Senior Citizens,
Good Practice and Quality of Life
in Residential Care Homes

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This thesis is an examination of the definition and implementation of 'good practice' in residential care for senior citizens. The central contention is that 'good practice' is a term that has been variously defined. Different groups define it in different ways, and their definitions have changed over time.

This reflexive qualitative study explores 'good practice' in local authority, voluntary and private residential care homes in Scotland from the perspective of policy, practice and the experience of senior citizens who live in them. The study is based on analysis of policy documents, historical studies, and reanalysed interview and survey data from two earlier studies conducted by the author and colleagues.

The thesis shows that the notion of 'good practice' that emerges in policy and practice documents is a confused and often conflicting set of ideas. Historically, the earliest were driven by concerns over cost. In more modern times, statements about 'good practice' have had a more benevolent intent but are frequently flawed by paternalistic and ageist assumptions.

It is shown that staff in residential homes typically adopt a different set of attitudes: their preoccupation is with safety and the avoidance of risk. Although benevolent in

intention, these interpretations of 'good practice' are also at variance with what residents themselves actually want.

Two particular models or styles of care are examined in detail. One of these is the use of 'keyworkers', often implemented in ways that fail to realise its potential. The other is the 'hotel' model of care. The potential of this model as an alternative to the statutory model is explored. The thesis concludes that it is a model that can realise the goal of enabling residents to exercise independence, choice and privacy while meeting their needs in residential care.

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The thesis is dedicated to my late mother, Elsie Fitch.

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Chapter One - Introduction

This thesis is about the concept of 'good practice'. My interest in the topic arose from the findings of previous research in residential care homes. I hoped that using indicators of 'good practice' in my investigation of quality of care would identify homes that provided residents with a good quality of life but the results did not show this. Interviews conducted with residents revealed that they were concerned about the quality of their lives in general rather than about care only. The study results therefore raised questions for me about the whole notion of what 'good practice' is or should be.

In the thesis, I unpick concepts of 'good practice', look at them in context, identify key problems, then argue how to proceed. I have chosen to use the term 'senior citizen' rather than 'older person' in the thesis for two reasons. Firstly, this is the term preferred by people in a study of 'older people's' attitudes and aspirations (Hayden *et al.*1999) and secondly because I am arguing for the rights of 'older people' as citizens to independence, choice and privacy in residential care.

What I set out to argue in the thesis is that ideas about 'good practice' in residential care should be based on what senior citizens themselves value and wish for in homes, not the assumptions of policymakers, practitioners or researchers about what they consider to be 'good' for residents. I am using interviews conducted with residents in two previous research studies in residential care some years ago, together with evidence from other, more recent studies, to support my argument that definitions of 'good practice' and its implementation in residential care homes still do not reflect the aspirations and priorities of senior citizens for their quality of life. The whole aim of the thesis is to address 'good practice' from the perspective of the 'consumer'.

I am examining residential care because it epitomizes people's worst fears about ageing, of losing control over their lives, particularly when the move is not from choice. I will argue that policy and practice rhetoric promote values such as independence, choice and privacy in later life but these values are in conflict with the focus on care, the emphasis on disabling, physical aspects of ageing and anxieties about risk. Social, emotional and practical aspects of life which matter to residents tend to be seen as unimportant and get neglected. This uncertainty and confusion about the nature of 'good practice' in homes may be understood within the broad context of an ageist society, manifested in social policy by ambivalence and minimalism. The concept of 'structured dependency' usefully makes explicit the socially constructed nature of many of the 'dependencies' that are typically associated with ageing. The cultural association of ageing with dependency is reflected in the attitudes and actions of professionals and relatives and in the policy rationale for residential homes as a 'need' for physical care. However, my study shows that despite being 'victims' of 'structured dependency' senior citizens still act to remain independent or autonomous in their everyday lives. The study also shows that not all social actors are ageist and that some models of residential care operate on other bases, such as the operators of the 'hotel' model of care.

For this study, I chose to investigate 'good practice' from three perspectives; namely policy, implementation and the experience of senior citizens living in residential homes. I pursued 'good practice' by undertaking detailed policy and guidance analysis, analysing the practice and residential research literature, investigating the origins, development and implementation of the keyworker role, investigating a different approach operated by a private home and by exploring the experiences of residents.

My aim in this thesis is to investigate how 'good practice' has been defined, by whom and for what purpose; to evaluate its implementation in residential homes, to determine how residents experience 'good practice' in terms of their quality of life, and to suggest ways in which 'good practice' might develop to reflect the priorities of residents.

I begin in Chapter Two, by looking at broader social attitudes and beliefs about ageing and senior citizens. I argue that one cannot begin to explore the various meanings and ideas of what constitutes 'good practice' in residential care without setting such explorations in the wider context of beliefs about how ageing and senior citizens should be 'managed'. I argue that the perception of ageing as a personal and social burden has a marked influence on social policies, social attitudes to and behaviour towards senior citizens. These ageist attitudes about the 'burden' of ageing and its assumed association with 'dependency' influence the pattern of what is seen as 'good practice' in terms of policy responses expressed in terms of a need for 'care'.

In Chapter Three, I begin to narrow the focus of my investigation into 'good practice' by looking at residential care as a policy response to ageing. I show that although there have been a number of policy initiatives and changes in how residential care is provided, there are a number of continuities underlying these changes. Most importantly, these are the policy of promoting independence from the state, expectations of family care and statutory provision of residential care as the 'last resort'.

In Chapter Four I narrow the focus still further, to examine how 'good practice' in residential care has been defined in policy documents and in social work and social care practice literature. I argue that 'good practice' has been used in many different ways by policymakers and professionals. Varying definitions of 'good practice' in

residential care have been contested and debated and these debates are reflected in legislation, policy and practice. Although 'good practice' is a term that is widely used in policy guidance, its definitions are varying, confused and often conflicting.

Ideas about what constitutes 'good practice' may refer to policies, to principles or values, ideologies, procedures, processes, activities or standards. Often 'good practice' is used to exercise power and induce conformity. It may be used to secure compliance with a set of behaviours or practices deemed to be in the interests of a particular group or body, to prescribe policies or the actions of others, or in pursuit of what is deemed to be the 'public good'. My review suggests that a common factor underlying this confusion and variation is the total failure to ask senior citizens what they think about residential care or what they want from it. The tacit assumption that professional definitions of 'good practice' benefit the people who use services, has not been developed or tested by seeking the views and experiences of residents. In this thesis, I explore what residents want and think about life in residential homes, examining some of the situations they find themselves in, in order to draw lessons about practice that would be regarded as 'good' by residents and enhancing their quality of life.

In Chapter Five, I discuss the influence and importance of methodology in social research into ageing and residential care. I am critical of my own quantitative methods in previous studies, which have tended to reinforce popular stereotypes of ageing and of senior citizens in terms of increasing 'dependency'. I argue that many previous studies of residential care, undertaken as surveys, have failed to elicit from residents their evaluations and perceptions of the quality of residential experience. In this study of 'good practice', I adopted a qualitative methodology in order to bring to the fore the 'voice' of senior citizens about aspects of life that matter to them as

residents and how they experience principles of 'good practice' when implemented. I seek their views and perceptions of the quality of their lives before and since moving into residential care. I emphasise the importance of context, both the institutional and the wider social context of attitudes to ageing when conducting interviews with senior citizens in residential care, and the likelihood that some residents are not there from choice. In my reanalysis of interviews undertaken in my previous studies, I am addressing how far senior citizens experience elements of professionally defined 'good practice' as positive enhancements of their quality of life rather than the narrow concept of quality of care.

In Chapter Six I report the views of residents about their experience of 'good practice' as implemented in a range of local authority, voluntary and private residential homes. I am using the concepts of independence, choice and privacy to investigate 'good practice' since these are aspects of life that are of great importance to senior citizens and their anticipated loss is often cited as reason for their reluctance to consider residential care. Policy and practice literature stresses the rights of residents to their independence, choice and privacy but this is not reflected in what residents said they experienced of 'good practice' in the residential homes I studied. For some people, their independence is immediately undermined because the move is not from choice. As residents, some people find their independence constrained by risk-aversive regimes of care that render them dependent on staff, leaving them with little scope for making or exercising choices. For some residents, privacy may be compromised by having to share accommodation with a stranger and by the attitudes of staff. Despite these difficulties, residents describe how they do exercise a measure of autonomy and choice and maintain their privacy by adopting strategies such as ignoring house rules,

'keeping themselves to themselves' and by opting out of communal aspects of residential life that they dislike.

Having discussed the very varied views and experiences of senior citizens of 'good practice' in a number of residential homes, I focus in Chapter Seven on one recent development in practice. I focus on the keyworker role and care plans as concrete examples of attempts to implement some of the principles of 'good practice'. The keyworker provides each resident with a relationship with a particular staff member and this is seen as a means of the resident exercising choice and having their individual wants and preferences addressed. These individual wants and preferences are captured in the care plan that is drawn up with the resident. The keyworker is seen as the basis for managing the tension between individualised care and the communal experience of residential life. My analysis of the origins and theory behind the keyworker and my interviews with residents show how these aspects appear in practice, demonstrating how policy is operated.

In Chapter Eight, I move on to examine a different approach to 'good practice' implemented by a private home, based on a 'hotel' model of care and compare it with the statutory or 'social care' model. The private home stood out in the previous research study as markedly different, both in terms of the approach to residential care adopted by the owners and the attitudes and behaviour of the residents. Interviews with the owners reveal that this home operates from the concept of 'hospitality', as do hotels, and on the basis of a 'personal service' or 'customer' ethos rather than a care or custodial philosophy. Together with its positive approach to the management of risk, this model of care gives residents a sense of continuing independence and freedom of choice. This model has the potential for wider emulation, since it shows that alternative approaches are possible, within the existing legislative framework,

that can and do respond positively to senior citizens' wishes and aspirations for their life in residential care whilst not neglecting or denying their care needs.

In Chapter Nine, I draw a number of conclusions from the study about the implementation of ideas about 'good practice', in the light of the experiences of senior citizens living in residential care homes. I suggest two ways in which 'good practice' could be made more relevant and responsive to the aspirations of residents for their quality of life in residential care. I argue that because senior citizens are highly heterogeneous individuals who place greater or lesser value on particular aspects of life, we need a number of models of residential care that cater for that diversity.

From my analysis of social policy, the views of senior citizens, the keyworker role and the 'hotel model' of care, I argue that there are glimmerings of hope and possibilities for change, with implications for policy and practice. For 'good practice' to become a means of enabling residents to enjoy a good quality of life it needs to be developed and tested in partnership with the people who use residential services, focusing on those aspects of life to which they attach importance rather than reflecting the beliefs and attitudes of policymakers, researchers and professionals.

Chapter Two - Social Attitudes to Ageing

Introduction

The focus of this thesis is 'good practice' in residential care for senior citizens. Residential care homes are part of a social response to ageing. In order to put ideas and definitions of 'good practice' in residential care into context, it is first necessary to consider how ageing is viewed and responded to more widely. In this chapter, I consider some of the strongly held beliefs about ageing and test the empirical basis for such beliefs. I argue that social policies towards senior citizens are discriminatory and that they reinforce the belief that to be 'old', however that is socially defined, is to be different from adults of other ages: so different, that to be 'old' is to no longer be adult. No longer being seen as an adult, results in loss of the status and power normally ascribed to adults. This loss of status and power is reinforced by biomedical understandings of ageing which see it in terms of physical and/or mental pathology that results in dependency. Thus ageing becomes a disease that requires treatment and a therapeutic approach for those defined as 'aged' and a de-valued status to be avoided or denied by those who fear being so defined.

The focus on the physical aspects of ageing tends to homogenize it as a process and an experience and masks the impact of social class, gender and ethnicity on how ageing is 'managed' and experienced. We still do not yet fully understand the processes of physiological ageing and have only just begun to explore with people who have lived for a great many years their views and experiences in the latter half of life. What we do know, but which social policies have only just begun to acknowledge, is that the way people experience age physiologically and socially varies, and that this variation is partly attributable to their class, gender and ethnicity.

Social policies now acknowledge the diversity of ageing as a process and an experience but they still do not acknowledge that ageing, in all its diversity, is a normal feature of the life course.

The biomedical view of ageing as pathological still retains its influence and inflexible social policies, such as those on statutory retirement, reinforce the belief that ageing 'starts' at 65 years rather than being a life-long process. These beliefs are reflected in social policies that marginalize ageing and 'aged' people, i.e. those over 65. This marginalization is manifested in the response to those whose ageing involves disability or chronic illness and who lack the necessary resources – financial, emotional or social – to enable them to maintain their independence. For them, the only way to access the resources they need to maintain their independence and quality of life may be by moving into residential care. However, ageist attitudes and policies see such needs in terms of 'dependency' to which the 'good practice' response is to provide 'care' in a residential care home.

An Ageing Society

In common with other developed western nations, the UK is characterised as an ageing society, due to increasing adult survival rates and a continuing fall in the birth rate. Population ageing is not a sudden or recent phenomenon. In 1954 the Phillips Report gave a surprisingly accurate estimate of 9.5 million people over pension age by 1979 but its implications were overlooked or ignored until the late 1970s and early 1980s when population ageing became the justification for cutting public expenditure, particularly on senior citizens (Phillipson 1998:6).

Between 1971 and 2003, the percentage of people aged 65 and over in the UK population increased by 3% to 16%, while the proportion of the population under 16

decreased (ONS 2004). This trend will continue during the first half of this century, as the relatively large numbers of people born post Second World War and in the 1960s 'baby boom', become older. In Scotland, between 1993 and 2003, the number of people aged 75 and over increased by 11% while the number of children under the age of 15 fell by 8% (General Register Office for Scotland 2004). The proportion of children under 16 is projected to continue falling and that of people aged 75 and over to continue increasing by 61% by 2027 (General Register Office for Scotland 2004).

It is the oldest age group, people aged 85 and over, that is predicted to show the largest relative increase, from 1.6% of the total population in 2000 to 3.1% by 2031 (Wood and Bain 2001). This age group is regarded as particularly significant. Twenty-two percent of people aged eighty-five and over are long-term residents of care homes or hospitals, compared with just 1% of 65-74 year olds and 4.7% of those aged between 75 and 84 years of age (Wood and Bain 2001, Macdonald and Raab 2004). However, more than three quarters (78%) of people over the age of 85 are not in long stay care or hospitals but still living at home. Recent evidence suggests that people reaching the age of 85 'are in much better shape than previously' (Kirkwood in Mullan 2002:188) and that the onset of major chronic illnesses is being delayed (Fries in Mullan 2002:189). In 2000 only 4.5% of the population aged 65 years or over was in long term care (Wood and Bain 2001:63), a percentage that has remained remarkably stable.

These demographic trends have caused politicians and policymakers to question the ability and willingness of the reducing working population to meet the costs of supporting the growing proportion of the adult population that is no longer economically active (the dependency ratio). The dependency ratio, which measures the number of children and/or people of retirement age relative to the number of

people of working age in the population, provides an alternative, albeit crude, way of assessing the impact of population ageing (Wood and Bain 2001:9, see also Mullan 2002:67). In Britain, the dependency ratio at the end of the twentieth century was virtually the same as it was at the beginning (Phillipson 1998:95). Although the increase in the numbers of people of retirement age has raised the dependency ratio, it is projected to stabilise in the UK overall at just over 700 'dependents' per 1,000 working age people from the late 2030s onwards (Wood and Bain 2001:9). This ratio is equivalent to the ratio in the early 1970s, when children were the majority of the 'dependents' (Wood and Bain 2001). Yet the reductions in health service and social security expenditure as a result of fewer children being born are rarely mentioned as offsetting the 'burden' of ageing (Mullan 2002:70).

This preoccupation with population ageing is particularly marked in health and social services, although care for 'older people' accounts for less than half (40%) of both the social work and health service budgets in Scotland (SE Health Plan 2000:63).

The policy response to increased population ageing has been to reduce public sector provision for senior citizens in health and social services and encourage the development of the private and voluntary sectors as providers of care, the so-called 'mixed economy of welfare' (see Tinker 1992:170). Medical care has been redefined as 'social care' which, unlike health care, is subject to means-testing (see Mullan 2002:181). In 2002, there were 1,163 care homes in Scotland, with 40,068 beds, two thirds of which were in nursing homes. Residential care homes numbered 605 with 14,843 beds and 558 care homes were private nursing homes with 25,225 beds (Scottish Executive 2003). The number of local authority residential homes has reduced by more than one third (37%) since 1990, while there have been increases of

3% and 10% respectively in private and voluntary sector residential homes over the same period (Scottish Executive 2003).

The most marked change in provision over this period has taken place in the services provided by the NHS. Between 1990/1 and 1998/9 acute available beds in NHSScotland hospitals reduced by 29% to 36,400 across Scotland (Forth Valley Health Board 2001), with further reductions under the Private Finance Initiative of around 30% anticipated (Dunnigan and Pollock 2003:905). Since 1990, NHSScotland long stay hospital bed provision has reduced by more than half (58%) (Woods and Bain 2001:60). Long stay geriatric hospital beds in 2002 numbered just 3,814, compared with 9,277 in 1990 (Scottish Executive 2003).

The outcome of these policy changes has been to move towards making 'care' in later life a private and personal responsibility of the individual rather than a collective responsibility as envisaged with the establishment of the Welfare State post Second World War.

I now consider how social attitudes and policies towards ageing and retirement reinforce the perception of ageing as a 'burden' on the population. This perception reflects the political and ideological barriers to enjoying full citizenship that people have to overcome in later life.

Ageing as an economic burden

Social policy literature discusses the increase in longevity in terms of governmental 'fear' and 'anxiety' about the cost of supporting a growing population of senior citizens (See Means 1985, Walker 1986). This is not a recent phenomenon. As long ago as 1942, the Beveridge Report, no less, warned of the 'dangers' of being 'lavish to old age' (Wilkin and Hughes 1986:169).

Beveridge explicitly related pension levels 'to the minimum subsistence' concept (limited in the main to the physical necessities of food, shelter and clothing (Townsend 1986:30)). The 1949 Royal Commission on Population was concerned about older people competing for consumer goods with the working generation, endangering the standard of living of both generations (Phillipson 1998:86). Social policy literature is consistent in the focus of governments on providing support and care only to senior citizens who need it, and at the least possible cost, whether through the mechanism of residential care or community care, depending on the economic wisdom of the times (see McIntyre 1977, Audit Commission 1985, 1986). Whether senior citizens receive support and care at home or in a Home is restricted by what services the state is prepared to underwrite (Wilkin and Hughes 1986).

Alongside economic considerations is the role of the family, particularly female relatives, in the support of older relations, and fears that the development of domiciliary forms of state support might undermine this informal support, despite abundant evidence to show that this is unfounded (Means 1986:100, Care Development Group 2001:16). Legislation enabling local authorities to develop domiciliary support services did not prevent residential care continuing to be the main local authority provision for older people throughout the 1960s and early 1970s (Means 1986:97).

The Conservative government White Paper 'Growing Older' (1981) linked services for senior citizens to the reduction and containment of inflation. It did this by putting the onus for meeting the 'increasing needs of the increasing numbers of older people 'back on to 'the Community' who were expected to provide the care rather than the public authorities or public finance' (p.59). A further assault on the wellbeing of senior citizens took place the following year, when the link between average earnings

and the state pension was broken and pension increases were linked to average increases in prices instead (Wilson 1993:57). This meant that senior citizens continued to become poorer relative to the rest of the population (Wilson 1993:58). Further economies in state support for later life were enacted in the 1986 Social Security Act, which changed the basis on which State Earnings Related Pension Scheme (SERPS) would be calculated, resulting in reduced average amounts of 'lifetime' earnings (Evandrou and Falkingham 1993:210). Despite growing campaigns to restore the link between the State pension and average earnings, governments have, so far, successfully resisted them. Recent work by the Pensions Commission on pension provision assumes that State pension rates will continue to be indexed to prices rather than average earnings (Pensions Commission 2004:76).

Anxiety about the costs to the State of supporting a growing percentage of senior citizens in the population has not been confined to the affordability of pensions. It has also been raised about the costs of health care, particularly senior citizens' use of acute hospital care. In Scotland in 1999, people aged 65 and over were half the day case and elective inpatient admissions and 65% of emergency inpatient admissions (Wood and Bain 2001:56-57). With increasing emphasis on achieving maximum effectiveness of hospital bed use, there has been growing pressure to reduce patient length of stay. This has been particularly difficult for senior citizens who may need longer to recover than younger patients. It can result in senior citizens being discharged before recovery is complete and before adequate arrangements to support them at home have been implemented (Harding 1999:39). Where a senior citizen is assessed as needing long term care which cannot be found for them straight away, necessitating their continued stay in hospital, they are described as a 'bed blocker' (Wilkin and Hughes 1986:169 and see also Phillipson 1982:89, Tinker 1992:108).

The language of 'blocked beds' has now been recast as 'delayed discharges' (see Wood and Bain 2001:59) but the pressure to minimize lengths of stay by senior citizens continues. Thus the senior citizen is blamed rather than the failure of the health care system to provide sufficient hospital beds and to act flexibly to meet their needs appropriately. 'Delayed discharges' of senior citizens rather than NHS bed closures are then seen as the reason for the shortage of hospital beds for other patients and become a vehicle for blame-laying between agencies, particularly health and social services reinforcing conflictual ageist views of senior citizens.

Perceptions of ageing and senior citizens

There are three recurring themes in the literature on ageing. The first theme is that ageing is a homogeneous experience; secondly that it is a predominantly negative experience involving disease and dependency and thirdly that it involves poverty. This is ageing viewed from the perspective of people who are not yet 'old' in the chronological sense of the word or who do not yet regard themselves as 'old'.

Attitudes to ageing among the 'not old' have tended to be predominantly negative (Bond and Coleman 1990, Arber and Ginn 1991, Hepworth 1995). Ageing generally is viewed as a burden to society, as a time of ill health, dependency, poverty and distress. There has been a marked increase in longevity in the UK since the beginning of the twentieth century. The average expectation of life has increased from 48 years for a man and 51.6 years for a woman, to 75.9 and 80.5 years respectively in 2002 (ONS 2005). As I have already shown, this increase tends to be seen as creating problems rather than being celebrated as a triumph of public health and raised living standards.

There are numerous myths and stereotypes about ageing and later life. Victor gave some examples (1987). 'The old are portrayed as dependent individuals, characterised by a lack of social autonomy, unloved and neglected by both their immediate family and friends; and posing a threat to the living standards of younger age groups by being a 'burden' that consumes without producing' (Victor 1987:preface); and as a single, homogeneous group for whom the experience of ageing is the same (Victor 1987, Arber and Ginn 1991). Coleman (1990:93) cited deterioration, self-absorption and rigidity as examples of the stereotypes and prejudices associated with old age. Arber and Evandrou (1993) offered other negative images of senior citizens as 'redundant, dependent, decrepit and inferior' (p.11). As Arber and Evandrou pointed out, these negative attitudes and stereotypes influence not only the attitudes and actions of younger people towards senior citizens but can also influence the self-perceptions and behaviour of senior citizens themselves (Arber and Evandrou 1993:11, Peace et al. 1997:63, Cook et al. 2004).

Coleman (1990:89) suggested that 'loss' is the most commonly used concept to describe the experience of ageing but he fails to make explicit whose perception he is talking about (see also Marris 1986). Coleman also stated that senior citizens cope well with loss (Coleman 1990:90-91) and showed that, contrary to popular belief, the capacity to adapt to change is enhanced rather than diminished in later life. For others, the gerontology literature was seen to emphasize the inevitability of decline, 'whether physical, psychological or social' as a key feature of ageing (Levin and Levin quoted in Bytheway 1995:31). Comfort associated later life with 'an increased liability to die, or an increasing loss of vigour' (Comfort in Bond and Coleman 1990:19).

By contrast, Laslett (1987, 1989a) aimed at developing a more positive image for age by proposing four stages of ageing, of which the Third Age was an opportunity for personal fulfilment (Bury 1995). However, the 'rosy scenario of a Third Age of self-development, autonomy, consumption and youthful lifestyles' has been criticised, perhaps rather too readily, for being an 'essentially bourgeois option' that is not available to people on low incomes or in poor health (Ginn and Arber 1995:8). Although Laslett's (1987) thesis of the four 'Ages of Man' (sic) was not strictly related to chronological age, his four ages did coincide with age-related structures and institutions, such as exit from the labour market, which marks the transition from the Second to the Third age (Bury 1995:22). Laslett made the same mistake as earlier theorists, treating ageing as a homogenous experience and one that focuses on the experience of the Third Age as retirement from paid work. He ignored the experience of ageing for disabled people and some women, for whom 'retirement' from domestic roles and from paid work, may be irrelevant (Bury 1995:24), thus laying himself open to criticism on grounds of elitism, sexism (Bury 1995) and disablism.

By characterising the Fourth Age as one of 'dependence, decrepitude and death' (Laslett 1989a), Laslett only moved the stigmatising of age to an older cohort rather than challenging it (see also Blaikie 1994). He concentrated the negative and homogenising stereotypes associated with ageing onto people 'largely those aged 85 and over' his so-called Fourth Age, which he characterised as one of 'decline and decrepitude' (Laslett 1989a: 41). Thus fears about ageing have now been concentrated on the Fourth Age or what Featherstone and Hepworth called 'deep old age' (1989) and that stage became stigmatized and the subject of taboo (Blaikie in Arber and Ginn 1995).

Arber and Evandrou (1993) explicitly challenged the negative social gerontological approaches that primarily see senior citizens in terms of their 'problems and welfare needs', and which treat them as a 'distinct subgroup of the population with different needs and concerns from the rest of society' (p.9). Likewise, Fennell et al. (1988) saw a risk from what they called a 'welfarizing' approach to senior citizens, since it involved a 'subtle mixture of diminution and patronage' (p.6). Such approaches create an image of senior citizens as 'in poor health, needing care, in poverty, role-less and socially desolate' (Arber and Evandrou 1993:9). Since later life, particularly later life as experienced in residential care homes, is primarily an experience of women (Cook et al. 2004) and ageist stereotypes of older women are 'particularly negative' (Arber and Ginn (1991:1. See also Bytheway 1995) it is women who are most damaged by such negative images of later life.

What have hitherto been largely missing from the discussions of ageing are the much more mixed views about growing older held by senior citizens themselves. There are signs that the prevailing misperceptions and omissions are finally being challenged and addressed (see Arber and Ginn 1993:9, Boaz et al. 1999, Scottish Executive 2001, Kirkwood 2001). I shall be discussing how senior citizens view ageing later in the chapter.

