discussed whether there was a clear, demonstrable link between the management of health and safety risk and the cultural orientation of the case study homes - discussed in Chapter 6. It was argued that such a link was not immediately obvious given that key risk control measures that impacted upon the residents' experience of their home appeared to apply more or less equally across the range of case study homes. The 'isolationist' effects of the regulated management of risk appear to arise from a systemic 'protectionist' agenda, arguably deriving from a wide interpretation of the regulatory framework that regards older adults as in need of protection from harm (Chapter 3). It has also been argued that this agenda might be reflected in key aspects of the National Minimum Standards, such as Standard 38, 'Safe working practice'. This in turn is likely to impact upon the cultural orientation of the homes by emphasising regulatory compliance and risk oriented management, at the expense of their own unique cultural identity. This 'systemic' perspective would appear to resonate with the conceptual framework, Figure 10 in Chapter 4, which places the cultural orientation of the home within a systems framework that acknowledges the social diversity and complexity of the mixed economy of care.

The chapter concluded by arguing that the interpretation of the regulatory framework in terms of control measures designed to eliminate risk can give rise to the possibility of what might be termed '*metastable*' states. These states can be theorised on two levels. On a superficial level the 'control measures' can be seen to work, as the risk appears to have been controlled. On the level of detail however, the control measure can be seen to have reduced choice and paradoxically to have introduced additional risks. The idea of the metastable state would thus appear to have a practical application in terms of its potential for persuading providers and home managers to consider their management of health and safety risks from all perspectives, including how it might impact on choice and the likelihood of possible 'institutional' outcomes.

Chapter 9 – Conclusion

9.0 Introduction

This thesis is concerned with the role played by health and safety legislation and how it is interpreted and applied by providers, home managers and their staff in shaping the experience of older adults living in residential homes. The thesis will conclude by looking at the key findings, their implications and therefore the extent to which the research design and implementation has addressed the research aims and questions. The aims of this thesis have been threefold. The first aim was to explore how safety legislation is applied within care homes for older adults and to evaluate which values tended to dominate. The second aim was to explore providers' and residents' perceptions and experiences of safety legislation in terms of their relationship with independence and choice. The third aim was to evaluate the extent to which the separate regulators of health, safety and care promote an integrated, enlightened and seamless approach to service delivery. Six research questions derive from these aims which were subsequently used to guide and to operationalise the research:

1. What mechanisms drive the interpretation and implementation of the health and safety regulatory framework in care homes for older adults?
2. Are there inherent contradictions within the regulatory framework that confuse managers and lead to the paradox of risk averse practice whilst failing to apply important control measures?
3. What role does organisational and professional culture play in the interpretation and management of risk in care homes for older adults?
4. Are current processes of risk assessment and management appropriate?
5. To what extent are 'homely values' allowed to flourish in the regulated domain of the care home?
6. To what extent are residents empowered to influence the management of the home and its safe working practices?

The research data to address the research aims and answer these questions was gathered from an information oriented sample of eight case study homes (Chapter 3). It comprised full verbatim transcripts, field-notes and care home inspection reports. The

process of analysing these sources involved the identification of around 180 general themes within the data. This analysis produced a 'spiders-web' of overlapping, interrelated material that was gradually grouped in accordance with around 13 more specific themes. These included, for example, keeping people safe, risk, its communication and management, policies, procedures, guidance and training, impact of the workplace, care planning and keyworking, blame and accidents.

These very broad themes derived from the primary analysis were gradually refined by secondary and tertiary analyses so that they could be amalgamated and refined into categories of similar evidence. This evidence was then related to the principal themes deriving from the literature and from the theoretical considerations discussed in chapter 4. The resulting broad themes of: home, care, risk, and organisational management characteristics were used in two ways: first to classify the homes according to their likely cultural orientation (Chapter 6). Second the evidence was used to elucidate how care home regulation and health and safety risk impacted upon the case study homes (Chapters 7 and 8). This process was both iterative and recursive whereby the analysis was informed by the literature and literature was used to try and make sense of the apparent complexity and contradictions arising from the data. For example, it was theorised that it *might* be possible to reconcile the 'classification' of a particular home with the thematic outcomes. Chapters 7 and 8 however demonstrated anomalies suggesting that such reconciliation had not been entirely possible for reasons that will be discussed again later on in this chapter.

The thesis has not set out with the intention of being critical of health and safety law, or the overall appropriateness of the risk control measures advocated by the regulatory framework, the safety literature or indeed those implemented within the case study homes. The thesis instead sets out to highlight how those who live and work within care homes have been affected by health and safety law and the consequences of implementation decisions across a range of different homes.

Health and safety law and the regulatory framework controlling care homes were shown in Chapter 3 to have evolved as separate entities, each with its own unique background and traditions. It was argued that whilst the Health and Safety at Work etc Act 1974 has applied to residential care homes since its inception, it was the advent of the Care

Standards Act 2000 that had the effect of bringing the health and safety agenda to the forefront of care home management thinking. In some respects this has been a good thing, for example, it would be wrong to suggest that potentially vulnerable people should be exposed to unsafe situations as the result of ignorance of the law. However, the interpretation of health and safety in terms of the 'rule' based control of risk at the expense of informed choice is questionable, especially when the 'rule' becomes a 'ritual' of regulatory compliance. Whilst such rules and rituals might be thought to address the letter of the law, they do not always address its spirit, with the consequence that *risk management* can overshadow a reasoned approach to *risk assessment*. Where risk assessment did take place, there was some evidence that it was done informally and was driven by 'rules of thumb' or heuristics that modelled what were perceived to be pre-determined 'safe' outcomes (Chapter 8).

In order to make sense of the complexity of the socio-legal context, the care home was conceptualised as comprising a number of different components operating as part of a culturally mediated system. The system was seen to include both internal and external components. For example, the internal components largely comprised the residents, staff, documentation and premises. The home's written documentation (Penchas, 2004), was seen as reflecting the provider's interpretation of the regulatory framework. The building, furniture and equipment (Chalmers, 2002), reflected the practical implementation of health and safety law in terms of the layout of the home, the type of furniture used and facilities for residents. The external components were seen to include regional management structures, local regulators and purchasers[44]. The residents, provider, manager and staff were seen as powerful cultural mediators who largely determined the impact of the regulatory framework by setting the level that risk constrained or enabled the activities of those who lived and worked within the home.

The chapter is structured in accordance with the following broad themes which are felt to reflect the principal findings and areas where further work may develop understanding. Part one will explore the idea of care home culture and the extent to which the the residents are an empowered or 'isolate' group. Part two will explore the degree to which the regulatory framework has succeeded in pressing home the health

[44] In this context a purchaser could be the local authority, a relative or legal representative.

and safety agenda, its likely consequences and its potential for emergence and metastability. Part three will explore rituals of regulatory compliance and the role of the home manager. Finally, Part four will briefly discuss the implications of findings for practice, policy and future research in the context of care home accidents and training.

9.1 Care home culture

The grid and group typology of Cultural Theory (CT) (Douglas and Wildavsky, 1982 and Thompson et al, 1990) was thought to provide an intuitive fit between the imposition of regulations (Grid) and their adoption, translation and application (Group) at local level. From a theoretical perspective the typology demonstrated the potential to illuminate the culturally mediated application of health and safety law across the case study homes.

The case study homes were nominally shown to exhibit a range of cultural orientations using the typology. For example, the smaller private homes appeared to exhibit the weak grid and group orientation of 'individualistic' cultures. The corporate, local authority and larger voluntary sector homes appeared to exhibit the strong grid and group characteristics of a 'hierarchical' culture, whilst the smaller voluntary sector homes appeared to exhibit the predominantly 'low grid' and 'high group' characteristics of an 'egalitarian' cultural orientation. However, there was ample evidence that the regulatory framework had begun to inextricably shift the apparent 'low grid' orientation of these homes towards the higher grid environments characterised by health and safety risk-oriented policies, procedures and systems of compliance. This finding was indeed seen to be the case within homes D and particularly within homes G and H who were gradually adopting more formalised systems of compliance. This suggests the culturally coercive effect of the regulatory framework characterised by a corrosion of the 'individualistic' and the 'egalitarian' effects that might have been thought to characterise some of the independent and voluntary sector homes whose raison d'être was to emulate the informality and choice based environment of 'home'. The assertion that some homes might be more homely than others is however challenged by Peace and Holland's (2001) work suggesting that whilst 'smaller' homes might be more 'domestic' in scale, they may nonetheless present as 'institutional' in their practice.

Chapter 8 supports this finding with respect to the management of health and safety risk, where all of the case study homes can be seen to have adopted control measures that impact directly upon residents' experience of 'home'. Peace and Holland argue that whilst: '*small homes are regarded as homely and domestic settings.…they are domestic settings which are also seen by their proprietors as a business*' (2001: 407). As such the care home is arguably subject to commercial pressures that are likely to take precedence over the 'preferred' cultural orientation of the small provider. Thus societal and regulatory pressures to adopt a 'protectionist' agenda (Chapter 2 and 3) may take precedence over other considerations.

These findings might also highlight a limitation with the typology itself. Bellaby (1989), for example has identified a possible limitation of the Grid, Group typology, whereby the model apparently lacks a basis for showing how (and possibly why) organisations might change from one risk culture to another (Chapter 4). Thus whilst the typology allows for a discussion and classification of the homes on one level, it has not provided a standalone framework for explanation. It has not, for example, been possible to correlate cultural orientation directly with the implementation of risk control measures. Indeed the outcome of such an analysis may provide apparently paradoxical outcomes. For example, whilst the manager of one of the smaller private homes (home D) insisted that bedroom doors were kept closed shut at night, there was evidence that the night staff in the corporate home (home I) permitted open bedroom doors, despite the provider's explicit policy for them to be closed. When viewed in the context of the conceptual model Figure 10 in Chapter 4 however, such apparent contradictions, arguably, begin to make sense. The model conceptualises the cultural orientation of the home as part of a complex social system comprising myriad different components exerting effects upon each other via 'feedback' loops. As argued in Chapter 4, the more complex the system, the more it is likely to give rise to some of the paradoxical effects observed. The grid and group typology might thus be seen as a 'lens' that helps understand an organisation. It does not provide a full description of reality (Evans, 2007).

9.1.1 The residents as an empowered or 'isolate' group

The characterisation of the case study homes using the grid and group typology was largely based on the way that the provider, home manager and staff adopted and used formal policies, procedures and rules (Chapter 6). Thus homes that did not tend to emphasise documented systems, but promoted a resident oriented agenda were likely to be characterised as 'low grid'. The smaller voluntary sector providers clearly fell into this category. However, in analysing the data it became apparent that that there was a disparity between the apparent low grid orientation of the home and the likely reality in terms of the degree to which resident lifestyle was constrained by the regulatory system and local 'rules'. The thesis produced material on opportunity and disempowerment that parallel similar debates taking place within literature exploring disability. For example Jingree (2009), cites several researchers who suggest that although support workers are responsible for facilitating the independence of service-users, this often takes place in the face of several conflicting agendas, including their 'well-being'. Due to space constraints, detailed discussions regarding equivalent experiences within the case study homes were not fully discussed in this thesis.

Chapter 7 showed how residents appeared to exhibit a disparate 'low group' orientation of relatively powerless individuals who joined established communities of practice (Lave and Wenger, 1991) in a process of 'becoming' a resident. Within these 'communities' residents were expected to comply with set 'rules' synonymous with a 'high grid' orientation. The 'rules' were generally non-negotiable and included restricted movement around the home, the inability to have either their bedroom door or window fully open, restrictions on furniture, smoking, indeed a lack of choice in any areas where 'risk' was felt to be a factor. This combination of 'high grid' and 'low group' thus characterised all of the case study residents as occupying a generally 'isolate' cultural orientation.

This was initially a surprising finding that did not appear to be in keeping with the idea that a particular care home was characterised as falling within a particular cultural orientation. It might for example have been expected that those residents living in an 'egalitarian' home were also characterised as 'egalitarian'. However, this did not seem to be the case. The theoretical framework appeared, however, to allow for this disparity

by acknowledging that not all of the participants within the homes necessarily needed to belong to the same 'group'. Indeed within the case study homes there were likely to be a number of different 'groups' living and working together that were afforded different levels of access to the 'decision making' process and thus different 'privileges'. For example, the activities coordinator at home I appeared to have been excluded from the care planning loop, potentially placing her at risk from hazards associated with the residents that she may be working with (Chapter 8).

Some residents were however able to assert their wishes and gain access to resources that might have been denied their less able peers. These different levels of access might be explained by applying the idea of *cultural pluralism* which allows for the fact that different cultural orientations can coexist alongside the dominant 'management' culture of the home. Thus, the case study residents did not appear to comprise a powerful homogenous group who could exert any significant influence upon the interpretation and management of risk within their homes. This is particularly significant as it provides further evidence that the regulatory framework appears to have had a culturally coercive effect upon the 'individualistic' and 'egalitarian' values of the providers within the case study homes. This resonates with Braithwaite's (2007) assertion that the emphasis on resident rights has been less marked, and that the regulatory process itself has been less resident centred in England than in either the US or Australia. Thus ideas about freedom of choice within the home have become highly qualified within what is deemed to be permitted within the regulatory framework of perceived health and safety 'rules'.

9.2 The effectiveness and impact of the regulatory system

There is an extensive and longstanding literature that has been critical of residential care homes in terms of poor standards of service and attitudes towards older adults (Bland, 2005). This 'literature of dysfunction' (Jones and Fowles, 1984) has been accompanied by a number of Government attempts to legislate for providing better standards of services for older adults (Chapter 3). The most recent attempts to do this have seen Government resort to more detailed regulation including setting National *Minimum* Standards (NMS). The Care Homes Regulations 2001 and the National Minimum Standards were evidenced to have been very successful in pressing home the health and

safety agenda. There was, for example, ample evidence of policies, procedures and physical systems within all of the case study homes that, rather than promoting resident oriented involvement and choice, had focussed attention on avoiding risk (Chapter 7 and 8).

Chapter 3 argued that rather than emphasising the reasoned assessment of risk in the context of a 'choice' based agenda, the NMS have stipulated or prescribed the risk oriented *obligations* of providers. This might, paradoxically, have resulted in contradictory messages regarding the rights of residents to 'choose' and the responsibilities of providers to 'protect'. It was argued in Chapters 7 and 8 that regulators and home managers might further accentuate these Standards by the application of street level bureaucracy (Lipsky, 1980). Thus the requirement to undertake a suitable and sufficient assessment of the risk of harm might instead be translated into a 'rule' or a 'prohibition' based agenda that results in reduced choice for residents in areas deemed to be subject to health and safety law. This would appear to support the argument that there has been little or no recognition of the structural factors that characterise older adults as generally 'dependent' and in need of protection from harm (Bland, 2005). These findings suggest what might be called a form of 'neo institutional' practice emanating from the strict 'rule' based application of workplace health and safety law within residential care homes for older adults.

Despite this apparent emphasis on health and safety law, the Health and Safety Executive continue to note that accident statistics for care homes have actually been increasing (HELA, 2009). In 2007/08 there were a total of 1,049 non-fatal accidents involving residents in the UK. This might suggest that the regulatory system has not necessarily achieved the broad objective of keeping residents 'safe'. What is particularly interesting about these figures is that they might actually represent a gross *underestimate* of the actual total of injuries. The data shown in the Health and Safety section of Appendix 4 (overview of the sampling frame), would suggest, for example, that whilst there were some 3,442 residents living in care homes within the sampling frame, there were very few examples of reference to 'reportable' accidents. Arguably, it might have been anticipated that a proportion of this group were likely to have sustained an injury requiring hospital attendance and thus a statutory report. However the inspection reports for the sampling frame suggested hardly any examples of reference

by an inspector to a 'reportable' accident. This theme was apparently repeated across the case study homes where the *reporting* of accidents did not appear to be given great prominence, although all homes did have systems for *recording* them. This finding is arguably supported by research undertaken for the Health and Safety Executive which suggests the under reporting of accidents across all industries (Davis et al, 2007, see also Chapter 1).

9.2.1 The regulatory framework as a source of emergence

Conceptualising the care home as comprising and being part of a complex system has allowed the interaction between the different parts of the system to be viewed in terms of emergent properties (Chapter 4). These properties include both planned emergence in terms of attaining the goals of local and public policy and unplanned in terms of potentially hazardous or oppressive practice.

The care home sector within the UK has seen a number of changes over the last decade, specifically a significant tightening of the regulatory framework. The sector has also seen three different regulatory regimes[45] since the inception of the Care Standards Act, 2000, the latest being the Care Quality Commission which came into being in April 2009. A significant consequence of the new regulatory framework for care is that it has arguably removed or blurred the dichotomy of safety and care by incorporating safety compliance within the management of the care home. The requirement for compliance with health and safety law is set out in Standard 38, Safe Working Practices, but is also included in a number of the other standards that deal with areas that interface in some way with safety law. For example Standard 25, deals with heating and lighting and requires homes to '*meet the relevant environmental health and safety requirements and the needs of individual service users*' and Standard 26, hygiene and the control of infection which is designed to control potential sources of infection that might arise from soiled laundry, clinical waste or spillage of body fluids.

[45] Since the Care Standards Act, homes have been regulated by: the National Care Standards Commission, the Commission for Social Care Inspection and the Care Quality Commission.

These Standards were critically evaluated in Chapter 3, which argued that there were significant inconsistencies and potential for confusion arising from the choice of regulations included and the way that they were presented. Of particular note was the complete failure of the NMS to make reference to the Health and Safety Executive's (HSE) own guidance, Health and Safety in Care Homes (HSG220, 2001). Whilst it could be argued that this publication was itself out of date, and not necessarily appropriate to the needs of care homes, it represented the views of the principal regulator for health and safety and for this reason it was surprising that it had been ignored.

The National Minimum Standards have arguably created a regulatory environment that exhibits 'emergent properties' where the interpretation of health and safety law has been by 'prescription' rather than by encouraging a reasoned assessment of the risks. Thus, as shown with the example of the Water Supply (Water Fittings) Regulations 1999 (Standard 26.9, discussed in Chapter 3), homes might invest resources in proving compliance, where arguably, these resources might be better utilised elsewhere. Indeed health and safety law is largely based upon the assessment of risk, where the home owner is expected to weigh the quantum of risk and the consequences of applying (or not applying) control measures. The recourse to a 'prescriptive' way of thinking was evidenced within the case study homes in forms of 'street level bureaucracy' where inspectors, providers and managers would apply their own 'interpretation' of the law. For example, Lisa the manager of home G recounted how she and another home manager had wanted to retain the original 1930's 'feature' floor in the main entrance to their homes. Whilst the health and safety perspective from the local EHO had been to undertake an assessment of any risk as part of the decision making process, the local CSCI inspector had simply issued a refusal on the basis of the perceived risk:

> "*But they just refused flat, she said it was a straight no, not even a risk assessment, whereas the health and safety from our point of view gave us the option, so we could have looked at it and thought, you know weighed up the risk for ourselves, but when I went down to see her she said don't even bother with it; going through all of that because CSCI have just said no to me*" (Lisa, manager home G – 4524M).

The apparently 'prescriptive' and 'list' based approach of the NMS and the absence of clear guidance on the interpretation of the regulatory framework within the Minimum

Standards has thus left plenty of room for 'interpretation' by regulators, providers and managers. This has often, it seems, been done with little regard for the 'big picture' implications of implementing the required control measures. For example, the stipulation that all hot water outlets were fitted with thermostatic mixer valves to control the risk of scalding, had resulted in some homes fitting mixer valves on most of their taps, including those in dining areas and residents' flats. This had the result that residents and staff are unable to hygienically wash crockery and cutlery in areas other than the main kitchen. It may therefore be necessary to boil a kettle in order to achieve the required temperature. Indeed one home manager, Cath at home D, related how she had seen this being done by one resident's relative in order to achieve a satisfactory temperature for their bath[46].

The prevention of falls from height has received similar high profile attention with the result that most care home windows are now restricted so that they cannot open more than 10cm (4 inches). Combining this requirement with the stipulation that the bedroom door must be kept shut in order to prevent the spread of fire and smoke has had the consequence that the residents' rooms cannot be adequately ventilated on very hot days. Thus, the Care Homes Regulations 2001, specifically the National Minimum Standards have arguably created a health and safety agenda that has been biased towards the implementation of prescribed control measures rather than the measured and reasoned assessment of risk. This apparent 'one size fits all' approach to the management of risk has contributed to environments where providers and managers tended to resort to 'heuristics' or 'rules' to control risk on the basis that they will be censured if they favour resident choice over visible control of what are deemed to be health and safety risks. There was, for example, evidence that the 'where there's blame there's a claim[47]' Woolf civil justice reforms had contributed towards a sense of vulnerability amongst some providers and home managers. This fear of litigation might therefore emphasise a risk rather than a choice based agenda, with the subsequent use of a heuristic or rule based approach to risk management (Chapter 8).