In the next section I discuss how these negative views about ageing are translated into discriminatory and marginalizing practices.

Age discrimination and the identification of ageism

The late twentieth century saw senior citizens under ideological attack (Arber and Ginn 1991:1). 'The Elderly' were conceptualized and treated as a homogeneous group, despite the differentiation in the experience of ageing for women and men, and

for members of different social classes or ethnic groups. Discrimination on grounds of age alone affects people throughout life, from birth onwards, 'imposing limits and constraints on expectations, relationships and opportunities' (Itzin in Johnson and Slater 1993:202) but in this thesis, we are only concerned with age discrimination in later life. The term 'ageism' has been coined by writers to describe discrimination or social oppression on grounds of age (Butler 1969, Comfort 1977, de Beauvoir 1977, Bytheway and Johnson 1990, Bytheway, 1995).

In 1973, Butler and Lewis first produced a definition of ageism as:

> '….a process of systematic stereotyping of and discrimination again people because they are old, just as racism and sexism accomplish this for skin colour and gender. Old people are categorized as senile, rigid in thought and manner, old-fashioned in morality and skills…Ageism allows the younger generations to see older people as different from themselves, thus they subtly cease to identify with their elders as human beings' (quoted in Bytheway 1995).

Later, in 1980, Butler developed his definition of ageism further by distinguishing between prejudicial attitudes, discriminatory practices and institutional policies, all of which, he claimed

> 'have contributed to the transformation of aging from a natural process into a social problem in which the elderly individual bears the detrimental consequences' (Butler 1980 quoted in Bytheway 1995:33).

This definition is helpful for this thesis in the way that it links individual and institutional aspects of ageism (see Bytheway 1995:33). However, Bytheway was also critical of Butler's definition of ageism (1995:118). Firstly, Bytheway claimed that ageism's equivalence with sexism and racism was not yet properly established.

Secondly, the definition fostered the belief that 'old people' exist as a group and thirdly, it failed to resolve what Bytheway called the 'us/them' question. That is to say, the definition perpetuates the description of senior citizens as 'other' and by implication, different from ourselves.

Other writers have usefully differentiated between various conceptualizations of ageism. Arber and Ginn have identified two forms of ageism, which they call 'compassionate' and 'conflictual' ageism (Arber and Ginn 1991). These have shifted in ascendancy, 'according to the economic and political climate' (p.50). Compassionate ageism typifies senior citizens as having a range of social problems, including poverty and disability (p.50). Whilst the compassionate model reflects 'good intentions to tackle poverty and ill-health', Arber and Ginn argued that it also reflects unconscious stereotyping of all senior citizens as 'weak, dependent and burdensome'. This is a one-sided view of ageing that does not acknowledge that many senior citizens are in good health, leading independent lives and continuing to make valuable social contributions (Binstock in Arber and Ginn 1991:51, Macdonald and Raab 2004). Professionals providing health and social care services used by senior citizens, such as social workers, nurses, doctors and others hold predominantly stereotypical and negative attitudes about ageing (see Stevenson and Parsloe 1978, Callahan 1987, Norman 1987, Bytheway 1995). As a result, there is a general reluctance among these professions to work with senior citizens because doing so lowers their professional status. Harrison (1993:216) described 'geriatric medicine as having been regarded in the past within the [medical] profession as a 'soft option', being unexciting and scarcely medicine' and Norman (1987) described professional social work with 'the elderly' being seen as 'a low status and unrewarding

occupation' (p.11). Phillips (1992) went so far as to describe it as a form of 'professional suicide'.

Social problems are defined in terms of the economic and political climate. In times of economic stringency, social problems are redefined to allow for cheaper 'solutions', such as I have just discussed in the health service. Senior citizens can find themselves scapegoated and ageism becomes conflictual (Arber and Ginn 1991:51). 'Conflictual ageism' reflects intergenerational resentment by portraying senior citizens as 'a financially secure and politically powerful group who are imposing an increasingly costly burden on the rest of society through their high use of ….state pensions and health and social services' (Arber and Ginn 1991:53). In the United States, the argument of conflictual ageists has been that 'the elderly' have used their influence over government 'to transfer to themselves the fruits of the productivity of the workforce generations' (Greene in Arber and Ginn 1991:54). One commentator on health care has talked of the need to make 'painful moral choices in the care of the dying elderly as a class, particularly among that growing number who end their days incompetent, incontinent, and grossly incapacitated, more dead than alive' (Callaghan in Johnson and Slater 1993:112). In Britain, Johnson et al. (1989) have used the rise in the dependency ratio to argue for reductions in pensions and delayed retirement in order to prevent 'intolerable and unjust levels of taxation' and intergenerational conflict (Arber and Ginn 1991:54). Opinion polls have shown that these alarmist views are not shared by younger people and that there is no basis for claiming that they view 'old people' as a burden (Mullan 2002:141, see also Walker 1990, Phillipson 1998). Yet both Phillipson (1998) and Mullan (2002) have stressed that despite the absence of evidence about intergenerational resentment, concern continues to spread, putting damaging ideological pressure on senior citizens.

Compassionate and conflictual ageism is reflected in the ambivalence of health and social policy and practice towards senior citizens. The dominant concept of compassionate ageism in social policies is constrained in meeting senior citizens' needs by the financial anxieties about population ageing and relative parsimony of spending on services for this group, an expression of conflictual ageism. I shall discuss how ageism reinforces the public perception of senior citizens as a distinct social group when I consider how age is constructed in social policy and the usefulness of the structured dependency thesis in understanding how social policies towards senior citizens affect the experience of ageing.

In policy terms, 'old age' was seen as a 'social problem', to a greater or lesser extent, throughout the twentieth century (Macintyre 1977) and this predominant perspective was evident through the language used by policy makers and health and social service planners. Alarmist, dramatic terms such as 'disaster', 'burden', 'rising tide' and 'impending crisis' were used in many official health and social services publications in the late eighties and early nineties to describe the perceived growing threat posed by an elderly population (Bond and Coleman 1990:1). Fennell et al. (1988:8) referred to the contrasting images of old age as desolation and as opportunity, both of which they too hastily condemned as specious, since senior citizens may experience ageing at times as desolation and at others, as opportunity in the life course.

There is a mismatch between negative social expectations of 'old age' and reality (Wilson 1995:98) and some writers have sought to explain the preoccupation with the negative aspects of growing older to the virtual exclusion of the positive. Fear and anxiety among younger people about what later life may be like for them seem to figure predominantly (Hari 2005). This fear, it is suggested, can lead to treating old people as 'a race apart, different from ourselves, or what we can bear to think we

might become' (Gearing in Byetheway 1995:x). Hockey and James (1993) suggested

that the need to preserve the notion of adulthood 'as embodying independence and

autonomy is preserved by not allowing physical or mental impairment to feature

among its possible manifestations' (Hockey and James 1993:37). The use of the

childhood metaphor denies that ageing and the frailty and disability that may

accompany it, is an experience of adults, a reality which is too fearful for younger

adults to confront. These elements of a socially organised response to later life

penalise some senior citizens more than others, particularly people who are poor and,

therefore, particularly, older women. My own theory is that the physiological signs of

ageing are intimations of our own mortality that we deal with by avoidance and denial

(see also Norman 1987, Featherstone and Hepworth 1989, The Hen Co-op 1993).

Sociologists have variously blamed the marginalisation of senior citizens on

industrialisation (Fennell et al. 1988:27) and features of modernisation (Cowgill

quoted in Fennell et al. 1988:28). Sociologists of the 1950s and 60s took the view

that the pre-industrial family cared for ageing and dependent relatives in a way that

the nuclear family was no longer thought to do (Fennell et al. 1988:28). Research has

subsequently challenged these stereotypical views about family attitudes by

establishing that changes in the family life of senior citizens are concerned with

patterns of marriage and family-building and life expectancy rather than changes in

customs and sentiment (Fennell et al. 1988:29). The basis of most people's support

network is still the family and marriage. Fertility patterns, migration history and

personality influence that network (Scott and Wenger 1995:159).

Featherstone and Hepworth (1990) suggested that a move was taking place towards

positive ageing by 'loosening the chronological bonds' and 'breaking with the

conventional images of ageing'(p.153). These changes are seen as part of a broader

process of the 'modernisation of ageing' which involves distancing from 'deep old age' by flexibly adjusting the 'gradually blurring boundaries of adult life' (Featherstone and Hepworth 1989:154). Other writers have likewise identified a tendency by some researchers, particularly Baltes (1987, 1991) 'to replace pessimistic models of later life with models that recognise gains and pleasures alongside constraints' (O'Hanlon and Coleman 2001:131).

There are, then, signs in the research literature on ageing that the previous negativity is slowly being replaced by a more balanced perspective. This perspective acknowledges the possibility of rewards and gains as well as losses in the experience (see Cook 2001, Healy 2001, Davey 2001, Bowling et al. 2002). This is due, not least, to a growth in research that elicits the views and opinions of senior citizens about wider aspects of life, particularly those aspects that affect its quality. What is emerging is that some senior citizens are more positive about their lives than younger adults would expect or believe, despite difficulties caused by poverty, poor health or disability (see Scharf et al. 2005:27). The views of senior citizens about ageing and the quality of life are addressed later in the chapter. I now consider the effect of social policies that use chronological age as the definition of 'old age' on perceptions of ageing as a negative, homogeneous experience.

When does ageing start? Defining 'old' chronologically

In the absence of agreed biological definitions about the onset of ageing, other indicators have been used to define the later phases of life. Chronological or calendar age refers to age in years. It has been increasingly adopted as a means of defining different phases of the human life course, including the onset of 'old age'. Giddens points out that the most widely used threshold of 'old age' in Britain is 65 but that this is 'pure and simple, a creation of the welfare state' (Giddens in Mullan 2002:24).

Bytheway (1995) concluded that it is impossible to define 'old age' because it does not have a definable beginning and ending (p.119). He suggested that 'old age' is a cultural concept that is useful in 'sustaining ageism within societies that need scapegoats' (1995:119).

Given the different rates at which individuals age physiologically, chronological age provides an unreliable guide to physiological ageing of the population. Chronological age is used as a criterion for defining 'age' in terms of the social meanings ascribed to particular ages. These vary from one society to another as well as changing over time. Normative expectations of growth, development and attainment of individuals are linked to chronological age and failure or inability to achieve these for whatever reason can have important social consequences in terms of adult status being accorded or denied (see Featherstone and Hepworth 1990:147). So chronological age has been infused with very strong social meanings and constructions in the same way as gender and ethnicity.

With survival beyond statutory retirement age now possible for thirty years or more, social scientists have used chronological definitions to sub-divide senior citizens. The so-called 'young old' are those aged between sixty and seventy-four, the 'old, old' aged from seventy-five to eighty-four and the 'oldest old' are those aged eighty-five years and over (see Marshall 1983, Means and Smith 1985, Mullan 2002).

Chronological age and social policy - institutional ageism

Eligibility for state benefits associated with unemployment, retirement and the perceived problems associated with ageing is established using chronological age. Discriminatory social policies towards ageing reflect wider social ambivalence and a preoccupation with minimizing service provision and cost to the public purse.

'Old age' has been flexibly and socially defined for pension and retirement purposes since the state pension was first introduced for men at the age of 70 in 1908 to reduce destitution and reliance on the Poor Law. Its reduction to 65 in the 1925 Pensions Act was intended to encourage earlier retirement and thus alleviate the high levels of unemployment (Mullan 2002:23). Mullan suggests that retirement and pensions are the key social factors behind the usual assumption that 'old age' begins at age 65 (2002:21). Retirement age has never been determined by biological factors but always by social circumstances (Mullan 2002:24). The statutory retirement ages for men and women of 65 years and 60 years respectively is unified at 65 years from 2005 as part of the government strategy to reduce its state pension liabilities. The Statutory Pension Age for women will gradually increase to 65 between 2010 and 2020 (Pensions Commission 2004:303). Retirement age in occupational pension schemes is a similarly flexible concept. Some members of occupational pension schemes in both private and public sector occupations are allowed (or may be compelled) to retire earlier than the statutory pension age, e.g. bank managers, police and fire service workers, while people in other occupations must work until 65 to gain full pension. Concerns about the inadequacy of pension provision led to the establishment of the Pensions Commission in 2002 to consider how to address the problem of under-provision. In its first report, the Commission suggests that one way forward is to raise the statutory pension qualifying age to 70 years, back to the original 1908 level (Pensions Commission 2004).

The key factor about the UK State pension is its inadequacy as a source of income. This is because it was primarily designed to prevent poverty rather than provide income replacement (Pensions Commission 2004:60). The UK state pension is among the least generous in the developed world, giving the average UK earner just

under 37% of earnings, compared with 70% in the Netherlands, 54% in France, 72% in Sweden and 45% in the US (Pensions Commission 2004:58). Since 1981, the gap between the richest and poorest pensioners in the UK has grown larger (Sutherland 1999:12). Figures for the Royal Commission showed that in 1999 the average weekly income of nearly half (44%) of single people over the age of 75 was £85 while 21% enjoyed an average weekly income of almost double that amount, at £165 (Sutherland 1999:12). Low income is more likely to be a feature of later life, particularly among older women. In 1999, 22% of women aged 85 or over in Scotland, who lived alone, reported a total net annual income of less than £4,000 (Macdonald et al. 2001). Thus the perception of later life as associated with poverty is correct for those who have to rely on the state pension. However, this poverty is not related to age but rather to the socio-economic and employment status of people before they reach retirement age.

A key source of difference in retirement income is between people who receive an occupational pension and those reliant solely on state benefits. A quarter of pensioners experienced relative poverty, that is less than half of average incomes, in 2001-2 (Scharf et al. 2004:83). On average, current female pensioners are significantly poorer than male pensioners (Pensions Commission 2004:260). Single female pensioners are poorer than single males because they have much lower occupational pension income and because more of their state benefit is means-tested. Married women pensioners have much lower independent sources of retirement income and their predominant source of pension income is linked to the man (Pensions Commission 2004:260). The low level of female occupational pension is due to their much lower levels of paid employment during their working life, a greater tendency to work part-time, to earn less and to work in service sectors making less provision for pensions (Pensions Commission 2004:262). The Pensions Commission

notably failed to mention disabled people unable to work and those who spend a lifetime as unpaid family carers, predominantly women. The popular belief that ageing implies poverty is true for between a quarter and a half of senior citizens, depending on the measure used. At the other end of the scale, over a fifth of senior citizens have substantial incomes, providing further evidence that ageing is a widely diverse rather than homogeneous experience. Poverty in later life is particularly a feature of women's experience of ageing but it is not related to ageing per se but to their role as mothers, wives and carers and through sex discrimination in the labour market (Arber and Ginn 1991:89).

Receipt of the State retirement pension confers eligibility for other benefits as well as penalties, particularly in the area of health and social care. The concessions and benefits provided to or withheld from senior citizens from time to time by governments, demonstrate clearly how 'old age' is a socially constructed and reconstructed concept. At varying times, governments have given and removed concessions for sight and hearing tests to people over statutory retirement age. People in receipt of the statutory pension are currently required to contribute to the cost of their in-patient hospital care, although a recent government consultation paper entitled 'Opportunity Age', promises to end this practice (Department for Work and Pensions 2005:16).

Age is also used to exclude people from certain welfare benefits for which they might otherwise qualify. For instance, the Independent Living Fund is not available to people over statutory retirement age and the mobility component of the Disability Allowance is not payable to people over the age of sixty or sixty-four who become disabled or develop problems with mobility after reaching those ages. The State response to people in later life is to treat them as a discrete, homogenous group, which

results in the needs of a minority remaining unmet. This is a prime example of how the inflexibility of policies based on categorization such as chronological age can obscure the diversity of ageing as an experience as well as great differences in need.

Assistance with additional specific needs in later life tends to be means-tested, a process which persists, despite its known extreme unpopularity with many senior citizens because of its stigmatizing association with charity and the requirement to reveal information about their private financial affairs. This leads to considerable under-claiming of benefits. Between £1.7 billion and £2.9 billion went unclaimed by senior citizens in 2002/3 (Office of the Deputy Prime Minister 2005:46). Moreover, non means-tested benefits specifically aimed at senior citizens such as the confusingly named Attendance Allowance, are not well publicised and hence not claimed by large numbers of people due to ignorance, doubts about entitlement and fear of stigma and humiliation (Macdonald 1999:54, Phillipson and Scharf 2004). By contrast, some senior citizens take pride in deliberately not claiming all their entitlements as a way of expressing their independence (see Dant 1988:172, and Phillipson and Scharf 2004:21, where senior citizens equated receipt of means-tested benefit with loss of independence and inability to cope).

People who move into residential or nursing home care and whose income is solely derived from the statutory pension are required to contribute most of that pension (the amount being determined annually), towards the cost of their care, with the shortfall supposed to be met by the local authority. The statutory personal allowance in residential care is so low it undermines the dignity of senior citizens and severely limits their independence. Although the 1990 NHS and Community Care Act emphasised people's right to choice in care, the Income Support Residential Allowance provided a perverse financial incentive to local authorities to continue to

offer residential rather than community care to senior citizens needing support. For people relying on local authority funding, choice could be undermined at the point where residential care was the only option made available to them (see Parker 1988:14). Although this perverse incentive has now been removed, the inclusion of capital assets, such as a person's home, when assessing contributions to long term residential care costs, continues to make residential care a more cost-effective solution for local authorities than providing high levels of domiciliary support. In Scotland, the introduction of Free Personal Care and Free Nursing Care in 2002, may, like other perverse financial incentives before it make residential care a more attractive financial solution to local authorities supporting people on state pension who have higher care needs. I shall discuss the outcome of the Royal Commission on Long Term Care proposals further in Chapter 4.

Whilst some policies discriminate positively in favour of senior citizens, they nevertheless reinforce perceptions of them as a distinct, separate social group, different from other adults, with 'special needs'. Concessionary travel schemes, winter fuel payments and television licence exemption are not so much indications of how 'different' senior citizens' needs are as how poor many of them are, relative to the rest of the population. It might also be argued that choosing to give concessions to senior citizens as a discrete group, at specific chronological ages, reinforces images of homogeneity and dependency as features of the ageing experience and is a prime example of institutional ageism.

Institutional ageism is reinforced in the way that official statistics about senior citizens are compiled. Senior citizens are omitted from some population surveys and are the sole subject in others, reinforcing perceptions of them as a distinctive social group. Government statistics use chronological age as the basis for reporting social

differences in national surveys and some surveys deliberately exclude the population over statutory retirement age. The 1998 Scottish Health Survey (Shaw et al. 2000) was a surprising example of age discrimination in this respect, as senior citizens are major users of the health services. The Survey used 74 as the upper age cut-off point and sampled only people living in private households, thus excluding all the people living in residential care (Shaw et al. 2000). The Scottish Household Surveys 1999-2002 have similarly excluded people in residential homes from their samples – over 39,000 people over the age of 65 according to the 2001 Census (Macdonald and Raab 2004:8). The perception of senior citizens as a distinct sub-group of the population is thus reinforced by statistics that either relate only to the social and health circumstances of people over statutory retirement age or omit sub-populations of senior citizens, such as residential home residents, altogether. Reported data on this 'sub-population' serve to emphasise the 'otherness' and 'distinctiveness' of senior citizens because they are not compared with other adults across the age spectrum. This also reinforces the perception that senior citizens are no longer counted as adults (see Victor 1987:24, who talked about 'the transition from adulthood to old age' receiving comparatively little formal recognition in modern society. Matthews 1979:58 saw 'no clear consensus on when a member of society becomes old' socially, or what she called 'postadult').

The use of chronological age in social policy reinforces beliefs that senior citizens are a distinct but homogenous social group that differs from other adults. It obscures the effects of social class, gender and ethnicity on the experience. I now discuss how biomedical perspectives influence social attitudes and beliefs that ageing involves illness and disease that leads to dependency.

The influence of biological perspectives

Readily observable physiological changes take place as human beings age. These include changes to the appearance and functions of the skin, joints, muscles, bones and to major organs such as the heart, lungs and digestive systems (Victor 1987:8). These changes are said to make it more difficult for the body to maintain its homeostatic function and successfully resist physiological stress, resulting in lowered resistance to disease and pathology (Victor 1987, Bond and Coleman 1990). Physiological ageing relates to functional ability and the gradual decline in bone density, muscle tone and strength that occurs as people get older (Ginn and Arber 1995:10). Individuals display the physiological changes associated with ageing at markedly varying speeds and stages of the life course (Victor 1987), depending on position in the social structure, especially gender and class (Arber and Ginn 1991a; 1993b). As I have already discussed, what is a process of change that takes place gradually over the life course is often perceived as beginning at one defined moment in life (Bytheway 1995), such as at retirement (see Mullan 2002:183), despite the lack of any biological basis for such a belief. Latest theories about ageing suggest that it comes about 'through the gradual build-up of unrepaired faults in the cells and tissues of our bodies as we live our lives, rather than as a result of some active mechanism for death and destruction' (Kirkwood 2001). Contrary to public perceptions, 'the prevalence of disability and use of health and social services increases broadly exponentially through adult life, with no discontinuity in later life' (Grimley Evans in Bytheway 1995).

The influence of biomedical perspectives

The medical definition of ageing in terms of individual disease or incapacity both pathologizes and homogenizes perceptions of ageing (see Briggs 1990:49). Doctors

have regularly failed to make the distinction between 'old age' and disability (Harrison 1993:215). For senior citizens who are disabled this can be doubly oppressive because 'it has implications for both the provision of services and the ability of individuals to control their own lives' (Zarb 1991:189). Most disabled people are senior citizens (Harrison 1993:215) which is why the medical tendency to regard disability as a normal part of ageing has serious implications for the way health services respond, or fail to respond, to senior citizens (see Sinclair et al. 1988:184, Neill et al. 1988:144, Mullan 2002:175). Health care professionals in hospital and primary care are often the main route by which senior citizens are referred to social services as being in need of long term care (Bland and Bland 1985, 5:14, Neill et al. 1988:32, Macdonald 1999:70). The popular perception that most senior citizens are disabled is not accurate. Less than half (45%) of adults aged 75 and over report that they have a disability and/or a long term illness (Scottish Executive 2004:5). Whether a disabled senior citizen is able to function independently or is physically dependent on another person for assistance is largely determined by social and environmental factors. Despite the greater likelihood of disability among older adults, the concept has not been applied to senior citizens in order to understand the problems of ageing better, or to devise policies and services to meet the needs identified (Townsend in Qureshi and Walker 1989:71).

Phillipson (1998) has described how the rise of biomedicine has influenced the reconstruction of 'old age' over the past 50 years. In the USA particularly, the biomedical sciences were seen as a means of tackling many of the problems and challenges of later life (Achenbaum in Phillipson 1998). This belief in the power of medicine and doctors (Porter in Phillipson 1998:33) had two effects on the development of ageing. First, ageing was socially constructed as a medical problem

and this was followed by the practice of treating ageing as a medical problem (Estes and Binney in Phillipson 1998:33). The biomedical model viewed ageing as characterized by various processes of decline and decay that could be alleviated or eradicated by medical science. 'Ageing' became a matter of individual organic pathology, with physicians in charge of the definition and treatment of 'old age' as a disease (Phillipson 1998:33).

The image that most senior citizens are ill is one of the most distorted expressions of the social construction of dependency (Mullan 2002:182). Wilkin and Hughes suggested that there are two features of this negative stereotype of 'old age' that have been especially important in shaping ideas about and responses to the health of 'old people' (1986:163). First, was the identification of 'the elderly' as a separate category, reinforcing the view that they are by and large, a homogeneous group (1986:164) and second, the assertion that later life is a period of deteriorating health, greater physical or mental infirmity and increasing dependency on others (Wilkin and Hughes 1986:164). The reality about health and ageing is far more diverse than the stereotype suggests. The extent to which people enjoy good health in later life is related to social class, gender and ethnicity.

There are major class-related inequalities in life expectancy and in health. At age 65, men in Social Class 1 have about four years greater life expectancy than men in Social Class 5, and the gap for women has widened considerably over the last twenty years (Pensions Commission 2004:48). Lower life expectancy is associated with poorer health. People in the lower socio-economic groups have a smaller percentage of post-retirement years free of disability and are more likely to leave work early on grounds of ill health (Pensions Commission 2004:48). However, there are signs that disability as a feature of ageing is decreasing. US research shows increasing numbers

of people aged 65+ are free of any disability and a decreasing percentage of senior citizens are experiencing immobility (Pensions Commission 2004:31). UK research has likewise found a substantial drop in people over the age of 80 facing difficulties with mobility (Pensions Commission 2004:30).

I now consider the substance behind the belief that ageing is an experience that involves dependency.

Ageing and Dependency

Using the concept of dependency in debates about ageing contributes to the stereotype of it 'as a universal experience of senility' caused by 'individual pathology rather than social and economic processes' (Qureshi and Walker 1989:69). As we have already established, disability is a feature of ageing for some people but having a disability does not necessarily involve dependency.

A number of attempts to define dependency have stressed that it is a function of a social relationship between an individual and another or others (see Walker 1989, Booth 1985, Dant 1988). For the purposes of this thesis, I am using Oliver's common-sense definition of 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' (Oliver 1993:50).

As Oliver pointed out, this definition applies to everyone in a modern industrial society, for we are all dependent on others for some aspects of our daily life. 'The dependence of disabled people, then, is not different in kind but in degree' (Oliver 1993:51). The same point can be made about senior citizens, who may depend more on others for assistance than other adults. Johnson (1990) saw dependency as closely tied to the concept of individual incompetence. Individuals who are incapable of

demonstrating their competence to act as full citizens or who are legally or socially deemed to be 'incompetent to live an independent and unsupervised life', were seen as 'dependent' (Johnson:1990:212). For Dant, however, dependency in relation to senior citizens in contemporary society needed to be understood more fully as 'a form of relationship [that is] characterised by an unequal distribution of power' (1988:171, see also Biggs 1992:87).

In health and social services, the needs of senior citizens are assessed in terms of their 'dependency'. Information about people's ability to manage their daily living, continence and mobility are collated and assumptions made about their levels of dependency (see also Qureshi and Walker's critique of the use of 'dependency' measures by residential care researchers 1989:69). This information tends to show the amount of assistance people receive rather than the level of their need for it. The assessed level of 'dependency', rather than disability, is then used to make judgements about the kind of care to be provided. It becomes the 'currency' of negotiations between health and social services agencies about whether individual or groups of senior citizens are 'appropriately placed' in health or social care settings (Means and Smith 1985:367. See also Warburton and McCracken 1999).

Having argued that the biomedical model has influenced perceptions of ageing as an individual physiological process involving illness and dependency, I now examine a theory that argues that structural rather than physiological reasons lie at the heart of the dependency experienced by some senior citizens.

Ageing and structured dependency

A number of writers have challenged the construction of 'dependency' as an individual attribute in later life and have written about the 'structured dependency' of

old age (Townsend, 1981, Phillipson, 1982, Walker, 1980, 1981, Hockey and James 1993). These writers 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 involving compulsory exit from the workforce, low incomes in retirement and the welfare responses of residential and community care, which varied according to people's position in the social structure.

These writers' analyses, although persuasive, can be criticized on various counts. Firstly, they failed sufficiently to highlight the gendered nature of the experience of ageing. Their concentration on an economic framework for their analysis rendered the experience of older women, particularly those who were disabled or who had not been in paid employment for many years, almost invisible. Only later was gender brought more fully into the argument by Walker (1981 and 1987) and by Estes (1986 and 1991. See also Arber and Ginn 1991).

Bury (1995) was also critical of Walker and of Estes for two further reasons. Firstly, he criticised the tendency of their argument to reinforce the homogenisation of ageing, despite their antipathy to it. Secondly, Bury criticised the fact that Walker's and Estes' analyses did not include the views of senior citizens themselves about their personal experiences of ageing in the light of the structured dependency thesis. As Bury (1995) pointed out, by reiterating the links between later life and dependency, poverty, inequality and low status, the structured dependency theorists were in grave danger of reinforcing the negative stereotypes of ageing whilst attempting to raise the political profile of senior citizens.

Townsend's critique of residential care as symbolising 'the dependency of senior citizens and legitimating their lack of access to equal status' with other adults is

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particularly relevant to this thesis (Townsend 1986:32). Drawing on numerous surveys of senior citizens in residential care, he demonstrated, that contrary to popular belief, substantial minorities of residents are able to undertake most self-care tasks with little or no help and are therefore not ostensibly 'dependent' or 'in need of care and attention' (Townsend 1986:33). However, measurements of physical 'dependency' as indicators of the need for residential care have their limitations in explaining why some people move into a residential care home. The omission of evidence from senior citizens themselves about the reasons for their move weakens the force of Townsend's argument. As Dant (1988) pointed out, Townsend's thesis does not allow for the fact that some senior citizens do actually choose to move into residential care, despite not being very disabled. Dant (1988), however, failed to acknowledge the power and influence of professionals, particularly health professionals, over senior citizens in determining the nature of their care and support and the financial limits on support imposed by the state which may weaken individual resistance to a move into residential care. There are certainly structural influences behind some people's move but there are also personal reasons, to do with family relationships which may make this a preferred, if qualified choice for a minority (Qureshi and Walker 1989:194, Oldman and Quilgars 1999:374, Kellaher 2000).

Wilson (1997) pointed out that there are problems with the structured dependency theory once senior citizens' views are taken into account because they very rarely see themselves as 'dependent' (p.347). Although many senior citizens are aware of their lower social status, this does not mean that an abstract aversion to 'the old' results in devaluing of self or friends or to an awareness of structural dependency (Wilson 1997:347). Wilson gave examples of how senior citizens act by buying in help to enable them to maintain their independence at home (p.348) but are less willing to

buy services that signal dependence. Structured dependency as a theory, has its limits. However, its usefulness lies in its analysis that it is inequitable social policies that render some people more liable to become 'dependent' in later life rather than their age.

I shall discuss my own evidence from senior citizens themselves about their move into a residential care home in the light of the structured dependency thesis when I report on my own research in Chapter Five.

Having considered how far popular stereotypes of ageing as a homogeneous negative experience, involving poverty, disease and dependency are well founded, I now examine how senior citizens themselves view the ageing process and what factors are important to them in maintaining their quality of life.

Senior citizens' attitudes to ageing and quality of life

The vast literature encapsulating theories and perspectives on ageing by the 'not-old' is now being balanced by a growing literature reporting the views of senior citizens about their experiences of ageing generally rather than their views on health and social services. What emerges from individuals' views about ageing is that it is perceived and experienced in very many different ways. As I have already demonstrated, the 'ageing population' is extremely diverse. A number of individual accounts demonstrate how variable feelings and experiences of individuals are where ageing is concerned (Johnson and Slater 1993). One account (Myers 1993:9) described relief that self-image and chronological age finally matched after a lifetime of being thought younger or older than her chronological age. At sixty-three Myers called herself 'an old woman' because doing so 'makes me feel strong and wise and important' (p.11). Barbara Macdonald reacted with rage because her age (she was

sixty-five at the time) caused fellow feminists to question her physical and judgemental abilities (Macdonald 1993:6). In these two accounts, we have contrasting examples of people who were more, or less, comfortable with their self-identity as they grew older and with how other people treated them in the light of their ageing. Since there is no consensus on when a member of society becomes 'old' (Matthews 1979:58), and since 'old' is a stigma, albeit a weak one (Matthews 1979:57) people may define themselves as 'old' at very different chronological ages or even continue to deny feeling 'old' for most of their lives. Matthews (1979) found a number of her interviewees (who were all over sixty-five, most over seventy and many over eighty years of age) felt 'they were poor informants about ageing because they were not old yet' (p.59). A recent study that followed people's experiences of ageing over ten years, found that by the age of 85, most respondents said they had now crossed the line into 'old age' (Heikkinen 2004). Researchers who undertook a study of 'older people's' attitudes and aspirations used 50 years and over as their criterion of 'aged' were surprised that 'those in their fifties did not consider themselves to be old' (Boaz et al. 1999:36).

Perhaps it is not surprising that most people do not define themselves primarily in terms of their chronological age. Subjectively, people experience, absorb and adapt to the physical and social changes associated with ageing gradually, as they occur, over the life course, barring major health crises which make much greater demands on the self. Sarton (quoted in Bytheway 1995) describing herself as 'a diminished old Sarton', recorded how she dealt with chronic pain over the course of a year and had to 'learn to be dependent' (Bytheway 1995:39). Newton (1980) wrote after having a stroke about her shock and despair at the experience of being in a nursing home and her sudden acquisition of an impaired identity and her high dependence on others.

Both these writers express the difficulties they experience in reconciling themselves to a 'dependent' status caused by illness in later life.

Some physically disabled adults view ageing as a 'second disability' (Zarb 1993:38) that threatens their often hard won independence, either because of further physical decline or the lack of suitable and acceptable support (Zarb 1993:38). The people in Zarb's study reacted to physical changes associated with ageing with a range of emotions – experiencing anxiety, frustration, aggression, impatience, apathy or resignation, depending on the attitudes they had developed towards independence, autonomy and responsibility over the course of their 'disabled career' (Zarb 1993:39).

What some people seem to find much harder to deal with, are the predominantly negative social expectations of ageing imposed on them by others. Elder wrote about ageing (quoted in Bytheway 1995) as an old age pensioner, 'I know very well…..what it feels like after a lifetime's struggle, to find oneself among society's cast-offs, duly labelled and slotted into the compartment called OAP' (Bytheway 1995:38).

A qualitative study of senior citizens' attitudes and aspirations carried out for the Inter-Ministerial Group on Older People (aged 50 years and over) emphasised the diversity of people whose varied experiences influence their individual attitudes and aspirations. The researchers found that age alone is an inadequate predictor of attitudes and aspirations (Hayden et al. 1999).

The way senior citizens experience later life is shaped by their previous life course experiences and their attitude to life in general informs their attitudes to ageing (Hayden et al. 1999:3). What all the people interviewed had in common was a desire to be as active as possible: physically, mentally and socially, for as long as possible (Hayden et al. 1999:7). Participants in all the focus groups were worried about

becoming dependent and having to go into residential care. They also linked means-testing with loss of independence because it emphasised a feeling of dependence on the state (Hayden et al. 1999:8).

Senior citizens identified the barriers to active ageing, independence and participation. They thought these could be overcome if governmental and societal attitudes to ageing were more positive and if services provided were more appropriate to their needs (Hayden et al. 1999:12). The UK Better Government for Older People Initiative aimed to improve public services for senior citizens by 'meeting their needs better, listening to their views and encouraging their contribution' (Scottish Executive 2001). Three of its twenty-eight pilot projects were in Scotland. The senior citizens who took part in the Scottish pilots identified ageism, in its various manifestations, as the key obstacle to their participation (Scottish Executive 2001). Senior citizens believe that they are discriminated against on grounds of age in the workplace (Walker 1993, Bytheway 1995) and some feel that as a group, senior citizens receive a poorer service from the NHS (Braunholtz and Stalker 2002:1). In the next section, I move on to discuss those aspects of life that senior citizens define as key to maintaining its quality.

Quality of Life

Quality of life is elusive as a concept. It has been described as a 'powerful but highly problematic concept that defies any attempt at systematic definition' (Sixsmith 1993:219) and as 'multidimensional and with no fixed boundary' (Hughes 1990:47). Providing a consistent and concise definition is problematic because 'definitions are largely a matter of personal or group preferences: different people value different things' (George and Bearon quoted in Hughes 1990:49). These difficulties have not

stopped social gerontologists from trying to define what they see as the constituent elements of life quality for senior citizens (see Hughes 1993:229).

George and Bearon suggested that life quality includes both the conditions of life and the experience of life (in Hughes 1990:50). Hughes (1990) took this argument further in relation to 'older people', arguing that ageism, as previously discussed, has had a major effect on the quality of life of senior citizens (p.53); firstly, through the ageist nature of services provided and their conditions of life and secondly, 'by determining, in part, their expectations and experiences' (1990:54). Whilst this argument fits well into this thesis, since I am arguing that senior citizens experience ageing in the context of an ageist society, this should not diminish or invalidate the perceptions of senior citizens about their quality of life, since many are well aware of the ageism with which they have to contend. However, this does not mean that the experience of ageism clouds all senior citizens' judgements about their quality of life. Many 'older people' are ageist themselves (see Wilson 1997:347). Within an ageist society how people perceive their quality of life will be mediated by their class, gender and ethnicity.

The growing awareness in government and among researchers that little was known about how senior citizens define quality of life as they grow older has led to a number of studies. In this thesis I am confining myself to examining subjective quality of life as defined by senior citizens. The definition I am adopting for this purpose, is that of Browne et al. quoted by Tester (2004:210):

> 'Quality of life is a dynamic interaction between the external conditions of an individual's life and the internal perception of those conditions'.

The ESRC Growing Older programme of research aimed to develop this area of knowledge about ageing. As I have shown in this chapter, the myth of ageing as homogeneity is being widely disproved, not least by the diverse evidence now coming from senior citizens themselves. However, there are common areas of later life that people value and others that give them cause for concern as potential threats to their life quality.

In many studies, senior citizens, particularly women, cite good social relationships - with family, friends and neighbours, staff and fellow residents – as key to their quality of life (Gabriel and Bowling 2004, Kellaher et al, 2004, Butt and Moriarty 2004, Tester et al. 2004). Butt and Moriarty found a gendered aspect to priorities in that men were more likely to mention good health or an adequate income before social relationships (2004:175). Having a positive outlook on life, a good home in a safe neighbourhood and being able to pursue activities and hobbies at home alone and elsewhere with other people are regarded as important to life quality (Gabriel and Bowling 2004, Tester et al. 2004). As might be anticipated, good health and mobility are also mentioned, as are adequate income and being independent and in control of one's life.

Most of the factors mentioned by people living in residential homes differed from the views of those still living in their own homes in degree rather than substance. The senior citizens in Tester et al's study (2004) saw being able to 'be themselves' in residential care as key to their quality of life; something that was not an issue for those still living at home. The people in residential care homes expressed their sense of self through their reaction to their own and others' strengths and frailties as well as their personal appearance, their possessions and being able to secure personal space (Tester et al. 2004:214). How far these senior citizens were able to do this depended

on a number of cultural and structural factors: 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 (p.213).

In another study which addressed the concept of independence with senior citizens, how independence was conceptualized and exercised was a function of their living environment. The healthy, active people interviewed defined independence as 'being able to look after oneself on a daily basis without the need to resort to any support or assistance from others' (Hayden et al. 1999:7). The less healthy participants who used care services, perceived their independence in terms of being enabled by these services to remain in their own homes. People living in residential care homes saw independence as being able to exercise choice over their day to day living arrangements (Hayden et al. 1999:7).

In the next section, I review research that has looked at the experiences of senior citizens living in their own homes and how they manage their lives as they age.

Ageing realities

A number of studies have questioned the negative stereotypes associated with ageing by investigating the coping styles and eliciting the experiences of people living in their own homes (Wenger 1984, Wilson 1995, Qureshi and Walker 1989, Macdonald 1999). Contrary to the stereotypes of ageing discussed earlier, these writers found that while problems did exist for some senior citizens, the majority 'led full and independent lives as participating members of their family and the local community' (Qureshi and Walker 1989:173). They were 'well, happy, participating and contributing citizens' (Wenger 1984:3. See also Burholt and Wenger 2001).

The studies revealed the importance of senior citizens' 'social embeddedness' and the strength of their informal networks. Contrary to the negative stereotype of senior citizens suffering poor health, the authors found respondents to be generally positive about their health and mostly enjoying high levels of mobility, despite around half the people in Wenger and Macdonald's studies reporting an illness or disability that limited their activities (Wenger 1984:28, Qureshi and Walker 1989:174, Macdonald 1999:13). Some people qualified their health in terms of it being 'all right for their age', indicating a high level of acceptance of physical limitation as a natural part of the ageing process (Wenger 1984:28, Bauld et al. 2000:63).

Senior citizens do not all feel the same about accepting help from formal services. Whilst people in one study had no inhibitions about accepting help from social services (Wenger 1984:64), in another, they were more likely to associate local authority services with charity and see it as demeaning (Wilson 1993:53). The role of statutory services was generally described as filling [some of the] gaps 'in the fabric of informal care for a minority' (Wenger 1984:180, Qureshi and Walker 1989:219, Wenger 1994). Macdonald (1999) found wide variations in people's experiences of statutory services and concluded that receiving adequate support from primary care or social services was 'largely a matter of chance' (p.76).

The studies concluded that, for the most part, senior citizens responded to the challenges of ageing by modifying their behaviour and developing coping strategies (Wenger 1984:180, Qureshi and Walker 1989:210) rather than accepting assistance from others. Senior citizens valued and wanted to preserve their physical independence (Qureshi and Walker 1989:18) and took pride in their continued autonomy, turning to their children (or friends and neighbours if childless) for help when needed, but with reluctance (Wenger 1984:180). For some people,

independence and autonomy means having choices and being in control of their support arrangements (Macdonald 1999:75, Wilson 1993:51). This is achieved by those who are able to buy support privately, often using the Attendance Allowance to do so (Macdonald 1999:75, Wilson 1993:51). Wenger found evidence that people can and do adapt to the changes that living longer presents, making changes in anticipation of later life or as a response to increasing frailty (1984:181) such as moving to be nearer relatives or to housing more suited to their needs (Macdonald 1999:25). The studies found that senior citizens are just as likely to be helpers of other people as to be helped themselves (Wenger 1984:182, Qureshi and Walker 1989:99, Macdonald and Raab 2004:27), confirming the reality of interdependence, not dependency, as the more usual pattern of later life suggested by other writers.

Conclusion

In this chapter, I have examined societal attitudes to ageing and how it has been defined and responded to in policy terms as a social problem. I have examined how far the perception of ageing as an experience involving disease, dependency and poverty are reflections of reality. I have argued that the stereotype of ageing as a negative, homogeneous experience is mistaken. Insofar as senior citizens comprise a group, they are extremely heterogeneous and their experience of ageing is equally differentiated, according to class, gender and ethnicity. I have argued that the biomedical model of ageing as dependency continues to influence perceptions of ageing and that ageist social policies reinforce beliefs that senior citizens are a marginalized group that differs from other members of the adult population. I have argued that ageism and structured dependency are useful frameworks for understanding that many of the 'dependencies' associated with ageing are structural factors associated with class, gender and ethnicity rather than the ageing process. The

extent to which ageing is an experience involving illness, disability and poverty is a feature of social rather than biological processes.

I investigated how far senior citizens' views about growing older reflect negative stereotypes about ageing. Senior citizens are extremely diverse and hold very varied perceptions and views about ageing. Some are positive, others negative and some reflect the same ageist stereotypes about the experience for other 'older people' which are not reflected in their own lives (see Midwinter 1991). Structural factors such as social class, gender and ethnicity, together with previous experiences across the life course and attitudes to life in general greatly influence how senior citizens view the ageing experience.

Senior citizens place great value on retaining their physical, mental and social independence but discriminatory social policies, such as the minimal level of state pension, means-testing and the ageist attitudes of health and social services professionals undermine that independence. Senior citizens strive to avoid reliance on family and friends and the State for as long as possible and adopt strategies to deal with changes in their health status and mobility that they feel do not compromise their independence (Boaz et al. 1999:7). Despite popular beliefs to the contrary, most senior citizens manage to retain their independence and interdependence as they grow older, supported by and, in their turn, supporting, their families and friends. Maintaining and developing good social relationships with family, friends, neighbours and others are seen by senior citizens as a key factor in their quality of life.

Senior citizens want health and social services that help and support them to retain their independence rather than undermine it. This is at variance with the prevailing service providers' perspective, which is that ageing is an experience of illness and dependency to which the appropriate response is to provide care. Becoming

dependent and needing to move into residential care, which they see as losing their

independence, is a widespread concern of senior citizens. This, then, is the social

context within residential care operates and notions of 'good practice' are developed.

In the next chapter I consider how residential care for senior citizens has been used as

an instrument of ageist social policy and examine studies that have identified different

models of residential care.

Chapter Three – Ageing, Residential Care Policy and Research

Introduction

In the previous chapter, I argued that perceptions of ageing as a homogeneous experience of illness, dependency and poverty are erroneous and are reinforced by the biomedical model of ageing and by social policies that are ageist. I showed that these attitudes are at variance with most senior citizens' views. The policy response to the minority of senior citizens who lack the personal, financial and social resources necessary to maintain their independence is residential care. Residential care is symbolic of fears about dependency in later life and a loss of the power and control associated with adult status and is therefore resisted by most senior citizens, who strive to remain independent.

In this chapter, I begin to narrow the focus of my investigation of 'good practice' by examining the continuities and changes in the philosophy and function of residential care as a policy response to ageing in the 19th, 20th and 21st centuries. I argue that the development of the statutory model of residential care practice has been influenced by attitudes to poverty, the understanding of ageing as disease and dependency and the development of hospital medicine. Residential care has to be understood within a broader context of policy principles on ageing and the response of senior citizens, both of which have remained remarkably persistent. These principles have been to promote independence and family responsibility and to minimise the statutory response. The response of senior citizens has been one of continuing resistance to reliance on the state and to residential care, in particular. I show how the philosophical emphasis of what constituted 'good practice' towards senior citizens in

nineteenth century and early twentieth century residential care remained ambivalent. Policies swung between an emphasis on compassion and deterrence, between outdoor relief and indoor relief, depending on the perceived moral worth of claimants and the economic demands being made on the State. Post-World War II the philosophy of 'good practice' towards senior citizens changed to an emphasis on 'welfare', 'domesticity' and 'care' in residential homes but research demonstrated continuing poor standards of provision and practice and a resistance to change in practice.

I then move on to review what the research literature has to say about what constitutes 'good' and 'bad' practice in residential care in the eyes of researchers and the much smaller literature that reports and analyses care practices as experienced by senior citizens as residents. I focus on the research that has identified and described care practices or regimes in terms of a number of different models. Earlier studies that criticized the persistence of institutional regimes in residential homes have tended to view residential care in isolation and have failed to acknowledge the ageist social attitudes and policy framework within which homes operate. Other studies have moved away from a preoccupation with 'care' and 'dependency' towards an emphasis on understanding and evaluating the quality of life in residential care from the point of view of the resident as consumer. This has resulted in the emergence of much more mixed views of residential care, reflecting the diversity of senior citizens, their views, their expectations and the circumstances that bring them into residential care, and the variable ways in which homes are run.

The thesis is primarily about 'good practice' in residential care in Scotland rather than the United Kingdom overall but much of the literature concerning its development relates to England and Wales. I have drawn predominantly on that literature in this chapter, noting where important differences between Scotland and England occur. By

the end of the chapter, I shall have demonstrated that despite apparent changes in policy, the underlying aim of government in responding to the challenges of ageing is to minimise state intervention and costs. Underneath the cloak of apparent change, the policy towards residential care for senior citizens remains that of 'last resort'. The persistent stereotypes of ageing, the constant low priority given to senior citizens and residential care and the practices of the health service perpetuate an ageist framework for 'good practice' in the statutory model of residential care.

Ageing, Poverty, Disability and Residential Care

The association between ageing, poverty, disability and residential care has a long history. In the seventeenth century, the English Elizabethan Poor Law put a statutory responsibility on family members – sons and daughters – to support their aged, destitute parents. The State's response to the 'poor, aged, and impotent' was to establish parish poorhouses in England and in Scotland (the result of a series of 16th century Acts of the Scottish Parliament). The aim of the Scottish Poor Law was to instil the ideals of thrift and self-help into the poor and encourage them to reform their presumably dissolute ways (Blackden 1979:244). Receipt of relief was conditional on proof of disability as well as destitution. Able-bodied people of any age who were unemployed could not be relieved under the Scottish Poor Law. Destitution was regarded as a contagious disease caused predominantly by moral defect among 'the poor' that must be eliminated for the national good rather than as the product of an unequal distribution of resources and power.

Poverty and destitution were relieved in one of two ways; by providing subsistence relief in cash or in kind to people in their own homes, known as 'outdoor or out-relief', or in the poorhouse, known as 'indoor relief'. The majority of the poor seeking help, known as 'paupers', received outdoor relief. The likelihood of

becoming a pauper increased markedly with age. Being an 'old' single or widowed woman almost certainly meant pauper status (Thomson:1980:26).

These systems of public provision existed alongside a small number of voluntary hospitals until the nineteenth century when growing industrialisation shifted the locus of work from the home to the factory. The onset of industrial society had a profound effect on social relations with the creation of the industrial working class and the gradual erosion of existing communities as labour moved to the new towns in search of employment (Oliver 1990:85). Those who were unsuccessful in finding work claimed relief under the English Poor Law in numbers that the existing system could not manage. In Scotland, the inadequacy of the system was highlighted by higher demands for relief.

Policy towards age, disability and poverty in the nineteenth century could be characterized as repeated attempts to reduce or minimise the cost to the state of dealing with the 'scourge' of pauperism. These attempts took the form of 'encouraging' the 'improvident poor' to remain 'independent' through policies of institutionalised discipline and deterrence. The rising costs of relieving the growing numbers of able-bodied unemployed led to reviews of the Poor Laws in England and in Scotland. In England the solution to the rising costs of outdoor relief was to change and extend the poorhouse system by making it into a deterrent workhouse instead and to make relief conditional on entry into the workhouse.

Applications for relief of poverty and destitution were judged on perceived moral worth or desert rather than severity of need. Attitudes towards 'the poor' distinguished between those seen as 'deserving' and those deemed 'undeserving' of public assistance. 'Aged and impotent' persons, that is senior citizens who were ill or disabled and unable to work, tended to be seen as 'deserving' or 'proper objects of

relief' (Report from His Majesty's Commissioners for Inquiring into the Administration and Practical Operation of the Poor Laws quoted in Townsend 1962:18).

The 'general mixed workhouse' became the residential model for the New Poor Law, on grounds of economy and ease of inspection (Crowther 1981:38). New Poor Law institutions became larger, many small ones were closed and it is likely that more young, old, sick and able-bodied poor were accommodated together than previously (Townsend 1962:22).

The philosophy of the New Poor Law was to deter applications for state relief and to encourage people to make provision for themselves and their families in 'old age'. Fear of ending up in the workhouse was intended to stimulate attitudes of independence, self-reliance and thrift. The aim was to phase out outdoor relief altogether. The principle of 'less eligibility' was instituted, whereby a person receiving relief should not enjoy living conditions as good as or better than 'an independent labourer of the lowest class' (Report of the …Poor Laws quoted in Townsend 1962:18).

Opinions were expressed in England and Scotland that relieving poverty undermined the motivation to work and family support and perpetuated pauperism (Williams 1981:55, Mitchison 1979:200). Some people in Scotland believed that 'the poor would, in the long run, be better spiritually, and hence happier, without State aid' (Mitchison 1979:207) and attempts were made to make disability as well as destitution a necessary qualification for relief (Mitchison 1979:200).

In England, the objectives of the poorhouse changed from care for the destitute and sick to that of deterrence of the able-bodied by imposing a disciplinary regime of

work in the workhouse. The introduction of these seemingly irreconcilable aims of care for the 'impotent' and strict discipline for the 'able-bodied' within the same institution epitomised a continuing ambivalence and uncertainty about the philosophy and objectives of residential care, which has persisted. In Scotland, relief under the Poor Law continued to be unavailable to the able-bodied unemployed and the poorhouse retained its original objective of providing shelter and care to the 'aged', young, sick and friendless who were incapable of maintaining themselves on outdoor relief (Paterson 1976:175).

The Poor Law Amendment (Scotland) Act of 1845 took a less punitive attitude towards poverty and the non-able-bodied poor than the English legislation. It gave the eligible poor rights of appeal and sick paupers rights to medical care (Levitt 1979:264). It focused on improving the administration of relief and ensuring that those deemed eligible were adequately relieved. Poor law expenditure by parochial boards was increased as a result of regulations specifying minimum standards of care and administration. The Act defined those eligible for relief as:

> 'all persons disabled by age or by mental or bodily infirmity from gaining a
> livelihood by working and having no means of subsistence; widows or deserted
> wives burdened with children….and orphan children' (Levitt 1979:263)

settled in the parish for five years. The terms 'destitute' and 'disabled' covered physical and mental illness and even 'a degree of economic or social deprivation' (Paterson 1976:185). Definitions of destitution and disability were very elastic, and were often applied differently within a single parish (Paterson 1976:185). Under the Act, parishes had to supply medicines to the sick poor and medical attendance to sick inmates of poorhouses and allow subscriptions to established hospitals (Blackden 1979:245).