[46] There was however little evidence from residents within the case study homes to suggest that their baths or showers were in fact too cool.
[47] This term derives from one of the country's claim management companies but was frequently used by home manager participants when acknowledging their concerns about the potential for litigation.

9.2.2 Reduced choice and metastability

The application of the 'rule' based approach to managing perceived risk has conversely seen the creation of what might be thought of as a 'risk paradox'. The intention behind the law to undertake a suitable, sufficient and reasoned assessment of risk has arguably been substituted by a model that elicits 'rules' and technical 'fixes'. For example, the 'prescription' to fit window restrictors[48] had apparently ignored the wider legal requirement to assess the integrity of the glass itself. None of the case study homes were able to demonstrate that a risk assessment, as required by Regulation 14 of the Workplace Health Safety and Welfare Regulations 1992, had been undertaken. The Regulation requires that every window should, where necessary, be protected against breakage. Indeed in some of the case study homes the glass was evidently as old as the building[49]. Thus it could be argued that there was a theoretical risk of someone falling through a flimsy pane of glass.

There were other examples of risk management by heuristic or 'rule' rather than by reasoned assessment, observed within the case study homes. Chapter 8, for example, discusses the prohibition of walking frames in some communal areas of homes E and H, and the use of combination locks to prevent access to 'unsafe' areas exemplified by homes B, E and I. The common feature of all of the control measures was that they had apparently ignored the possibility that they might themselves introduce further risk. In the first instance the control measures (rules) ignored the likely 'biographical' risk to the residents who were being disempowered by the removal of the choice to determine their own level of risk. The second level of risk appeared to arise from the control measures themselves. For example, removing the choice does not necessarily remove the motivation to achieve some personal objective. The resident who chooses to leave the table may do so without their walking frame and in doing so they will be at an increased risk of falling.

Chapter 4 adopted the theoretical systems based idea of 'metastability' to explain this phenomenon. It could be argued that these are simply examples of 'poor' risk

[48] These restrictors are not 'fit and forget' they also need to be tested and maintained periodically.
[49] There was no evidence of the safety 'kite mark', the glass was sometimes cracked and in some homes the glass was of a leaded stained glass construction.

assessment, however, perhaps a 'poor' risk assessment is itself synonymous with the idea of a metastable state. Within the metastable state the management of risk is conceptualised as existing on two distinct levels. On one level the risk had been eliminated by removing the hazard. Prohibiting the walking frame removed the risk of someone tripping over it and met the home's need to prove control of the risk. On another level however, the control measure had introduced a degree of imbalance into the social system. The 'normal' activity of the individual had been disrupted and this introduced the potential for other forms of harm.

It was interesting that the apparent adoption of a 'rule' based model of risk management appeared to be just as prominent in the case study homes classified as 'egalitarian' as in the high grid 'hierarchical' homes. Indeed even the larger of the two independent sector private homes with a low grid, individualistic cultural orientation had tended to adopt a range of risk management measures that often mitigated resident choice. This would lend support to the argument that the regulatory framework had pressed home a risk oriented and health and safety based agenda.

9.3 Rituals of regulatory compliance

The national minimum standards (NMS) for care homes have arguably been very effective at compelling homes to introduce written systems in order to 'demonstrate' regulatory compliance. Braithwaite et al (2007: 154) provide evidence of how CSCI inspectors might spend a significant proportion of their inspections in the office with the home manager talking about and reviewing the home's documentation. Chapter 6, for example, showed how providers and managers were expected to have systems in place to satisfy CSCI inspectors who arrived at the home to examine documentation, whilst perhaps missing the real 'workings' of the home (Burton, 2006). This may result in a situation where *some* homes have introduced *some* policies and procedures that have little substance in terms of their implementation and effect. The possession of systems that were not implemented was conceptualised as a form of *ritualism* (Braithwaite, 1993) where the care home could demonstrate the required documented policies and procedures, although in fact they only existed as part of a *ritual of compliance* performing little or no real management function. This phenomenon was particularly evident within those homes managed by larger provider organisations such as homes E

and I, where written policies were not always reflected in practice. For example, whilst home E had a number of documented systems the home's inspection report had been critical of the fact that some of them had apparently not been implemented.

The NMS might therefore be thought of as encouraging such forms of documentary ritualism whereby care home managers and provider organisations concentrate on 'evidence' of their activities rather than promoting resident choice. Indeed it could be argued that the regulator's self assessment based Annual Quality Assurance Assessment (AQAA) methodology has (by removing some of the regular contact with inspectors), encouraged an even greater emphasis on written systems.

Thus the existence of diverse and informal choice based cultures within the care home sector might be seen as subject to erosion by pressure to conform to the 'rules' and 'rituals' set out in the Key Lines of Regulatory Accountability and encouraged by a model of self assessment rather that localised support from a CSCI[50] inspector. There was also evidence that the apparent increase in regulatory burden had not been matched by regulatory support and guidance, indeed some home managers had reported a decline in regulator support. This was clearly evidenced within two of the case study homes, homes G and H who had invested in external management support systems in order to derive confidence that they were complying with the law. Again, these findings resonate with Braithwaite et al (2007: 330) who suggest that homes '*are embattled by regulatory oversight*' and this may have resulted in '*less than desirable care for the frail elderly*'.

9.3.1 The role of the home manager

The role of the home manager in shaping the residents' experience of 'home' and of the care home was clearly evident during the fieldwork. The home manager was the person who granted access for the research and they were the individuals who set the limits within which *local* policy was often drafted and implemented. The home manager's network of support sometimes included administrators, deputies, and the home's handyperson. This 'technical' post appeared to be important in terms of health and safety checks, tests and repairs. However, the nature of this relationship was not

[50] This would now be an inspector from the Care Quality Commission

investigated in any way that would allow significant, detailed or meaningful conclusions to be drawn.

In most of the case study homes it was the home manager who took the lead on managing risk. This might be guided by the provider's systems, the local CSCI inspector's requirements, and advice from the local Environmental Health Officer or guidance drawn from documentary, internet or consultancy sources. Chapters 6, 7 and 8 provided evidence to suggest that home managers frequently behaved as 'street level bureaucrats' interpreting guidance, policies, procedures or advice in accordance with their own local perspective (Chapters 3 and 4). Risk control measures might thus derive from the manager's own predispositions towards a particular risk scenario in terms of a 'heuristic' device or 'rule' that appeared to fit. For example, knowledge of previous or similar accidents or fear of litigation might cause the home manager to discourage the use of kettles (home G), rugs or carpets in residents' rooms (home B) or walking frames in dining rooms (homes H and I). The home manager was thus able to exert a powerful influence upon the home in terms of establishing a local community of practice that residents and new staff were expected to 'join' and to fit in with (Chapter 7). There was also no evidence to suggest that the provider's area or regional managers ('supervisors') challenged these local 'rules'. The provider of home I, for example, marketed its home as one that allowed residents to smoke. However, during one of the fieldwork visits, the home manager stated that her policy was not to 'admit smokers', which met with no challenge from the visiting manager who was present at the time. This would appear to support Evans (2009) argument (Chapter 4) that 'Bureau managers' might share, be sympathetic with, or support the 'street level' interpretation of policy.

9.4 Summary of principal findings and implications for practice

The final part of the thesis will draw together the principal findings of the empirical work and briefly discuss them in the context of their resonance and relevance in a wider contemporary setting. The findings are also cross referenced against the research aims and questions (Table 13), in order to summarise how the objectives of the research have translated into outcomes. The research findings suggest that there are some practical and achievable implications for care homes and for the health and safety policy framework as it applies to the mixed economy of care.

9.4.1 Findings and practice

The regulatory framework appears to have been very successful in driving forward the health and safety agenda. By integrating health and safety law into the National Minimum Standards, the regulator, CSCI, has highlighted health and safety law as a principal component of care home management. This safety oriented agenda was consequently seen to be a powerful mediating factor in the management decision making process. The design of the regulatory framework should consider the paradox of control instead of empowerment. The documentation that sets out the regulatory framework and the standards required to meet its implementation should be aligned with the objectives of the new Care Quality Commission (CQC) which replaced CSCI in 2010. Such an alignment would be undertaken in order to reflect how healthy and safe care might be achieved within the espoused value base of the regulator's standards for care. The CQC has set out an agenda for change which includes the re-registration of services by all health and social care providers by October 2010. This is accompanied by 'new' standards setting broad objectives for service delivery. It will be interesting to see how the new commission and the new standards manage the interface between objectives for independence and choice and the regulation of health and safety risk.

Similarly it would seem appropriate for the Health and Safety Executive to take the opportunity to align their guidance, specifically HSG220[51] with the revised CQC standards so that the objectives of health and safety law better reflect the health and social care value base, around issues of choice and risk. It is interesting to note here that a perception that the regulation of health and safety is a 'bureaucratic and resource intensive process', has precipitated a review by Lord Young on behalf of the Conservative party (SHP, 2010). This review *may* be a precursor to regulatory changes that subsequently impact upon HSE guidance to care homes. Thus, rather than consolidating and improving existing best practice from the regulators, providers may instead be required to contend with a further period of regulatory change.

It was argued in Chapter 3 that the origins and consequences of a risk oriented agenda may arise from societal concerns about the 'protection' of vulnerable adults which have become conflated with the management of health and safety. Thus 'health and safety'

[51] HSE guidance publication: Health and Safety in Care Homes (2001)

may have become a 'mantra' for protecting people from risk rather than identifying 'work' related hazards and assessing 'unreasonable' risks to those who might be affected. The fieldwork suggested that the reasoned assessment of health and safety risk was not a well developed feature of the case study homes, although the implementation of control measures was. It was argued in Chapter 7 that whilst individual residents may have been able to negotiate resources and to derive 'social capital', as a group, they were generally disempowered and subject to the safety based constraints of an 'isolate' cultural group. It was shown in Chapter 8, that these constraints often derived from control measures that were 'encouraged' or perceived to be encouraged by the National Minimum Standards. Thus, the regulatory framework may have a potentially coercive impact on the cultural orientation of care homes, reducing choice, limiting independence and creating 'neo institutional' environments.

The theoretical framework and empirical work identified two further factors which impact upon the way that the regulatory framework is, or is not, applied in practice. First, street level bureaucracy was shown to mediate how systems were devised or adapted in accordance with perceived need. It was argued in Chapter 3 that societal concerns about the protection of 'vulnerable' people, a fear of litigation, and a perception that the law mandates 'risk eradication', set an agenda for subsequent decisions. Inspectors, providers and home managers may therefore interpret regulations in order to fulfil these 'requirements', even where such agendas contradict the underpinning values of the regulator, provider or the society within which the home exists. Second, rituals of compliance were seen to be a feature of the regulatory regime where providers evidenced systems without 'meaningful' implementation in fact. Thus, a home might have written policies that they do not apply in practice or physical control measures (such as closing fire doors) that their staff may disregard.

An interesting and potentially useful finding was how control measures designed to manage risk, may on occasion, give rise to paradoxical effects. This phenomenon was described in terms of the concept of the 'metastable state' which appears to have merit as a tool to help think about risk on the different levels of control and wider consequences. The regulator's self assessment methodology, the Annual Quality Assurance Assessment could be updated to include an overview of the home's risk assessment or risk control strategies and require the homes to identify any areas of

potential ‘metastability’. This might include the identification of areas where risk control measures impinge on independence and choice, introduce unintended risks or derive from ‘street level bureaucracy’.

From a methodological perspective, chapters 7 and 8 highlighted an apparent dissonance between the theoretical classification of the case study homes using the grid and group typology and some of the apparent findings. Whilst the grid and group typology offered a means to classify the homes, it did not appear to provide a complete framework for explanation. This finding touches upon the systemic complexity associated with the highly regulated and diverse mixed economy of residential care. The care home is not seen as one homogenous collection of like minded people but a complex mix of individuals and groups who have different levels of access to social resources, and who are subject to different regulatory constraints. The conceptual model, Figure 10, places the cultural orientation of the home within a framework that acknowledges its place within such a complex system. The ‘system’ itself gives rise to ‘feedback loops’ that impact upon local culture. Thus the safety agenda might be seen as a highly potent cultural mediator in its own right, to the extent that it is arguably seen as a necessary, praiseworthy and desirable feature of care home management. Under these circumstances, a failure to apply sufficient safety controls, especially where linked to an accident, may result in calls for tighter and more rigorous control.

Thus, the application of health and safety law within care homes can be seen to have contributed towards the paradox of a rights-based agenda that appears to have been subordinated to one concerned primarily with risk. This arguably resonates with Moran’s (2002: 401) contention that the application of ‘command law’ to social systems can produce pathological consequences. If this argument is accepted as valid, it represents a challenge to regulators and providers to engage more actively with stakeholders in meaningful dialogue regarding how health and safety risk can be managed without attenuating individual rights and choice.

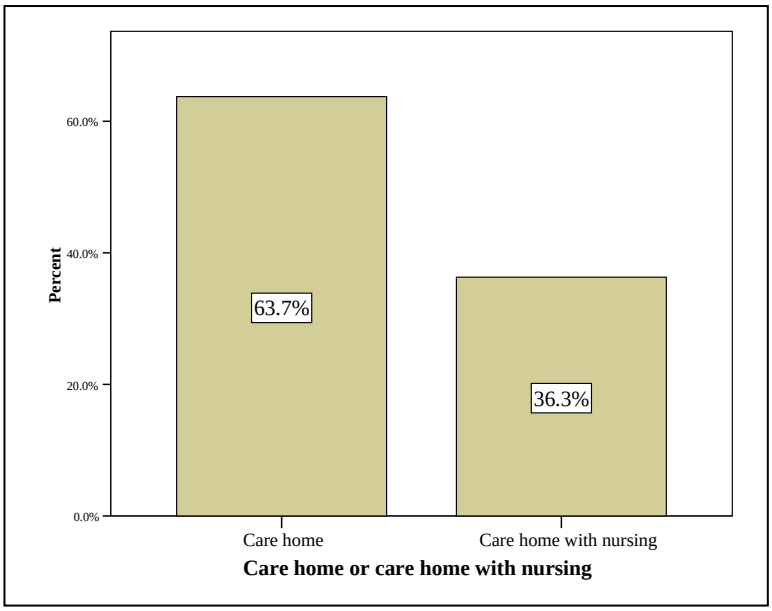
Aims and questions	Summary findings
A1 How is safety legislation applied within care homes and which values tended to dominate?	The regulator for care homes (CSCI) has set minimum standards for health and safety risk which tends to set the agenda for the home. The management and elimination of health and safety risk is arguably the dominant agenda.
A2 What are residents' perceptions and experiences of safety legislation with respect to independence and choice?	Independence and choice were found to be highly qualified with respect to perceived risk or regulatory expedience. The perception of risk to the health, safety or welfare of the resident tended to determine the outcome. Residents appeared to be largely passive recipients of this process.
A3 To what extent do the separate regulators of health, safety and care promote an enlightened and seamless approach?	CSCI has adopted and adapted components of the health and safety regulatory framework within its minimum standards. These do not cross reference the Health and Safety Executive's own guidance for care homes.
Q1 What mechanisms drive the interpretation and implementation of the health and safety regulatory framework?	The National Minimum Standards tended to set a risk oriented agenda that was arguably amplified by concerns about potential litigation and subsequent regulator and local street level bureaucracy.
Q2 Are there inherent contradictions within the regulatory framework that confuse managers and lead to the paradox of risk averse practice whilst failing to apply controls?	Health and safety standards within the National Minimum Standards are prescriptive, sometimes out of date and do not always cross reference industry specific guidance. The way that some of the Standards are written, interpreted and applied was shown in Chapters 7 and 8 to lead to some risk averse outcomes. Risk assessment, whilst frequently cited, was rarely evidenced.
Q3 What role does organisational and professional culture play in the interpretation and management of risk in care homes for older adults?	The role of 'Culture' was arguably subordinated to, or dominated by, an agenda driven by regulatory compliance and wider societal concerns about protecting people from harm. The likelihood of harm was further dominated in some homes by a perception that 'where there's blame there's a claim'.
Q4 Are current processes of risk assessment and management appropriate?	Risk assessment was not always in evidence. Controls appeared to be mandated by the regulator. Where risk assessments did take place they tended not to involve residents, were rarely written down, and on occasion had the potential to create additional 'unforeseen' risks.
Q5 To what extent are 'homely values' allowed to flourish in the regulated domain of the care home?	'Homely values' were shown, generally, to be subordinated to the control of risk. This occurred across the sample of homes and challenged the theoretical idea that a smaller 'individualistic' or 'egalitarian' home might be less 'institutional'.
Q6 To what extent are residents empowered to influence the management of the home and its safe working practices?	Whilst there were forums for consultation, the management of the home was directed by the provider. Chapter 7 and 8 argued that the management of risk was undertaken without widespread consultation with residents. Thus residents were generally seen to be a 'disempowered' group without significant influence upon the management of their home.

Table 13: *Summary aims, questions and findings*

Appendix 1 - Overview of the sampling frame

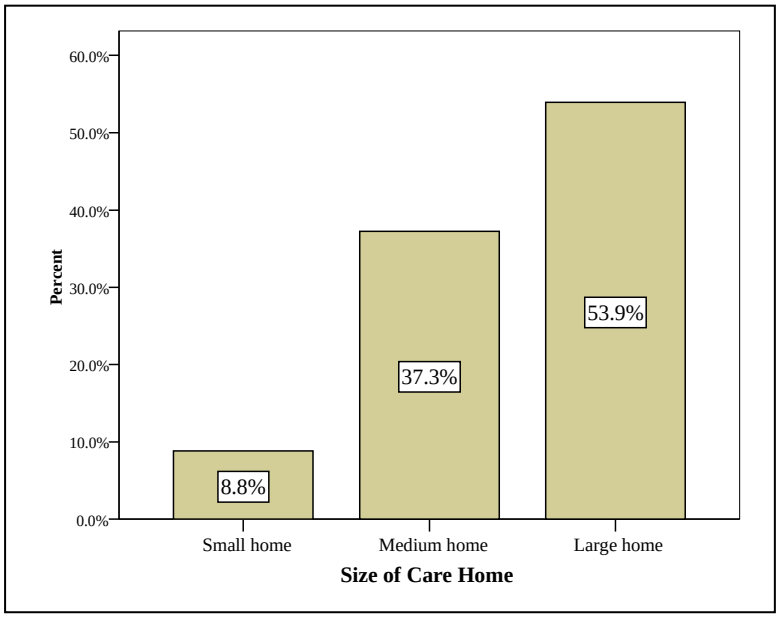
An overview of the homes

According to the Commission for Social care Inspection (CSCI) publication 'The State of Social Care in England 2005-2006' a total of 18,718 homes were registered with the CSCI in 2006. Of this number almost fifteen thousand (14,947) were social care homes and just over four thousand were care homes with nursing (4,058 or nearly 22%).



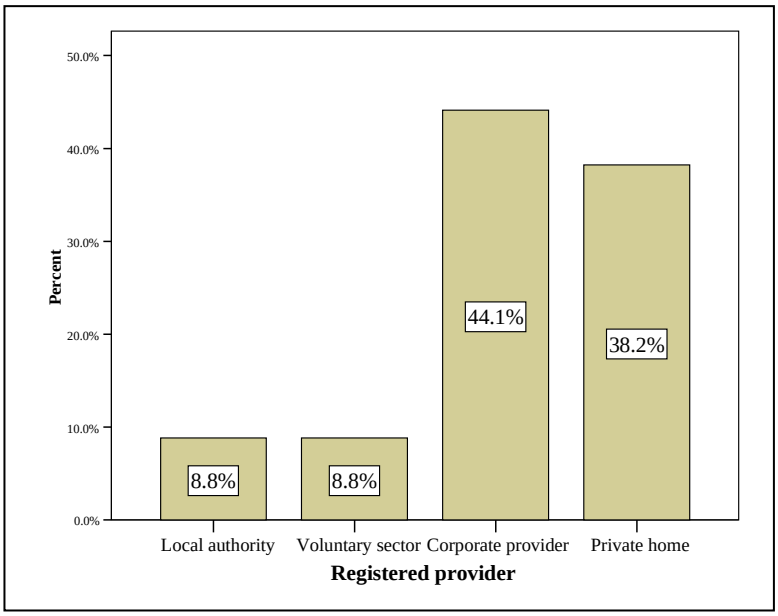
Within the sampling frame over thirty percent of the homes provide nursing care. The number of registered homes has been falling, although the number of places has actually risen, reflecting the trend for larger homes (i.e. fewer but larger homes).