However, like England, Scottish Poor Law policy proceeded to make the poorhouse the focus for relief, in a bid to reduce the greatly increased numbers of people claiming out-relief, who outnumbered those in the poorhouse by 15:1. Parochial boards were urged to be more discriminating in granting relief. The number of poorhouses in Scotland trebled, but they were never fully occupied (Paterson 1976:190). Destitution was judged to be due to misfortune, illness or improvidence. Male and female paupers were classified into groups as 'sick', 'old', 'young', 'respectable' or 'dissolute', put into separate wards and treated differently, depending on their classification (Paterson 1976:191). The aim was to reduce the future incidence of pauperism by rehabilitation or retraining in the poorhouse rather than through work, which, unlike England, was not compulsory (Paterson 1976:190).

Entry into the Scottish poorhouse came to be seen as stigmatizing (Paterson 1976:191) as outdoor relief became increasingly reserved for people judged to be 'respectable', 'deserving' paupers. Despite this central policy change and the increase in poorhouses, the majority of Scottish paupers continued to receive outdoor relief (Paterson 1986:192). Parochial boards preferred out-relief mainly because it was cheaper and easier to organise than institutional care and paupers much preferred it (Paterson 1976:187). Those who needed institutional care, such as the sick, the homeless, the 'aged' and the young, received it in the poorhouse and in charity hospitals (Paterson 1976:186). Despite improved poorhouse provision in purpose-built buildings with central heating and sanitary facilities 'superior to those of the labouring class', the stigma associated with entry resulted in poorhouses continuing to be shunned by the poor and consequently under-occupied (Paterson 1976:192).

In England, the 1834 Poor Law Amendment Act centralised the administration of poor law responsibilities to a centralised Board and 643 unions (Townsend 1962:22).

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Hundreds of new, general mixed workhouses were built, housing on average, two hundred paupers (Townsend 1962:22) to implement the new, disciplinary regime. Paupers were classified into seven groups, based on their age, gender and physical condition:

> 'Aged or infirm men, able-bodied males over thirteen years of age, boys between seven and thirteen years, aged or infirm women, able-bodied women and girls over sixteen years, all children under seven years' (Williams 1981:108).

A strict regime of discipline through work was instituted as a means of controlling and reforming the 'dissolute' poor. Groups of paupers were segregated into different wards, day rooms and exercise yards. A fixed timetable was laid down when all paupers were to rise, eat and go to bed. All classes of paupers were to work every day except Sunday, Good Friday and Christmas Day (Williams 1981:109). The food was prescribed for all classes, other than those exempted by the medical officer, as were restrictions on alcohol and tobacco and rules about temporary leave of absence (Williams 1981:109). Guardians were allowed some discretion as far as 'the aged' were concerned. They could make concessions about bedtimes and employment for 'the aged' and did not have to separate married couples (Williams 1981:113).

The 1834 Act was principally concerned with deterring the able-bodied poor from seeking relief, rather than 'the aged' as a group. Towards the end of the century, when the numbers of 'aged poor' seeking relief grew considerably, attitudes towards them hardened. Most 'aged poor' were, like other adults, given outdoor relief in their own homes. Yet only a small proportion of the population resorted to the Poor Law, such was the stigma and opprobrium it attracted.

The policy of making relief conditional on workhouse entry, thereby cutting outdoor relief costs, resulted in dramatic falls in the proportion of 'aged and infirm' men and women using the workhouse. (Thomson 1980:36, Thomson 1983:46). Securing entry to the workhouse at age sixty was difficult unless the person was also ill or disabled. After the age of seventy, the poor law authorities accepted 'age' alone as an adequate explanation of destitution (Thomson 1980:106). People over the age of seventy enjoyed greater privileges in the workhouse, and were expected to perform less work.

By 1871, following a long period of economic depression, about one million people (4.6% of the population) in England and Wales were getting poor relief, most of it outdoors (Parker 1988:9). Less than one percent of the population were in poor law institutions, one third of them children (Parker 1988:9). Further attempts were made to reduce the cost of relief to the State and to expand family support. A further campaign against outdoor relief was instituted by even greater use of the workhouse test and by tightening the eligibility criteria for relief (Williams 1981:97). This more stringent test was applied to all classes of paupers, including 'the aged' to induce their relatives to look after them (Webb, S. & Webb, B., quoted in Townsend 1964:23. See also Thomson 1980:140).

Circulars announced a change of policy towards the workhouse populations involving a new system of classification and treatment in specialist institutions rather than the general mixed workhouse. Conditions of life for senior citizens were to improve through a more liberal regime involving 'a better diet, tobacco, more privacy, better facilities for visitors and to be able to pay visits' (Macintyre 1977 quoted in Means and Smith 1998:80). However, pensions and mass unemployment were seen as more pressing political issues at the time and these circulars were not implemented.

Although the total number of outdoor paupers fell by one third (Williams 1981:102), the numbers of people going into the workhouse did not increase as people denied out-relief did not draw relief at all (Williams 1981:102). Although the total 'aged' population had risen by nearly a half by 1890, the proportion of senior citizens being assisted by the Poor Law had actually halved since the 1860s (Thomson 1980:213).

In 1895, a Royal Commission examined the situation of the 'Aged Poor', criticised the harsh conditions in some workhouses and recommended a change in attitude towards senior citizens. Institutions should not deter but actually 'encourage the helpless to enjoy better facilities than in their own homes' (Crowther 1981:63). The Commission was told by Poor Law Guardians that outdoor relief payment to 'the aged' was 'quite inadequate' and 'not sufficient to live on' (Thomson 1980:273). Studies of family budgets, prompted by Booth and Rowntree's research showed that the amount needed for life at the subsistence level, was double what elderly paupers were getting from the Poor Law. In the 1880s and 1890s, these inadequate allowances, and the preference by those 'aged' refused outdoor relief to stay at home and die rather than accept the workhouse produced allegations of starvation (Thomson 1980:316).

At the end of the nineteenth century, the 'aged poor' remained a low government priority. Royal Commission recommendations for separate and better accommodation were ignored. The idea persisted that the bulk of the poor and 'aged' were 'undeserving' of relief because their situation was of their own making. Both the English workhouse and Scottish poorhouse became symbolic of the stigma associated with destitution. The deterrent workhouse of the New Poor Law was a successful instrument of policy minimisation in reducing the costs of state relief of destitution. In Scotland, it was not so much the regime of the poorhouse as the association of

entry with classification as 'undeserving' that made it so unpopular with the poor and caused destitute people to shun it.

Charles Booth's investigations into pauperism and 'old age' of 1892 and 1894 demonstrated that age and sickness were among the 'principal' causes of pauperism (Williams 1981:341). Official statistics had previously counted 'aged' and 'infirm' paupers together as 'non-able-bodied' which had obscured the extent of poverty among 'the aged' (Williams 1981:341). Booth's 1894 study of the 'aged poor' showed that the second campaign to reduce out-relief merely resulted in increased numbers of 'old people' receiving relief in the workhouse (Williams 1981:101). A similar campaign against outdoor medical relief to prevent it 'generating or encouraging pauperism or malingering' (Sixth Annual Report Poor Law Board quoted in Abel-Smith 1964:47) had the incidental but important effect of increasing the use of hospitals by the sick poor (Abel-Smith 1964:152).

The official response to the Royal Commission was a Circular stating that 'aged deserving persons' should not be urged to enter the workhouse at all unless necessary but should be given 'adequate' outdoor relief in recognition of their 'decent' and 'deserving' past lives (Williams 1981:129). Attitudes to destitution moderated, as pauperism came to be seen as a 'condition' to be 'treated' rather than suppressed. By 1901, the population of people aged sixty-five and over had grown to 1.5 million and was reflected in the proportion of workhouse inmates who were 'aged' being double the 1851 figure (Royal Commission report quoted in Townsend 1962:26). The government reaction to this increase in destitution was to renew the liability of relatives to support their aged parents and to make illegal attempts to widen liability to other relatives through moral pressure. A basic, non-contributory pension for men over the age of seventy was introduced in 1908 in a bid to reduce the number of

'aged' persons dependent on the Poor Law, although this proved less effective than hoped.

In 1909, a further Royal Commission once again urged improvements to workhouse conditions, transfer of responsibilities back to local authorities, and an extension of separate provision for the 'deserving aged'. Only a tiny minority were living in separate establishments in Scotland and in England rather than the general mixed workhouse in England (Townsend 1962:25). The Commission's Minority Report made it clear that Homes for the Aged were intended for the 'helpless deserving poor'. The Aged Poor of Bad Conduct should only be offered 'institutional provision' (Minority Report of the Royal Commission on the Poor Laws Cd4499 in Townsend 1962:24).

The Commission's Majority Report defined what they considered to be a 'good' workhouse model. This dealt with people on the basis of their moral worth and desert. This involved the classification of 'the aged inmates according to character' accommodating each class entirely separately in widely differing standards of accommodation, furnishings, food and freedom (Report of the Royal Commission on the Poor Laws quoted in Townsend 1962:25).

Yet again, Royal Commission recommendations for improvement were not implemented. Conditions in workhouses at the outbreak of the First World War showed little change in institutional standards or in classification of inmates within and by institutions. The needs of senior citizens in the workhouse continued to be a low policy priority. Priorities for reform were dealing with the unemployed, the sick and, to a lesser extent, children outwith the Poor Law (Townsend 1962:26).

Although Poor Law administration reverted back to local authorities under the 1929 Local Government Act, little changed in the way that pauperism was relieved (Means and Smith 1985:17). The workhouse was renamed the Public Assistance Institution (PAI) but the system of relief was largely unchanged for nearly forty years, during which time the population over the age of sixty-five more than doubled (Townsend 1962:27). There was public pressure from charitable organisations to improve the large PAIs by introducing more variety into the food, clothing and surroundings and to pay a 'pocket money' allowance to those senior citizens who had had to forfeit their pension on entry (Means and Smith 1985:18). Local authorities were granted legal powers to pay weekly 'pocket money' from the rates but few did so.

The key effect of these nineteenth century policies towards ageing, disability and poverty on the subsequent development of residential care was to reinforce its public image as a stigmatizing response to need in later life. Senior citizens assessed as 'needing residential care' saw this as a judgement on their moral character and worth, implying that they had somehow 'failed' socially in not managing to remain 'independent' due to mismanagement, improvidence or 'dissolute' behaviour on their part. The basic system of pauper relief remained unchanged, despite public pressure, as governments gave higher priority to areas of policy with greater political importance, such as unemployment and pensions. The policy of 'good practice' in relation to the relief of destitution remained consistent in its aims. These were to focus on keeping down costs to the State by pressurizing families to provide support, by restricting eligibility for outrelief, by paying inadequate doles and using the stigmatizing, deterrent workhouse and its disciplinary regime to reduce the numbers of claimants.

I now consider how the parallel development of 19th century hospitals and their attitudes and practice in relation to treating the 'aged poor' affected the way in which the role and practice of local authority residential care developed.

Ageing, infirmity and the role of hospitals

At the time of the English New Poor Law, illness was normally managed at home, with care provided by family members (Abel-Smith 1964:2). Sick paupers might be able to get medicine or relief in kind from a local doctor, under contract from the parish council (Abel-Smith 1964:3). For the sick who were destitute, homeless or without family support, the alternative was the voluntary hospital or the workhouse (Abel-Smith 1964:4). Early in the nineteenth century it is likely that more sick people were in workhouses than in hospitals (Abel-Smith 1964:4).

Voluntary hospitals founded by laymen (Abel-Smith 1964:5) were funded either by endowment or subscription. The poor gained access to these general hospitals through a letter of recommendation from a subscriber (Abel-Smith 1964:6). Decisions about who should gain admission to the wards were usually made by the lay governors, presumably on moral grounds, rather than by the medical staff, which sometimes had the effect of keeping out many of those who were acutely sick (Abel-Smith 1964:10). Some hospitals concentrated on cases that were 'curable', a tendency that increased as the century advanced, to the particular disadvantage of 'the infirm aged' and disabled people. The voluntary hospitals refused to admit paupers because they were not prepared to pay for their funerals (Abel-Smith 1964:12). Gradually, other groups also began to be excluded by the voluntary hospitals who concentrated on the acute medical and surgical needs of the 'sick and lame poor' (Abel-Smith 1964:14).

In the first half of the nineteenth century the number of patients more than doubled as hospitals became popular with higher social groups, stimulated by doctors keen to have hospitals, and patients, to meet their needs for training and research (Abel-Smith 1964:16). There was a rapid growth of special hospitals set up by doctors to treat groups that either could not be accommodated safely in general hospitals or which members of the Royal Colleges of Physicians and Surgeons were not interested in treating (Abel-Smith 1964:22).

In Scotland, sick wards in poorhouses had been encouraged from the outset but epidemics of infectious diseases hastened their development and led to municipal fever hospitals being established (Blackden 1979:259). However, the outdoor medical service was by far the most important service provided by the parish (Blackden 1979:249). The enduring stigma associated with poorhouse entry meant that paupers remained antagonistic towards indoor relief, even in the sick wards (Blackden 1979:250). Outdoor medical relief was preferred because its receipt was more easily concealed and thus preserved an individual's dignity (Blackden 1979:250). By the end of the century, parishes were paying charitable nursing organisations to provide a domiciliary service to seriously ill pauper patients (Blackden 1979:250).

By 1861, although the number of patients in voluntary hospitals in England had increased, most sick people were still in workhouse sick wards under the care of the workhouse medical officer. They were rejected by the voluntary hospitals (Abel-Smith 1964:46) either on account of their destitution or the chronic nature of their illness. These exclusions hit 'aged and infirm' people particularly hard because they were more likely to be both paupers and suffering from chronic illness or disability. In general, provision for sick paupers in the workhouse sick wards was much worse

than that made for the sick poor by the voluntary hospitals (Abel-Smith 1964:50), although standards varied enormously. The physical environment in the workhouse was overcrowded, poorly furnished and dirty (Abel-Smith 1964:51). Whereas the voluntary hospitals began to employ trained nurses to work alongside increasingly better-trained doctors, in the workhouse able-bodied paupers continued to act as 'nurses'. 'Aged' paupers particularly were employed in this role because they were more likely to stay in the workhouse for long periods (Abel-Smith 1964:57).

At the start of the 1870s, standards in Scottish parochial hospitals were also extremely low and falling far behind the voluntary hospitals, with cold, damp, draughty wards, monotonous meals and reports of patient ill-treatment and neglect (Blackden 1979:258). Medical staff only worked part-time and most of the nursing was undertaken by female paupers, supervised by paid nurses, until a circular recommended the system of trained nurses adopted by Poor Law infirmaries in England (Blackden 1979:260).

In England, infirmaries were set up under the Poor Law to care for the sick poor, following enquiries into poor treatment and very high mortality rates in workhouses (Abel-Smith 1964:81). The stigma of the infirmary as a pauper institution was designed to deter all but the genuinely sick from entry (Abel-Smith 1964:85). By establishing separate infirmaries for the sick currently in workhouse wards the Poor Law Board hoped to 'restore due discipline among the able-bodied' in the workhouse and eradicate outdoor medical relief, which had been increasing throughout the Sixties (Abel-Smith 1964:85).

However, in England, the infirmaries did not develop into the stigmatizing institutions they were intended to be. The appointment of medical superintendents to run them, more doctors than in the workhouses and nurses recruited from outside produced

higher standards and better treatment, which attracted non-paupers to seek and gain admission (Parker 1988:20). Senior citizens, with their chronic rather than acute illnesses, were excluded (Abel-Smith 1964:215). The infirmaries, like the voluntary hospitals, concentrated on treating the acute sick and the chronic sick were discharged to or remained in the workhouse sick wards, with their stigma and inferior standards of care (Parker 1988:21).

In Scotland, the determination to make the Poor Law work more efficiently after 1889 was reflected in rather different attitudes towards the sick poor. Plans were made to separate the pauper sick, infirm and mentally ill from the general body of paupers by extending general hospital building to provide a non-stigmatising environment and better standard of medical care. The aim was to overcome the great reluctance of the outdoor poor to be treated in parochial hospitals (Blackden 1979:261). By 1939, there were 137 general hospitals with accommodation for 67,000 sick people in England but a similar number were still in the remaining Poor Law institutions (Townsend 1962:29).

The disruptions of World War II revealed the continuing low government priority of senior citizens as a group and exposed the inferior state of residential care to a much wider social audience. People rendered homeless by bombing or who had been evacuated found themselves in Public Assistance Institutions. The Old People's Welfare Committee accused the government of treating war victims like paupers (Means and Smith 1998:28). A survey of beds in Emergency Medical Service (EMS) hospitals and Public Assistance Institutions highlighted poor medical care of many patients and the mixing of people from very different social backgrounds alongside 'mental, senile and poor law cases' (Age Concern Archives in Means and Smith

1998:28). EMS hospitals were reluctant to take sick and frail senior citizens, who were not seen as a priority.

Eventually, public criticisms forced the government to develop a policy for 'old people' opening hostels for those who had been evacuated or made homeless by war (Means and Smith 1998:30). A crucial feature of both types of hostel was that they were not covered by poor law legislation. The people using them had resident rather than inmate status and did not have to forego their pensions (Means and Smith 1998:30). After the War, the Government tried unsuccessfully to get charitable organisations to take the hostels over. Local authorities were encouraged to take them over for use as residential accommodation under the forthcoming National Assistance Act.

Later, Titmuss expressed extremely ageist remarks about the way the 'the problem of aged and chronic sick …in war' had been managed. 'It was wasteful to admit them to specifically equipped and staffed emergency bed schemes. To nurse them was not only uninteresting but often unpleasant; the work soon dampened the enthusiasm of newly enrolled VADs who had expected to nurse soldiers not incontinent and senile old people'. It was agreed that the emergency hospital service must give priority to 'potential effectives' (Titmuss 1976 quoted in Means and Smith 1998:52).

However, such ageist attitudes began to shift as 'humane treatment of so-called 'dependent groups' became an important symbol of post-Beveridge Britain' (Means and Smith 1998:52). The Beveridge report, published in 1942, set out the foundations of the new Welfare State. It proposed social insurance as the means of tackling poverty to replace the system based on the Poor Law.

The 1947 Report of a Nuffield Foundation survey into 'the problems of ageing and the care of old people' (Means and Smith 1998:75) made the case for abolishing Public Assistance Institutions but failed to mention what the individual objectives of residential care should be (Knapp quoted in Judge 1986:7). It identified bad conditions of care in both public and private residential homes and called for a statutory inspection scheme. The Report proposed four kinds of local authority home to provide accommodation for different groups of 'old people' – from the so-called 'normal' to the 'demented'. The language was different but these proposed sub-divisions of the elderly population were similar to the classificatory systems so recently used and advocated by the Poor Law authorities.

The Chief General Inspector stressed the need for change in residential care, while acknowledging that a lack of staff and premises were major obstacles to improvement (Means and Smith 1998:78). Charitable organisations representing senior citizens and the National Association of Local Government Social Welfare Officers continued to attack deplorable conditions 'whereby aged and chronic sick were deprived of necessary care and attention to alleviate their pain and discomfort' (Means and Smith 1998:78). The National Old People's Welfare Committee continued to criticise the quality of provision in 'chronic sick' hospitals and Public Assistance Institutions.

This public pressure for improvement caused the reissue of the 1895 and 1896 Circular on 'care of the aged in homes and institutions'. This called on PAIs to improve their regimes by allowing residents greater freedom and smartening up buildings by improving the furniture and furnishings (Means and Smith 1998:79).

The Welfare State

The 1948 National Assistance Act replaced the Poor Law and responsibility for 'outdoor' relief of poor people passed to the National Assistance Board. Local authorities were to provide residential accommodation for people who, by virtue of 'age, infirmity or any other circumstances' were 'in need of care and attention not otherwise available to them' (Townsend 1962:33).

By the end of the War, despite the promise of a 'new relationship' between senior citizens and the State, the rhetoric was not matched by reality. The policy issue that dominated State provision for senior citizens post-war was the universal interest in pensions. Residential care, which concerned only a very small proportion of the elderly population, was of little political importance. Only a few of the 'small' residential homes for senior citizens advocated by Nuffield had been built. Some 130,000 people in England and Wales were still living in Public Assistance Institutions (PAI) i.e. in former workhouses (Townsend 1962:33). About a hundred of these PAIs were transferred to the Ministry of Health and became National Health Service hospitals. Nearly two hundred institutions became 'joint-user' establishments, housing sick and other persons and were used by both Regional Hospital Boards and local authorities. The remaining one hundred or so institutions owned by local authorities were used to provide residential accommodation (Townsend 1962:33).

The National Assistance Act has been criticised for its concentration on institutional provision for senior citizens at the expense of alternative means of supporting them, in contrast to the policies to maintain family life that were embodied in the Children Act (Parker 1965, quoted in Means and Smith 1998:143). However, the whole history of Poor Law policy towards senior citizens has been to limit expenditure on them by

confining assistance to stigmatizing institutions. Ageing was seen as synonymous with poverty and infirmity. Senior citizens were a low social priority and institutional care was the most efficient means of meeting need (Means and Smith 1998:143). There was no national debate involving senior citizens themselves, about what forms of institutional and non-institutional support they would find acceptable post-Poor Law (see Means and Smith 1998:146).

The abolition of the Poor Law was supposed to replace the 'master' and 'inmate' relationship which had existed between PAI managers and senior citizens, with one resembling that between hotel manager and guest (Townsend 1962). There was widespread support for the proposal that residential provision for all senior citizens needing it, should be provided in accommodation similar to the small private hotels used by affluent senior citizens (Judge 1986:6). A 'hotel relationship' would become feasible because people would go into residential homes from choice rather than necessity using their retirement pension to pay for their care (Means and Smith 1983). If an economic rent was charged, 'any old people who would wish to go may go there in exactly the same way as many well-to-do people have been accustomed to go into *residential hotels'* (my emphasis), (Bevan quoted in Sinclair 1988:244).

However, the financial resources to implement these changes were not forthcoming. Pension levels were set at basic subsistence level, too low to enable most people to pay the full costs of residential care so local authority subsidy was required. 'Need' remained the determinant of admission (Sinclair 1988), but defined by professional gatekeepers not, as Bevan had intended, by senior citizens themselves.

Post-war, the same policy ambivalence towards senior citizens and uncertainty about the purpose and form of the new residential home model persisted. Government guidance to local authorities on the design and function of new residential homes

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changed every few years. Whereas, the '48 Act had envisaged that public residential provision for senior citizens should not exclude people who were physically independent, by 1957 a circular had shifted the emphasis towards the 'frail' elderly population (Judge 1986:7). Guidance signalled a retreat from the Nuffield 'hotel' model back towards a 'hospital model' of provision and a much frailer resident population. The 'type of old person' for whom residential accommodation under the National Assistance Act was needed was redefined as 'very infirm' and likely to need 'periods in bed' (Means and Smith 1998:174). A high proportion of four to six bedded rooms on the ground floor and reduced space in living rooms was recommended for new residential homes.

Between 1949 and 1960, the numbers of senior citizens living in PAIs had only reduced by some five thousand (Townsend 1962:34) and little progress had been made in replacing old buildings. By 1962, policy guidance on residential care homes had changed yet again, back to the Nuffield recommended model. A new circular (11/62) in the form of a Building Note stressed that smaller homes, now defined as 'between 30 and 50 places' were generally preferable, and a high proportion of single bedrooms was in favour once more (Means and Smith 1998:193, Townsend 1962:39).

The major policy shift in the use of residential homes was announced in a memorandum in 1965. Residential homes were now for senior citizens who were 'unable to maintain themselves in their own homes, even with full support from outside' provided they did not need 'continuous care by nursing staff' (Judge 1986:7). Residential care homes, with their much lower costs were to take over from the hospital service those 'impaired' senior citizens needing long term care.

The 1948 National Health Service Act moved control of hospitals from local authorities to regional hospital boards. The hospital sector dominated the new health

service and the treatment of senior citizens continued to be perceived as of low status and low priority (Means and Smith 1998:117), an enduring ageist bias evident since the evolution of hospitals in the nineteenth century that I have already discussed. 'Reforms' in the medical care of senior citizens included a growing interest in the medical speciality of geriatrics, which was seen as the main solution to the 'problem' of 'chronically sick' elderly patients 'blocking' hospital beds.

New geriatric departments in selected general hospitals were recommended, to provide senior citizens with a proper diagnosis and treatment before being classified as 'chronic'. Hospital care of 'chronic sick' and 'elderly people' people was characterized by neglect. There was a lack of treatment, too little rehabilitation and an atmosphere of defeatism. Many people were in bed for long periods, resulting in 'avoidable contractures and deformities' (Anderson Report 1947 quoted in Means and Smith 1985:120). A strong but unsuccessful case was made for the medical control of any future local authority residential care for senior citizens, since maintaining high rates of hospital discharge depended on the availability of residential care (Means and Smith 1998:121). Between 1949 and 1958, geriatric and chronic sick beds in hospitals increased by only 13%, whereas local authority residential accommodation increased by almost two thirds (62%) over the same period (Townsend 1962:34).

The post-war legislation divided responsibility for senior citizens between the new National Health Service and local authorities. This imposed an arbitrary distinction between senior citizens who were deemed to be 'frail in need of general care and attention' and 'the sick in need of medical and nursing support' (see also Townsend 1962:33). The unspoken differences between these two groups were age and disability and the means devised of distinguishing between them was by their degree

of 'dependency'. The National Health Service was to provide for the 'sick' and local authorities would provide residential care for those needing 'care and attention'.

Bed shortages and growing pressure on local authority provision fuelled disputes about the respective responsibilities of these public services towards senior citizens. The high cost of hospital care relative to local authority provision was emphasised in reports. Bed shortages had a detrimental effect on senior citizens in hospital and in residential homes, in that health and local authorities were reluctant to accept transfers between their services. Infamous systems of 'swaps' were instituted, whereby a senior citizen in a residential home needing hospital treatment would only be accepted on condition the local authority accepted an elderly hospital patient in return (Neill 1982, Phillips 1992). The needs of senior citizens were secondary to the need of agencies to defend their boundaries.

Means and Smith (1998) conclude, like Townsend, that residential homes have increasingly accepted senior citizens with higher levels of illness and disability than originally intended. What I have argued is that the objectives for residential homes were never debated or spelt out when the Poor Law was repealed. The high cost of beds in the new National Health Service hospitals combined with the ageist attitudes of hospitals to the care and treatment of 'infirm' senior citizens resulted in residential care becoming a de facto adjunct to the health service. In the absence of clear new objectives and a lack of investment in reform, the institutional regime of the Poor Law lingered on in residential care. I shall pursue my own analysis on this point in the next chapter.

In this next section, I discuss how the research critique of residential care homes and the identification of different models of care have influenced attitudes to and

understandings about what should constitute 'good practice' in care for senior citizens.

Residential care research

Townsend's 1962 survey of residential institutions for 'the aged' in England and Wales examined residential care from a social policy perspective. He found that half the local authority accommodation for 'the aged and handicapped' was still in the former workhouses (Townsend 1962:63). Townsend measured how far homes reached a 'reasonable standard', based on the physical facilities, staffing, activities, freedom in daily life and social provisions for residents. The overall standard of homes was low. Of the 92 local authority homes in Townsend's sample, only three achieved his standard of 'reasonableness'. Private homes were better and voluntary homes were best, although the quality of independent sector homes was more variable than in the public sector homes (Townsend 1962:213). Townsend expressed astonishment that new policies were introduced and modified 'without any detailed inquiry taking place into the best use of existing buildings and the *needs and wishes of persons living there'* (Townsend 1962:39) [my emphasis]. As I shall show in the next chapter, the development of residential care before and since Townsend's study shows that decisions about its form and function have not been taken in consultation with senior citizens or other groups of service users.

On the basis of his findings, Townsend advocated replacing residential care with sheltered housing, extending the hospital system, expanding domiciliary services and by developing general practice (Townsend 1962:436). These proposals found no favour with central or local government officials, who, at the time, were preoccupied with issues of race and juvenile crime rates in the inner cities (Means and Smith 1998:213). The policy priority so far as senior citizens were concerned was to keep

down costs and government continued to argue that residential care was the most economic provision for the most 'impaired' (Means and Smith 1998:209). Reduced expenditure on senior citizens was to be achieved by reducing hospital geriatric beds and greatly expanding residential care (Means and Smith 1998:204).

In the 60s and 70s, other studies of long stay hospital and residential care (Robb 1967, Meacher 1972, Miller and Gwynne 1972) were 'equally damning of residential care' (Jack 1998:17). Since most residential care was provided by local authorities, these criticisms were of the unreformed model of care provided in public sector homes. This vein of criticism in residential care research continued into the 1980s, again most of it conducted in local authority homes. Researchers continued to criticize the poor quality of physical provision, the lack of resident self-determination and the oppressive attitudes and behaviour of staff (Clough, 1981, Godlove et al. 1982, Booth 1985, Booth and Philips 1987, Willcocks et al. 1987, Wilkin and Hughes 1987). This was what Jones and Fowles (1984) called the literature of 'dysfunction', with its emphasis on the failure of residential care as a tool of social policy.

With the rapid growth of the private sector from the late 1970s on, research into residential care broadened its focus. Studies examined the motivation of private care providers and how they reconciled maximising profit and providing high quality care (Weaver et al. 1985b, Phillips et al. 1988, Wistow et al. 1996). Much of the work on private homes made similar criticisms to those made about public sector homes (Townsend 1962, Phillips et al. 1988). Other authors were more positive, believing that the best private sector care and its management strategies could make a positive contribution to the overall development and quality of residential care if they were replicated by the statutory sector (Townsend 1962, Willcocks et al. 1987, Payne 1989). One writer (Adams 1996) wondered whether the private sector could provide

'acceptable hotel-style accommodation' (p.159) or whether residential homes would remain essentially 'places of last resort' (Sinclair 1988). Norman's study of innovative designs in local authority homes (1984) showed the futility of changing building design without also changing the regime. In one example, attempts to enhance privacy by the provision of en-suite accommodation were defeated by a regime that denied residents access to their rooms during the day.

The change of emphasis from 'welfare' to 'consumerism' in social services, generated studies into how far the 'mixed economy of welfare' enabled senior citizens to exercise choice about their move into residential care. The study of 'consumer choice' and participation by Allen et al. (1992) was conducted during a period of unprecedented growth in the numbers of people going into voluntary and private residential care homes funded by social security. While most people in their study felt they had had some control over the decision to seek residential care, they had left the actual choice of home to others. In local authority homes there was usually no choice, since it was more a question of bed availability and locality (Allen et al. 1992:312).

However, a substantial minority of people had made 'a positive choice' to move into private residential care because they were lonely, afraid or tired of managing for themselves (Allen et al. 1992:312). In another study, around a quarter of the people interviewed had also made a positive decision to opt for residential living themselves (Oldman and Quilgars 1999:375). Residents reported a reasonable degree of choice about aspects of daily life, such as meals, baths and showers and staying all day in their flats if they wished (Oldman and Quilgars 1999:377). What was still missing from the quality manuals was any contribution from senior citizens about what mattered to them, their quality of life (which I have already discussed in Chapter 2).

For these residents, quality of life meant having more time with care staff, more opportunities to get out and most importantly, events to enliven their day-to-day existence (Oldman and Quilgars 1999:379). The use of residential care as 'the last resort' by targeting services on the very frail, physically and mentally, had a negative effect on those people seeking to benefit from making a positive choice for communal living (Oldman and Quilgars 1999:380).

Peace et al's (1997) review of the role of residential care questioned whether it was still seen as a negative form of institutional care that limited autonomy and choice or whether it was a positive option for some people. They concluded that despite major improvements, particularly in physical standards, the role of residential care remained ambiguous and that with some few exceptions, residential/nursing care home provision was still seen by senior citizens as the option of last resort (Peace et al. 1997:119). This wariness of senior citizens about residential care was still justified, they concluded, because of its continued threat to individuality and the sense of self (p.122).

I now want to consider research studies that identified a number of different forms of residential care in terms of models.

Models of residential care

Since the 1960s, researchers have identified a number of different models of institutional care. Goffman's (1961) definition of the characteristics of what he called 'total' institutions had a profound effect on researchers and became almost the definition of what 'good practice' in an institution should seek to avoid. The institutional totality Goffman described was where all aspects of social life were carried out in the same place, with the same large group of people who were all

treated alike and required to do the same thing under the same authority. The potential danger Goffman saw in total institutions was their ability to force change upon people and to experiment 'on what can be done to the self' (Goffman 1961:22).

A study of children's homes devised a schedule built on Goffman's four dimensions of institutional life (King et al. 1971). Their interest was in seeing whether homes differed in their characteristics in terms of these dimensions and the effect, if any, on the residents. They characterized the way that the homes were run as 'institution oriented' or 'child oriented'. Children in the child oriented homes showed far higher levels of development. These findings showed that institutions varied in their effects and that regimes that focused on the needs of residents rather than the institution could be more beneficial to them.

Townsend and Kimbell (1975) used a modification of the King et al. scale (1971) in a study of residential care homes for senior citizens in Cheshire to explore the relationship between differences in regime and the residents' 'dependency' but failed to find any relationship between them. Other studies of residential care for senior citizens have attempted to find links between regime or social environment and resident 'dependency' without success (Evans et al. 1981, Booth 1985). Researchers have been able to identify homes where staff attitudes and behaviour made the homes pleasant places to live. However, they have been unable to show a link between staff attitudes and behaviour and resident 'dependency'.

Booth (1985) identified a methodological problem about measuring outcomes of residential care when there was no agreement about its objectives in his study of local authority residential homes. In the end, he used dependency. He justified using 'quality of care' in his study because it was 'safer and more practical' to compare regimes on that criterion rather than on the quality of life they afford (Booth

1985:104). He was looking for an objective measure of residential care rather than a subjective one, such as quality of life, 'which is a judgement made in terms of the characteristics of the environment and the individual's subjective response to them' (p.104). Such judgements did not fit with the purpose of his study which was to test the 'induced dependency hypothesis' – that regimes 'made' residents more or less 'dependent' . Booth concluded that the homogeneity of regime he found, which tended towards routinisation and control, was due to the function of residential homes, namely to provide care. The model of residential care being operated in Booth's study was the institution-oriented model described by King et al. (1971) but their findings that institutional function does not dictate homogeneity in practice, seem to have been discounted by Booth.

Further evidence that the function of care does not necessarily determine the regime came from a study by Miller and Gwynne (1972). In their attempts to define what the primary task of residential care should be, Miller and Gwynne (1972) identified two distinct models of care being operated in homes for physically disabled adults. Homes operating what Miller and Gwynne called the 'warehousing' model defined their primary task as prolonging physical life, importing the hospital model of care to do so and expecting residents to acknowledge their 'dependent' role in the process. The disabled person's physical dependence on staff for certain aspects of daily living was transmuted into a notion of total dependence on them for all aspects of life.

Homes operating the 'horticultural' model saw their main function as developing the unfulfilled capacities of their residents, thereby denying residents' 'dependency' needs. Miller and Gwynne (1972) concluded that both these models of care were inadequate in the way they met residents' needs. By concentrating care on the physical body, the warehousing model's view of residents' helplessness pervaded

their whole life and could destroy the person. This model fitted Goffman's typology of a total institution. The horticultural model's contrasting emphasis on development of individual capacities seemed initially to provide a model of care that focused positively on residents as independent individuals. However, Miller and Gwynne argued that to focus on developing peoples' capacities to the neglect of their physical needs was also inappropriate and distressing for people with progressive diseases and could result in some peoples' need for physical care not being met (Miller and Gwynne 1972).

The authors concluded that since the homes they studied were for people who were 'incurable', it was inappropriate to define the primary task of the institution as rehabilitation and discharge back to the community. The quality of living within the institution must be an end in itself (p.189). The focus on quality of life involved recognising the individual's right to choose 'dependency' or to take advantage of such developmental opportunities as the home offered. Once the person had made that choice, the task of the institution was to provide a setting in which the individual could find his or her best way of relating to the outside world and to him- or herself, without their individuality being destroyed, or their need for assistance being denied (Miller and Gwynne 1972).

The study is useful for the arguments in this thesis in the way that it makes explicit how models of long term care that focus solely on promoting resident activity and independence or on their physical dependency, may result in other important needs being unmet. It is also useful in its identification of quality of life rather than quality of care only as the primary task for long stay institutions. These useful insights are somewhat undermined by Miller and Gwynne's analysis of a move into residential care as the 'social death' of individuals. Such an analysis reinforces rather than

challenges the negative social perception of residential care that they were involved in trying to change and implies that anyone who chooses residential care as the means of getting their care needs met is committing a form of 'social suicide'.

Other research has looked at the relationship between design, regime and resident 'dependency'. An enthusiastic evaluation of an experimental 'grouped unit' design of residential home in Cambridgeshire (Hitch and Simpson 1972) based on a 'domestic' or 'family' style of care, concluded that the design and social environment were responsible for residents being more active and engaged than those in the comparator 'traditional' homes. The model was built around five, self-contained small 'family' sized groups of eight residents who ate and sat together but each had their own room. This design was subsequently recommended in policy guidance to local authorities, which is discussed in Chapter Four. Group living was seen as an important step forward in developing 'good practice' in residential care for senior citizens, improving their quality of life and avoiding the harmful effects of institutionalisation.

This success led to the development of a number of variations on this 'domestic' pattern or 'pseudo-family group' (Willcocks et al. 1987:129) and became known as the Small Group or Group Living model of residential care. Variants ranged from physically separate bungalows with their own catering facilities, through separate sitting/dining rooms supplied by a common kitchen, to separate lounges with a common dining area (Bland and Bland 1985). The strongest claims about small group living were made by Marston and Gupta (1977) and Marston (1979). They experimented with minor alterations to existing 'traditional' homes in Northamptonshire to create small groups of residents similar to the Cambridgeshire model but at far less cost. By providing a focus for group activity that resembled 'ordinary' domestic life and giving residents real choices, they claimed to have

overcome what they described as resident 'under-functioning' which they believed existed in traditional homes. Residents in the small groups were said to be far more active, vocal and enjoyed 'pottering' (Bland and Bland 1985). Marston and Gupta argued that almost any building could be adapted for Group Living with careful planning and preparation and lots of imagination. This low-cost example gave further impetus for the model to spread (Booth and Phillips 1987).

Later evaluations of Group Living were critical of the Cambridge study's methodology and were mixed in their conclusions about the model's positive effect on residents' morale and activity. Some suggested that the model was an essential pre-requisite and others that staff attitudes and behaviour towards residents were more influential (Wyvern Partnership 1979, Thomas 1981, Peace and Harding 1980).

The Consumer study of residential homes (Willcocks et al. 1987) found little relationship between resident wellbeing and physical environment. In the group and 'semi-group' homes they studied, residents were more dissatisfied with their relationships with staff and staff saw the model causing them 'more work and worry' (p. 131). The authors identified a need for privacy as key to the quality of life for senior citizens in residential homes and recommended the residential flatlet as the physical entity within which residents might 'preserve an individual and private lifestyle' (Willcocks et al. 1987:161). Booth and Phillips concluded from their two year evaluation of Group Living that it had been 'oversold' as a model and that it promised more than it could deliver (1987). Whilst Group Homes tended to let residents have more opportunities for self-determination, there were more similarities between regimes in the Group and traditional homes in their study than there were differences.

Youll and McCourt-Perring (1993) described six models of 'caring' identified by individuals and staff groups in their evaluation of the Caring in Homes Initiative. These were what they called 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 (p.172.).

The authors identified two sets of assumptions running through these models about the nature of the relationship between the resident and the staff member which influence the approach to care. The first assumption concerned where power and authority lay 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.

The researchers highlighted the kinship model of caring as different from the other models identified, in that it assumed relationships between staff and residents based on cultural rather than organisational norms. They gave as an example, the continued deference rather than infantilising treatment 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).

A more recent study by Kellaher (2000) was intended to uncover the determinants of good residential care provision by examining the model of Care adopted by Methodist Homes (2000:vii). Kellaher adopted a different methodology to many previous studies that have taken the form of surveys. By interviewing residents, Kellaher was

able to test out how far the Methodist Model, which places concern for the individual and mutual respect between residents and staff at the heart of its philosophy, resonated with their experiences as individuals. The vast majority of her interviewees were unequivocal that their move into the care home had been the right one. People found other residents open, welcoming and friendly. They commented on the friendliness shown in the home towards prospective residents and the care and help given to new arrivals by other residents.

Kellaher concluded that the mix of friendliness, respect and support shown in the Methodist Homes Model – which she called mutuality - was an important resource for residents to draw on in reconciling their individual interiority with the external reality of residential care living (p.83). The structuring of 'friendliness' and mutuality into the Methodist Homes standards was the defining feature that marked them out as different from other residential settings (Kellaher 2000:85). Kellaher suggested mutuality as a governing principle could be employed as successfully in homes run by other 'affinity' groups as a way of linking residents with each other and with staff in the pursuit of a sense of community in residential care (p.86), as Youll and McCourt-Perring (1993) also suggested.

However, there were some key differences about the residents, the social environment and the organisational definition of the residential task in Kellaher's study compared with public sector homes. Most importantly, the elderly people themselves had made an informed choice to move into a Methodist Home, through seeing a brochure, making a preliminary visit or having a 'trial stay'. They understood and liked that particular model of care. For most people, it had been a planned move at a time of their choosing. Very few had moved in an emergency or come in straight from hospital. Secondly, the physical accommodation in the homes was of superior quality

and dimensions to the 'minimum national standards' required by legislation. Three quarters of the residents' spacious bed-sitting rooms had en-suite facilities - a factor that many interviewees said had been of critical importance in their choice of home.

The mutuality that Kellaher identified between residents was positive, being based on a common, life-long identity as Methodists, rather than the stigmatizing identity associated with age and dependency. Finally, the primary function of senior staff, explicitly stated in the Quality Standards Manual, was to maintain a good atmosphere in the home through mutual respect and to pay attention to individuality, rather than to provide physical care. This model of 'good care practice' is successful because its ethos of Christian Methodism promotes a culture of friendliness and mutual respect that is owned and shared by most of its residents and staff. It is a privileged model of residential care whose generous levels of resourcing enable it to provide a standard of accommodation, care and quality of life that is in accordance with its residents' expectations.

Other studies have identified what they called 'hotel' models of care operating in a minority of residential homes but they failed to define or describe these in any detail (Townsend 1962, DHSS 1979, Counsel and Care 1992). The fullest description of what they call a 'modified' hotel model was provided by Goldberg and Connelly (1982). This model consisted of 'relaxed regimes where people can get up when they like, look after their own rooms as far as they are capable, potter as they might have done at home, come together in small groups for knitting or gossiping, or spend as much time as they like in their bedsitting rooms and have their meals in the restaurant or have them sent to their rooms' (p.204). Unfortunately, Goldberg and Connelly (1982) did not go into any detail about the organisation operating the model.

The hotel or catering model identified by Youll and McCourt-Perring (1993) was described by them 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' (p.173). One worker in a mental health hostel for senior citizens, who had formerly run a pub, found little difference between peoples' needs in the two occupational settings. Brearley (1990) acknowledged that the services provided by hotels, such as accommodation, meals, laundry and entertainment, resembled those provided by residential care in many ways. Brearley (1990) saw considerable potential advantage to residents in residential care homes being seen as 'customers who are always right' (Phillips et. al. 1988:108), as hotel guests are supposed to be, rather than the more usual view of residents as passive recipients of care. I pursue the 'hotel' model of residential care further when I discuss my own case study research in a private home in Chapter Eight.

I argue that what all these studies of 'dependency' and 'models' failed to acknowledge was, the structurally determined aspects underlying the circumstances of senior citizens entering residential care homes. The focus on physical 'dependency' obscured the fact that poverty was and, I argue, still is, a major influence on entry into residential care.

Conclusion

In this chapter I have argued that despite apparent changes in policy towards senior citizens and residential care, the underlying aim of government in responding to the challenges of ageing is to minimise intervention and costs. I argued that the 19th century policy change that made poverty relief conditional on entry into the workhouse/poorhouse reinforced the association of residential care with moral and social failure in 'old age'. This stigma successfully deterred most senior citizens from

seeking help in times of need. Institutional care became what it was always intended to be - the last resort of the desperate. Entry to the workhouse/poorhouse was due to 'dependency' – whether on grounds of destitution, sickness or disability - rather than age. The policy response to increased demand was to reduce costs by restricting eligibility and exerting pressure on families.

I argued that an ageist policy of low priority and neglect towards the needs of senior citizens in residential care persisted throughout the 19th and first half of the 20th centuries, despite continued public criticism. Promises of a new 'deal' between senior citizens in residential care and government in the Welfare State failed to materialize. The function of residential care changed from deterrence to meeting the long term care needs of senior citizens being discharged from high cost NHS hospital beds. I argue that underlying this change in function, policy towards residential care remained the same, namely that its response should be minimal and entry should be restricted to the small minority of senior citizens lacking the necessary financial, physical or social resources to maintain their independence.

Research studies of public sector residential homes have been critical of the institution and staff for the poor quality of residential care rather than seeing it as the reflection of widely held attitudes and beliefs about ageing of an ageist society. Many studies have perpetuated ageist stereotypes of senior citizens, focusing on residents in terms of their physical and mental dependency and on quality of care rather than quality of life in residential homes. The exception to this tendency was the study of homes for physically disabled adults (Miller and Gwynne 1972). It concluded that the primary function of long stay institutions was to enable quality of life rather than quality of care only. This meant recognising residents' independence and dependency needs, and offering them the choice as individuals to take or reject opportunities and support

for both kinds of need to be satisfied. However, the focus on physical disability as 'dependency' in many studies failed to acknowledge the structural influences on senior citizens entering residential care homes. I have argued that poverty has been and continues to be a major factor behind the entry of senior citizens into residential care.

Studies of senior citizens' views as 'consumers' in a mixed economy of care have begun to reveal their more mixed views of residential care as a way of meeting their needs. For a minority, residential care is a 'positive choice'. These studies have shown that residents' priorities are focused on aspects of their quality of life rather than the quality of care. What studies have not so far explored is how 'good practice' in residential care is implemented and its effect on the quality of life of senior citizens.

In the next chapter, I focus more closely on what is meant by 'good practice' in residential care by examining the definitions and meanings given to it by policymakers and professionals. I examine how ageist attitudes have influenced ideologies and principles about what should constitute 'good practice' in residential care for senior citizens by my analysis of policy and practice documents and literature. I argue that the concept of 'good practice' has been used in many different ways by policymakers and professionals. Varying and changing definitions of what 'good practice' is, or should be have been debated and contested among policymakers and professionals and are reflected in legislation, policy and practice. These debates have been conducted by professionals and 'experts' largely in ignorance of senior citizens' views and without their active involvement.

Chapter Four – The Meanings of 'Good Practice'

Introduction

In Chapter Two, I argued that an examination of what is meant by 'good practice' in residential care for senior citizens has to be grounded in a broader understanding of how ageing and senior citizens are regarded in wider society, which, I argued was ageist. I argued that attitudes to ageing tend to see it as personally and socially 'burdensome'. Ageing and its assumed negative characteristics of poverty, disease and 'dependency' have to be 'managed'. The policy response to 'dependency', I argued, is a 'need for care', which residential homes exist to meet.

In Chapter Three, I discussed residential care as the 'good practice' policy response of an ageist society to 'need' and 'dependency' among senior citizens in the nineteenth and first half of the twentieth century. I argued that underlying policies towards ageing and senior citizens have remained consistent despite apparent change. I argued that 'good practice' in policy terms has been ambivalent and minimalist. Attitudes towards senior citizens unable to retain their independence in later life remained ambivalent, tinged with suspicions of improvidence and moral failure. These ageist attitudes were reflected in policy neglect and repeated disinclination to improve the situation of senior citizens in public assistance institutions, despite public disquiet. I argued that the negative attitudes of hospitals towards 'dependent' senior citizens before and after the institution of the Welfare State perpetuated an ageist framework for 'good practice' in the statutory model of residential care.

I argued that the research critique of residential care failed to acknowledge that the public sector model of which researchers were so critical was a reflection of a society that deprecated and marginalised ageing, disability and poverty. I criticized the

research contribution to understanding 'good practice' in residential care for its narrow preoccupation with physical and mental 'dependency' and emphasis on 'care' of senior citizens rather than quality of life. I argued that their concentration on physical disability as 'dependency' obscured the influence of poverty on senior citizens entering residential care homes. Studies giving 'voice' to senior citizens' views as consumers revealed different priorities and varying attitudes to residential care. These views suggest that the definitions of 'good practice' senior citizens apply to residential care may be different.

In this chapter I am going to examine ideas about what constitutes 'good practice' in residential care in the context of an ageist society. I argue that definitions of 'good practice' have been contested and debated since the late 1960s and these debates have been reflected in legislation, policy and practice. As I have already discussed in the Introduction to the thesis, I have chosen to investigate 'good practice' using the concepts of independence, choice and privacy. I have chosen these particular concepts since they are both highly valued by senior citizens and also figure prominently in policy and practice documents concerned with 'good practice' in residential care.

I examine my contention that 'good practice' is a variously defined, disputed concept. I begin by examining who defines 'good practice', how it is defined and for what purpose. I argue that 'good practice' in residential care has been defined by policymakers in terms of legislation and guidance and by practitioners in terms of values and principles of practice and their role in implementing legislation and policy. I explore the changing legislative context within which definitions of 'good practice' by policymakers and professionals have been changed, debated and contested. I argue that although 'good practice' is a term that is widely used in policy guidance, its

definitions are varying, confused and often conflicting, emphasizing the independence of senior citizens in residential care within a theoretical understanding of ageing as 'dependency' and a 'need for care'. I review repeated attempts through enquiries and codes of practice to define 'good practice' in response to public concerns about low standards and poor practice in residential homes and about the quality of care in the growing private sector. My review shows that a common factor underlying these attempts was a complete failure to ask senior citizens for their views on residential care and what it should provide.

I argue that there are two distinct and competing ideologies articulated in the various policy and practice documents. One that defines 'good practice' narrowly, in terms of dependency, physical care and risk avoidance, and the other that defines 'good practice' more broadly in terms of independence, the right of residents to take risks and quality of life in residential homes. I argue that the failure among policymakers and professionals to agree and define 'good practice' and the objectives of residential care, reflected a continuing underlying ambivalence towards senior citizens and a policy preoccupation with the retention of residential care as a response of 'last resort'.

I argue that the policy response to these contested definitions has been to define 'good practice' in terms of standards and to use regulation as the means of securing 'good practice' in the independent sector. I argue that this has left the stigmatizing emphasis on dependency and need for physical care as criteria for entry into residential care unchanged. The professional and practice literature has defined 'good practice' in terms of key principles or values that affirm residents' rights, not least to their independence, privacy, dignity and some element of choice. I argue that the key differences between these documents are in their interpretation of what constitutes

'good practice,' in the application of these principles in the light of understandings about the ageing process, and appropriate responses to it in residential care. I argue that amid the debates and enquiries into how 'good practice' in residential care should be defined, the voice of the people using the service, that of senior citizens, has continually been excluded or ignored as irrelevant or unimportant. 'Good practice' has continued to be defined by 'experts' in terms of the assumed benefits to people using the service – an assumption that has never been tested. I then consider the influence of practitioners on defining and developing 'good practice' in residential care. I argue that this has been minimal, due to diversionary intra-professional disputes about status, ageist attitudes and ambivalence towards senior citizens and residential care and the lack of training among social care staff in homes. Finally, I review the contribution to definitions of 'good practice' by social work research, which has focused on social worker involvement in the move to residential care and the practice of care within homes, from both staff and resident perspectives.

I argue that what is currently defined as 'good practice' in the care of senior citizens is a gradually accumulated set of administrative procedures and processes that continue to focus on the physical care of residents rather than their quality of life. This reflects societal attitudes and beliefs about ageing and dependency in later life. These procedures and processes owe more to historical precedent and 'practice wisdom' than any proven value in enhancing the quality of senior citizens' lives.

Defining 'good practice'

A key issue in the exploration of 'good practice' is how the concept is defined. My study showed that there are multiple definitions applied, depending on the orientation and framework within which the interpreter is working. In social work and social care, 'good practice' is defined by policymakers through legislation and policy

guidance, and by professionals and practitioners in terms of the principles and ethics of social care practice to be applied in their work.

One way in which 'good practice' has been defined has been in terms of service quality. Determining what constitutes quality in social services has been mediated by social work professionals' definitions of 'good practice'. These definitions have been based on a combination of vocational ethics and the legal norms and bureaucratic procedures of local authorities. 'Good practice' depends on staff for implementation and standards are the foundation upon which 'good practice' can be built (McCreadie 2001). Quality assumed greater significance in the 1990s as it became a means of pursuing value for money in public services, drawing on approaches derived from business and commercial models of quality definition and measurement (Evers et al. 1997). Government guidance and codes of practice issued to local authorities came to be couched in terms of what was deemed to be 'good' or 'best' practice according to the current state of professional knowledge, fashion and experience.