This trend is reflected within the sampling frame where over half of the homes have over thirty places, the average size of a care home with nursing is forty four places.



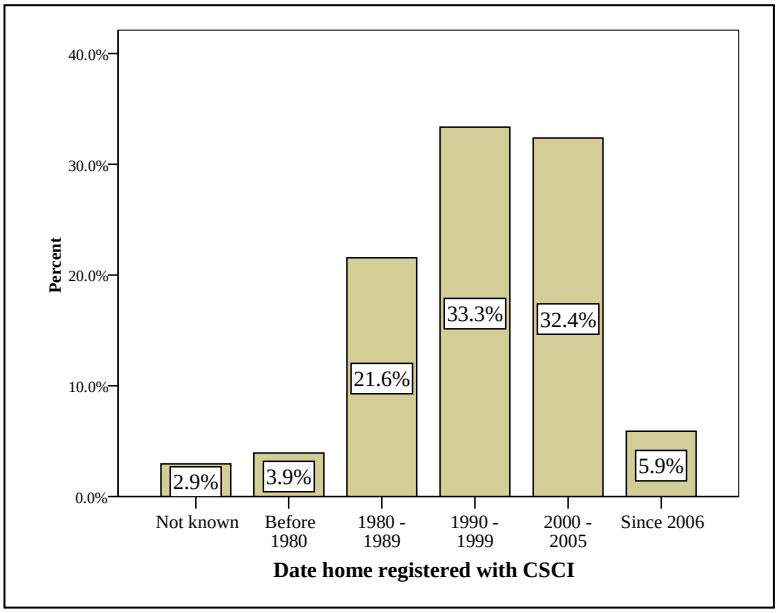
Smaller homes have been identified as those comprising between one and fifteen resident places, the smallest within the sampling frame has three places.
Medium homes comprise between sixteen and thirty places.
Large homes comprise over thirty places. The largest within the sampling frame have seventy and eighty eight places respectively.

Around three quarters (71.8%) of all care homes in England are owned by the independent sector, whilst nineteen percent are owned by the voluntary sector. Within the sampling frame independent sector homes have been subdivided into the 'private' and 'corporate' sectors. Homes were recorded as 'private' where the proprietor was identified by their family name. Limited or public limited companies were designated as corporate providers, although it is anticipated that of this number some will be small family owned businesses that have limited liability status.



Within the sampling frame around eighty percent (82.3%) of the homes belong to the independent sector, of which around forty four percent are owned by limited or public limited companies. There are much smaller numbers of local authority and voluntary sector homes comprising housing associations and other 'not for profit' providers.

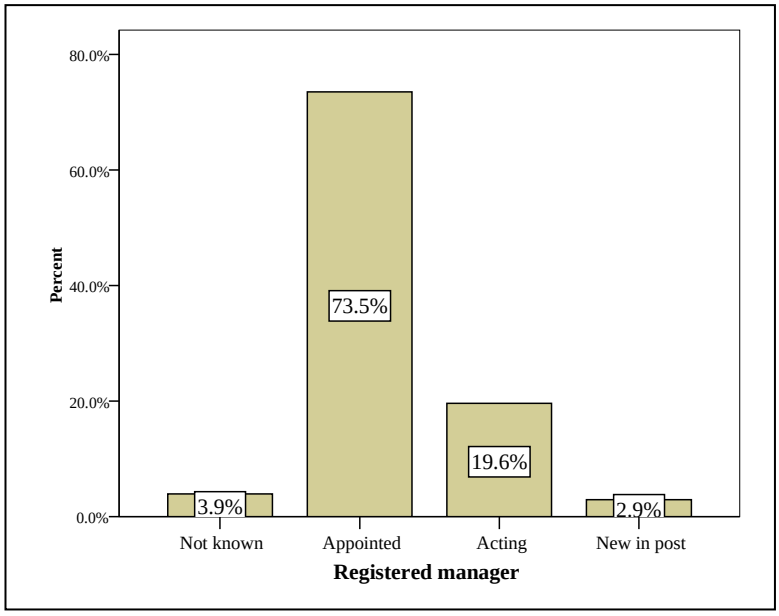
The CSCI provide data on the 'age' of the home in terms of when it was first registered, although this information may not be an entirely accurate predictor of the time a home has actually been open. Homes may have been closed, refurbished and re-registered or registered to a different proprietor or for a different client group.



Within the sampling frame around one third of homes were first registered during the period 1990 to 1999. A similar number were registered in the period 2000 to 2005. Despite reducing numbers of care homes, a significant number (nearly 6%) have been registered in very recent years.

The registered manager

The registered manager is a significant factor in the success of any care home. They are appointed both as a statutory requirement and as individuals with the necessary skills knowledge and ability to lead the management of both resident care and the premises within which the care is delivered.



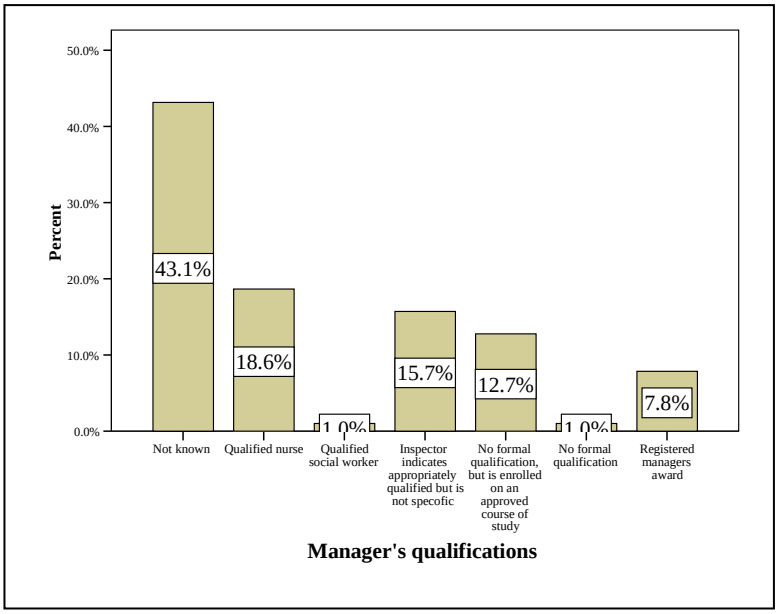
Around three quarters of the care homes within the sampling frame have an appointed and experienced home manager. Around a fifth of homes had no registered manager in post at the time of the inspection. Under these circumstances the registered manager was recorded as 'acting'.

Qualifications and experience

Prior to the Care Standards Act 2000 there was no statutory requirement for the manager of a residential care home to be qualified in any discipline, to be trained to any level or to demonstrate any particular level of appropriate experience. Under the Registered Homes Act 1984, local registering authorities would determine locally who they deemed to be 'fit persons', giving rise to a wide range of different 'qualification' standards. The Care Standards Act 2000 created the General Social Care Council, who register individual staff holding particular positions. Part of the expectation for registration is the achievement of approved qualifications. The registered manager is now required to be qualified, competent and experienced i.e. they must have at least two years experience in a senior position in managing a relevant care home setting within the last five years and by 2005 have attained a qualification at level 4 NVQ, in management and care or equivalent, or be registered on an appropriate course of study. Registered managers should have completed their qualification by September 30th 2007 (subject to any changes to these targets which emerge from the Department of Health review of regulations and standards). Where nursing care is provided, the manager must be a first level registered nurse and have a relevant management qualification.

As the home manager's qualifications and experience are not recorded directly it was necessary to derive this data using content analysis, coding the inspector's narrative according to reference to qualifications, experience or other specified criteria. Within the sampling frame the qualification of the home manager was not obvious in just over forty percent of reports.

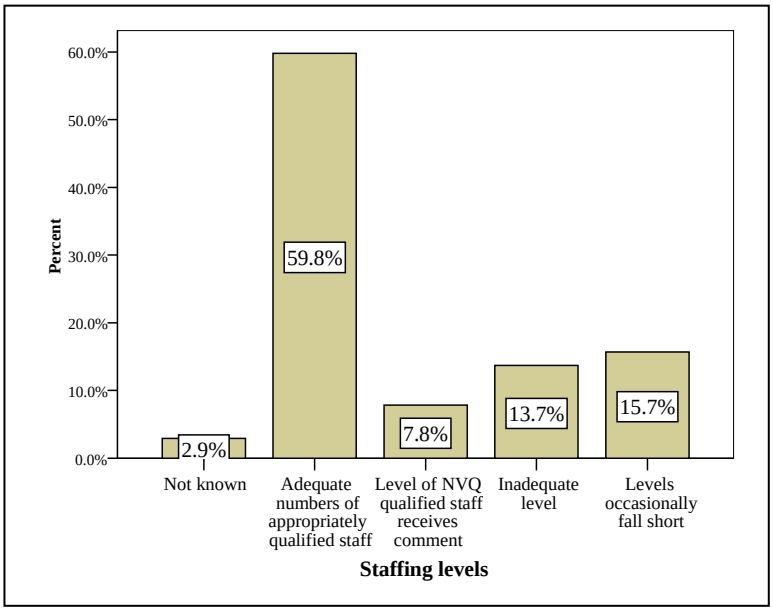
A little less than one fifth (18.6%) of all home managers were identified as being qualified nurses, just over one fifth (21.1%) of whom work in social care homes. Around fifteen percent of reports identified the manager as 'appropriately qualified' but were not specific.



A small number of managers were identified as having achieved a suitable management qualification (the registered manager award or equivalent NVQ), whilst nearly thirteen percent (12.7%) were working towards this qualification. A tiny minority of reports suggest that the manager was not appropriately qualified.

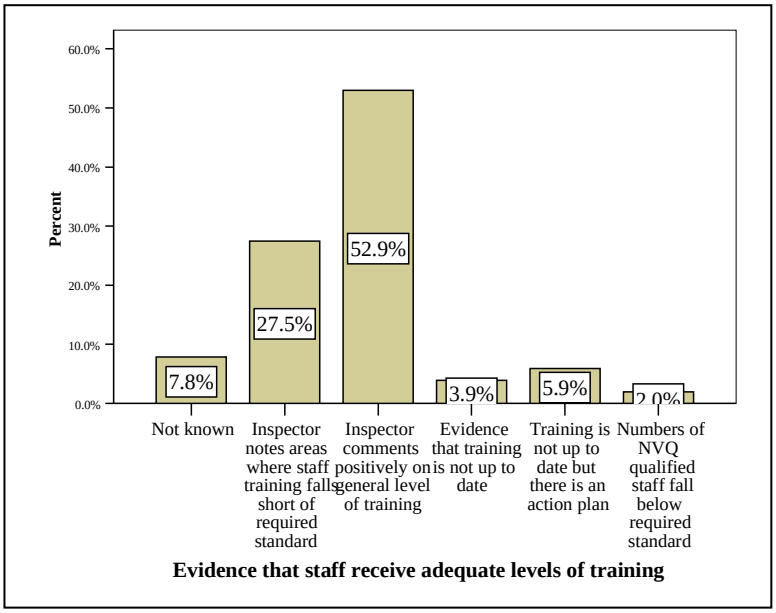
Care home staff

The numbers, experience and training of care staff impacts directly on the service delivery and thereby a resident's experience of residential care. The Care Homes Regulations 2001 include reference to the numbers and qualifications of staff: *'The registered person shall, having regard to the size of the care home, the statement of purpose and the number and needs of service users' and 'ensure that at all times suitably qualified, competent and experienced persons are working at the care home in such numbers as are appropriate for the health and welfare of service users'* (Regulation 19(5, b)). The CSCI inspector will obviously focus significant attention on these aspects of the service provision and their narrative is often insightful.



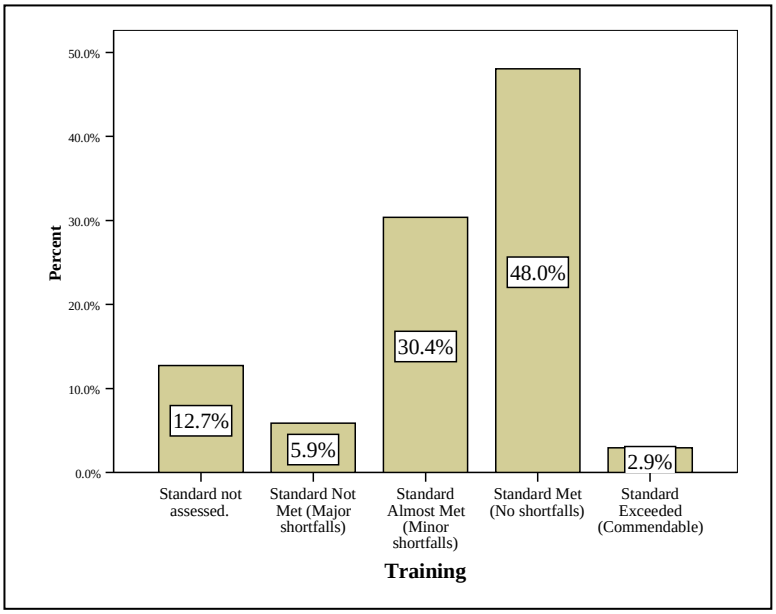
Within the sampling frame over half of care homes scored highly in terms of staffing levels. In just over thirteen percent of homes however, reports indicated that staffing levels fell below those required. In just over fifteen percent of reports the number of care staff occasionally fell below the required level.

Standard 28 of the 'National Minimum Standards for Care Homes for Older People' states: 'A minimum ratio of 50% trained members of care staff (NVQ level 2 or equivalent) [must be] achieved by 2005, excluding the registered manager and/or care manager, and in care homes providing nursing, excluding those members of the care staff who are registered nurses'. 'Any agency staff working in the home are included in the 50% ratio'. Only a minority of the reports examined appeared to cover NVQ qualification in any detail. A few reports (7.8%) commented on the numbers of NVQ qualified staff in terms of staffing levels, whilst only two percent of reports identified a real shortfall in the numbers of NVQ qualified staff overall. Generally, the inspector's comments addressed the broad range of in-house training available for staff (such as health and safety), rather than the attainment of NVQ's.



In around half of homes the comments were positive about the training provided. Just over a quarter of reports were however critical of training provision. A relatively small number of reports identified shortfalls whereby training was not up to date. In many cases such shortfalls had also been identified by the home manager who had an action plan was in place.

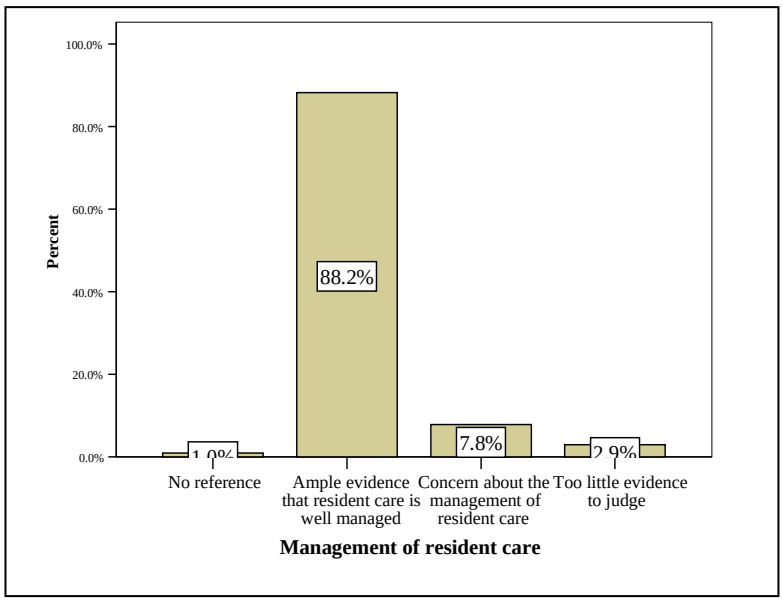
The inspector's narrative concludes with the allocation of a 'score' denoting the extent to which the home has attained a particular national minimum standard (NMS). The NMS for training (Standard 30) was assessed in the majority of homes.



Just under half of the care homes within the sampling frame met the standard with no shortfalls. Around one third of homes almost met the standard, whilst a small minority of around three percent exceeded it. Fewer than six percent of homes failed to meet the standard. Nationally seventy two percent of homes meet or exceed the standard.

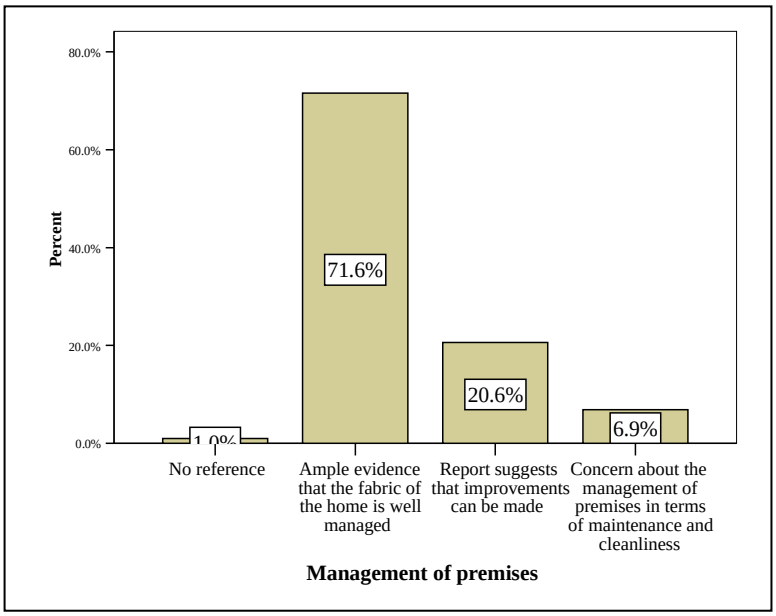
Service provision

The inspector's narrative provides an insight into how well the home appears to manage resident care. The inspector's observations derive from discussion with residents, relatives, professionals and staff, observation of care being provided during their visit to the home, record keeping and other physical evidence. The inspector's narrative thus gives an indication of any concerns about the delivery of care.



The majority of reports provide ample evidence that care is being well managed. Only a minority of reports suggested that the inspector had concerns about the delivery of care.

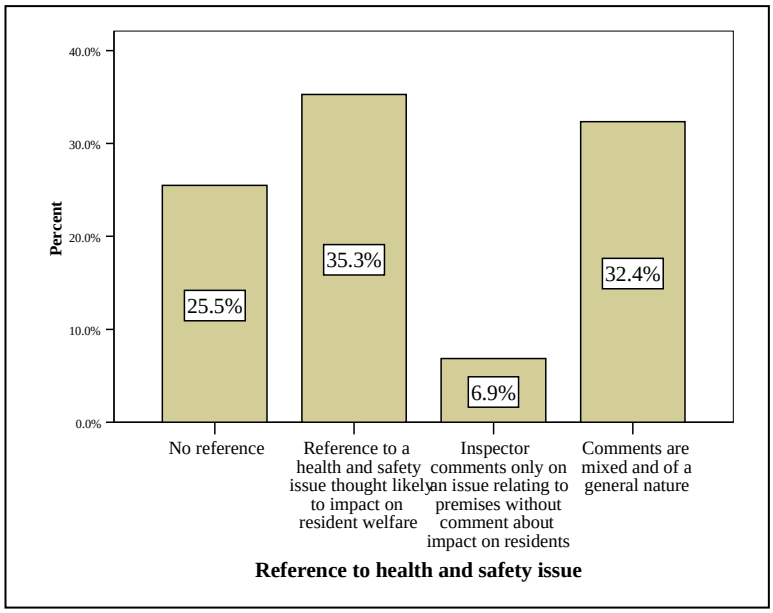
The management of the premises within which the care is provided is a significant management responsibility. Again the majority of reports suggest that premises are generally well managed.



Around one fifth (20.6%) of reports however suggest that an improvement can be made and a small minority of reports indicate a level of concern about the management of premises in terms of their maintenance and cleanliness.