'Good practice' may be also defined by professionals working as government inspectors, in order to secure implementation of policy objectives. In these circumstances, 'good practice' may be couched in terms of structures, procedures and practices intended, but not necessarily proven, to achieve adherence to current policies and sometimes, but not always, to produce better outcomes for senior citizens. Often, definitions of 'good practice' in the context of policy may conflict with professional definitions, in the way that they may actually obstruct or prevent implementation of the professionally defined principles, such as choice, for senior citizens (see Bainbridge and Ricketts 2003). Examples of 'good practice' quoted by inspectors may be meeting some other area of government policy for local authorities, such as the requirement for them to secure Best Value in purchasing services

(Bainbridge and Ricketts 2003:55). Sometimes the definition of 'good practice' in one area of activity can conflict with definitions of it in another sphere. For instance, the focus on 'good practice' in reducing delayed discharges of senior citizens from hospital into a care home, and the introduction in England of financial penalties where delays exceed three days (OFT 2005:49), conflicts with other definitions of 'good practice' in terms of independence and choice.

At the level of the individual practitioner, Howe (1987) suggested that the ingredients of 'good practice' in social work were discussion and clarity between the worker and the service user about the worker's role, purpose and methods of working, and the expectations each of the other (1987:6). In a residential care context, the key worker would be the logical person to hold such a discussion with a resident. Davies and Knapp (1981), following Kushlick, stated that it is the workers who have most direct and continual contact with residents whose quality of work is vital in affecting the quality of life (p.79). They suggested that 'good practice' in residential care should be judged in terms of quality of life for residents and in promoting their wellbeing (Davies and Knapp 1981). Challis (1981) suggested seven dimensions of wellbeing are nurturance, compensation for disability, independence, morale, social integration, family relationships and community development, not all of which are relevant to residential care. Ignatieff (1984) drew a distinction between what is needed to flourish – love, respect, honour, dignity, solidarity with others – rather than simply survive, emphasising that the nature of the relationship within which any help is given will influence its effectiveness. He stressed that what counts in providing services is the manner in which the services are provided and the moral basis on which they are given, since these are what convey respect and dignity to the person (Ignatieff quoted in Cheetham et al. 1992:12).

I now examine the legislative framework within which 'good practice' has been developed across the United Kingdom and that which is specific to England and Wales, or to Scotland. I shall then go on to discuss how definitions and ideas about 'good practice' have developed within this legal framework.

The legislative context

Legislation provides the statutory context within which local authorities and other organisations provide residential care to people who are deemed to need it. It sets out what services local authorities must provide, as well as their discretion to provide other services. People who are judged to be in need of care provided or purchased by the State are characterized as 'vulnerable' (see Webb and Wistow 1987, Stevenson 1996) or 'at risk' (see Brearley 1982, Wenger 1997), requiring to have their interests protected and their welfare safeguarded. Public and professional anxieties about the quality of residential care homes have been and continue to be addressed through policy documents, government guidance and by legislative change.

As I have already discussed in Chapter Three, post-World War II, most residential care homes were run by local authorities. The minority of homes run by voluntary organisations and private individuals or organisations were subject to registration and inspection by local authorities. The National Assistance Act remained the relevant legislation governing residential care across the United Kingdom until 1968, when reorganisation of social work in Scotland led to the Social Work (Scotland) Act. In England and Wales, residential care homes were regulated under Part 3 of the '48 Act until 1984, when new legislation relating to residential care was enacted.

The 1968 Act gave local authorities in Scotland a broader remit in terms of providing help to adults and children in need. Authorities had a duty to 'promote social welfare'

by making available 'advice, guidance and assistance' (Section 12) as well as providing or arranging residential care for people in need in kind, or exceptionally, in cash. Residential homes in Scotland then became subject to regulation under Part 4 of the Social Work (Scotland) Act, which was periodically amended thereafter. Nursing Homes in Scotland continued to be regulated by Health Boards under the 1938 Nursing Homes Act, as amended. In England, 1968 saw the publication of the Seebohm Report on the future of Local Authority and Allied Personal Social Services and the outcome was the creation of Social Services Departments in 1971. Local authority Social Work Departments were created in Scotland in 1969.

During the Eighties the predominance of public sector provision ceased. The rapid growth in the number of private homes which took place resulted in that sector becoming a major provider of residential care. This raised anxieties about the quality of care and practice and resulted in new legislation. The Residential Homes Act 1984 (amended in 1986 to include small homes) covered both residential and nursing homes and the Registered Establishments (Scotland) Act 1987 laid down standards for independent sector homes.

The policy and 'good practice' emphasis changed again, away from the frailty and incapacity of residents needing care towards a more positive affirmation of the quality of life that senior citizens in homes were entitled to enjoy. However, the legislative criteria for providing residential care continued to be focused on individual 'need for care' and included 'old age' as a reason why 'personal care' might be needed. The 1984 Act defined a residential care home 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).

Later, the UK-wide 1990 NHS and Community Care Act used tighter regulation to address low standards and poor care by reinforcing and expanding the existing registration and inspection function of local authorities with regard to residential homes. Inspection units were set up as quasi-independent, operating at 'arm's length' from social work departments, yet accountable to the director of social work. 'Good practice', in the form of standards which were determined locally, was to be 'enforced' through periodic inspection. For the first time, local authority homes were subject to inspection in the same way as private and voluntary homes but since they were not registrable, these homes could not be compelled to meet the new standards.

The main philosophical emphasis of the Community Care Act, however, was on supporting people to live as independently as possible 'in the community' in their own homes where at all possible. 'Good practice' was defined in terms of giving people greater choice and involvement in assessing their needs and deciding how these should be met. Professional assessments were to change to reflect people's actual needs rather than merely the services already available. Where a person was assessed as needing residential care, they were to be offered a measure of choice over the particular residential or nursing home.

With the passing of the Scotland Act 1999 and the setting up of the Scottish Parliament, a number of powers were devolved from Westminster to Holyrood, including responsibility for health and social work services. Social security, which underpins much of social work and social care activity, including residential and nursing home care, remains a United Kingdom power reserved to Westminster.

In 1999, the issue of 'good practice' was addressed in separate White Papers issued for England and Wales and for Scotland, setting out the respective governments' legislative intention to raise the standard of practice in social work and social care. This was to take the form of extended and centralised registration of care services, including residential and nursing homes, and a process of workforce registration to address 'good practice' in social work and social care. All residential care homes, including those run by local authorities as well as nursing homes, are now required to meet a set of unified *national* care standards to qualify for registration under the new legislation. This legislation finally responded to two discrete campaigns. The social work profession had campaigned for more than twenty years for a national registration council to regulate and set standards of 'good practice' for people working in social work and social care. Separate campaigns had been waged by independent residential care providers for local authority homes to be regulated to the same 'good practice' standards as they were obliged to meet and for an independent national inspection and registration authority to regulate all care providers.

In Scotland, the issue of codifying 'good practice' for residential and nursing homes was taken forward by the National Care Standards Committee. This Committee had representation from people who use social services and family carers as well as local government, social work, health and housing professionals. Under the Regulation of Care (Scotland) Act 2001 new homes have a common registration as 'care homes', and the distinction between residential and nursing homes will gradually disappear. Homes are required to meet the changing needs of their residents and staff them appropriately. Senior citizens who live in residential care homes will not necessarily need to move if they require higher levels of care, other than acute health care, requiring hospitalisation.

The Scottish Commission for the Regulation of Care became the independent registration and inspection body charged with enforcing the new national 'good practice' standards. Local authority homes became subject to the same regulation and standards as the independent sector, removing the regulatory function from local authorities and their potential conflicts of interest as regulators as well as purchasers and providers of care.

At the same time, the issue of implementing 'good practice' standards was addressed by making the social work and social care workforces subject to registration by the Scottish Social Services Council. Priority was given to registering managers of residential care homes. Registration for care staff working in homes for senior citizens would follow later.

Similar organisations were set up in England to perform the same functions – the General Social Care Council to register and regulate the social services workforce in 2001 and the National Care Standards Council to undertake the regulatory functions of local authorities in 2002. The National Care Standards Council was amalgamated with the Social Services Inspectorate, SSI/Audit Commission Joint Review Team into the Commission for Social Care Inspection in 2004 (Health and Social Care (Community Health and Standards Act 2003).

In this section, I have shown how public unease about the lack of 'good practice' in residential care was addressed through legislative change and tighter regulation of care providers and the social care workforce. In the next section, I discuss further attempts to define 'good practice' in residential care in the form of policy guidance to local authorities.

The policy influence on 'good practice'

After 1948, government priorities as far as residential homes were concerned, were to replace public assistance institutions with new buildings to match the new philosophy of 'welfare' rather than discipline and deterrence that had characterized the workhouse (Townsend 1962, Willcocks et al. 1987, Phillips 1992). This commitment did not extend to a similar investment in staff to implement this new philosophy. Evidence from a committee of enquiry (the Williams Committee, 1967) suggested that training, better conditions of service and an improved career structure were of paramount importance if 'people of calibre' were to be recruited to work in residential care but was ignored.

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. Between 1969 and 1979, a series of design and 'good practice' guidance Building Notes for new local authority homes was issued. Separate and distinct versions of the second of these Notes (DHSS 1973, SED 1973, SED 1979) were issued for England and Wales, and for Scotland. The design of home and philosophy of care practice set out in these two sets of Guidance provided the blueprint for the large numbers of public sector homes built in the 1970s and early 1980s. What received much less attention was how to achieve the change in regime and staff attitudes and behaviour that would also be needed. The notion of 'domesticity' was adopted, to emphasise the move away from 'the institution', with staff cast in the role of 'caring relative'. This metaphor gave completely different messages about the supposed 'new' relationship between home staff and residents from the 'hotel keeper and guest' relationship invoked by Bevan in 1948, and which I have already discussed in Chapter Three. Rather than being an adult relationship between equals, many staff understood that 'caring relative' meant

their adopting a responsible, parenting role *vis a vis* residents, which led in some cases to infantilising and controlling practices.

The English guidance

The 1972 Building Note on Residential Accommodation for elderly people in England and Wales provided a frame of reference for new local authority homes. The guidance set out the function, purpose and size of rooms and the ratios of facilities to residents. The purpose of 'good practice' was to provide 'considerate and skilful care in comfortable surroundings for elderly people who, even with help, were unable to live in their own homes' (DHSS 1973:1). Local authority homes were expected to cater for higher levels of frailty among residents than previously.

Definitions of 'good practice' were based on the concepts of 'domesticity', 'normality' and the need to respect the individuality, independence and personal dignity of residents, giving them and their visitors 'reasonable privacy'. 'Best practice' was to adopt a 'positive approach to residents' abilities rather than their deficits', to enable them to use these abilities as fully as they wished and could, and to recognise the possibility of a return to their own home if circumstances improved. The emphasis was clearly on encouraging residents to be as independent as they wished and were able to be.

Authorities were encouraged to pursue the theme of 'domesticity' in care practice by experimenting with the new 'group' or 'family' unit design originally pioneered in Cambridgeshire and which I have already discussed in Chapter Three. The grouped unit design was seen as a valuable development because it enabled staff to create smaller, compatible groups of residents within the home. The aim was to involve more active residents in running the home and consequently give staff a less active

role. The staff role was likened to that of 'caring relatives', organising the housekeeping aspects of the home and encouraging residents who wished to participate. Residents were expected to be increasingly frail, yet the Note emphasised the importance of fostering their independence.

The numbers of staff required to implement this new 'domestic' model of care were to be enough to provide 'adequate' cover at all times. The tone throughout the document was that staff did not need specific skills or training to implement this new philosophy of 'good practice', despite the introductory rhetoric that 'skilful care' would be available to residents.

The Scottish guidance

The emphasis of the Scottish Guidance was slightly different. Residential homes offered 'an alternative home with care' to people who 'were no longer able and who no longer wished' (SWSG 1973:1) to look after themselves in their own homes, implying that individual choice as well as need might be a criterion for a move into care. Unlike the English guidance, no rehabilitative role for homes, nor the possibility of returning home were mentioned. The guidance suggested that growth in other forms of support, such as sheltered housing and day care, would result in people remaining at home for longer, so that those moving into residential homes would 'almost certainly' be very frail, mentally or physically infirm and require a great deal of care. This rationale was based on what Hunter et al. called the concept of 'a continuum of care' (Hunter et al. 1988:40).

The 'continuum of care' is a concept used by policymakers and planners to describe a 'dependency' graded care system to meet peoples' physical and mental needs. The system 'encompasses maximum independence at one end and total dependence at the

other, with people supposedly moving in a linear fashion from one form of provision to another as their dependency alters' (Hunter et al. 1988:40. See also Webb and Wistow 1987 who write of a search for a 'continuum of service' and a 'continuum of provision ranging from minimal support at home to complete assumption of responsibility for care in residential settings' (P.52). However, the reality is very different, since factors affecting which services people use are outside direct policy control, being subject to provider priorities, the decisions of senior citizens and the attitude of professionals and relatives. Many studies have documented the very varied physical 'dependency' of residential care home residents, which showed convincingly that the theory behind 'the continuum of care' was often at variance with reality (see, for example, Townsend 1986, Booth 1985, Bland and Bland 1985, Webb and Wistow 1987:183).

The guidance assumed from the outset that senior citizens would have very negative attitudes about living in a residential care home. These were to be countered by encouraging residents to remain active, and by recruiting locally, so that residents could maintain their local connections. This would avoid 'mental deterioration (a 'major problem in the care of the elderly') accelerated by boredom, feelings of ineffectiveness, isolation and uselessness to the community' (p.1). 'Good practice' was to avoid being overprotective of residents, enabling them to do as much as possible for themselves in order to 'reduce feelings of purposelessness and uselessness' (p.2).

The grouped unit design of home (which I have already discussed in Chapter Three) was recommended, since living on this so-called 'domestic' scale, would help residents to 'retain their identity' (p.2). Maximum home size was set at 60 places

larger than the recommended English maximum, with allowance for smaller homes in rural areas.

Since it 'was unreasonable to expect two or more people to accept being arbitrarily thrown together' (p.10) and having to share a bedroom, homes should offer mainly single rooms, with up to 20% being double rooms for married couples and other people wanting to share. The Guidance acknowledged that the bedroom was the only place in a residential establishment where a resident might secure their privacy or a 'sense of territorial right' (p.10). Unlike England, residents were to be encouraged to bring in some of their own furniture and should have the choice of a bath or shower.

The Scottish document advocated specialist homes for people with dementia (the 'elderly mentally infirm'), designed so that staff could 'observe the movements of the residents with ease' (p.5). The practice emphasis was also different. Higher staff ratios would be needed to supervise and keep residents 'under surveillance', which might mean some loss of their privacy. 'Good practice' in caring for people with dementia was equated with a custodial model of care.

The Scottish guidance reflected a more medicalized approach to 'care' than its English counterpart, whilst still invoking the 'caring relative' role for staff. Staff were to give 'general care and simple nursing' including terminal care, 'as a relative at home might give' (p.4), with medical and nursing care being provided by the general practitioner and the district nurse respectively. The presumed frailty of residents implied considerable staff involvement in physical care and a dependent role for residents. Staff were to supervise residents when bathing, retain and administer their medication and serve them their meals. Residents were expected to spend most of the day in the sitting room 'because of their relative immobility' (p.6). The guidance gave conflicting messages to authorities about the characteristics of the

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people and the model of 'good practice' that homes were to provide for. It stressed the importance of promoting residents' independence whilst stressing their likely frailty and inability to do much for themselves and giving responsibility and control over everyday life to staff.

The economic crisis in the mid 1970s and cuts in public expenditure halted local authority residential home building and no further design guidance was issued. The final Social Work Building Note (No.5, published 1979) was a guide to fire precautions for architects designing new homes and spelled out the role of staff in fire prevention following a number of accidents and fatalities caused by fires in residential care homes for senior citizens.

In this section, I have argued that policy guidance documents to local authorities gave confused and contradictory definitions of what should constitute 'good practice' in residential homes. These documents were at pains to stress the independence residents should enjoy, yet emphasised their physical frailty which required a caring response from staff who, nevertheless, continued to be untrained.

In the next section, I discuss how the government dealt with recurring problems in residential care homes. I argue that varying and conflicting definitions of what 'good practice' in residential care should become were put forward by the various enquiries and committees set up to advise the government on how the changes needed to address the loss of public confidence should be implemented.

The need for change

The first of these enquiries was set up in 1974 after a series of incidents in residential homes aroused public anxiety. The Personal Social Services Council (PSSC) was commissioned to identify the problems and to recommend guidance for local

authorities and voluntary and private care home providers on principles of care and practice, devising a code of practice for the management and administration of homes (PSSC 1975). The Council's working group identified a lack of co-ordinated policy, philosophy and public support for residential care, compounded by shortage of finance, staffing difficulties, risk-aversion and stigma. It set out some general principles in an interim report which was then widely consulted on. The Council concluded that the essential task was to devise a system of care that was not seen by the public as stigmatizing. The report set out a number of general principles for 'good practice'. Broadly, the Council set out to improve the status of care by giving residents rights and securing training for staff. Residential care should be one of a range of service choices. It needed an agreed philosophy of care. People should be informed and prepared for making the move. Care practices should do more than just avoid harm and meet basic human needs. They should encourage resident participation, choice and decision-making and maintain personal identity. Residents and homes should have regular reviews and staff should be trained. These statements are striking in their ordinariness in terms of taken-for-granted rights of people living in their own homes. The fact that the Council felt it had to make such statements, shows just how 'abnormal' residential care practice still was and how stigmatized people resident in homes continued to be, despite the Poor Law's abolition.

The Council called for significant changes at all levels. It proposed a national forum to promote standards and 'good practice' and to inform the public about the supposed changed nature and purpose of residential care, to counteract its continuing poor image. It called for opportunities for staff, residents and their families to express their views at individual home levels, locally and nationally. Local authorities should devise a residential care development plan and review their registration and inspection

procedures. At the level of the individual home, the recommendations dealt with enhancement of residents' rights to information about the home, and a mechanism for complaining about their care. These changes were recommended to apply to all residential care homes.

The Council's second report in 1977 was much more muted in tone. The idea of contracts between the providing authority and the resident had aroused 'considerable interest and controversy' among local authorities because 'contract' has legal connotations. Authorities feared legal liability if their homes failed to fulfil the terms of a residential contract and it was replaced with the much weaker 'statement of intent'.

The Council reiterated its belief that acceptance of risk was fundamental to 'good residential care practice, both for the resident and for the staff' (PSSC 1977:7) and called for an explicit policy statement about risk-taking backed up by management support. It endorsed the aims of Building Note No. 2 and set out the working group's views about the status of people entering residential care. Adults resident in homes had a right to lead a satisfying life, have their needs met with dignity, privacy and humanity, to participate fully in decisions about daily living, to take risks, to mix 'with the outside world' and to use community health and education services. The Council recommended that for senior citizens, the provision of a permanent 'home' should be emphasised. These recommendations were not acted on for some considerable time. The new approach proposed by the PSSC was at variance with the philosophy and needs of the Health Service to use local authority residential homes to provide long stay care to senior citizens being discharged from hospital. A rights-based definition of 'good practice' in care was in conflict with policy intentions for residential homes.

In the next section, I argue that 'good practice' in residential care was redefined as 'health care' to meet the needs of hospitals to maintain their focus on acute care. This relied on the ability of hospitals to discharge senior citizens with disabilities and long term care needs. Residential care homes, with their much lower costs, I argue, provided a highly cost effective solution to the 'problem' of poor senior citizens in need of long term care.

Further medicalisation of 'good practice'

In the same year that the PSSC report was published, local government and health services were reorganised and, rather than following the model outlined by the PSSC, residential care moved further towards a health based, dependency model. Increased responsibility for providing care for impaired senior citizens was passed from the health service to local authorities. This required them to implement a care regime in homes that closely resembled hospital based nursing practice. Guidance about new health care arrangements for people in residential homes was issued, again stressing the increasing age and anticipated physical incapacity of residents.

Despite the presumption of greater frailty among residents, the guidance reiterated that the care was 'broadly equivalent to what a competent and caring relative' might provide (Para.3). Again, the practice emphasis was on 'normality'. People should be encouraged to personalise their rooms, pursue their own interests and activities such as going shopping or to the pub. Senior citizens in homes retained their individuality, dignity and status as adults. Entering a home should involve no more loss of rights and privileges 'than any other person would on entering a hotel' (para.4). Resident independence and activity were seen to be important to their dignity and physical and mental wellbeing. Despite this rhetoric, the document elaborated a regime that resembled a hospital rather than a domestic or hotel style of care, reinforcing the

biomedical model of ageing as dependency. Local authority homes were to assume the care of a group of senior citizens who had previously been cared for by the health service. Once again, acute hospitals were opting out of the care of senior citizens by transferring responsibility for them to a cheaper form of care elsewhere (see Webb and Wistow 1987).

Again, the Guidance gave very mixed and confusing messages about 'good practice' and the status of senior citizens in residential care, stressing their rights on one hand whilst inaugurating care processes that undermined these rights and exerted greater control over them on the other. Despite the 'caring relative' analogy for staff, the guidance suggested that all staff should have some form of training; social care training for care staff and professional social work training for heads of homes. Although senior staff would need nursing skills to administer medication and care for people with dementia, they would need additional training and experience. The 'sickness' model of ageing was reinforced by the introduction of individual health records noting medical consultations, treatment and care and separate medication records. Some residents would want to keep charge of their medicines themselves but the preferred practice was for staff to do so. Somewhat archly, the document argued that as staff were performing roles that a competent, caring relative might undertake, 'it is not felt that any loss of rights or status need arise on this account' (para. A5).

The mixed economy of care

Debates about 'good practice' and the role of residential care were revived by the significant private sector growth that took place in the 1980s as a result of alterations in supplementary benefit rules. The quantity and type of residential provision expanded enormously theoretically at least, increasing choice for senior citizens – though not in the way that Bevan had originally intended (Sinclair 1988, Phillips

1992). The poorer majority of senior citizens had an opportunity to move into independent sector residential care using social security funding, since eligibility for entry was determined by lack of financial resources rather than 'physical need'. Numbers of senior citizens entering homes on supplementary benefit increased dramatically as local authorities took advantage of this alternative source of funding to cease their sponsorship of people in private and voluntary care (Phillips 1992:35). Hospitals discharged senior citizens direct to residential and nursing home care on social security funding, bypassing local authority involvement and the possibility of the person being supported to return home. In one study, two thirds of residents in private homes had been admitted from hospital and only one third had played a part in initiating their move (Sinclair 1988:263). In the light of such evidence, the suggestion that most senior citizens exercised choice themselves to move into residential care is highly questionable (see also Sutherland 1999:38).

The entry of large numbers of private organisations into the provision of residential care raised anxieties about the quality of practice and care. The result, in England, was new legislation (1980 and 1984) and a Code of Practice for independent sector homes (Avebury 1984) drawn up by a working party of 'experts', including care providers and social and health care professionals. The direct interests of residential staff, the people using residential care and their families were not represented.

This Code, like the PSSC report, took a rights-based (Avebury 1984:15) rather than welfare or health based approach to the situation of residents in homes. It set out 'good practice' principles and procedures for private and voluntary homes to meet the new registration and inspection requirements of local authorities. These same principles had first been recommended by the PSSC for *all* residential homes some

nine years previously but rejected in favour of a health-based 'care' approach to 'good practice'.

Residents' rights to privacy, autonomy, individuality and choice and to take risks were reiterated. The Code defined, in great detail, the procedures and processes to be followed before and after a person moved into a home. Again, the right to information about the home and the terms and conditions of residence, the importance of preliminary visits and a trial stay were emphasised.

The Code covered administrative aspects of residential care, such as confidentiality of information and residents' rights to see their records. The philosophy of 'good practice' it advocated was one of minimal rules and routines to ensure as 'normal a lifestyle as possible'. Residents had the right to make complaints, to have adequately furnished and heated private space and to receive visitors. Shared bedrooms and bathrooms must have screens to 'maximise' residents' independence and privacy. The Code had the status of government Guidance to local authorities but the standards it set were only applicable to independent sector homes. The failure to bring local authority homes within the ambit of the new Code created two definitions of 'good practice' in residential care homes; the new definition based on residents' rights now required in private and voluntary homes and the existing definition of 'good practice' as physical care in public sector homes where quality of care was equally variable. This caused resentment in the independent sector, particularly among private providers. More importantly, residents living in public sector homes did not enjoy the rights conferred on people entering independent sector homes.

The struggle between these competing definitions of 'good practice' in residential care was continued in two other influential reports (Wagner 1988, DoH/SSI 1989).

The Wagner Committee's remit was to review the role of residential care in relation to other personal social services in England and Wales. It commissioned a comprehensive review of the research literature and took evidence from a wide range of stakeholders, including people using residential care, their relatives and staff of residential homes. Senior citizens were not represented on the Committee whose membership, once again, was comprised of 'experts'. 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 (p.2). I argue that this philosophy was still a matter of debate and contention that continued to be unresolved.

The stated aim of the Review was to bring about a fundamental change in public perceptions of residential care as the stigmatizing 'last resort' by making it part of the 'spectrum of social care' in the community (Wagner 1988:3). The Committee acknowledged that there was still much bad practice in homes. This latter observation was confirmed in 1987, whilst the Committee were sitting, when abuse of senior citizens in local authority homes in Southwark and Camden and in several registered independent homes was confirmed in a number of reports (Biggs et al. 1995:79).

Like the PSSC (1977) and Avebury Committees (1984), Wagner defined 'good practice' in terms of according people their rights as consumers in residential care. They believed that giving primacy to the views and wishes of people using services would alter the context in which residential services operated. The Committee's recommendations repeated earlier calls for change. The principles set down what life in a residential home should be like, reasserted residents' rights as citizens and acknowledged the importance and value of the staff. Above all, the Committee stressed that a move into residential care should be by positive choice, and should

ensure a better quality of life than available elsewhere. Giving people the power of choice between different models of care would, in time, the Committee believed, change the dynamics of the relationship between the service user and the professional. The most important recommendation as far as the rights of senior citizens were concerned was (as made by the PSSC in 1977) that local authorities should have a duty to offer a range of alternatives to residential care. This would enable a person to choose whether they received care at home or in a residential home.

Again, Wagner echoed Avebury (1984), in calling for prospectuses for intending residents and written contracts. The Committee asserted peoples' basic adult rights: to control their finances (rather than hand over their pension and financial control to the local authority) not to have to share a bedroom (a point acknowledged in previous Guidance) and to have a key to their room. These were rights that many people in residential care homes, particularly public sector homes, still did not enjoy. Regulation should be the means of maintaining standards and promoting 'good practice' across all sectors, including public sector homes. National inspection guidelines should cover accommodation standards, residents' quality of life, staff qualifications and homes' performance.