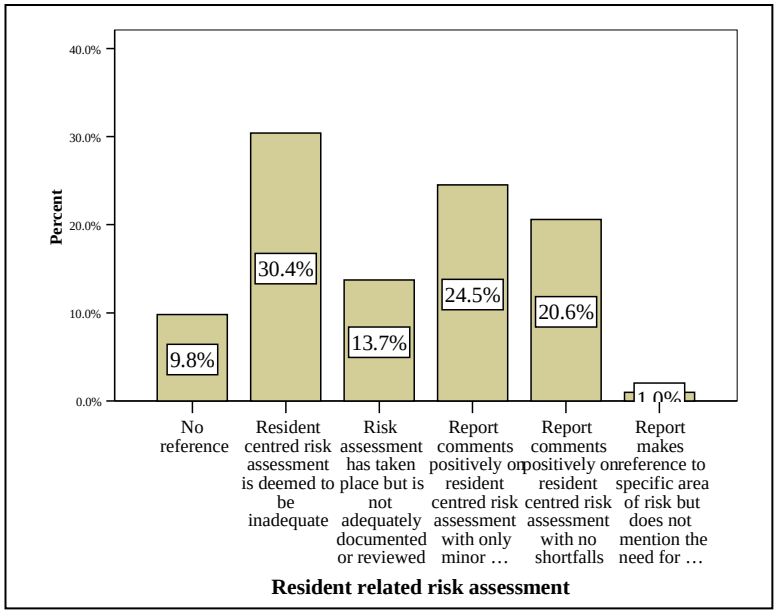
Health and safety

The content analysis targeted three themes within the reports: 1. reference to a specific health and safety issue, 2. the management of resident related risk, and 3. the management of premises related risk.



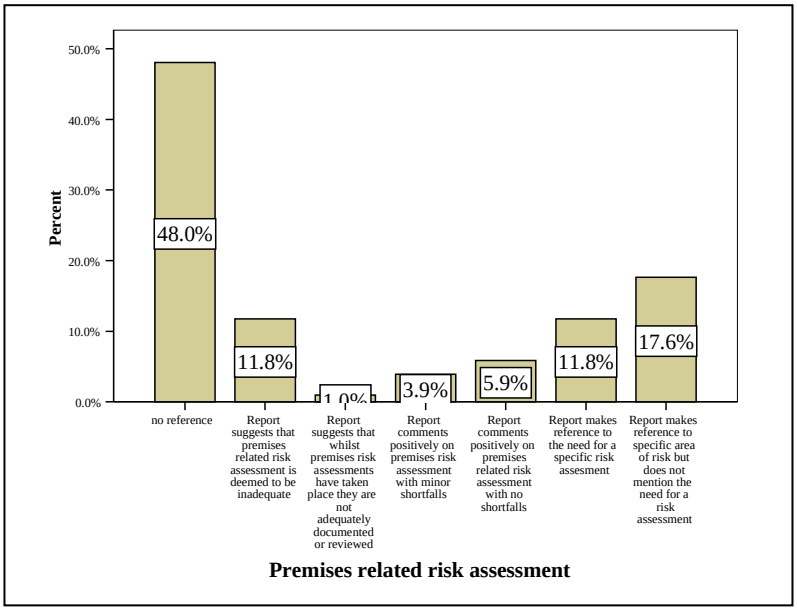
A quarter of reports did not make reference to any particular health and safety issue. Just over one third did however identify something thought likely to impact on resident welfare such as hot water, or access to an 'unsafe' area. A further third of comments were of a general nature, including the inspection of electrical appliances and other tests and checks.

None of the reports identified 'oppressive' safety practices restricting resident choice. In relation to individual 'resident related risk', the reports did not always deal with risk assessment in a clear and easy to comprehend manner, perhaps reflecting the apparent confusion that exists. The National Association for Safety and Health in Care Services suggest that they are regularly approached about the issue of risk assessment in care plans. The Nottingham coroner has also commented on the need for managers to 'correlate' premises and resident based risk assessments (Chapman in the Evening Post 2006).



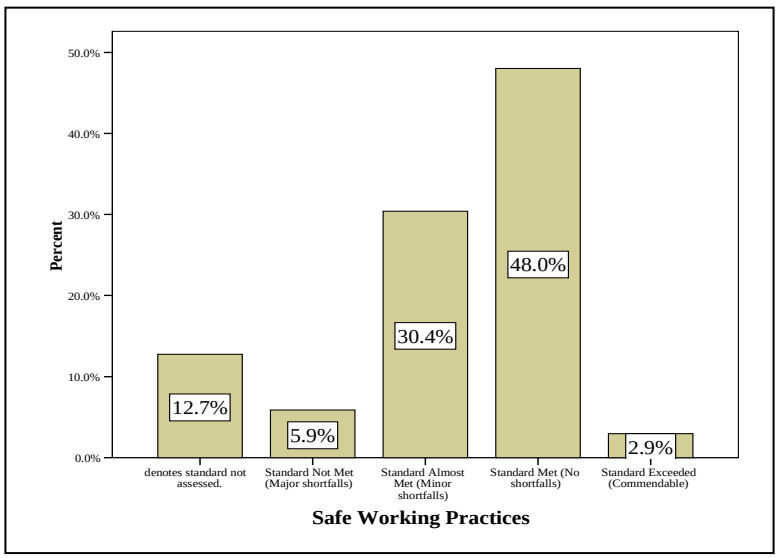
Thirty percent of reports suggested that the resident risk assessment was deemed to fall short of the inspector's expectations. In thirteen percent risk was not adequately recorded. Just under half of reports commented positively on resident risk assessment, a quarter (24.5%) showing minor shortfalls such as omitting a particular risk area. Almost ten percent of reports made no reference at all.

Premises related risk assessment is perhaps easier to comprehend. The Management of Health and Safety at Work Regulations 1999 (Regulation 3), requires a suitable and sufficient assessment of the risks relating to work activities. Standard 38 (safe working practices) of the Care Home Regulations 2000, requires the home to comply with this and other health and safety regulations. Arguably, the inspector could identify the home's compliance with the requirement to undertake a risk assessment by examining their written risk assessment document and noting that one exists and appears to be suitable. In reality it was often quite difficult to identify specific 'written' premises 'risk assessments' within the inspection report. Indeed just under half of the care home reports did not mention any form of premises related risk assessment. Often it was necessary to 'deduce' when the inspector was referring to an entity that could be coded as relating to risk assessment.



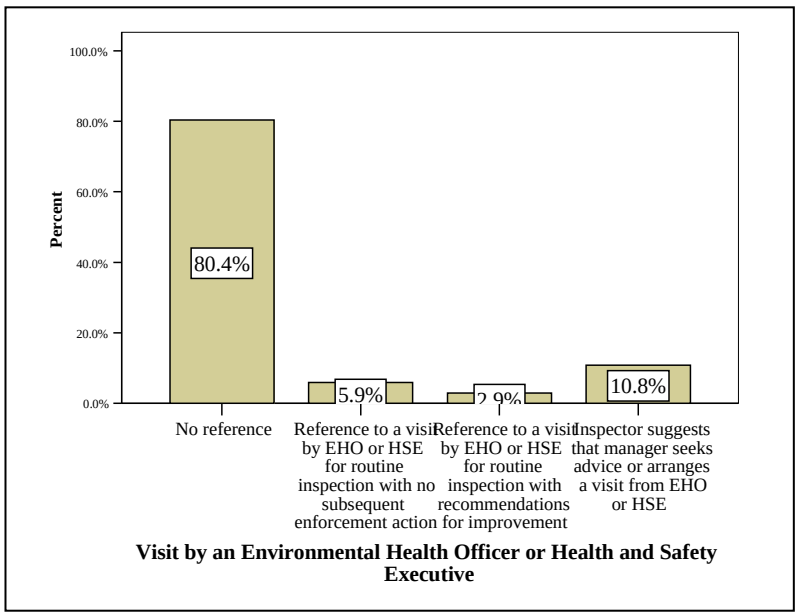
Around ten percent of reports comment positively on the home's premises related risk assessment; eleven percent deemed assessments inadequate or identified the need for a specific risk assessment. Nearly one fifth identified a risk but did not relate it to a risk assessment.

Standard 38 'safe working practices' represents the inspector's overall assessment of the home's health and safety performance. Nationally just over half (54%) of care homes meet or exceed the standard for safe working practices.



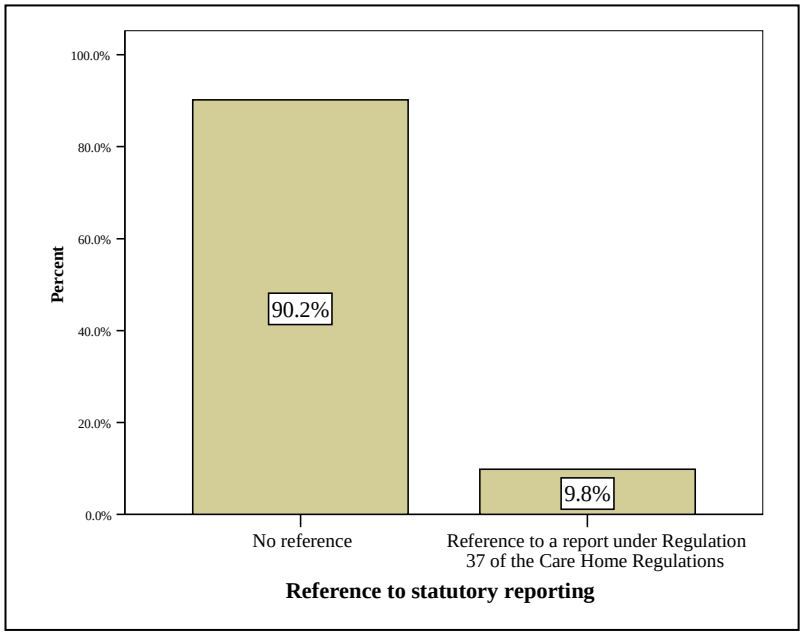
Within the sampling frame around seventy percent of homes met or almost met the standard. Fewer than six percent fail to meet the standard, whilst a very small number of around three percent exceed it.

A partner in the enforcement of standards within care homes is the local authority environmental health officer (EHO) or the Health and Safety Executive (HSE) for nursing homes. It might therefore be argued that there should be evidence of partnership working when examining the standard for safe working practices. Eight out of ten reports however made no reference at all to either the EHO or HSE.



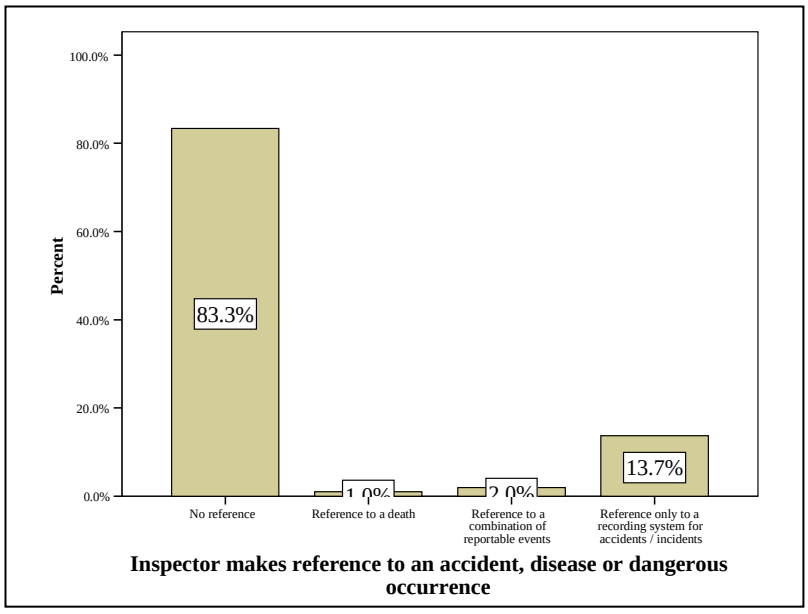
Just over one tenth of reports make reference to the need for the home manager to contact either the HSE or EHO for advice on a particular topic, for example preventing Legionnaires disease.
Around nine percent of reports identify enforcement visits, but there is often no mention of the outcome or details of recommendations.

Arguably, the recommendations of an EHO or the HSE should be incorporated into the CSCI report, yet often such visits appear to be mentioned only in passing. A significant part of the regulatory framework for health and safety relates to the identification of hazards and mechanisms for their prevention or management. The Reporting of Injuries, Diseases or Dangerous Occurrences Regulations 1995 (RIDDOR) requires employers to inform the local enforcing authority (EHO or HSE) of certain 'reportable' events. For example if a resident is injured 'out of or in connection with work' and is subsequently taken to hospital (even if no treatment is required) the home manager is obliged to make a report.



Interestingly no reports make reference to RIDDOR. Around ten percent do however cite Regulation 37 of the Care Home Regulations which is roughly equivalent to RIDDOR requiring certain 'reportable' events to be notified directly to the CSCI.

It might reasonably be assumed that the reason for no RIDDOR reports and so few Regulation 37 reports relates to there having been no incidents within the homes.



Indeed over eight out of ten of the reports make no reference to an accident. Just over thirteen percent do however refer to a recording system or the need for the home to cross reference incident records. Only three percent of reports make reference to a potentially reportable event.

Accidents in care homes are and have been subject to comment for some years (Thrale, 1990; Chapter 1). The scale of accidents has also received tabloid press attention, for example the Stoke Sentinel (September, 2006) noted that 'Thousands in council care hurt every year', whereby an average of forty injuries are reported in each *council run home* in Stoke-on-Trent and Staffordshire each year.

Research undertaken for the Health and Safety Executive (Bajekal et al, 2001: Table 8), suggests that the injury rate for women is 28 per 100 persons (17 for men) when care homes are included in the statistics. Many of these injuries result from falls, indeed, community studies have estimated that approximately one third of people aged 65 or over will sustain a fall related injury at least once a year (Cryer and Patel, 2001). It has also long been recognised that the risk of falls increases with age, the rate of accident and emergency attendance per 10,000 population for unintentional falls is almost three times higher in those aged over seventy five (Scuffham et al, 2003). An individual who has already fallen is also at an increased risk of falling again, and therefore of eventually incurring serious injury. Some authors also rate falls within institutions as almost three times higher than for older people living in the community, with injury rates also considerably higher, 10-20% of falls resulting in a fracture (Rubenstein et al, 2001, and Cali et al, 1995).

There were some 3,442 residents living in care homes within the sampling frame. Arguably, it might be anticipated that a significant proportion of this group are likely to sustain a fall related (or other) injury requiring attendance at their local hospital. Such an injury is likely to meet the criteria for reporting under the provisions of RIDDOR 95 and Regulation 37.

Appendix 2 - Overview of case study homes

Home code	Name	Size	Home type	Star rating	Service description
Code 14	B	19	Voluntary sector	2 Good	The home is two large semi detached houses which have been adapted and extended to provide what CSCI describe as comfortable living accommodation for up to 19 older people. There is car parking to the front of the home and a well planned and a courtyard garden. The location offers good access to local facilities including shops, a church and public transport.
Code 22	F	16	Council	3 Excellent	The home is what CSCI describe as a multi-functional complex situated in a residential area that has a high proportion of elderly residents. The home is near to a range of community facilities including a church, shops and a community centre. The building is single storey with sixteen single flats, none of which meet the National Minimum Standards size requirements. All rooms are well decorated and comfortably furnished. None of the flats have en-suite facilities but there are sufficient toilets and bathrooms, conveniently located throughout the building. There is an inner courtyard garden, which has been well maintained and is accessible by all residents. The residential home is part of a complex that offers a range of facilities to people 65 years old and over, for example the home offers a laundry and bathing service to the local community, and a range of other health care professionals work along side the carers to help ensure that the residents and service users receive a fully inclusive service that is designed to enable some residents to return to their home following a period of assessment and rehabilitation.
Code 27	E	40	Voluntary sector	1 Adequate	The home is purpose built for 40 older adults and is situated close to the city centre - within walking distance or by bus, and provides easy access to local community facilities. CSCI describe the building as being in a good state of repair and has undergone refurbishment recently, providing additional aids and facilities. Residents are accommodated on four floors, which are level throughout and accessible by a passenger lift.
Code 45	G	19	Voluntary sector	2 Good	The home is a well established converted 1930's town house owned by a voluntary organisation with extension and a large garden which is situated on a main road, convenient for shops, public transport and medical services. It is an older property which has been extended and converted to provide 19 single bedrooms for 18 long stay residents and 1 short stay resident. All resident flats are single and 10 have en suite facilities, one room is below national minimum space requirements and is only used for respite care.

Home code	Name	Size	Home type	Star rating	Service description
Code 51	C	4	Private	2 Good	The home was first registered just a few years ago for just 3 older adults. Resident accommodation is integrated with the proprietor's private house. Residents are provided with a separate lounge and kitchen / dinette. One bedroom situated on the ground floor and two bedrooms on the first floor. A chair lift is available for access. A bathroom is located on the ground floor and has an assisted hoist and shower facility. A remote alarm call bell is also available. Professional health care arrangements are organised as required. A large garden to the rear of the property offers a relaxing environment.
Code 65	D	12	Private	2 Good	The home is an adapted family home situated within walking distance of the local town centre. The home is registered to provide residential care for up to twelve older adults. They are not currently registered to provide a service to people with Dementia. CSCI describe the home as small and comfortable, and has private gardens to the rear of the property.
Code 6	H	22	Voluntary sector	1 Adequate	The home is situated in adapted detached premises in a residential area, but close to shopping areas, all amenities and public transport routes. Accommodation and care is offered to the older members of a faith based community only. Bedrooms are on two floors with a lift to the upper floor level and a choice of communal areas is provided. All meals are prepared on the premises.
Code 72	I	54	Private / corporate	2 good	The home is located in an inner city area of Nottingham and is registered for 54 older adults. The accommodation is a purpose built building, comprising 54 single rooms, of which 28 have en-suite facilities. In addition 4 adjoining rooms are available. All rooms are fitted with a Call System and are furnished, although residents are encouraged to personalise the rooms with their own furniture. The home has one large lounge, incorporating a designated dining area. A small lounge facility is used as a hairdressing room and a separate designated smoking area. There are four bathrooms, of which two are fitted with a bathing hoist and one with a Parker bath and two separate shower rooms. The grounds are compact with seating to the front and rear of the property. The kitchen offers a varied menu. An activities co-ordinator is employed by the home to ensure service users are provided with a variety of social and leisure activities. A hairdresser visits the home weekly. Healthcare professionals will visit the home on request.

Appendix 3 - Interview Schedules

Interview Schedule 1 – home manager

Question	Prompt
M2: What is it like having responsibility for a place that is both a home and a place of work?	Prompts: For residents it is their home, for staff their place of work. Is there any confusion between guidance from the HSE and National Minimum Standards from the CSCI etc?
M2a: How do you make residents feel at home?	Prompt: How do you emphasise 'home' within a 'workplace'?
M2b: What advice / guidance do you receive from the CSCI or local authority to help you?	Prompts: Are inspectors consistent in their messages about health and safety? Has guidance changed since the CSA 2000?
M3: What guidance might you follow if a resident is taken to hospital after an accident (e.g. tripping over a torn corridor carpet)?	Prompts: Is there any confusion between reporting requirements for Regulation 37 and RIDDOR 95. Are there other examples?
M4: What role do care assistants play in supporting you to manage health and safety within the home?	Prompts: Are care staff involved in risk assessments, how are risks communicated to care staff (meetings, supervision, handovers etc.)
M5: How do you involve residents in keeping themselves and others safe within the home?	Prompts: Whilst residents have rights, what are their responsibilities within the home?
M6: Does the proprietor / home owner have any influence on the way health and safety is managed in your home?	Prompt: Proprietors often have management / quality / health and safety manuals and systems that homes are required to comply with.
M6a: Does anyone support you to make sure that *you* comply with the law – who are they, what are their roles, how do they help you?	Prompt: Does the proprietor employ a health and safety specialist to help homes comply with their legal duties?

Interview Schedule 1 – home manager

Question	Prompt
M6b: What are the key factors / things that influence the way you apply health and safety rules in the home?	Prompt: For example, professionals may be required to work in accordance with defined codes of professional conduct that may influence their approach to management practice, especially risk.
M7: Who undertakes risk assessments in the home and how are they recorded?	Prompt: Do you or your staff undertake the assessments or are they done by someone else, for example an advisor?
M7a: How are resident and premises related risks correlated together?	Prompts: The Nottingham coroner comments on the need to correlate resident and premises related risks and the National Association for Safety and Health in Care Services comments that '*confusion appears to arise at times of visits from the CSCI*'
M8: What health and safety rules are residents expected to follow? M8a: How do they know about these rules?	Prompt: How do people know about the home's rules, are there handbooks – how do you balance choice with 'safety rules'?
M9: How do you involve residents in the management of the home?	Prompts: Is there a residents committee?
M9a How do you involve residents in the management of their own care?	Prompt: What role do residents play in care planning, are they involved in writing / reviewing their care plans?
M10: What health and safety policies and procedures do you have? M10a: Who provided your policies and procedures?	Prompt: Are your procedures part of a quality system like ISO 9002 (BS5750) and do they cover practical safety procedures like COSHH, gas and electrical safety, maintenance etc. *See sub-prompts attached
M1: What do you think are the key risks you routinely manage in this home – how do you manage them?	Prompt: What have you identified that might cause harm to residents or staff within the home?
M1a: How do you prioritise the risks that you manage?	Prompts: Fear of litigation; the ethic of care; the regulatory framework; National Minimum Standards; visits from CSCI, EHO; the proprietor?