Compulsory training was recommended for staff, re-grading was recommended for care staff and the employment of social workers rather than nurses in senior posts. These changes were part of an attempt to shift the focus of 'good practice' away from physical care, to improve the self-image of residential care and integrate it with other social care services.

The government response to the Wagner proposals was characteristically low-key. It commissioned a three year research and development programme - *The Caring in Homes Initiative* - to take forward some of the Wagner recommendations. The aim

was to develop practice in all sectors that would 'help to promote and ensure *quality of life* (my emphasis) of people living in residential care homes' by 'translating principles of 'good practice' and broad policy statements into workable and useful ideas and approaches' (Youll and McCourt-Perring 1993:4). The four Wagner recommendations chosen for development - information, community links, home reviews, and training - addressed both resident and staff issues in residential care but not the rights of residents. The evaluators of the Initiative developed their discussion of user-led services in terms of citizenship rather than consumerism because citizenship confirmed 'the rights and responsibilities of people living in residential settings to participate in society and its political processes' (Youll and McCourt-Perring 1993:195). The need for care or support had often led to residents in homes being seen as 'less than a person' rather than as adults with rights as citizens (Youll and McCourt-Perring, 1993:196).

Although, like Wagner, it had focused on the interests of the residents, the Initiative had limited success in involving them in the various projects due to a tendency to 'over-protectiveness' by staff (Youll and McCourt-Perring 1993). The evaluation identified three barriers to the development of 'good practice' found in other studies; a lack of clarity about the objectives of individual residential establishments, the tendency of management, professionals and care staff to see their role as protective and caring, and the failure to recognise (or enquire) what mattered most to residents (Youll and McCourt-Perring, 1993). The evaluation of the Initiative concluded that the structures and cultural shift needed to enable service users to voice their opinions and influence their care were 'hardly in place' (Youll and McCourt-Perring 1993:194).

Crucially, I argue, the Initiative did not address the most important of the Wagner proposals which would have changed the whole dynamic and context of residential care, namely, to give senior citizens the right of choice about entry to residential care and to enhance peoples' rights within residential homes. As I have already demonstrated, numerous reports to government have called for the basis of entry into residential care to be changed from professionally defined 'need' to one of entitlement, but this has continued to be resisted. A recent White Paper, setting out the latest vision for social care over the next ten to fifteen years seeks views on giving individuals the 'right to request' not to live in a residential setting (DoH 2005).

The second response to Wagner was to address quality issues through tighter regulation of the independent sector. New guidelines for inspectors were developed jointly by the Social Services Inspectorate (SSI) and local authorities for use in independent sector homes (DOH/SSI 1989). The document widened the philosophical focus to quality of care *and* quality of life for residents but drew on the functional model of ageing in its definition of 'good practice' as physical care rather than the rights of residents. Residents' rights, the document stated, were limited to their entitlement as citizens, to exercise their franchise in elections. This report was enthusiastically received by social care staff and widely used in public sector homes. I argue that this report provided a detailed rationale for the *ad hoc* procedures and practices that had characterized the unreformed public sector model of residential care since the Poor Law. Its aim, I argue, was to re-state policy in relation to residential care, namely that its function and use should continue to be defined and determined by government as it saw fit and in the light of other policy requirements. These policy requirements, I argue, were to enable the continued smooth functioning of NHS hospitals in providing acute medical care to the general population. The use of

residential care was to be determined by 'dependency and the 'need for care' rather than by individual volition.

In her Foreword, Wagner revealed her frustration at the government's failure to implement her Committee's reforms. She was encouraged to know that SSI 'believe that homes should do more than merely house people and keep them clean, safe and well nourished' (DOH/SSI 1989:3). She described the evaluative model as a 'valuable contribution towards a *future response* (my emphasis) by the Department of Health to the Report of the Independent Review of Residential Care' (DOH/SSI 1989:3). The major changes to the definition of 'good practice' and the status of people in residential care that Wagner sought were further delayed.

The Social Services Inspectorate acknowledged that its existing methods of monitoring standards were 'inappropriate and ineffective' (DOH/SSI 1989:6). Its preoccupation with buildings, staffing and records in homes had resulted in the comparative neglect of quality of life for residents. Like its predecessors, the working group failed to involve any consumers or providers of the service. Residents' rights and quality of life were again professionally defined. The model for care put forward in the document was confused and contradictory. The definition of 'good practice' was to be judged by a strange mixture of physical and procedural criteria; namely, how far the physical environment, care practices, case records, procedures, staff, and meals were judged *by inspectors* to protect and promote the rights of residents.

The Wagner Committee continued to pursue its aim of improving the image and practice of residential care. It set up a Development Group consisting of care providers in all sectors and representatives from central and local government and other public agencies. The stated aim was to take forward unresolved issues from its original report such as residents' rights, security of tenure, and staff training. Its

report, *Positive Answers*, admitted the failure to include service user representatives in the original Committee, but did not explain why they had continued to be excluded from the Development Group. Five years on from *A Positive Choice* (1989) the Group concluded that not much had changed. Residential care had still not shaken off its 'Cinderella' image. Residential care staff had failed to achieve parity with field social workers in terms of salaries and training; 80% of care staff were still not qualified (Wagner Development Group 1993:10). However, the Group was hopeful that residential care would be treated 'as central to mainstream social work' in the new Diploma in Social Work qualification (Wagner Development Group 1993:17). Residential care for children and young people rather than for senior citizens now dominated public debate in the wake of recent scandals in children's homes. The Group continued to assert that residential care was central to welfare provision and that despite its journey in 'a long, dark tunnel' it had a future (Wagner Development Group 1993:17).

By the end of the 1980s, the growth in private residential care homes and the associated escalating public costs of care was deemed unsustainable. There was no discussion about the implication of the fact that large numbers of senior citizens were living on very low incomes. The NHS and Community Care Act (1990) transferred responsibility for people needing help with residential or nursing home fees from central to local government. Eligibility for residential care became subject to social worker assessment of individual 'need' and financial means once more. Local authorities in England were given financial incentives to use private sector homes rather than continue as providers of residential care themselves.

The unresolved debates about issues of quality and definitions of 'good practice' in residential care produced further codes of practice, both principally aimed at providers

and regulators of residential care. Working Groups consisting of health and social care professionals, care providers, academia and family carers but not senior citizens produced *A Better Home Life* (1996), in which 'good practice' was defined in the form of standards in nursing homes and residential care homes for senior citizens. The Code invoked the same principles as its predecessor publication, now describing them as principles of 'good practice' rather than principles of care. Again, the focus was on the resident's right to self-determination, dignity, respect and normality. However, I argue that it was still based on a physical dependency model of ageing. The second document was produced by the Residential Forum, a broad coalition of public, private and voluntary sector care providers operating under the auspices of the National Institute for Social Work (NISW). The Forum had been set up in 1994 'to promote high standards in Homes and contribute to improving the quality of service to the public' (Residential Forum 1996:3). Its Standards Guide Working Group had representation from health, local authorities, social work academia and social care, as well as organisations representing people using services and family carers.

Creating a Home from Home (Residential Forum 1996) was written for providers, contractors and regulators of residential care supposedly from the perspective of people using care homes and their relatives. However, this perspective was largely informed by practitioner views of what residents of homes wanted or needed rather than drawing directly on consumers' views. The report claimed to focus on the quality of life of people in homes and to put their needs, wishes and convenience first in setting standards of 'good practice'. It set out its definition of 'good practice' in terms of principles, processes and procedures. The Guide claimed to be 'more comprehensive' (sic) (NISW 1996:17) than its predecessor publications and to reflect the changing attitudes and language of the 1990s, its purpose being to 'promote

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debate and provide a basis for negotiations' (NISW 1996:7). The standards by which the quality of care (rather than quality of life) of people in homes would be judged were based on the principles, which were applicable to all adult service users. Despite its stated focus on quality of life, the Guide was a re-statement of the traditional care practices that the PSSC and Avebury Committee had been trying to change for decades. 'Good practice' was defined in terms of processes and procedures related to dependency and physical care in homes rather than independence, rights and quality of life.

In the 1990s, growing public anxiety about residential care became focused on bad practice in relation to its funding. Media reports of distress caused to people having to move residential home when their own funds or local authority funding ran out, resulted in a Royal Commission. Its remit was to consider how long term care for senior citizens should be funded and the respective responsibilities of individuals and the State. Although not included in its original remit, the Commission considered the quality of care provided and made a number of recommendations that it felt would lead to high-quality and more appropriate care (p.xii). It suggested a number of ways in which its proposed National Care Commission could encourage the development of better services. Improvements in practice quality and innovation would be encouraged by disseminating 'good practice' and by devices such as league tables (Sutherland 1999:77).

The Commission criticized the current system of funding residential care as unfair, inconsistent and complex. It described the true nature of the current system of paying for long term care as one that helped people who were poor, demanded that people of modest means make themselves poor before it would help, and affected people to a lesser degree the richer they were (p.36). It suggested that the current system pushed

people into residential care, thereby compromising their dignity and independence sooner than might be necessary (1999:41). The amount of choice available to people depended on what was available locally and the state of the local authority's budget, which was very variable. The system was biased towards residential care irrespective of appropriateness and best value for the individual, which militated against independence (p.41). The Commission called for senior citizens to be given more opportunities to make what it called 'real choice' and urged the extension of Direct Payments to people over the age of 65 (Sutherland 1999:91). The report called for a re-focussing on the needs of the individual. The Government approach to welfare reform that the overriding policy aim should be 'independence' rather than 'dependence' required a change in attitude across society (p.81). The Commission called for better quality of care, for greater flexibility in care provision, with a variety of models and a mixture of providers.

The Commission made a number of recommendations to Government about changes to 'good practice' in the funding of long term care for senior citizens. The two principal changes it urged were that in future, personal care[1] should be funded by the State to all people assessed as needing it. Secondly, it recommended the setting up of an independent National Care Commission to take responsibility for a range of matters relating to long-term care for senior citizens. The Royal Commission recommended other changes to the means-testing system for care, including the provision of free nursing care to people in long stay care.

In the event, England and Scotland reacted differently to the Commission's main recommendations, although both countries accepted the recommendation about Direct

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[1] 'Personal care is defined as care that directly involves touching a person's body…. and is distinct both from treatment/therapy… and from indirect care such as home-help or the provision of meals' (p.67).

Payments and made it mandatory on local authorities to offer this to senior citizens. However, in 2003, only about 1,000 senior citizens in England were receiving Direct Payments. Direct Payments in Scotland did not become mandatory until 2004.

Both England and Scotland accepted and implemented the Royal Commission recommendation about a National Care Commission but in England, despite public pressure, it was decided to make free nursing care in care homes subject to a means test and to continue the means test for personal care. In Scotland, the Holyrood Parliament decided to make both personal care and nursing care free. A Care Development Group was formed to take the decision forward (2001) and the policy was implemented in July 2002. Between July 2002 and June 2004, the numbers of people in Scotland receiving free personal care in a care home and free nursing care each rose by 15%. The number receiving free personal care at home over the same period showed a much greater increase – up 74%. Expenditure on free personal care for care home residents between July 2002 and March 2003 was £42.1 million. Free nursing care for care home residents aged 65 or over was just £12.1 million over the same period (Scottish Executive Statistics Release 2004). It is still not possible to discern whether implementing this policy has enabled a larger proportion of care to be provided to people in their own homes, as the Commission had intended.

In this section of the chapter, I have shown that government ambivalence towards senior citizens and the objectives of residential care has been demonstrated in the confusing and contradictory messages in policy guidance about the objectives of residential care and the nature of 'good practice'. Guidance documents that stressed the rights of senior citizens as residents also laid down care processes that undermined those rights by giving responsibility for and control of residents to staff. The spur to reform the 'traditional' role and model of residential care (see Wagner 1988:3) were

scandals and public anxiety about the poor quality of care practice – initially in public sector homes in the 1970s and later in the fast-growing private sector in the 1980s. *Home Life* (CPA 1984) was the first of a series of attempts to codify the ethical principles and values of professionals into procedures and processes believed to be the components of 'good care practice'. These codes were primarily written to aid inspection rather than the development of 'good practice', for local authorities regulating the growing independent sector and for the proprietors and managers of these homes. The Wagner Report (1988) argued unsuccessfully that reform of the basis on which people entered care was needed if new, rights-based models of 'good practice' were to be successfully implemented. I argued that attempts to change the focus of 'good practice' from 'quality of care' to 'quality of life' and a rights-based approach through the mechanisms of inspection and registration have been unsuccessful. Such an approach is incompatible with ageist attitudes and beliefs about ageing and what is the appropriate model of residential care for senior citizens, seen as 'dependent', incompetent and in need of 'care'.

As outlined earlier in the chapter, I argue that the most recent government attempts to raise standards in homes have once again resorted to regulation as the means of defining 'good practice' for people in residential care homes. I argue that there has been no recognition of the structural factors that continue to influence the stigmatizing 'dependency' associated with residential care in the public mind or of the effect of ageism on the definition and development of 'good practice' in residential care. I argue that it is this stigma and ageist attitudes that prevent the change in culture and hamper the development of 'good practice' (see McHugh 2003).

In the next section, I consider how professionals and practitioners in social care have influenced the development and definition of 'good practice' in residential care of senior citizens.

'Good practice' and the influence of practitioners

The influence or interest of social workers and social care practitioners in developing 'good practice' in residential care for senior citizens is hard to discern. Notable exceptions to this, have been Norman (1980, 1984, 1987) and Brearley (1980,1982, 1990), both of whom have written at length about 'good practice' in social work and social care and about the rights of senior citizens. In particular, both these writers have written about 'good practice' in terms of perceived and actual 'risk' as an issue for practitioners in relation to senior citizens and their care. What professionals regard as 'good practice' in relation to risk and how it is perceived and managed is relevant to this thesis, since it can influence how far senior citizens are able or allowed to exercise their independence, choice and privacy in their own homes or in residential care. In Chapter Eight I shall be discussing two contrasting approaches to the issue of risk in residential homes encountered in my research.

Brearley (1982) defined 'good practice' in relation to risk and senior citizens within the context of social work assessment of need. Risk assessment, which is now supposed to be a routine part of social work assessments (see Little 2002:27), involves estimating the risk to the person and identifying any hazards such as poor housing or deteriorating health, which increase the possibility or probability of an undesirable outcome. Brearley stated that the key factor in defining 'good practice' with senior citizens is maintaining a balance between safety and freedom and protection and control (p.72). There is often a conflict between wishing to maintain physical safety and enabling self-determination. If ensuring safety means loss of self-determination

and the right to choose, then it may be unacceptable (p.67) (but see also Payne 1999:251) who, while acknowledging that self-determination is a central value of social work, points out that social work is also about helping clients to follow rules or be interdependent).

In his discussion of the risks for a senior citizen of admission to residential care, Brearley identified those that may be individual – such as a low income, living alone or lacking family support – but also those that are societal. He cited the anxiety of relatives about elderly relations running risks and the pressure on social workers to ensure the safety of senior citizens, which may be related more to the anxieties of others than to the hazard to the senior citizen. Demands from hospital staff to provide residential care and lack of community resources can create pressure on social workers to admit an elderly person to the assumed safety of residential care, since they are what Brearley described as 'realistically anxious to protect themselves from blame and guilt' (P.72).

Alison Norman defined 'good practice' and risk in relation to people's rights or civil liberties in later life and ageism (1980, 1987). She usefully distinguished between moral rights and legal rights, pointing out that whilst senior citizens have a moral right to services, legally they enjoy no such right, a point which I have already made in relation to residential care. She argued that senior citizens are further restricted in exercising choice by the imposition of forms of care and treatment which are the result of ageist social perceptions, anxiety, convenience or custom. Norman citing Brearley, stated that in defining whether a senior citizen was 'at risk', the practitioner also had to take account of the potential damage to their professional and personal reputation, because the extent of their duty to protect senior citizens was unclear (Brearley in Norman 1980:9). However, according to Laming (1995) decisions about

risk assessment are not individual professional decisions but multidisciplinary corporate decisions taken on behalf of the local authority. Wenger (1997) related the prediction of elderly people 'at risk' and the nature of the potential risk to the typology of their social network. I argue that 'good practice' in relation to senior citizens and risk is defined in terms of the perceived risk to the professional reputation of the social worker and wider public anxieties rather than the hazard to the senior citizen. Norman highlighted societal inconsistency about 'allowable' risks, comparing the freedom (of the able-bodied) to climb mountains with the restrictions imposed on disabled people. Her solution was for a shift in attitudes towards senior citizens and disabled people, away from patronising and paternalistic over-protection from risk to an acknowledgement of their right to be self-determining as far as individually possible (Norman 1987:8).

I argue that what both Brearley and Norman underlined, although from different perspectives, is that while factors such as poor health and lack of resources may pose a risk or hazard to senior citizens, it is social attitudes to ageing and disability and the defensive behaviour of practitioners that define 'good practice'. It is this definition of 'good practice' that poses the greatest risk to senior citizens' independence. More recently, Parker et al. (2004) have argued that a focus on Health and Safety requirements in care homes can create risk-aversive environments which act against the quality of life of residents, particularly for those who are least frail.

I now want to explore some of the reasons for social workers' ambivalence towards senior citizens and residential care; the lack of social care training and the contested status of social work and social care.

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Ambivalent attitudes

Social workers have demonstrated a certain ambivalence both in their attitudes to senior citizens and towards residential care, reflecting the wider ageism which I have already discussed in Chapter Two (Miller and Gwynne 1972, DHSS 1978, Ward 1980, Rowlings 1981). Brearley (1990) argued that the fundamental social ambivalence as to whether institutions exist to control or care for people who live in them accounted for the mixed feelings that staff, residents and their relatives have about residential care. Residents were not thought competent to make decisions for themselves about their lives (see Norman 1980).

Senior citizens are numerically the largest group requiring social care support in the community and residential care (Stevenson 1996:207, Little 2002:42). Yet senior citizens, along with people with a learning disability, have been the least popular client group, 'especially among trained social workers' (Goldberg and Connelly (1982:92) who tended at that time to work with children and their families. In the 1960s and 70s very little qualified social work time was spent in work with senior citizens and 'attitudes expressed towards them were frequently patronising, if not derogatory' (Stevenson 1996:204). Caring for senior citizens is still perceived as being a low status, unskilled occupation (SSSC 2004:24) and the majority of staff working in this area still have no relevant qualifications (p.10).

The community care reforms of the 1990s emphasised empowerment and partnership with service users, including senior citizens. The raised awareness of the needs of many senior citizens provided an opportunity for social work attitudes towards them to change, to offer them more sensitive and imaginative services that respected their feelings and wishes (Stevenson 1996:206). However, practitioners must not only provide choice for service users and their families. They also act as gatekeepers to

scarce resources, determining eligibility for services and operating in the uncomfortable gap between policy ideal and operational reality (Ellis 1993:10).

Social care staff working in residential homes have found it difficult to acknowledge and meet residents' needs for support and assistance, while enabling and permitting them to control areas of their lives of greatest emotional significance to them (Stevenson 1989). Moniz-Cook et al.'s (1997) study of job satisfaction among care staff in local authority residential homes, found stress levels equivalent to those among nurses working in the NHS and identified a lack of clarity among staff about the job they were required to perform (Moniz-Cook et al. 1997). More recent studies have identified conflicts between an individualistic understanding of autonomy alongside the emphasis on person-centred practice (Eales et al. 2001). Staff have experienced difficulties in understanding and implementing client- or person-centred philosophies of care that emphasise senior citizens' decision-making abilities and respect for their values and preferences (Eales et al. 2001, McCormack 2001). A lucid discussion of this dilemma, which exists for both staff and residents, was developed by Miller and Gwynne (1972), whose research I discussed in Chapter Three. I argue that this is because staff in residential homes hold the same ageist attitudes as the rest of society (see Roberts et al. 2002, Hudson et al. 2004). Moreover, the people moving into residential homes have been assessed as 'needing' residential care because of their 'dependency'. Some social care practitioners have been unable to acknowledge that the need may not be for total care (see NISW 1988:53, Youll and McCourt Perring 1993), I contend, because to do so would undermine their role as 'carers'. I argue that they define 'good practice' as 'control' in residential care because they fear being held accountable in the event of tragedy or accident to residents already defined as 'vulnerable' and 'at risk' (see Brearley et al.

1980). (See also Wilson et al. 2003 who cited 'fear of things going wrong' as a main reason why social workers in Scotland leave their posts).

Professional definitions of 'good practice' in residential social work have been expressed negatively as working in areas of people's day-to-day experience of living 'not ordinarily experienced by a social worker' (Ward 1980). The workplace for staff, is also 'home', temporarily or long term, for the 'client'. The definition of 'good practice' is in terms of a territorial contest between worker and service user in a way that does not occur in field social work. Residential care has been defined as the 'boundary' where field and residential social worker roles meet, overlap or clash, in undertaking the core activity of enabling people to cope more effectively in their new environment (Ward 1980, Willcocks et al., 1987, Phillips 1992). Indeed, it was this difficulty in working collaboratively rather than competitively that the development of the keyworker role was designed to resolve (Bland 1997) and which I shall discuss further in Chapter Seven.

I argue that underlying these very varied definitions of 'good practice' is a continuing ambivalence and uncertainty about the objectives of residential care homes for senior citizens. It is very difficult to set down guidelines for 'good practice' when there is no consensus in the profession about aims or objectives in social work (Davies 1985. See also SSSC 2004). As I showed in the earlier part of this chapter, ambivalence about senior citizens and what the objectives of residential care for them are, or should be, has been reflected in policy guidance that is both confusing and contradictory. I have also argued that this ambivalence has been reflected in the debates that have been conducted between professionals as to whether 'good practice' in residential care is about taking care of senior citizens as 'dependent' people or according them rights as independent adults. What has been little debated is the

ageism that is endemic in social work and social care and its effect on deliberations about defining 'good practice' with senior citizens.

Ward (1980:26) suggested that institutions fulfil the dual functions of providing care for people who are 'failing to cope' in the community while providing 'space for the unwanted feelings of society'. How the home defines its objectives, Ward argued, influences the regime that is applied. If the objective is to deal with 'rejects', the home will define 'good practice' as custody and control. If the objective is to 'protect the helpless', 'good practice' is likely to be defined as looking after and doing things for people (Ward 1980:26). I argue that what Ward failed to acknowledge was that 'protecting the helpless' can also be experienced as custodial and controlling. If her analysis is correct, it is understandable why there is such a mismatch between regimes in residential homes and the wishes of senior citizens who, generally, are not seeking 'protection' and who are certainly not 'helpless' (see Abbott et al. 2000). Ward's analysis pointed up how important the lack of a proper debate about what the objectives of residential care homes for senior citizens should be, a debate that, I argue, must be conducted with senior citizens themselves.

The Barclay Committee, which examined the role and tasks of social workers, recognised the 'big organisational divide between residential and fieldwork in social services departments' and the continuing stigma of being in residential care (Barclay 1982). I argue that its report re-emphasized the boundaries between field social work and residential social care practice.

Evidence to Barclay from the Residential Care Association asserted that local authorities were often unaware of the nature of residential social work practice and that homes were unlikely to fulfil their role without a major change of attitudes (Barclay 1982). The Committee's conclusions were unlikely to change attitudes. The

Report identified three broad 'approaches' to residential and day care: refuge, control and learning, and growth and development. The Committee defined the major purpose of residential care for senior citizens as providing *physical care* (my emphasis), within a 'refuge' approach. I argue that the Committee demonstrated its ageist and disablist views in stating that a growth and development approach was inappropriate for 'the very old and the very handicapped' whose capacities for development or making decisions was seriously limited (Barclay 1982). Beresford, in criticizing the Barclay report for the lack of service user views, argued that the insecurity of social work as a profession has not helped the understanding and achievement of service users' wants and rights (Beresford in Philpot 1982). However, that explanation does not hold good for medicine, a profession that is very secure in itself but which is also very poor at understanding service users' wants and rights. I would argue that the very professionalisation of occupations gives them a knowledge and power base and accords them 'expertise' that is hard for service users to challenge.

Barclay identified the 'formal social work' roles and tasks in residential care as those of manager, consultant or direct care-giver, keyworker and counsellor. The 'basic tasks' of tending, providing satisfying experiences and maintaining links with family and others did not constitute formal social work (Barclay 1982). The Committee identified the difficulties caused by poor conditions of service, high staff turnover and lack of training (80% of staff in residential work at that time were untrained) and recommended increasing the proportion of qualified staff in residential homes as a matter of urgency (Barclay 1982). It recommended that the 'rigid distinction' between fieldwork and residential work (that it had reinforced) would need to be 'rethought and modified'. The way to alter the perception of residential

establishments as isolated institutions was for them to become part of their local neighbourhood by developing community social work (Barclay 1982).

In this section I have argued that professional debates about the definition of 'good practice' have hinged on the narrow question of whether the objectives of residential care is to care for people or control them. I argue that social workers have continued to distance themselves from residential care for senior citizens as being inconsistent with their definitions of themselves as professionals because of their ageist attitudes, ambivalence and uncertainty about the objectives of residential care for senior citizens.

In the next section, I argue that the continued employment of unqualified and untrained people in residential care prevents them from participating in debates about the definition of 'good practice'.

An untrained social care workforce

Few practitioners in residential care are trained in social care or are professionally qualified social workers, despite numerous recommendations in other reports to governments before and after Barclay about the importance of having a trained workforce (PSSC 1975, 1977, Wagner 1988, Howe 1992, SCA Education 1992, SSSC 2004). The Howe Enquiry repeated earlier calls to raise the status of residential workers in their own eyes as well as in relation to field social workers and identified low pay and few training resources available to residential workers as a major part of the problem. She argued that 'in the public mind, professionalism and qualifications go hand in hand' (Howe 1992:30). I argue that this remains true even in residential care provision for children, which is allegedly given greater importance than care for adults. Despite a continuing litany of abuse and scandals in children's homes and

subsequent enquiries highlighting the need for a properly trained workforce, many staff continue to be untrained (Ainsworth 1981, Utting 1991, SWSI 1992. See also SSSC 2004, which found that over half (57%) of residential child care staff in Scotland have no qualification).