Interview Schedule 1 – home manager

Question	Prompt
M1b: How does health and safety rate in terms of *your* priorities for the management of the home?	Prompt: How do you prioritise compliance with health and safety (law) with your other responsibilities?
M11: What training have you had in health and safety?	Prompt: What level was the training - was it part of a care based course of training or aimed specifically at health and safety (NEBOSH etc)?
M11a: How well did the training balance health, safety and care? M11b: To what extent did the training prepare you for what you do in practice?	Prompt: To what extent did the training prepare you to comply with health and safety legislation whilst promoting homely values?

***Sub-prompts M10: premises related question areas**

Question area	Yes	No
System for monitoring / controlling Legionella		
Systems / procedures for preventing scalding		
Systems / procedures for preventing burns from hot surfaces		
System of portable appliance checking and testing, does it include resident appliances		
COSHH assessment for laundry / body fluids		
Window restrictors fitted to windows where there is a risk of falling		
Asbestos risk assessment		
Assessment of glass / glazing		
Fire procedures and the management of fire doors (are they propped open etc)		

Do you have copies of the following types of documents that I can look at?

Document	Seen
Health and safety policy statement	
Premises related risk assessments	
Resident risk assessment (subject to confidentiality)	
Health and safety procedures	
Health and safety checklists for use by home staff	
Maintenance records	
Health and safety training records (subject to confidentiality)	
Accident / incident recording systems (subject to confidentiality)	
Landlords gas safety and other certificates	

Interview Schedule 2 – Staff Member

Question (Your experience with residents)	**Prompt**
Introduction: What is your job, and how long have you worked here?	
S0: How do you make residents feel at home here?	Prompt: How do you enable residents to lead their chosen lifestyle?
S1: Are you a 'keyworker' for any of the residents?	Prompt: Have you been allocated a resident or group of residents in order to ensure that their wishes are heard, recorded and carried out?
S6: How do you (as a staff team) involve the resident in planning their own care?	Prompt: What say do residents and important others have in planning care?
S1a: How are residents protected from harm?	Prompt: A resident might be at risk of falling, being scalded or burned etc.
S1b: How are you told about risk to a particular resident and what you might need to do when caring for them?	Prompt: Is there a 'handover', a diary or communications book etc.?
S2: What (safety) rules are in place about what a resident can and can't do in the home?	Prompt: There may be 'rules' like no smoking in certain areas, residents not allowed into the kitchen, the laundry etc.
S5: Do the residents meet together to discuss how they want the home to be run for them (a residents committee)?	Prompt: How often do they meet, who is included (staff, all residents etc), are safety rules ever discussed, can you think of an example?
S7: Can you think of an occasion when a resident has wanted to do something, but has not been able to because of concern for their safety, or perhaps the safety of others?	Prompt: Do residents ever say that their bath isn't warm enough or that they would like their window to open wider, or to be able to do something like go in the kitchen or laundry?

Interview Schedule 2 – Staff Member

Question (Your experience as a member of staff)	**Prompt**
S4: Describe the health and safety risks associated with your job (what are the risks to you as a carer)?	Prompt: Things that could cause you harm, for example using chemicals, cleaning, lifting and handling, slipping or tripping, violence or aggression etc.
S4a: How did you find out about these risks (are they written down)?	Prompt: Does the home have written 'risk assessments'?
S3: Tell me about the (health and safety) procedures you are supposed to follow (in order to avoid the risks that you have just described)?	Prompt: Written instructions or guidance on how to do something: lifting and handling practices, assisting residents to bathe, accidents and incidents – do these procedures make sense to you?
S8: What health and safety training have you received?	Prompt: Did the course consider the needs of residents or was it just about general safety?
S8a: Who provided your health and safety training?	Prompt: Was the training provided by senior staff in this home, was it part of a course in health and social care or a specific health and safety course?
S9: How well did your training prepare you for your job?	Prompt: Has anything happened that you were not trained for?
S10: How do you deal with any health and safety concerns that you may have?	Prompt: How do you pass on any concerns that you may have?
S10a: How are health and safety issues discussed or communicated within the home?	Prompt: Is health and safety covered during staff meetings; are there any other staff forums that cover health and safety topics relating to your job here?

Interview Schedule 3 – Resident

Question	Prompt
Introduction: Do you mind if I ask you your age and how long you have lived here?	
R1: Do you feel at home here - tell me about living here, describe your daily routine?	Prompt: Are things done at certain times, for example waiting to have a bath?
R1a: What furniture do you have in your room, is it your own?	Prompt: Did you have a choice in what you could bring with you (check homes brochure)?
R2: If you need something, or want to do something, who would you ask?	Prompt: Do you ask the manager or do you have a 'keyworker', special member of staff to talk to?
R2a: Is there a special member of staff you talk to about your care?	Prompt: Does someone sit down with you and talk about your care, what you need etc. (a keyworker)?
R2b: How do care assistants know what sort of support you need them to provide for you?	Prompt: Are your wishes written down somewhere for others to see and follow and can you change the arrangements if you need / want to?
R3: Do staff talk to you about things that might be harmful to you?	Prompt: Risks and risk taking as part of your care plan, things you can't do because they might harm you or someone else
R4: How much choice do you have about what you do and don't do?	Prompt: Do you feel that you have complete freedom, or are there things you don't feel able to do?
R4a: Does the home have any rules that you are expected to follow?	Prompt: Health and safety rules like going into the kitchen or laundry, bathwater temperature, having windows open, things you can't bring into the home, things you can't do in the home.

Interview Schedule 3 – Resident

Question	**Prompt**
R6: Do you have any hobbies or interests that you like to keep busy with?	Prompt: Baking, gardening, cleaning your room etc.
R6a: Are there things you are not able to do in the home that you might like to do?	Prompt: You may want to do some baking, laundry or gardening but are not able to go into the kitchen, laundry room or use the garden tools.
R5: How are residents involved in running the home?	Prompt: Do residents meet together to discuss the running of the home?
R5a: How are you kept in touch with any decisions that are made by other residents (residents committee) or the home manager?	Prompt: Is there a resident handbook, newsletter or notice board?
Conclusion: Thank you for your time, one last question – what (if anything) would you like to change here?	

Interview Schedule 4 – Professional (Key informants used to derive supporting information to inform the thesis and appropriate literature)

Question	**Prompt**
P1: What role does RIDDOR data (for residents) play in terms of your (enforcement) approach to care homes?	Prompts: Is RIDDOR data used to target enforcement activity, is it used to identify particular hazards
P1a: How accurate is RIDDOR data with respect to resident related reporting?	Prompt: Is there an estimate for the level of underreporting?
P2: How does health and safety guidance integrate with concept of being at home?	Prompts: Being at home involves choice – are there contradictions between such ideas and health and safety law? The HSE have produced
P2a: How well does the guidance for care homes produced by the HSE reflect the concepts of 'home' that underpin the work of the CSCI?	HSG 220 and the CSCI have Standard 38. Do these documents complement each other? Are there any plans to update them?
P3: Do you think there are any contradictions in regulatory framework, likely to confuse home managers - what are they?	Prompts: Care homes are both a home for residents and a place of work for staff. Are there any practical examples of apparent duplication / contradictions or confusion in the respective regulatory systems, for example the requirements under RIDDOR 95 and Regulation 37
P3a: Can you think of any examples where the guidance has been misinterpreted by home managers or other agencies?	Prompt: Is risk assessment being taken seriously by the proprietor, is it delegated to the home manager or to a consultant?
P4: How do care homes approach the task of undertaking risk assessments?	Prompt: The Nottingham coroner commented on the need to correlate resident and premises related risks
P4a: Are resident and premises related risks being correlated so that they reflect the needs of the residents?	

Interview Schedule 4 – Professional

Question	Prompt
P5: What role do proprietors / owners play in managing health and safety, how many employ professional advisors?	Prompts: Proprietors often have management / quality / health and safety manuals and systems that homes are required to comply with
P5a: What factors do you consider are involved in how a manager interprets and applies health and safety law?	Prompts: Professional affiliations, for example nurses and social workers may be required to work in accordance with defined codes of professional conduct that may influence their approach.
P6: To what extent is the current regulatory framework effective in terms of promoting a healthy and safe home for residents?	Prompt: Care homes are primarily a home for the residents first and secondarily a workplace for staff – can regulations designed for the workplace be applied 'effectively' in the home?
New question: What form should 'competent advice/support' take, especially in smaller homes that do not have access to the support of larger providers?	Two of the smaller homes visited have no one identified who can provide them with advice – one home relies on briefing notes from the Royal Bank of Scotland to keep them up to date.

Appendix 4 - Propositions & theoretical orientation of case study homes

Hypotheses 1. Hierarchical orientation - Case study home I

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Boundaries are very clear and based on systems of authority and management accountability existing within the organisation and within the home	Yes (1)	As a national provider there are clear lines of management accountability backed up by policies, procedures and rules that are made available on the company intranet.
2.0 **Discretion in the use and interpretation of systems** Those working in hierarchical homes are expected to follow systems with little discretion. There will be tasks to complete according to protocols and within defined roles and responsibilities.	Yes (1)	The manager and staff have clear systems to follow which appear to include defined limits of discretion.
2.1 **Street level bureaucracy** Likely to be limited due to national protocols and systems comprising policies, procedures and rules of conduct.	Yes (1)	There are national protocols in place and no real evidence of street level bureaucracy by the regulator.
2.2 **Rituals of compliance** The apparent rigidity of the systems and the failure to involve those who apply them *may* lead to localised custom and practice that 'circumvents' some of the organisations procedures leading rituals of compliance without compliance in fact.	Yes (1)	Arguably there was some evidence that national policy is not always applied as intended, with localised custom and practice (e.g. doors at open night, prohibition on smoking). There was some evidence of ritualism as practice did not always equate with company policy.
3.0 **Role of provider at local level** Compliance oriented with an emphasis on checking and audit.	Yes (1)	The provider's representatives were seen several times during the fieldwork undertaking checks and audits of the home.
4.0 **Conceptualisation of 'home'** Whilst residents are the focus of the organisation's values and activities, it is the systems for meeting compliance that drives the organisations management practices. Residents are well cared for and safe, yet, their experience might be equated more with the hotel than the home whereby care services are formalised and focussed on protection.	Yes (1)	There is a clear emphasis on 'hotel services', indeed some parts of the home appear to be set out and marketed in these terms. There was ample evidence of good standards of care, yet, the culture of the home was arguably 'corporate' in terms of systems and practices.
	Total (6)	

Hypotheses 2. Individualistic orientation - Case study home I

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Practice is determined at local level allowing for significant discretion. Policies and procedures are likely to be few, whilst the local culture is strong.	No (0)	Policies and procedures are applied within a strong corporate ethos of compliance. Issues at local level may arguably conspire on occasion to circumvent national policy.
2.0 **Discretion in the use and interpretation of systems** Whilst written systems may exist, carers are more likely to interact with the home manager and use whatever degree of discretion the manager allows.	No (0)	A strict management hierarchy exists within the home. The home manager has little to do with the direct provision of services.
2.1 **Street level bureaucracy** Street level bureaucracy is likely to be a significant factor. In the absence of centralised systems the requirements of Regulator's is likely to be reflected in the homes written systems.	No (0)	Street level bureaucracy did not appear to be a factor. There was little doubt that the home belonged to a large provider with centralised systems.
2.2 **Rituals of compliance** The degree to which documented systems are applied *ritualistically* will depend on how and why they were created and implemented.	No (0)	There was arguably some evidence of ritualism or failure to apply policy (smoking prohibited although national policy acknowledged resident choice).
3.0 **Role of provider at local level** The manager is likely to be the provider and will take a direct and personal interest in the practical day to day running of the home, spending less time on documented audits.	No (0)	There was little evidence of direct interaction between care staff and the home manager. The home manager's role was arguably focussed on the management of the 'business' aspects of the home rather than the management of 'care'.
4.0 **Conceptualisation of 'home'** Residents experience is determined by the value base of the owner and home manager. Homes may emulate the characteristics of a domestic environment in terms of informality, access to facilities and relationships. Care services are likely to be person centred and informal.	No (0)	Care services appeared to be relatively formal in nature and were arguably determined by company policy rather than spontaneous choice. Care staff were both observed and reported to be busy for much of the time. An activities coordinator was employed for the purpose of structured social activities.
	Total (0)	

Hypotheses 3. Egalitarian orientation - Case study home I

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Characterised by a shared commitment to the values and principles of the organisation. Systems & rules will be framed within the value base of the organisation and the needs of residents.	No (0)	Arguably the home was not characterised by a shared commitment to the systems and values of the provider. There was evidence during fieldwork and within inspection reports of management and staffing issues suggesting that provider and home were not completely aligned.
2.0 **Discretion in the use and interpretation of systems** Discretion is likely to be encouraged so long as it reflects the values of the provider.	No (0)	Systems were provided and these were supposed to be followed.
2.1 **Street level bureaucracy** Is likely to vary according to how well the home is bound to the organisation by systems and protocols.	No (0)	The home was clearly characterised by a 'corporate and hierarchical culture' where national systems left little room for street level bureaucracy.
2.2 **Rituals of compliance** Rituals of compliance are likely to be limited by the strong local culture that is largely aligned with the provider's management of the home.	Some evidence (0.5)	There was evidence of organisational audits by the proprietor. There was however *some* evidence of local practice which might constitute a ritual, for example, the two participant residents' did not know that they had key workers.
3.0 **Role of provider at local level** The values and involvement of the provider *may* exert a direct influence in their own right, by for example being directly involved within the home. The provider's role is seen as practical and supportive.	Generally no (0.5)	There was evidence that visiting managers spent time in the home and were familiar with it. However, they did not appear to be directly involved within the home itself, their role was primarily support, training or audit based.
4.0 **Conceptualisation of 'home'** Residents are the focus of the home as they are often the sole reason for its existence. The value base of the provider is likely to resonate with those who choose to move into the home and therefore a resident's expectations of the home and its systems are perhaps more likely to be aligned.	No (0) Total (1)	There was some evidence to suggest that the 'services for sale' ethos dominated. In this respect expectations were aligned, however, dependency and workload arguably created a task focused service rather than one that was person centred, for example, despite the rhetoric there was little evidence of key working. Staff shortages also impinged upon personal care.

Hypotheses 4. Isolate orientation - Case study home I

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Characterised by short term coping strategies. The home may belong to a larger provider with systems that are seen as constraining.	No (0)	Short term coping strategies were only applied in terms of staffing the home. There was ample evidence that the proprietor's systems dominated management and care practice.
2.0 **Discretion in the use and interpretation of systems** Those who work within the home may feel a sense of hopelessness as they have no option but to comply with the provider's rules.	No (0)	Whilst the home's management and carers were subject to strict rules, there was little evidence to suggest that they felt any sense of hopelessness.
2.1 **Street level bureaucracy** Street level bureaucracy is unlikely as the manager is completely constrained by the provider's systems.	No (0)	No real evidence of street level bureaucracy.
2.2 **Rituals of compliance** Rituals of compliance are likely to be well developed, as the home manager attempts to prove compliance with the provider's myriad systems.	Yes (1)	There was evidence that the safety rule of having resident doors closed was being ignored. This fact was either not detected or ignored by visiting managers.
3.0 **Role of provider at local level** Compliance oriented with an emphasis on checking, audit and blame.	Yes (1)	There was a clear emphasis on auditing for compliance. The home was subject to regular compliance audits and checks.
4.0 **Conceptualisation of 'home'** Residents are supposed to be the focus of the home; however they may become 'pawns' in debates between proprietor, regulator and home staff.	No (0)	There was absolutely no evidence that residents were 'pawns in any debates' with the proprietor or regulator. Arguably 'care' was paramount.
	Total (2)	

Hypotheses 1. Hierarchical orientation - Case study home H

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Boundaries are very clear and based on systems of authority and management accountability existing within the organisation and within the home	Yes (1)	Another provider had been contracted to introduce a number of management systems. These effectively constrained the home manager's decision making powers.
2.0 **Discretion in the use and interpretation of systems** Those working in hierarchical homes are expected to follow systems with little discretion. There will be tasks to complete according to protocols and within defined roles and responsibilities.	Some evidence (0.5)	Whilst the home had been characterised by a complete lack of systems, the new home manager had been attempting to introduce basic systems. The external consultant organisation had also started to introduce robust systems leading to what was becoming an increasingly 'high-grid' orientation.
2.1 **Street level bureaucracy** Likely to be limited due to national protocols and systems comprising policies, procedures and rules of conduct.	No (0)	Street level bureaucracy had arguably been a factor. However the introduction of a large provider's management systems is likely to address any issues with local inspectors.
2.2 **Rituals of compliance** The apparent rigidity of the systems and the failure to involve those who apply them *may* lead to localised custom and practice that 'circumvents' some of the organisations procedures leading rituals of compliance without compliance in fact.	Some evidence (0.5)	The home manager was being encouraged to adopt a series of new policies and procedures that had been created for use within the managing organisations own homes. The introduction of 'alien' systems might arguably lead to some rituals of compliance.
3.0 **Role of provider at local level** Compliance oriented with an emphasis on checking and audit.	No (0)	Whilst the provider undoubtedly exerted a significant influence upon the home, there was little if any checking / auditing of systems.
4.0 **Conceptualisation of 'home'** Whilst residents are the focus of the organisation's values and activities, it is the systems for meeting compliance that drives the organisations management practices. Residents are well cared for and safe, yet, their experience might be equated more with the hotel than the home whereby care services are formalised and focussed on protection.	Yes (1)	There were arguably a number of elements within the home that might attract the label of 'hotel'. The home manager appeared to focus a significant amount of attention to systems related issues. 'Safety' was clearly a paramount consideration and there was evidence that this, at times, constrained choice.
	Total 3	

Hypotheses 2. Individualistic orientation - Case study home H

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Practice is determined at local level allowing for significant discretion. Policies and procedures are likely to be few, whilst the local culture is strong.	Yes (1)	The home had a strong local identity and there were few policies and procedures. More recently a new home manager and supervisory management arrangements had begun to formalise the home's systems.
2.0 **Discretion in the use and interpretation of systems** Whilst written systems may exist, carers are more likely to interact with the home manager and use whatever degree of discretion the manager allows.	Yes (1)	The previous home manager had considerable autonomy and focussed attention on the running of the home with little regard for formal systems. The new manager has been required to adopt a systems oriented approach.
2.1 **Street level bureaucracy** Street level bureaucracy is likely to be a significant factor. In the absence of centralised systems the requirements of Regulator's is likely to be reflected in the homes written systems.	No (0)	Street level bureaucracy was arguably a factor with systems being drafted largely in response to the regulator's requests. The advent of a large national provider acting in a supervisory / systems capacity is likely to introduce more formalised training, policies and procedures.
2.2 **Rituals of compliance** The degree to which documented systems are applied *ritualistically* will depend on how and why they were created and implemented.	Some evidence (0.5)	Arguably rituals of compliance may well emerge as the home is required to demonstrate compliance with the managing organisations systems.
3.0 **Role of provider at local level** The manager is likely to be the provider and will take a direct and personal interest in the practical day to day running of the home, spending less time on documented audits.	No (0)	The provider exists as a managing committee who take a direct personal interest in the home. However, this did not appear to extend to its management, where the home manager had traditionally taken the lead.
4.0 **Conceptualisation of 'home'** Residents experience is determined by the value base of the owner and home manager. Homes may emulate the characteristics of a domestic environment in terms of informality, access to facilities and relationships. Care services are likely to be person centred and informal.	Yes (1)	Residents experience was clearly determined by the faith based values of the provider. Whilst services had arguably been person centred and informal, the new regime was *arguably* becoming more formalised and systems oriented.
	Total (3.5)	

Hypotheses 3. Egalitarian orientation - Case study home H

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Characterised by a shared commitment to the values and principles of the organisation. Systems & rules will be framed within the value base of the organisation and the needs of residents.	Generally yes (0.5)	The ethos and values of the provider were clearly evidenced. However, the degree to which the home manager held a shared commitment to these principles was arguable. The new systems were also derived from a different organisation, with different values.
2.0 **Discretion in the use and interpretation of systems** Discretion is likely to be encouraged so long as it reflects the values of the provider.	Some evidence (0.5)	Discretion had been encouraged at home manager and senior care assistant levels. The introduction of new systems was likely to shift this dynamic towards a systems orientation.
2.1 **Street level bureaucracy** Is likely to vary according to how well the home is bound to the organisation by systems and protocols.	Yes (1)	Street level bureaucracy may have played a part in bringing about the transition from localised system development to a decision to introduce the services of a managing organisation. In effect this decision arguably reduced the likelihood of street level bureaucracy.
2.2 **Rituals of compliance** Rituals of compliance are likely to be limited by the strong local culture that is largely aligned with the provider's management of the home.	Yes (1)	At the time of the fieldwork there was no real evidence of rituals of compliance. The home was however in transition from having no real systems to being expected to comply with those designed by a larger provider.
3.0 **Role of provider at local level** The values and involvement of the provider *may* exert a direct influence in their own right, by for example being directly involved within the home. The provider's role is seen as practical and supportive.	Yes (1)	Whilst the provider appeared to exert little influence upon the management systems of the home, they were integral to the character of the home. The committee's faith based ethos was clearly in evidence and exerted an influence.
4.0 **Conceptualisation of 'home'** Residents are the focus of the home as they are often the sole reason for its existence. The value base of the provider is likely to resonate with those who choose to move into the home and therefore a resident's expectations of the home and its systems are perhaps more likely to be aligned.	Generally yes (0.5) Total (4.5)	Residents were clearly the main focus of the home, providing faith oriented accommodation and care. However, the degree to which the 'new' systems were aligned with the provider's original ethos was evolving at the time of the fieldwork.

Hypotheses 4. Isolate orientation - Case study home H

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Characterised by short term coping strategies. The home may belong to a larger provider with systems that are seen as constraining.	Generally yes (0.5)	Whilst the home had maintained a high degree of local identity, arguably it was also characterised as adopting short terms coping strategies, leading to demands for more formalised management arrangements.
2.0 **Discretion in the use and interpretation of systems** Those who work within the home may feel a sense of hopelessness as they have no option but to comply with the provider's rules.	No (0)	The provider's rules had originally derived entirely from 'matron'. The new manager was in the process of implementing new systems; however, there was no evidence during the fieldwork that these had impacted negatively upon staff.
2.1 **Street level bureaucracy** Street level bureaucracy is unlikely as the manager is completely constrained by the provider's systems.	No (0)	Street level bureaucracy was arguably in evidence in terms of how the home manager and regulator interpreted disciplinary rules.
2.2 **Rituals of compliance** Rituals of compliance are likely to be well developed, as the home manager attempts to prove compliance with the provider's myriad systems.	Generally no (0.5)	Whilst it was too early during the fieldwork to observe evidence of ritualism with the new systems, there was some evidence that the consultant's new procedures were causing robust debates between the home manager and committee.
3.0 **Role of provider at local level** Compliance oriented with an emphasis on checking, audit and blame.	No (0)	The local committee appeared to distance themselves from compliance auditing of the home.
4.0 **Conceptualisation of 'home'** Residents are supposed to be the focus of the home; however they may become 'pawns' in debates between proprietor, regulator and home staff.	Generally no (0.5)	Residents were clearly the focus of the home. The extent to which they might be 'pawns' in debates was arguable.
	Total (1.5)	

Hypotheses 1. Hierarchical orientation - Case study home C

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Boundaries are very clear and based on systems of authority and management accountability existing within the organisation and within the home	No (0)	This is a very small home whose registered manager is also the owner and therefore directs its systems.
2.0 **Discretion in the use and interpretation of systems** Those working in hierarchical homes are expected to follow systems with little discretion. There will be tasks to complete according to protocols and within defined roles and responsibilities.	No (0)	The home manager had complete discretion about the development and use of systems. Carers were generally allowed to act on their discretion too.
2.1 **Street level bureaucracy** Likely to be limited due to national protocols and systems comprising policies, procedures and rules of conduct.	No (0)	Street level bureaucracy was arguably an issue as there was evidence that the regulator wanted the home to comply with standards normally expected of larger homes. The home did not rely heavily on policies and procedures.
2.2 **Rituals of compliance** The apparent rigidity of the systems and the failure to involve those who apply them *may* lead to localised custom and practice that 'circumvents' some of the organisations procedures leading rituals of compliance without compliance in fact.	No (0)	There was no evidence of ritualism. If the manager did not have the required systems in place, there was no apparent motivation to 'pretend' otherwise.
3.0 **Role of provider at local level** Compliance oriented with an emphasis on checking and audit.	No (0)	The provider / home manager lived on the premises presenting an informal domestic environment.
4.0 **Conceptualisation of 'home'** Whilst residents are the focus of the organisation's values and activities, it is the systems for meeting compliance that drives the organisations management practices. Residents are well cared for and safe, yet, their experience might be equated more with the hotel than the home whereby care services are formalised and focussed on protection.	No (0)	Residents are the focus of the home and this is not impinged upon by regulatory systems. As a very small home, it arguably emulated a domestic environment far more closely than other homes in the sample.
	Total (0)	

Hypotheses 2. Individualistic orientation - Case study home C

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Practice is determined at local level allowing for significant discretion. Policies and procedures are likely to be few, whilst the local culture is strong.	Yes (1)	'Rules' were only used insofar as they might apply 'at home'. The home had few written policies and procedures, preferring instead to consult directly with residents. Carers were afforded a significant amount of discretion.
2.0 **Discretion in the use and interpretation of systems** Whilst written systems may exist, carers are more likely to interact with the home manager and use whatever degree of discretion the manager allows.	Yes (1)	The carer on duty was seen to have a close working relationship with the home manager. When on duty carers had significant discretion with respect to their role.
2.1 **Street level bureaucracy** Street level bureaucracy is likely to be a significant factor. In the absence of centralised systems the requirements of Regulator's is likely to be reflected in the homes written systems.	Yes (1)	Street level bureaucracy was arguably a factor. The home manager articulated that regulators apparently translated the law in their own terms, setting out what the home *should* look like.
2.2 **Rituals of compliance** The degree to which documented systems are applied *ritualistically* will depend on how and why they were created and implemented.	Yes (1)	Documented systems were arguably secondary to relationships and the manager was seen to be involved in domestic tasks such as shopping and cleaning.
3.0 **Role of provider at local level** The manager is likely to be the provider and will take a direct and personal interest in the practical day to day running of the home, spending less time on documented audits.	Yes (1)	Care was clearly in accordance with the needs of residents, and was both supervised by and occasionally observed to be delivered by the home manager. Carers were seen to interact with the home manager when on duty.
4.0 **Conceptualisation of 'home'** Residents experience is determined by the value base of the owner and home manager. Homes may emulate the characteristics of a domestic environment in terms of informality, access to facilities and relationships. Care services are likely to be person centred and informal.	Yes (1) Total (6)	One resident participant explained how he had heard about the home, and had wanted to move into it. The relationship between residents and manager appeared friendly, and the environment and culture arguably emulated the characteristics of a domestic home environment.

Hypotheses 3. Egalitarian orientation - Case study home C

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Characterised by a shared commitment to the values and principles of the organisation. Systems & rules will be framed within the value base of the organisation and the needs of residents.	Yes (1)	There was ample evidence of shared commitment to the values and principles of the home / owner. Systems & rules were designed to meet the needs of the home.
2.0 **Discretion in the use and interpretation of systems** Discretion is likely to be encouraged so long as it reflects the values of the provider.	Yes (1)	The size of the home meant that those on duty had little option but to exercise their discretion. The alternative would have required the owner to be permanently on duty.
2.1 **Street level bureaucracy** Is likely to vary according to how well the home is bound to the organisation by systems and protocols.	Yes (1)	Street level bureaucracy was in evidence in terms of the regulator's influence upon the home manager. The home manager was however focussed on the needs of the home in terms of ensuring that it was a 'home' for those who lived there.
2.2 **Rituals of compliance** Rituals of compliance are likely to be limited by the strong local culture that is largely aligned with the provider's management of the home.	No (0)	Systems were entirely at the discretion of the home manager/owner in response to the perceived needs of residents and staff. There was no evidence of ritualism.
3.0 **Role of provider at local level** The values and involvement of the provider *may* exert a direct influence in their own right, by for example being directly involved within the home. The provider's role is seen as practical and supportive.	Yes (1)	The owner / manager actually lived within the home. The care home is therefore the manager's 'home' and arguably reflected these values.
4.0 **Conceptualisation of 'home'** Residents are the focus of the home as they are often the sole reason for its existence. The value base of the provider is likely to resonate with those who choose to move into the home and therefore a resident's expectations of the home and its systems are perhaps more likely to be aligned.	Generally yes (0.5)	Residents were the focus of the home although they were not the sole reason for its existence. The home had been the proprietor's own home before conversion. There was however evidence that the care of older adults is a strong motivating factor for the homes existence.
	Total (4.5)	

Hypotheses 4. Isolate orientation - Case study home C

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Characterised by short term coping strategies. The home may belong to a larger provider with systems that are seen as constraining.	No (0)	Arguably some short term coping, but generally there was evidence of forward planning and systems that met the needs of the home. Those systems that existed were clearly felt to be necessary for the management of the home.
2.0 **Discretion in the use and interpretation of systems** Those who work within the home may feel a sense of hopelessness as they have no option but to comply with the provider's rules.	No (0)	Those who lived and worked within the home appeared positive and generally optimistic. As carers were delegated significant discretion, there was no sense that they were constrained by 'rules'.
2.1 **Street level bureaucracy** Street level bureaucracy is unlikely as the manager is completely constrained by the provider's systems.	No (0)	Street level bureaucracy arguably existed. However, it had not undermined the provider's systems as 'inappropriate' requests from regulators, like the 'prohibition' of free range eggs were challenged.
2.2 **Rituals of compliance** Rituals of compliance are likely to be well developed, as the home manager attempts to prove compliance with the provider's myriad systems.	No (0)	There was no real evidence of any rituals. The systems that the manager had developed could be evidenced in use.
3.0 **Role of provider at local level** Compliance oriented with an emphasis on checking, audit and blame.	No (0)	There was arguably a shared vision for the home, as the staff participant appeared to recognise the manager's vision for the home.
4.0 **Conceptualisation of 'home'** Residents are supposed to be the focus of the home; however they may become 'pawns' in debates between proprietor, regulator and home staff.	No (0)	Residents appeared to be the focus of the homes activities and were not obviously used as pawns in debates with regulators.
	Total (0)	

Hypotheses 1. Hierarchical orientation - Case study home E

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Boundaries are very clear and based on systems of authority and management accountability existing within the organisation and within the home	Some evidence (0.5)	The home belonged to a national 'not for profit' provider and was able to draw on centralised systems. However, implementation appeared to be a matter for the home.
2.0 **Discretion in the use and interpretation of systems** Those working in hierarchical homes are expected to follow systems with little discretion. There will be tasks to complete according to protocols and within defined roles and responsibilities.	Yes (1)	Authority appeared to be vested with the home manager who answered to a local committee. The provider's systems did not appear to be rigid and the manager appears to exercise significant discretion around implementation. Local custom and practice 'rules' appear to be the norm.
2.1 **Street level bureaucracy** Likely to be limited due to national protocols and systems comprising policies, procedures and rules of conduct.	Some evidence (0.5)	There were national protocols in place and no real evidence of street level bureaucracy by the regulator. However, the manager cited interpretation of the law by the regulator as an issue and applied local 'rules' to manage risk.
2.2 **Rituals of compliance** The apparent rigidity of the systems and the failure to involve those who apply them *may* lead to localised custom and practice that 'circumvents' some of the organisations procedures leading rituals of compliance without compliance in fact.	Yes (1)	Documented systems were in place and cited, however, evidence within inspection reports would suggest they were not necessarily all used. There was also evidence of local custom and practice in terms of 'rules' applied by the home manager and staff.
3.0 **Role of provider at local level** Compliance oriented with an emphasis on checking and audit.	Some evidence (0.5)	The home manager appeared to exercise significant discretion, with support from a local committee.
4.0 **Conceptualisation of 'home'** Whilst residents are the focus of the organisation's values and activities, it is the systems for meeting compliance that drives the organisations management practices. Residents are well cared for and safe, yet, their experience might be equated more with the hotel than the home whereby care services are formalised and focussed on protection.	Some evidence (0.5)	The organisations management systems do not appear to drive care services. The residents' experience arguably cannot be compared to that of a hotel. Care practices are apparently reactive and derive from what was described as a 'common sense' approach. However 'care' appears to be focussed on protection.
	Total (4)	

Hypotheses 2. Individualistic orientation - Case study home E

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Practice is determined at local level allowing for significant discretion. Policies and procedures are likely to be few, whilst the local culture is strong.	Some evidence (0.5)	The home belonged to a national provider who could evidence written systems. However, the manager appeared to exercise significant local discretion. 'Rules' determined at local level also appeared to be a feature of the home.
2.0 **Discretion in the use and interpretation of systems** Whilst written systems may exist, carers are more likely to interact with the home manager and use whatever degree of discretion the manager allows.	Generally no (0.5)	Carers appeared to work in accordance with the homes systems and the local community of practice, which at times appeared 'rules' oriented. Care staff (keyworkers) arguably applied the discretion allowed by the home manager.
2.1 **Street level bureaucracy** Street level bureaucracy is likely to be a significant factor. In the absence of centralised systems the requirements of Regulator's is likely to be reflected in the homes written systems.	Some evidence (0.5)	There was little evidence that street level bureaucracy was a significant factor. Written systems were available from the proprietor. Arguably, a 'localised' form was in use, where protection was seen as the principal legal expedient.
2.2 **Rituals of compliance** The degree to which documented systems are applied *ritualistically* will depend on how and why they were created and implemented.	No (0)	There was some evidence to suggest that the proprietors written systems were used ritualistically. They were used as 'evidence' during inspections, but CSCI reports suggest they were not always realised in practice.
3.0 **Role of provider at local level** The manager is likely to be the provider and will take a direct and personal interest in the practical day to day running of the home, spending less time on documented audits.	No (0)	Whilst the provider clearly exercised an influence upon the homes ethos and direction, the day to day running of the home was delegated to the home manager.
4.0 **Conceptualisation of 'home'** Residents experience is determined by the value base of the owner and home manager. Homes may emulate the characteristics of a domestic environment in terms of informality, access to facilities and relationships. Care services are likely to be person centred and informal.	No (0)	Care was in accordance with the perceived needs of the residents. Clearly the residents' experience was determined by the value base of the home manager. Care services appeared to be informal and arguably person centred in some areas but not others. The safety of residents seemed to be the prime consideration of the care staff and this was arguably to the detriment of lifestyle choice.
	Total (1.5)	

Hypotheses 3. Egalitarian orientation - Case study home E

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Characterised by a shared commitment to the values and principles of the organisation. Systems & rules will be framed within the value base of the organisation and the needs of residents.	Some evidence (0.5)	There was evidence to suggest that the faith based values of the home and provider were generally aligned. Whilst the provider's systems were not always clearly in evidence, the home manager appeared to have been given discretion in this respect.
2.0 **Discretion in the use and interpretation of systems** Discretion is likely to be encouraged so long as it reflects the values of the provider.	Yes (1)	Discretion was apparent at home manager level and was arguably delegated to other senior staff and carers with respect to some aspects of the care of residents.
2.1 **Street level bureaucracy** Is likely to vary according to how well the home is bound to the organisation by systems and protocols.	Some evidence (0.5)	Street level bureaucracy was arguably only in evidence at a local level. The home manager made reference to the likelihood of street level bureaucracy in terms of how the regulator's interpretation of the system might differ from his.
2.2 **Rituals of compliance** Rituals of compliance are likely to be limited by the strong local culture that is largely aligned with the provider's management of the home.	No (0)	There was evidence within inspection reports that whilst the home was able to show certain procedures to the regulator, these were not always evidenced in fact.
3.0 **Role of provider at local level** The values and involvement of the provider *may* exert a direct influence in their own right, by for example being directly involved within the home. The provider's role is seen as practical and supportive.	Some evidence (0.5)	The faith based values of the provider were evidenced within the home in terms of some practical activities. The local advisory group could theoretically exert a real influence upon the management of the home. However, this did not appear to be the case as the group's role was seen as support rather than direction.
4.0 **Conceptualisation of 'home'** Residents are the focus of the home as they are often the sole reason for its existence. The value base of the provider is likely to resonate with those who choose to move into the home and therefore a resident's expectations of the home and its systems are perhaps more likely to be aligned.	Some evidence (0.5)	There was significant evidence that residents' appreciated the faith based ethos of the provider and their activities. There was, however, also evidence that residents' expectations and care needs were not always met. Their safety rather than their lifestyle choice was arguably a feature of the home.
	Total (3)	

Hypotheses 4. Isolate orientation - Case study home E

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Characterised by short term coping strategies. The home may belong to a larger provider with systems that are seen as constraining.	No (0)	Cope by adopting a clear hierarchy and 'rules'. Do not distance themselves from the provider's systems. Home maintains provider's identity although arguably not always their documented / intended practice.
2.0 **Discretion in the use and interpretation of systems** Those who work within the home may feel a sense of hopelessness as they have no option but to comply with the provider's rules.	No (0)	Whilst the home belongs to a large provider, it is the interpretation of the legal system by regulators that is seen as constraining rather than the provider's systems.
2.1 **Street level bureaucracy** Street level bureaucracy is unlikely as the manager is completely constrained by the provider's systems.	Some evidence (0.5)	The local culture appeared strong and was supported by a large provider's written systems. However, 'localised' street level bureaucracy was evidenced in terms of local 'rules'.
2.2 **Rituals of compliance** Rituals of compliance are likely to be well developed, as the home manager attempts to prove compliance with the provider's myriad systems.	Some evidence (0.5)	Whilst there were arguably rituals of compliance, these did not appear to be as the result of a disagreement with the provider's systems – it was a matter of their implementation.
3.0 **Role of provider at local level** Compliance oriented with an emphasis on checking, audit and blame.	No (0)	There was little evidence that the provider intensively checked or audited local systems.
4.0 **Conceptualisation of 'home'** Residents are supposed to be the focus of the home; however they may become 'pawns' in debates between proprietor, regulator and home staff.	No (0)	Residents were not obviously impacted upon by local politics.
	Total (1)	

Hypotheses 1. Hierarchical orientation - Case study home G

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Boundaries are very clear and based on systems of authority and management accountability existing within the organisation and within the home	No (0)	The home belonged to a faith based provider, who exerted control via a local committee. There were no constraints upon the home manager in terms of the provider's systems.
2.0 **Discretion in the use and interpretation of systems** Those working in hierarchical homes are expected to follow systems with little discretion. There will be tasks to complete according to protocols and within defined roles and responsibilities.	No (0)	Whilst there was a voluntary committee, it did not prescribe management systems for the home. The committee appeared to work in partnership with the home manager and delegated considerable autonomy and discretion.
2.1 **Street level bureaucracy** Likely to be limited due to national protocols and systems comprising policies, procedures and rules of conduct.	No (0)	There was arguably evidence of street level bureaucracy that influenced the home manager's development and application of systems.
2.2 **Rituals of compliance** The apparent rigidity of the systems and the failure to involve those who apply them *may* lead to localised custom and practice that 'circumvents' some of the organisations procedures leading rituals of compliance without compliance in fact.	No (0)	As the design and implementation of systems was done at local level, there was arguably a high level of compliance and a low level of ritualism. The involvement of a consultancy organisation *may* eventually however shift this dynamic towards a more ritualistic orientation.
3.0 **Role of provider at local level** Compliance oriented with an emphasis on checking and audit.	No (0)	The provider appeared to delegate the checking and auditing role to the home manager. The committee were however supportive.
4.0 **Conceptualisation of 'home'** Whilst residents are the focus of the organisation's values and activities, it is the systems for meeting compliance that drives the organisations management practices. Residents are well cared for and safe, yet, their experience might be equated more with the hotel than the home whereby care services are formalised and focussed on protection.	No (0)	The ethos of the home arguably drives system development and implementation. Residents appeared to live within an informal environment characterised by an apparent respect for their lifestyle choices.
	Total (0)	

Hypotheses 2. Individualistic orientation - Case study home G

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Practice is determined at local level allowing for significant discretion. Policies and procedures are likely to be few, whilst the local culture is strong.	Yes (1)	The committee had delegated significant autonomy to the home manager and the home was characterised by practice determined at local level. The local culture appeared strong.
2.0 **Discretion in the use and interpretation of systems** Whilst written systems may exist, carers are more likely to interact with the home manager and use whatever degree of discretion the manager allows.	Some evidence (0.5)	The home manager, her deputy and carers had worked to develop written systems to guide them in their day to day tasks. There was also a strong ethos of training. However, teamwork was evident and carers were seen to consult with the home manager.
2.1 **Street level bureaucracy** Street level bureaucracy is likely to be a significant factor. In the absence of centralised systems the requirements of Regulator's is likely to be reflected in the homes written systems.	Some evidence (0.5)	Street level bureaucracy was arguably a factor as the home manager did not have the support of a larger provider. Systems were arguably created in response to regulatory requirements.
2.2 **Rituals of compliance** The degree to which documented systems are applied *ritualistically* will depend on how and why they were created and implemented.	No (0)	There was evidence that the home manager felt vulnerable as the result of being responsible for the creation and management of the home's systems. A consultancy had therefore been asked to provide support.
3.0 **Role of provider at local level** The manager is likely to be the provider and will take a direct and personal interest in the practical day to day running of the home, spending less time on documented audits.	No (0)	Whilst the provider arguably took a direct interest in the management of the home, they did not support this process directly. A consultant had recently been appointed to assist in the design and implementation of robust systems.
4.0 **Conceptualisation of 'home'** Residents experience is determined by the value base of the owner and home manager. Homes may emulate the characteristics of a domestic environment in terms of informality, access to facilities and relationships. Care services are likely to be person centred and informal.	Yes (1)	The residents appeared to benefit from a home whose management committee included their relatives and operated according to faith based principles. The home manager was arguably given the latitude to ensure that 'choice' and meeting the needs of the residents was the focus of the home.
	Total (3)	

Hypotheses 3. Egalitarian orientation - Case study home G

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Characterised by a shared commitment to the values and principles of the organisation. Systems & rules will be framed within the value base of the organisation and the needs of residents.	Yes (1)	The home operated within a framework of faith based values, applied by a manager who had worked in the home since being recruited as a care assistant.
2.0 **Discretion in the use and interpretation of systems** Discretion is likely to be encouraged so long as it reflects the values of the provider.	Yes (1)	There was ample evidence of local discretion.
2.1 **Street level bureaucracy** Is likely to vary according to how well the home is bound to the organisation by systems and protocols.	Yes (1)	Street level bureaucracy was arguably a factor, however, there was little or no evidence that it impacted in a particularly negative way.
2.2 **Rituals of compliance** Rituals of compliance are likely to be limited by the strong local culture that is largely aligned with the provider's management of the home.	Yes (1)	Whilst the home manager was 'accountable' to a local voluntary committee, it afforded a considerable amount of autonomy. Systems were therefore developed and implemented by the home manager in consultation with the staff. The introduction of a consultancy will arguably shift this dynamic towards hierarchy.
3.0 **Role of provider at local level** The values and involvement of the provider *may* exert a direct influence in their own right, by for example being directly involved within the home. The provider's role is seen as practical and supportive.	Yes (1)	The relationship between the home manager and committee allowed considerable autonomy within a framework of faith based values. The committee comprised relatives and friends of the home who took a direct and personal interest in its success.
4.0 **Conceptualisation of 'home'** Residents are the focus of the home as they are often the sole reason for its existence. The value base of the provider is likely to resonate with those who choose to move into the home and therefore a resident's expectations of the home and its systems are perhaps more likely to be aligned.	Yes (1) Total (6)	Again, given the above statement, the residents were clearly the focus of the home. The faith oriented value base of the provider clearly resonated with the ethos of the home. Residents appeared to be able to exercise lifestyle choices rather than being protected from risk.

Hypotheses 4. Isolate orientation - Case study home G

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Characterised by short term coping strategies. The home may belong to a larger provider with systems that are seen as constraining.	No (0)	There was arguably no evidence of short term coping strategies or any distance between the local committee and management team.
2.0 **Discretion in the use and interpretation of systems** Those who work within the home may feel a sense of hopelessness as they have no option but to comply with the provider's rules.	No (0)	Staff presented as well motivated and supportive of the provider's ethos and systems.
2.1 **Street level bureaucracy** Street level bureaucracy is unlikely as the manager is completely constrained by the provider's systems.	No (0)	Street level bureaucracy was not an issue in terms of undermining or challenging systems. The staff team and managing committee presented as an aligned and cohesive unit.
2.2 **Rituals of compliance** Rituals of compliance are likely to be well developed, as the home manager attempts to prove compliance with the provider's myriad systems.	No (0)	Arguably there was no evidence of ritualism as most systems had been developed at local level. This might however change when the consultant's systems are implemented.
3.0 **Role of provider at local level** Compliance oriented with an emphasis on checking, audit and blame.	No (0)	There was evidence of clear alignment between the value base of the managing committee, home manager and staff.
4.0 **Conceptualisation of 'home'** Residents are supposed to be the focus of the home; however they may become 'pawns' in debates between proprietor, regulator and home staff.	No (0) Total (0)	Residents were the focus of the home and did not appear to be pawns in any debates with either regulator or local committee.

Hypotheses 1. Hierarchical orientation - Case study home B

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Boundaries are very clear and based on systems of authority and management accountability existing within the organisation and within the home	Yes (1)	The home is part of a large voluntary sector provider group with well defined boundaries, systems, policies and procedures.
2.0 **Discretion in the use and interpretation of systems** Those working in hierarchical homes are expected to follow systems with little discretion. There will be tasks to complete according to protocols and within defined roles and responsibilities.	Yes (1)	As a large provider there are clear systems of authority which prescribe the limits of management discretion.
2.1 **Street level bureaucracy** Likely to be limited due to national protocols and systems comprising policies, procedures and rules of conduct.	Generally yes (0.5)	Street level bureaucracy is limited by national protocols and visiting managers check that systems are implemented as required. However, there was evidence of local 'rules'.
2.2 **Rituals of compliance** The apparent rigidity of the systems and the failure to involve those who apply them *may* lead to localised custom and practice that 'circumvents' some of the organisations procedures leading rituals of compliance without compliance in fact.	Yes (1)	Systems were arguably well designed and implemented, however, there was some evidence of local 'rules'. For example, whilst written policy espoused choice, this was not always evidenced in fact. There was also evidence that regulatory systems were not always welcomed in terms of the accompanying 'bureaucratic' workload.
3.0 **Role of provider at local level** Compliance oriented with an emphasis on checking and audit.	Generally yes (0.5)	There was evidence of visiting managers whose role included support and internal audit.
4.0 **Conceptualisation of 'home'** Whilst residents are the focus of the organisation's values and activities, it is the systems for meeting compliance that drives the organisations management practices. Residents are well cared for and safe, yet, their experience might be equated more with the hotel than the home whereby care services are formalised and focussed on protection.	Generally yes (0.5)	Whilst 'hotel services' were arguably a significant factor, there was also evidence to suggest that person centred care was important. There was however evidence that risks were managed by 'rules' for example, the risk of tripping over a bedside rug was managed by prohibiting them.
	Total (4.5)	

Hypotheses 2. Individualistic orientation - Case study home B

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Practice is determined at local level allowing for significant discretion. Policies and procedures are likely to be few, whilst the local culture is strong.	No (0)	There was little evidence of a localised 'rule' based culture. The proprietor had comprehensive systems that were accessible and evidenced in use.
2.0 **Discretion in the use and interpretation of systems** Whilst written systems may exist, carers are more likely to interact with the home manager and use whatever degree of discretion the manager allows.	No (0)	The home manager and carers were expected to comply with the provider's systems within a supervisory hierarchy.
2.1 **Street level bureaucracy** Street level bureaucracy is likely to be a significant factor. In the absence of centralised systems the requirements of Regulator's is likely to be reflected in the homes written systems.	No (0)	Street level bureaucracy was arguably not a factor. The home accepted the proprietor's systems, and there was evidence of a close working relationship between the home manager and area manager. However, local 'rules' were in evidence.
2.2 **Rituals of compliance** The degree to which documented systems are applied *ritualistically* will depend on how and why they were created and implemented.	No (0)	There was little evidence that systems were applied ritualistically, although there were some local 'rules'.
3.0 **Role of provider at local level** The manager is likely to be the provider and will take a direct and personal interest in the practical day to day running of the home, spending less time on documented audits.	No (0)	The home manager appeared to take an overview of services rather than being directly and closely involved. The provider was represented by a visiting area manager.
4.0 **Conceptualisation of 'home'** Residents experience is determined by the value base of the owner and home manager. Homes may emulate the characteristics of a domestic environment in terms of informality, access to facilities and relationships. Care services are likely to be person centred and informal.	No (0)	The residents experience was arguably a function of the proprietor's ethos of care. As the home comprised an older property with modern extension it possessed an individual, arguably domestic character. There was however an aire of formality about the home that derived from its formalised systems and a sense that residents needed to be 'protected' from harm.
	Total (0)	

Hypotheses 3. Egalitarian orientation - Case study home B

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Characterised by a shared commitment to the values and principles of the organisation. Systems & rules will be framed within the value base of the organisation and the needs of residents.	Generally yes (0.5)	There was evidence of a shared commitment to the values of the organisation. Systems and rules arguably reflected the values of the organisation. However, there was an emphasis on documented systems that the manager felt distracted her from time with residents.
2.0 **Discretion in the use and interpretation of systems** Discretion is likely to be encouraged so long as it reflects the values of the provider.	No (0)	The home manager was generally constrained by the provider's systems. The area manager and other support managers arguably exerted influence on the home by supporting the manager, staff and spending time in the home.
2.1 **Street level bureaucracy** Is likely to vary according to how well the home is bound to the organisation by systems and protocols.	Generally no (0.5)	There was no evidence of street level bureaucracy from the regulator as systems were derived from the national minimum standards. However, there was evidence of local 'rules'.
2.2 **Rituals of compliance** Rituals of compliance are likely to be limited by the strong local culture that is largely aligned with the provider's management of the home.	Yes (1)	There was little evidence that systems were applied ritualistically, although there were some local 'rules'.
3.0 **Role of provider at local level** The values and involvement of the provider *may* exert a direct influence in their own right, by for example being directly involved within the home. The provider's role is seen as practical and supportive.	Some evidence (0.5)	The home is subject to the management scrutiny of the provider. There was evidence of a good relationship with the area manager and the existence of specialist managers (e.g. safety manager) who provided implementation support.
4.0 **Conceptualisation of 'home'** Residents are the focus of the home as they are often the sole reason for its existence. The value base of the provider is likely to resonate with those who choose to move into the home and therefore a resident's expectations of the home and its systems are perhaps more likely to be aligned.	Some evidence (0.5)	Residents were arguably the focus of the home, and the residents' expectations appeared to be generally aligned with the provider. However, there was also evidence that concerns about 'risk' did distract from some areas of lifestyle choice.
	Total (3)	

Hypotheses 4. Isolate orientation - Case study home B

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Characterised by short term coping strategies. The home may belong to a larger provider with systems that are seen as constraining.	No (0)	There was arguably no evidence of short term coping strategise. The home's management was pro-active and problem solving oriented. The home was aligned with the provider's system and arguably reflected the provider's identity.
2.0 **Discretion in the use and interpretation of systems** Those who work within the home may feel a sense of hopelessness as they have no option but to comply with the provider's rules.	No (0)	Home staff appeared to support the provider's systems.
2.1 **Street level bureaucracy** Street level bureaucracy is unlikely as the manager is completely constrained by the provider's systems.	Generally no (0.5)	Street level bureaucracy was generally not evidenced. The close working relationship between manager and provider allowed regulators to be challenged where necessary.
2.2 **Rituals of compliance** Rituals of compliance are likely to be well developed, as the home manager attempts to prove compliance with the provider's myriad systems.	Generally no (0.5)	There was little evidence of any overt rituals of compliance, although residents and one member of staff were not entirely clear about the keyworker system.
3.0 **Role of provider at local level** Compliance oriented with an emphasis on checking, audit and blame.	No (0)	Whilst the area manager's role included checking systems, there was evidence of a supportive working relationship with the home manager.
4.0 **Conceptualisation of 'home'** Residents are supposed to be the focus of the home; however they may become 'pawns' in debates between proprietor, regulator and home staff.	No (0) Total (1)	Residents were the focus of the home and all actions were directed at providing 'safe' and effective care.

Hypotheses 1. Hierarchical orientation - Case study home D

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Boundaries are very clear and based on systems of authority and management accountability existing within the organisation and within the home	No (0)	As a small private home there were no constraints imposed by a parent provider.
2.0 **Discretion in the use and interpretation of systems** Those working in hierarchical homes are expected to follow systems with little discretion. There will be tasks to complete according to protocols and within defined roles and responsibilities.	No (0)	Boundaries were very clear in terms of ownership and management. Arguably there were few systems that carers were required to follow. As a small private home, those working there were expected to use their discretion and therefore systems were developed in accordance with local need and expedience.
2.1 **Street level bureaucracy** Likely to be limited due to national protocols and systems comprising policies, procedures and rules of conduct.	No (0)	Street level bureaucracy was potentially an issue as the interface was simply between regulator and owner / manager without hierarchical support.
2.2 **Rituals of compliance** The apparent rigidity of the systems and the failure to involve those who apply them *may* lead to localised custom and practice that 'circumvents' some of the organisations procedures leading rituals of compliance without compliance in fact.	No (0)	There was little evidence of ritualism.
3.0 **Role of provider at local level** Compliance oriented with an emphasis on checking and audit.	No (0)	The home manager was clearly the focus of the home and care staff appeared to understand what was expected of them.
4.0 **Conceptualisation of 'home'** Whilst residents are the focus of the organisation's values and activities, it is the systems for meeting compliance that drives the organisations management practices. Residents are well cared for and safe, yet, their experience might be equated more with the hotel than the home whereby care services are formalised and focussed on protection.	Some evidence (0.5) Total (0.5)	Arguably residents were the sole focus of the home. However, the regulatory framework appeared to have caused the home manager to focus on the safety and welfare of residents. This arguably meant that some areas of lifestyle choice were constrained.

Hypotheses 2. Individualistic orientation - Case study home D

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Practice is determined at local level allowing for significant discretion. Policies and procedures are likely to be few, whilst the local culture is strong.	Yes (1)	The home was managed by the owner and there was a strong sense of local culture. There were policies and procedures that had been drawn up at local level to meet local circumstances.
2.0 **Discretion in the use and interpretation of systems** Whilst written systems may exist, carers are more likely to interact with the home manager and use whatever degree of discretion the manager allows.	Yes (1)	Care was clearly under the supervision of the home manager and was arguably in accordance with resident need. There was clear evidence that whilst there were written procedures, there was discretion and interaction between manager and staff in most activities.
2.1 **Street level bureaucracy** Street level bureaucracy is likely to be a significant factor. In the absence of centralised systems the requirements of Regulator's is likely to be reflected in the homes written systems.	Yes (1)	Street level bureaucracy was arguably a factor as the home manager was influenced by regulatory requirements. Written systems were also influenced by the manager's NVQ and the perceived need to prove regulatory compliance.
2.2 **Rituals of compliance** The degree to which documented systems are applied *ritualistically* will depend on how and why they were created and implemented.	Yes (1)	The systems were created by the owner / manager for use within the home. There was no real evidence that the systems were applied ritualistically.
3.0 **Role of provider at local level** The manager is likely to be the provider and will take a direct and personal interest in the practical day to day running of the home, spending less time on documented audits.	Yes (1)	The manager was clearly focussed on all aspects of the success of the home and took a direct personal interest in the practical day to day running of the home. This included shopping for the home, which included residents if they so wished.
4.0 **Conceptualisation of 'home'** Residents experience is determined by the value base of the owner and home manager. Homes may emulate the characteristics of a domestic environment in terms of informality, access to facilities and relationships. Care services are likely to be person centred and informal.	Some evidence (0.5) Total (5.5)	The value base of the home was clearly aligned with the owner /manager. In many respects the home did emulate the characteristics of a domestic household. However, there was evidence that CSCI inspections and the National Minimum Standards had raised awareness of the need to manage risk. This arguably distracted from some aspects of lifestyle choice.

Hypotheses 3. Egalitarian orientation - Case study home D

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Characterised by a shared commitment to the values and principles of the organisation. Systems & rules will be framed within the value base of the organisation and the needs of residents.	Yes (1)	As the home manager both owns the home and sets its strategic direction, there was arguably considerable alignment in values and systems.
2.0 **Discretion in the use and interpretation of systems** Discretion is likely to be encouraged so long as it reflects the values of the provider.	Some evidence (0.5)	Street level bureaucracy was arguably evidenced within the home. This did not however detract from the considerable amount of discretion that the home manager and staff were able to exercise.
2.1 **Street level bureaucracy** Is likely to vary according to how well the home is bound to the organisation by systems and protocols.	Yes (1)	It was difficult to assess / evaluate the level of ritualism within the home, although it is likely that the home manager and staff would be more likely to ensure compliance with systems designed by them to meet local need.
2.2 **Rituals of compliance** Rituals of compliance are likely to be limited by the strong local culture that is largely aligned with the provider's management of the home.	No (0)	
3.0 **Role of provider at local level** The values and involvement of the provider *may* exert a direct influence in their own right, by for example, being directly involved within the home. The provider's role is seen as practical and supportive.	Some evidence (0.5)	The direct involvement of the provider as owner and manager ensured that her value base was reflected in the day to day running of the home in every respect.
4.0 **Conceptualisation of 'home'** Residents are the focus of the home as they are often the sole reason for its existence. The value base of the provider is likely to resonate with those who choose to move into the home and therefore a resident's expectations of the home and its systems are perhaps more likely to be aligned.	No(0) Total (3)	Residents were arguably the focus of the home, although the home was also a small business with the accompanying constraints of financial and legal compliance. There was ample evidence that the home met the physical and emotional needs of the residents, however, the management of 'risk' was arguably becoming an increasing priority.

Hypotheses 4. Isolate orientation - Case study home D

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Characterised by short term coping strategies. The home may belong to a larger provider with systems that are seen as constraining.	No (0)	Whilst arguably the home did resort to some short term strategies, there was ample evidence of well planned and managed systems that were aligned with the ethos of the home.
2.0 **Discretion in the use and interpretation of systems** Those who work within the home may feel a sense of hopelessness as they have no option but to comply with the provider's rules.	No (0)	The home was owned and managed by one person as part of a family business. This ensured strong alignment between the values of the home and the systems that were applied.
2.1 **Street level bureaucracy** Street level bureaucracy is unlikely as the manager is completely constrained by the provider's systems.	No (0)	Street level bureaucracy was evidenced, but this was part of an ongoing dialogue between the regulators and the proprietor. It was not used in any sense to undermine the home's systems.
2.2 **Rituals of compliance** Rituals of compliance are likely to be well developed, as the home manager attempts to prove compliance with the provider's myriad systems.	No (0)	There was no real evidence of rituals of compliance, although arguably some are likely given the large number of standards and regulations a small private business is required to comply with.
3.0 **Role of provider at local level** Compliance oriented with an emphasis on checking, audit and blame.	No (0)	The home manager's and staff's perspectives appeared to be aligned. There was no evidence of an emphasis on checking and compliance auditing.
4.0 **Conceptualisation of 'home'** Residents are supposed to be the focus of the home; however they may become 'pawns' in debates between proprietor, regulator and home staff.	No (0) Total (0)	Residents were evidenced as being the general focus of the home and were arguably not seen to be pawns in any debates with the regulator.

Hypotheses 1. Hierarchical orientation - Case study home F

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Boundaries are very clear and based on systems of authority and management accountability existing within the organisation and within the home	Yes (1)	As a local authority home there was evidence of comprehensive systems and a defined management structure to direct the operation of the service.
2.0 **Discretion in the use and interpretation of systems** Those working in hierarchical homes are expected to follow systems with little discretion. There will be tasks to complete according to protocols and within defined roles and responsibilities.	Yes (1)	Boundaries of authority were arguably very clear with written systems, audits and checks in place to ensure compliance.
2.1 **Street level bureaucracy** Likely to be limited due to national protocols and systems comprising policies, procedures and rules of conduct.	Yes (1)	There was no evidence of street level bureaucracy as systems based on regulatory compliance were provided by the local authority.
2.2 **Rituals of compliance** The apparent rigidity of the systems and the failure to involve those who apply them *may* lead to localised custom and practice that 'circumvents' some of the organisations procedures leading rituals of compliance without compliance in fact.	Yes (1)	There was no evidence of ritualism as home staff appeared conversant with the home's systems and understood why there were in place. There was evidence that local judgement was facilitated by the home's systems and that staff knew the limits of such authority.
3.0 **Role of provider at local level** Compliance oriented with an emphasis on checking and audit.	Yes (1)	There was clear evidence of compliance oriented management. A rigorous health and safety audit was observed during the fieldwork.
4.0 **Conceptualisation of 'home'** Whilst residents are the focus of the organisation's values and activities, it is the systems for meeting compliance that drives the organisations management practices. Residents are well cared for and safe, yet, their experience might be equated more with the hotel than the home whereby care services are formalised and focussed on protection.	Some evidence (0.5)	Arguably whilst the home appeared very person centred, this was within a framework of clearly defined policies, procedures and a management hierarchy. As a local authority home, carers were very conscious of the need to manage risk. Residents' appeared to be well cared for and were generally 'protected' from harm, although the home also offered a wide range of facilities not necessarily available within the other case study homes.
	Total (5.5)	

Hypotheses 2. Individualistic orientation - Case study home F

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Practice is determined at local level allowing for significant discretion. Policies and procedures are likely to be few, whilst the local culture is strong.	No (0)	There was arguably little evidence that rules were determined at local level. The home operated within a strong framework of local authority policies and procedures.
2.0 **Discretion in the use and interpretation of systems** Whilst written systems may exist, carers are more likely to interact with the home manager and use whatever degree of discretion the manager allows.	No (0)	Street level bureaucracy was arguably not a factor. The local authority provided all of the home's systems and supervisory support.
2.1 **Street level bureaucracy** Street level bureaucracy is likely to be a significant factor. In the absence of centralised systems the requirements of Regulator's is likely to be reflected in the homes written systems.	No (0)	There was little evidence of ritualism, there appeared to be a genuine understanding of why the systems were required.
2.2 **Rituals of compliance** The degree to which documented systems are applied *ritualistically* will depend on how and why they were created and implemented.	No (0)	The home manager was an employee, and whilst he spent time with residents on practical tasks, his primary function was the management of the service.
3.0 **Role of provider at local level** The manager is likely to be the provider and will take a direct and personal interest in the practical day to day running of the home, spending less time on documented audits.	No (0)	Whilst the home arguably had a unique identity of its own, this was framed within the ethos of the local authority, its policies, procedures and systems. The management of risk was arguably a high priority, and care was highly formalised. However, the provision of services within the home offered choices not necessarily available in many of the other case study homes.
4.0 **Conceptualisation of 'home'** Residents experience is determined by the value base of the owner and home manager. Homes may emulate the characteristics of a domestic environment in terms of informality, access to facilities and relationships. Care services are likely to be person centred and informal.	No (0)	
	Total (0)	

Hypotheses 3. Egalitarian orientation - Case study home F

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Characterised by a shared commitment to the values and principles of the organisation. Systems & rules will be framed within the value base of the organisation and the needs of residents.	Yes (1)	There was evidence that staff shared the values of the local authority in terms of service provision and the systems designed to support this. The systems appeared to reflect the ethos of the local authority provider and were generally aimed at 'safely' meeting the needs of residents.
2.0 **Discretion in the use and interpretation of systems** Discretion is likely to be encouraged so long as it reflects the values of the provider.	No (0)	The home manager and care staff were generally expected to comply with the provider's systems.
2.1 **Street level bureaucracy** Is likely to vary according to how well the home is bound to the organisation by systems and protocols.	No (0)	Street level bureaucracy was arguably not an issue for the home. Systems covered most aspects of the home's management including areas of regulatory compliance. The home manager was allowed only a little latitude with respect to the interpretation of systems.
2.2 **Rituals of compliance** Rituals of compliance are likely to be limited by the strong local culture that is largely aligned with the provider's management of the home.	Yes (1)	There was no evidence of ritualism.
3.0 **Role of provider at local level** The values and involvement of the provider *may* exert a direct influence in their own right, by for example being directly involved within the home. The provider's role is seen as practical and supportive.	Some evidence (0.5)	Whilst the home manager was controlled by the provider's systems, there was evidence of shared values and general support for them. Representatives from the provider, including councillors were also involved with the home.
4.0 **Conceptualisation of 'home'** Residents are the focus of the home as they are often the sole reason for its existence. The value base of the provider is likely to resonate with those who choose to move into the home and therefore a resident's expectations of the home and its systems are perhaps more likely to be aligned.	Some evidence (0.5) Total (3)	Residents were clearly the focus of the home and were clearly why the home existed. Residents appeared to be genuinely impressed by the service. However, the management of risk was perhaps seen as more important than the promotion of choice.

Hypotheses 4. Isolate orientation - Case study home F

1. Proposition	Evidence	Notes
1.0 **Organisation and authority** Characterised by short term coping strategies. The home may belong to a larger provider with systems that are seen as constraining.	No (0)	Systems were arguably designed with long term objectives in mind and appeared to be fully supported by staff. Whilst the home clearly had its own identity, the ethos of the local authority provider was also evident.
2.0 **Discretion in the use and interpretation of systems** Those who work within the home may feel a sense of hopelessness as they have no option but to comply with the provider's rules.	No (0)	There was evidence that the home manager and carers felt supported by the provider's systems.
2.1 **Street level bureaucracy** Street level bureaucracy is unlikely as the manager is completely constrained by the provider's systems.	No (0)	There was arguably no question of street level bureaucracy being used to undermine the provider's systems. Visiting managers were seen to support the home and appeared to be held in high regard.
2.2 **Rituals of compliance** Rituals of compliance are likely to be well developed, as the home manager attempts to prove compliance with the provider's myriad systems.	No (0)	There were arguably no rituals of compliance. Systems were supported by home staff and audited by external professionals from the local authority.
3.0 **Role of provider at local level** Compliance oriented with an emphasis on checking, audit and blame.	No (0)	There was clear evidence of a close working relationship between the home manager and staff, but of equally high regard for their local authority employer.
4.0 **Conceptualisation of 'home'** Residents are supposed to be the focus of the home; however they may become 'pawns' in debates between proprietor, regulator and home staff.	No (0)	Residents were clearly the focus of both provider and home.
	Total (0)	

Cultural biases and expected organisational factors for all case study homes

Home B - Cultural biases and expected organisational factors

Management areas	**Hierarchy**, strong grid, strong group	**Egalitarian**, weak grid, strong group	**Individual**, weak grid, weak group	**Isolate**, strong grid, weak group
Management structure	Clearly defined by staff grades and reporting structures			
Risk assessment	Clearly set out within policies & procedures.	*Adaptable according to perceived need and concern*		
Risk management - Residents	Prescribed by 'rules'. Risk taking was unlikely	*Very capable residents could arguably influence choice*		
Risk management - Premises	Prescribed by 'Rules' and managed by specialists			
Training	Set by organisational policy			
Staff involvement in management of the home	Set by policy and procedure. Home manager leads within parameters set by provider			
Resident involvement	Set by policy in order to demonstrate 'compliance'	*Residents views were respected*		
Key working	Set by policy in order to demonstrate 'compliance'			
Care planning	Proceduralised & compliance oriented			
Likelihood of uniform	Corporate identity with uniform			

Items shown in *italics* are 'secondary' cultural characteristics felt to be features of the case study home.

Home C - Cultural matrix for case study homes

Management areas	**Hierarchy**, strong grid, strong group	**Egalitarian**, weak grid, strong group	**Individual**, weak grid, weak group	**Isolate**, strong grid, weak group
Management structure			Owner managed the home. Flat staffing structure	
Risk assessment		*Adaptable according to perceived need and concern*	Locally determined & arguably biased towards revenue	
'Rules' & Risk management - Residents		*Needs and consultation based. Risk taking is possible*	Relaxed approach, however likely 'blame' was a determining factor	
'Rules' & Risk management - Premises			Relaxed attitude to premises risk. It is 'home'.	
Training			Adaptable to local need according to resources	
Staff involvement in management of the home			Instructions to staff were general rather than specific and at owners discretion	
Resident involvement		*Residents views were respected*	In accordance with local expedience	
Key working			Key working was not seen as viable in such a small home	
Care planning			Informal	
Likelihood of uniform			Informal. Simple tabard	

Home D - Cultural matrix for case study homes

Management areas	**Hierarchy**, strong grid, strong group	**Egalitarian**, weak grid, strong group	**Individual**, weak grid, weak group	**Isolate**, strong grid, weak group
Management structure			Owner managed the home. Flat staffing structure	
Risk assessment		*Adaptable according to perceived need and concern*	Locally determined & arguably biased towards revenue	
'Rules' & Risk management - Residents			Relaxed approach, 'blame' was arguably a determining factor	
'Rules' & Risk management - Premises		*Adaptable to local circumstances & concerns*	Relaxed attitude to premises risk. It is 'home'.	
Training			Adaptable to local need according to resources	
Staff involvement in management of the home			Instructions to staff were general rather than specific and at owners discretion	
Resident involvement			In accordance with local expedience	
Key working		*Residents were seen as important 'partners'*	Key working was not seen as viable	
Care planning			Informal	
Likelihood of uniform			Informal. Simple tabard	

Home E - Cultural matrix for case study homes

Management areas	**Hierarchy**, strong grid, strong group	**Egalitarian**, weak grid, strong group	**Individual**, weak grid, weak group	**Isolate**, strong grid, weak group
Management structure	Clearly defined by staff grades and reporting structures			
Risk assessment	Clearly set out within policies & procedures.	*Adaptable according to perceived need and concern*		
'Rules' & Risk management - Residents	Prescribed by procedure. Risk taking was unlikely			
'Rules' & Risk management - Premises	Prescribed by procedure	*Adaptable to local circumstances & concerns*		
Training	Set by organisational policy			
Staff involvement in management of the home	Set by policy and procedure. Home manager leads within parameters set by provider	*Staff appeared to be involved at all levels*		
Resident involvement	Set by policy in order to demonstrate 'compliance'			
Key working	Set by policy and in order to demonstrate 'compliance'			
Care planning	Prescribed by procedure			
Likelihood of uniform	Corporate identity with uniform			

Home F - Cultural matrix for case study homes

Management areas	**Hierarchy**, strong grid, strong group	**Egalitarian**, weak grid, strong group	**Individual**, weak grid, weak group	**Isolate**, strong grid, weak group
Management structure	Clearly defined by staff grades and reporting structures			
Risk assessment	Clearly set out within policies & procedures.	*Adaptable according to locally perceived need and concern*		
'Rules' & Risk management - Residents	Prescribed by procedure. Risk taking was unlikely			
'Rules' & Risk management - Premises	Prescribed by procedure			
Training	Set by organisational policy			
Staff involvement in management of the home	Set by policy and procedure. Home manager leads within parameters set by provider			
Resident involvement	Set by policy in order to demonstrate 'compliance'	*Residents views were respected*		
Key working	Set by policy			
Care planning	Prescribed by procedure			
Likelihood of uniform	Corporate identity with uniform			

Home G - Cultural matrix for case study homes

Management areas	**Hierarchy**, strong grid, strong group	**Egalitarian**, weak grid, strong group	**Individual**, weak grid, weak group	**Isolate**, strong grid, weak group
Management structure		Relatively flat with few clearly defined grades		
Risk assessment		Adaptable according to perceived need and concern		
'Rules' & Risk management - Residents		Needs and consultation based. Risk taking was possible		
'Rules' & Risk management - Premises		Adaptable to local circumstances & concerns	*Relaxed attitude to premises risk. It is 'home'.*	
Training		Adaptable to need, staff encouraged to share skills		
Staff involvement in management of the home		Staff are involved at all levels	*Instructions to staff appeared general rather than specific*	
Resident involvement		Residents views were generally respected		
Key working		Residents were seen as important 'partners'		
Care planning		Formal system was in place		
Likelihood of uniform			Informal. Simple tabard / tunic	

Home H - Cultural matrix for case study homes

Management areas	**Hierarchy**, strong grid, strong group	**Egalitarian**, weak grid, strong group	**Individual**, weak grid, weak group	**Isolate**, strong grid, weak group
Management structure	*Clearly defined by staff grades and reporting structures*	Relatively flat with few clearly defined grades		
Risk assessment		Adaptable according to perceived need and concern		*Some evidence of 'fire fighting'*
'Rules' & Risk management - Residents		Needs and consultation based. Risk taking is possible		*Some evidence of erratic, crisis driven implementation*
'Rules' & Risk management - Premises		Adaptable to local circumstances & concerns		
Training		Adaptable to need, staff encouraged to share skills		*Ad hoc unless prescribed by owner*
Staff involvement in management of the home		Senior care staff were involved at all levels	*Instructions to staff were general rather than specific*	
Resident involvement		Residents views were respected	*In accordance with local expedience*	
Key working		Residents were seen as important 'partners'	*Key working was an evolving concept*	
Care planning		Care planning was an evolving concept	*Informal*	
Likelihood of uniform			Informal. Simple tabard / tunic	

Home I - Cultural matrix for case study homes

Management areas	**Hierarchy**, strong grid, strong group	**Egalitarian**, weak grid, strong group	**Individual**, weak grid, weak group	**Isolate**, strong grid, weak group
Management structure	Clearly defined by staff grades and reporting structures			
Risk assessment	Clearly set out within policies and procedures.			
'Rules' & Risk management - Residents	Prescribed by procedure. Risk taking was unlikely			
'Rules' & Risk management - Premises	Prescribed by procedure			
Training	Set by organisational policy			
Staff involvement in management of the home	Set by policy and procedure. Home manager leads within parameters set by provider			
Resident involvement	Set by policy in order to demonstrate 'compliance'			*Set by policy but erratic and ritualistic*
Key working	Set by policy and in order to demonstrate 'compliance'			*Set by policy but erratic and ritualistic*
Care planning	Prescribed by procedure			*Set by policy but erratic and ritualistic*
Likelihood of uniform	Corporate identity with uniform			

Summary showing expected organisational factors and representative case study homes

Management areas	**Hierarchy, strong grid, strong group**	**Representative case study homes**	**Egalitarian, weak grid, strong group**	**Representative case study homes**
Management structure	Clearly defined by staff grades and reporting structures	B, E, F and I	Relatively flat with few clearly defined grades	G & H
Risk assessment	Clearly set out within policies and procedures.	B, E, F and I	Adaptable according to perceived need and concern	G & H also C, D,B, E, and F
'Rules' & Risk management - Residents	Prescribed by procedure. Risk taking is unlikely	B, E, F and I	Needs and consultation based. Risk taking is possible	G & H also C and E
'Rules' & Risk management - Premises	Prescribed by procedure	B, E, F and I	Adaptable to local circumstances & concerns	G & H also D
Training	Set by organisational policy	B, E, F and I	Adaptable to need, staff encouraged to share skills	G & H also C and D
Staff involvement in management of the home	Set by policy and procedure. Home manager leads within parameters set by proprietor	B, E, F and I	Staff are involved at all levels	G & H also E
Resident involvement	Set by policy in order to demonstrate 'compliance'	B, E, F and I	Residents views are respected	G & H also B, C, F
Key working	Set by policy and in order to demonstrate 'compliance'	B, E, F and I	Residents are seen as important 'partners'	G & H also D
Care planning	Prescribed by procedure	B, E, F and I	Continuum of informal to formal	G and H
Likelihood of uniform	Corporate identity with uniform	B, E, F and I	Informal without uniform	G and H

Management areas	**Individual, weak grid, weak group**	**Representative case study homes**	**Isolate, strong grid, weak group**	**Representative case study homes**
Management structure	Owner likely to manage the home. Flat staffing structure	C & D	Presence of a 'personality' manager. 'Silo' management	
Risk assessment	Locally determined & arguably biased towards revenue	C & D	Little forward planning & characterised by 'fire fighting'	Some fire fighting evidenced in home H
'Rules' & Risk management - Residents	Relaxed approach, however likely 'blame' is a determining factor	C & D	May be procedural yet erratic, crisis driven implementation	Some evidence in home H
'Rules' & Risk management - Premises	Relaxed attitude to premises risk. It is 'home'.	Predominately home C and G, also G	Procedural yet erratic, crisis driven implementation	
Training	Adaptable to local need according to resources	C & D, but also H	Ad hoc unless prescribed by owner	H
Staff involvement in management of the home	Instructions to staff are general rather than specific and at owners discretion	C, D and G	Staff tend to operate in 'silos' according to management 'rules'	
Resident involvement	In accordance with local expedience	C & D, but also H	Set by policy but erratic and ritualistic	Some evidence in home I
Key working	Key working may not be seen as viable in small homes	C & D	Set by policy but erratic and ritualistic	I and H
Care planning	Informal	C & D	Set by policy but erratic and ritualistic	I and H
Likelihood of uniform	Likely to be informal. Simple tabard	C, D, and G	Uniform	

'Enumerated' Grid and Group Table

Home	Hierarchical	Individualistic	Egalitarian	Isolate	Totals
I	6	0	1	2	9
H	3	3.5	4.5	1.5	12.5
C	0	6	4.5	0	10.5
E	4	1.5	3	1	9.5
G	0	3	6	0	9
B	4.5	0	3	1	8.5
D	0.5	5.5	3	0	9
F	5.5	0	3	0	8.5

Note: The numbers allocated here are based upon qualitative judgements used simply in order to assist in classifying the predominant or principal cultural orientation of each home. They have no relevance or meaning in quantitative terms.

Home	Principal cultural orientation
I	Hierarchical
H	Egalitarian
C	Individualistic
E	Hierarchical
G	Egalitarian
B	Hierarchical
D	Individualistic
F	Hierarchical

Home	Likely general cultural orientation
B Voluntary sector home	Generally a high grid and high group orientation suggesting a hierarchical culture.
C Very small private home	Generally a low grid and low group orientation suggesting an individualistic culture
D Small private home	Generally a low grid and low group orientation suggesting an individualistic culture
E Large voluntary sector home	The 'rule' based management impacted upon the residents' freedom of choice in some areas and therefore emulated a hierarchical culture
F Local authority home	Generally a high grid and high group orientation suggesting a hierarchical culture.
G Voluntary sector home – local managing committee	Generally the low grid and high group characteristics of an egalitarian culture, however, the adoption of formal systems would arguably shifting the home towards a high grid and thus hierarchical orientation.
H Voluntary sector home – local managing committee	The low grid and high group orientation arguably contributed to the disabling characteristics of an egalitarian culture. The formal systems being introduced were also shifting the home towards a high grid and thus a hierarchical cultural orientation.
I Large corporate provider	Generally a high grid and high group orientation suggesting a hierarchical culture. There was some evidence of a 'lower-grid' orientation and thus the characteristics of an 'isolate' culture.

Acts and Regulations

Acts

Morals of Apprentices Act 1802

Nurses Registration Act of 1919

Nursing Homes Registration Act 1927

Local Government Act 1929

National Health Service Act 1946

National Assistance Act 1948

Occupiers' Liability Act 1957

Factories Act 1961

Offices Shops and Railway Premises Act 1963

Health Services and Public Health Act 1968

Health and Safety at Work etc Act 1974

Nursing Homes Act 1975

Housing Act 1980

Local Government Finance Act 1982

Registered Homes Act 1984

Occupiers' Liability Act 1984

Single European Act 1986

National Health Service and Community Care Act 1990

Human Rights Act 1998

Care Standards Act 2000

Domestic Violence, Crime and Victims Act 2004

The Mental Capacity Act 2005

Legislative and Regulatory Reform Act 2006

Mental Health Act 2007

Regulations

National Assistance Act Registration of Homes Regulations 1949

The National Assistance Act Conduct of Homes Regulations 1962

Health & Safety (Enforcing Authority) Regulations 1977

Care Homes Regulations 1984

Registered Homes (Amendment) Regulations 1991

Manual Handling Operations Regulations 1992

Workplace Health Safety and Welfare Regulations 1992

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995

Fire Precautions (Workplace) Regulations 1997

Provision and Use of Work Equipment Regulations 1998

Water Supply (Water Fittings) Regulations 1999

Management of Health and Safety at Work Regulations 1999

Care Homes Regulations 2001

Control of Substances Hazardous to Health Regulations 2002

Regulatory Reform (Fire Safety) Order 2005

Smoke-free (Premises and Enforcement) Regulations 2006

Smoke-free (Exemptions and Vehicles) Regulations 2007

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