I argue that definitions of 'good practice' in residential care for senior citizens have not developed from a core training curriculum, from practitioner based research or from the views of senior citizens but from accumulated bureaucratic procedures imposed on a largely unskilled and untrained workforce. The rationale for these procedures (many of them developed through 'custom and practice' over time) has not been tested or proven in terms of producing good outcomes for people using residential care. As a result, there is still a lack of knowledge and understanding among social care staff of the theoretical, ethical and value bases on which 'good practice' is supposed to be built.

In the next section, I argue that the involvement of practitioners in the development and definition of 'good practice' has been hindered by unresolved disputes between social workers and social care practitioners about their status.

Intra-professional rivalry

There is an ongoing unresolved debate within social work, as to whether residential or group care is, or is not, part of social work (CCETSW 1973, 1974, Rowlings 1981, Barclay Committee 1982, Senior 1989, Jack 1998). I argue that failure to resolve this debate has diverted attention away from and compromised debates about the development of 'good practice' in residential care.

Residential care or 'group care' as it is sometimes known (see Fulcher and Ainsworth 1985) has always enjoyed an inferior status in relation to 'field' social work (Wagner

1988, Senior 1989, Howe 1992) and residential care for adults has always enjoyed lower status than residential child care. This has been reflected in the lack of staff training and, until relatively recently, poorer remuneration and terms of employment. Despite the development of employment based qualifying training for people working in residential care, the resultant Certificate of Social Services (CSS) qualification did not provide the passport into field social work posts that had been hoped for by students (Barr 1987:71). Neither did it, I argue, change the way in which 'good practice' in residential care was defined. Few of the residential staff who obtained secondment to full-time professional training courses returned to residential care practice on qualifying as social workers (Barr 1987:156). A 1986 study by the Local Government Management Board found that less than ten percent of residential and day care staff working with adults had a social work qualification compared with two thirds of field social workers (Wagner 1988). A later survey of care assistants attending training workshops found that the vast majority (91.5%) of attenders had no previous qualifications or training (SCA/Help the Aged 1992). Professional social work courses where critical perspectives and new models of practice in residential care should have developed were largely criticized for their inadequate coverage of residential care theory and practice in their curricula (Barr 1987:70). So the opportunity for academic social work to influence the development of 'good practice' in residential care practice was largely foregone, certainly in the case of senior citizens. (The work of Fulcher and Ainsworth (1981, 1985) in developing theory and practice in group care of children was an honourable exception). Although the proportion of suitably qualified staff working in social care has risen since the 1980s and 1990s, a SSSC study of the social care workforce in Scotland (2004) found that

more than half (55%) of staff working in day care for adults, including senior citizens, had no qualification (p.11).

I argue that intra-professional dissension has diverted attention from the need for a radical re-examination of the objectives of residential care for children and for adults. As a result, governments have hitherto largely avoided the necessarily expensive investment in a comprehensive training structure for the large numbers of people employed in residential care. Such training places as are available have tended to go primarily to people working in residential child care. I contend that there is still only a minority of staff trained and qualified in residential care who are able to provide a critical analysis of 'good practice' or promote the changes that research has shown are sorely needed (Miller and Gwynne 1972, Clough 1981, Power et al. 1983, Booth 1985, Willcocks et al. 1987, Sinclair 1988, Bland et al. 1992, Lee et al.2002, Koren and Doron 2005).

Stevenson (2005) describes social work education and practice as having been 'blown off course' by external factors, particularly political factors but sees hope of a new impetus to restore and regenerate the essence of 'good practice'.

In the next section I conclude my review of definitions of 'good practice' by discussing the contribution to the debate of social work practitioner research.

Practitioner research

Social worker research into 'good practice' with senior citizens has investigated the involvement of social workers in the move to residential care as well as the practice of care within homes from both staff and resident perspectives.

Neill et al (1988) investigated why senior citizens applied to enter local authority homes, given their known reluctance and government attempts to implement a policy

of community care. The focus of interest was how far this decision was the person's choice, a topic that has also been of interest to other researchers, as I have already discussed in Chapter Three. Neill et al found that people had been faced with 'a sort of Hobson's choice' (1988:177) in that many applicants did not want to go into a home but had not been provided with an attractive alternative to residential care, or offered intensive domiciliary services. Often people had not had their needs properly assessed (see also Bowl 1986). Social workers estimated at the time that up to half the people applying for residential care could have been supported at home had adequate resources been available (Neill et al 1988).

Phillips (1992) also looked at the reasons for senior citizens moving into private residential homes and the role played by social workers in the mixed economy of care. She found that choice for senior citizens 'depended on the particular social worker to whom they were allocated' (p.237), which resulted in an unfair and inequitable service. Social workers were seen as gatekeepers to scarce public sector residential resources and most people moving into private care did not involve them. Relatives undertook this function in applications to private homes. Phillips concluded that admission into private residential care was not a free market choice. Choice in the sector was 'surprisingly restricted'. Senior citizens were constrained in their choice by their own geographical preferences, their financial circumstances, the home-owners' restrictive practices and the availability of a vacancy when it was needed.

Clough's (1981) study of life in one residential home found an unresolved tension between staff's wish to 'care' for residents and residents' desire to maintain some degree of control over their lives. Clough thought it essential that the rights and authority of the senior citizen 'as an adult who has had responsibility for her life for

over half a century', should be asserted (Clough 1981:198). He argued, like Miller and Gwynne (1972), whose study I have already discussed in Chapter Three, that the residential social work task is to enable individual residents to choose whether to be independent or to be dependent and to support them in that choice.

Following a review of research into residential care and its implications for the development of 'good practice' (Judge and Sinclair 1986), two action research studies were undertaken (Potter and Wiseman 1989, Dixon 1991). The aim was to achieve the 'good practice' objectives of self-determination, choice, control and privacy for residents in a small number of residential homes by working with staff to change their attitudes and behaviour (Potter and Wiseman 1989, Dixon 1991).

Both studies reported some progress and some small changes in staff attitudes to senior citizens. However, Potter and Wiseman (1989) wondered whether a more effective way of bringing about fundamental change in staff treatment of senior citizens might have been to adopt an advocacy and empowerment approach with the residents instead. While residential staff paid lip service to concepts such as choice and self-determination for residents, they were unwilling to relinquish their control. Staff feared that if residents were allowed to make choices about how they lived their lives, this would lead to abuse of their freedom and cause chaos (Dixon 1991). Staff assumed that residents would elect to stay in bed all day and so would deteriorate physically. Independence was narrowly interpreted in functional terms as 'maintaining physical mobility for as long as possible' (Dixon 1991:49) and using 'gentle force' if need be, to secure residents' compliance (Dixon 1991:70), rather than as autonomy. These two studies demonstrated the powerful effect of ageism on both staff and residents' attitudes and expectations and the need for senior citizens to

exercise their rights and responsibilities in residential care (see also Secker et al. 2003).

As part of the same project, the Practice and Development Exchange group at The National Institute of Social Work (NISW) translated research findings into practical recommendations for 'good practice' to improve the lives of senior citizens in residential homes (NISW 1988, 1989). The group concluded from the research that changes were needed in policies as well as practice – changes which researchers continue to call for (see Hudson et al. 2004, JRF Task Group 2005). The NISW Group recommended alternative housing options, more intensive domiciliary services and better management of services to enable people to make real choices (NISW 1988:49). The group highlighted the need to improve social workers' practice before a decision to move into a care home was made; for better assessment and information to assist senior citizens in making choices, for reviews of moves into a home, particularly in emergencies, to safeguard people's rights. However, it laid greatest stress on enabling senior citizens to make choices by listening to them and actively seeking their views. Practitioners would need to be helped to develop skills and attitudes to achieve this (NISW 1988:50). Petr and Uta (2005) argue for a broader, multidimensional framework for determining 'best practice', including the experiences and preferences of consumers.

Mallinson, investigated how keyworking and care planning, two core principles of professionally defined 'good practice', were implemented in Scottish residential homes (Mallinson 1995, 1996). I discuss the findings of his research and their implications when I present my own investigation and analysis of keyworking and care planning as core components of 'good practice' in Chapter Seven.

Shaw (2005) argues that although practitioner research reflects multiple concerns about good professional practice, its function has been restricted that of 'simply providing technical information' rather than realising its potential to promote critical practice.

Conclusion

In this chapter I have examined ideas about what constitutes 'good practice' in residential care for senior citizens in the context of an ageist society, using the concepts of independence, choice and privacy. I have argued that definitions of 'good practice' have been contested and debated by policymakers, professionals and practitioners in the context of legislation, policy and practice, often in the context of public concern about low standards and poor quality care in residential homes. I argued that although 'good practice' is a widely used term in policy guidance, its definitions are varying, confused and often contradictory, emphasising the need to promote the independence of senior citizens within a functional dependency model of ageing and a 'need for care'.

I argued that there are two distinct and competing ideologies articulated in the various policy and practice documents. One of these is based on a view of senior citizens as physically dependent and in need of care and protection, and the other as independent adults with rights to quality of life in residential homes. I argued that failure to agree and define the objectives of residential reflects a continuing ambivalence towards senior citizens and a policy preoccupation with residential care as a response of 'last resort'. In all these debated and contested definitions of 'good practice', I argued that the voice of senior citizens and their contribution to the debate has been notably absent.

I argued that the policy response to these contested definitions has been to define 'good practice' in terms of standards and to use regulation as the means of securing 'good practice' in the independent sector. I argued that this has left the stigmatizing emphasis on dependency and the 'need' for 'physical care' as criteria for entry to residential care unchanged. I argued that professional and practice literature has defined 'good practice' in terms of key principles and values that affirm residents' rights to independence, privacy, dignity and some element of choice. However, there have been differences in the application of these principles in the light of understandings about the ageing process and appropriate responses to it in residential care.

'Good practice' has continued to be defined by 'experts' on the assumption that it benefits senior citizens as residents – an assumption that has never been tested. I argued that social work practitioners have failed to influence the development of 'good practice' due to their ageist attitudes to senior citizens and residential care, distracting disputes about the status of social care in relation to social work and the lack of training among social care staff in homes.

Finally, I reviewed the contribution to definitions of 'good practice' by social work research, which has revealed the failure of social workers to implement professional principles of 'good practice' in their work with senior citizens. Their involvement has largely been confined to assessing and defining the eligibility of senior citizens reliant on state financial support to meet the cost of their residential care in terms of their 'dependency'.

Having identified the absence of senior citizens' views and aspirations about 'good practice' in residential care, I move on in the next chapter to discuss how my own efforts and experiences in giving senior citizens in residential homes 'voice'. I review

my own previous research methods critically and discuss the contribution of gerontological research into residential care, including some of my own previous work. This, I argue, has reinforced stereotypical views of ageing by its preoccupation with the physical, disabling aspects of ageing, the measurement of 'dependency' and the use of a quantitative methodology.

Chapter Five – Methods and Methodology

Introduction

In this chapter, I discuss my research methods, the approach and perspective initially adopted, why the focus altered and how interviews with residents led me to question attitudes to ageing and the rationale behind residential care. I discuss the context within which the original research data was collected. The focus of this thesis is 'good practice' in residential care homes from the perspective of policy, practice and the experience of senior citizens who live in them. I begin by summarising my previous research and then discuss the methods used to carry out work for the thesis. For the thesis, I carried out detailed policy analysis in relation to residential care for senior citizens, investigated the origins of one aspect of 'good practice', carried out a case study of a private residential home and reanalysed interviews with residents in residential homes conducted in two previous studies. Previous residential care research had alerted me to a gap between policy and philosophical definitions of 'good practice' and the patterns of care delivered within homes. I discuss the influence of my own social work background on my approach to the research and to interviews. I then consider the importance and influence of context when interviewing residents in residential care homes, including the influence of social attitudes to ageing on the process and experience for both researchers and the researched.

My previous residential care research

I am drawing on interviews conducted in two previous studies as part of the empirical evidence for this thesis. The first study involved my interviewing almost all (387) the senior citizens living in thirteen of the fourteen residential care homes run by one

Scottish regional authority between 1982-4. I re-interviewed a random half of those people still resident, a year later (93 interviews). The aim of the study, which was Scottish Office funded, was to 'see how the characteristics of the residents might affect the style of care of the Home, and *vice versa'* (Bland and Bland 1985). The authority had recently started to introduce 'small group living' (Hitch and Simpson 1972) into its homes and we aimed to evaluate the effects of the change on the lives and abilities of the residents.

I carried out semi-structured interviews individually with residents.   The first interview schedule, as printed, (see Appendix 2) consisted of predominantly closed questions but the interview included 'an unstructured discussion of the resident's recent history, the circumstances of his or her admission, their life in the Home and their feelings about it'. In all cases this unstructured element formed the larger part of the interview, which could sometimes last an hour or more' (Bland and Bland 1985, 3:1).

The aim of the research was to gather longitudinal information from residents about their ability to care for themselves; at home[2] before moving into the Care Home, and as residents over a two-year period. Information about individual residents' mental health[3], continence and behavioural status was provided by staff.

The second interview (see Appendix 2), a year later repeated the questions about self-care abilities and added closed and open-ended questions to investigate how much autonomy, choice and privacy individual residents enjoyed in day-to-day living such as the waking and rising process, how meals and snacks were organised, arrangements for bathing and going out of the home. Statistical analysis of demographic data and

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[2] Drawing on Townsend's Household Capacity Scale (1962).
[3] Drawing on the work of Meacher (1972).

'dependency' was carried out by computer. The qualitative data from the first interview were transferred on to index cards and analysed thematically. I developed a typology of explanations for the move into care, enlarging it until I was satisfied that I had covered all the cases. Residents' responses to the questions about activities of daily life were compared with the staff responses to the Institutional Regimes Questionnaire (IRQ) (Booth 1985). This 31 question instrument investigates regime along the dimensions of choice, privacy, segregation and participation. As Booth himself admitted (1985:144), the IRQ is a way of gauging administrative practice rather than how people actually behave. Homes may well provide facilities for residents to make themselves tea but residents may choose not to do so. Residents may be able to bring in their own furniture but this freedom is irrelevant if residents do not know this. Like other similar scales measuring regime, the IRQ could not detect the subtleties behind people's behaviours. It was essentially a blunt instrument which could distinguish homes which, in principle, offered residents choice from others that did not.

My second source of interview data was from a second Scottish Office funded national study of quality of care and costs in one hundred residential care homes (see Appendix 1), which I undertook with others in 1991/2 (Bland et al. 1992). In the second phase of that study, I sought the views of residents in a sub-set of six homes by means of postal questionnaires and semi-structured interviews. Every resident who the home said did not have dementia was sent a letter explaining the purpose of the research and a questionnaire. We asked about aspects of life which previous research had identified as important to people in residential care (Sinclair 1988, NISW 1988), as well as addressing the core values of 'good practice' promoted by the SSI (DoH/SSI 1989). Residents were asked closed questions relating to privacy,

control of their immediate environment, activities and access to community health services. Residents were also invited to say what they liked, disliked or wanted to change about the home. The closed questions were analysed by computer, the free text responses by hand.

I subsequently interviewed thirty-seven people, all but one of whom had been selected at random, living in the six homes run by the private, voluntary and local authority sectors. Preliminary data analysis of the hundred homes showed these six homes had scored highly on quality of care and costs. We were interested to compare resident views of these homes with our measure of quality. We investigated these homes individually in greater detail, adopting a case study approach (Yin 1984). The study had revealed remarkable variations between and within the three sectors providing residential care homes and we were keen to explore further with these providers (two homes in each sector) how they had successfully managed to combine good quality of care (by our measurement) with cost-effectiveness.

In pilot interviews with seven residents in a private home outwith the sample, I had attempted an unstructured approach, which was not a success. I discuss this lack of success further in the section of the chapter concerning the context of interviews. Learning from my piloting experiences, I used a thematic guide for the second study interviews (see Appendix 4) to investigate people's views about the circumstances of their move and aspects of home life, including elements regarded as 'good practice'. I recorded residents' views in a notebook, as they spoke, later transferring the data to index cards for subsequent analysis. This was done on a home by home basis, using the concepts of independence, choice and privacy. The analysis was then refined within topic headings in terms of comments expressed.

This 'consumer' element of the study was an addition to the previously agreed research design and had to be completed within the original time-scale. Since the concept of social services users as 'consumers' (DoH/SSI 1989) was being widely introduced into social policy at the time, I felt that it was important to elicit the views of people using the service about its quality and to see whether they supported the survey findings.

Having collected these two sets of interview data myself enabled me to reflect and develop and question my understanding over a period of some ten years about the various meanings residential care has for senior citizens who use it. In the first study, I got to know the residential care homes and their staff well over the two years I was carrying out the fieldwork. This participant observational element of the study was a valuable added source of information in helping me understand the lived worlds of residents in residential care homes. A finding of the research that surprised me, was that few people saw themselves as having chosen this move, with consequences for their subsequent experience of life in residential care.

New work for the thesis

By the end of the second study, four issues had emerged that I wanted to explore further. These were; quality of life in residential homes from the residents' perspective, the nature of 'good practice' and its effect on quality of life in residential care; a different approach to residential care that I had encountered in a private home; and the dominance of social policy and sociological perspectives in residential care research, to the relative neglect of service users' views. My interviews with residents had revealed different concerns and priorities from those discussed in the literature. I was keen to give 'voice' (see also Phillips 1992:46) to the people I interviewed about their experience of 'good practice' in residential care homes.

The investigation of these four topics, together with the two sets of resident interview data, forms the basis of the thesis. I have adopted a reflexive, qualitative approach to the work. Like the two previous residential care studies, I used multiple research methods, adopting what Bryman (1988) describes as a 'methodologically ecumenical strategy' (p.155), namely documentary research, quantitative data, case studies and interviews. My methodological decisions were influenced by my realisation that much social policy research in residential care (including my own previous studies) had adopted a predominantly quantitative methodology which, with its emphasis on measurement of care and resident dependency, tended to obscure the diversity of residents and their experiences in homes. Such research reinforces ageist beliefs and stereotypes about ageing as a homogeneous experience involving increasing physical and mental dependency. What I was seeking to do was to redress what I perceived as an imbalance in perceptions of senior citizens and residential care by eliciting the views of the people who use it.

1. In depth policy analysis

In order to ground this further work in an informed understanding of the recent history of policymaking in the area of residential care and senior citizens, I analysed published reports of government initiated enquiries into aspects of residential care. I read about the treatment of senior citizens in the English workhouse (Thomson 1980), Townsend's useful historical introduction to *The Last Refuge* (1962) and a number of documents and articles about the functioning of the Scottish poorhouse (Smout (ed.) 1979). Since the needs of senior citizens have been for health as well as social care, I read about the early history of hospitals in Scotland and in England and Wales (Abel-Smith 1964).

I examined the reports produced by the numerous enquiries into residential care that were conducted in the 1970s, 80s and the 1990s, particularly their recommendations for policy. These included the work of the Personal Social Services Council (1975,1977), Avebury (1984,1996), Wagner (1988), The Wagner Development Group (1993), Youll and McCourt-Perring (1993), The Social Services Inspectorate (DoH/SSI 1989, 1995), Howe (1992), the Residential Forum (1996) and the Royal Commission on Long Term Care (Sutherland 1999).

I analysed policy guidance and Building Notes for local authorities relating to residential care for senior citizens issued in the 1960s and 70s. The key questions were how did 'good practice' develop in policy terms towards senior citizens and residential care in the nineteenth and twentieth centuries. What effect had changes in departmental responsibility had on the social construction of attitudes towards ageing and towards the emerging model of residential care? I questioned the preoccupation with buildings rather than regimes, residents or staffing in residential homes. Indications of what might be considered 'good practice' in terms of the desirable social environment of homes and the relationship between staff and residents only began to appear in guidance documents in the 1970s. Guidance about the expected standards and what was considered 'good practice' in managing the processes of admission and residence in residential homes did not appear until the Avebury code of practice for independent homes was published in the 1980s (Avebury 1984). I analysed the reports of the various public enquiries into residential care, noting particularly their analysis of what needed to be changed or implemented to improve the quality of residential care, their recommendations to government and the policy outcome of those recommendations.

2 Investigation of 'good practice'

In the second research study, we had used the six concepts identified by the Social Services Inspectorate (DoH/SSI 1989) as contributing to 'good quality care and life experience' (DoH/SSI 1989:7) as a basis for our quality of care questionnaire, together with professionally defined 'good practice' processes and procedures. The concepts or 'six basic values' (DoH/SSI 1989:7) were privacy, dignity, independence, choice, rights and fulfilment. The 'good practice' indicators included questions addressing preparation for admission, the individualisation of care, and resident participation in home life and organisation.

In the subsequent work for this thesis, I used documentary analysis to develop a deeper understanding of 'good practice' in residential care for senior citizens, consulting documents that addressed the topic from the perspectives of policymakers and practitioners as well as researchers. Dominant themes in this literature were identified and analysed. This gave me access to the policy background and the social care development of and research into 'good practice' over some thirty years.

My focus was now on quality of life rather than the narrower concept of quality of care. I wanted to investigate apparent discrepancies between the policy and philosophy of 'good practice' and its practical application observed during my fieldwork and as experienced by the people I had interviewed. I used these data to assist my understanding of the 'good practice' findings in my empirical data reanalysis. I have discussed my analysis of how 'good practice' in residential care homes has been progressively defined and described in policy papers, professional papers and documents and research studies in Chapter Four.

I reanalysed data from the staff postal questionnaires on Time Use in the 100 homes to see how much time they devoted to activities specifically designated as 'good

practice', such as meetings with residents, or developing a care plan with them, as well as activities associated with quality of life. All employees working in the homes had indicated on a list provided[4] which activities they 'usually', 'sometimes' or 'never' undertook in the course of their work. There were some weaknesses in this questionnaire. For example, we should have provided space for additional 'other activities' undertaken that were not on our list. We also asked staff to detail the activities they had undertaken on their last shift, but again, we asked for this only in terms of the activities we had already specified. These data enabled me to look at how different levels of staff used their time and then to see whether there were discernible differences between the sectors.

I used the staff time use data in my investigation of key working and care planning. I was interested to see the extent of their involvement in activities to promote quality of life for residents as opposed to quality of care and which staff undertook such activities.

I then compared the findings from the staff questionnaire for each of the six case study homes from phase two with the responses about key workers and care plans from my resident interviews, on a home by home basis. How this work helped me to develop the argument of the thesis is discussed in Chapter Six.

3. A new approach to care?

In phase two of the national study (Bland et al. 1992) we selected six homes from our original sample of one hundred for further exploration jointly as case studies, or what Stake (1998:89) calls 'a collective case study'. The 'phenomenon' we were keen to investigate further was 'efficiently' managed homes, where 'efficiency' was defined as delivering high quality care at below average cost. In each sector, two homes

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[4] Using the work of Imber (1977).

which met these criteria were each visited twice by the research team. The first visit was to see the home and have a discussion with the owners or managers. We were interested in how these homes managed the constraints and used the opportunities available to run 'efficiently'. The second visit, the following day, was to interview a random sample of residents to elicit their perspectives on quality of life in the home.

One of the private homes visited impressed us all as qualitatively different from the other five homes we visited. Each of us later described this difference as being 'more like a hotel than an old people's home'. This became of great interest to me when I learned, through my interviews, that the attitudes and conduct of the residents were also markedly different from those of residents in other homes I had researched. I wondered whether some of this difference might be attributable to the hotel background of the owners.

For the thesis, I subsequently researched the sociological literature on hotels in order to understand the conceptual framework for hotel-keeping. I also compared the resident and relative questionnaire results for this home with the other five case study homes. My focus had shifted from the original interest in the home's 'efficiency' to an exploration of its whole approach to residential care and its residents.

I carried out a detailed case study of this care home in relation to its approach to residential care using material from the interview conducted with the owners and interview data with residents to explore the way the home operated. The case study is a useful method of investigation because it enables the researcher to explore a phenomenon within its real life context where the boundaries between the object being investigated and its context are not clear and where multiple sources of evidence are used (Yin 1984). A case study may be qualitative or quantitative or a combination of the two (Stake 1998). Yin (1982) identified four common

commitments in three research studies that he examined: to bring expert knowledge to the phenomena being studied, to collect all relevant data, examine rival interpretations and to ponder and probe how far the findings have implications elsewhere (Stake 1998). My own commitment was to understand what the nature of the difference of this home was, to describe it and attempt to explain it and evaluate it in terms of the quality of life experienced by its residents.

I used the staffing questionnaire responses on time use in the six case study homes, together with material from the residents' questionnaires and interviews, to compare the residents' experience of life in the private case study home with the other five homes. The effectiveness of the case study home's approach in enabling residents to continue to enjoy their independence, privacy and right to make choices is discussed in Chapter Eight.

4. The absence of senior citizens' voices in residential care research

I investigated this question by reflecting more widely on how senior citizens in general are viewed and how they view themselves in society. I focused on the problematisation of old age in social policy, looking particularly at the health and social security services. I looked for literature by senior citizens on their experience of ageing. The little I found talked of the ageing experience as stigmatising (Macdonald and Rich 1984). This led me to Goffman's work on stigma (1968). I looked for literature on senior citizens' definitions of quality of life. Failure to find literature on self-advocacy among senior citizens led me to the literature on self-advocacy by younger disabled adults. I found the challenge to existing models of disability and services for people with physical disabilities by disabled people (Morris 1994, Beresford and Harding 1993, Zarb 1991, 1993, Oliver 1991, 1993) particularly

helpful. I noted the tendency in so much ageing research (including our own previous studies) to characterize senior citizens generally as 'dependent' rather than 'disabled'.

I read about the identification of ageism (Butler 1973, McEwan 1990, Bytheway 1995) and considered its social influence generally and on social science research specifically. Reading about systematic discrimination applied on the grounds of age made me think critically about the common-sense, taken-for-granted approach adopted by researchers into aspects of ageing, particularly the field of residential care and how ageist much of it is. I noted particularly that despite a great deal of research, many of the criticisms of long term care made by Peter Townsend (1962) forty years ago still applied.

As the critique of the 'literature of dysfunction' (Jones and Fowles 1984) in institutions demonstrated, inhumane regimes in long term care reflect wider social processes and attitudes. In order to understand long term care for senior citizens, I realised one had to study the social position of senior citizens generally. I drew on the literature on ageing, disability, discrimination and on residential care to inform my reanalysis of the data and my understanding and analysis of the keyworker role, which is discussed in Chapter Seven.

For the keyworker analysis, I researched the origins, aims and development of the role and of care planning, in the practice literature. From the literature, I identified a number of different models of keyworking and I used these to reanalyse the staff time use data. I wanted to discover three things: what keyworkers did with residents, who they were, in terms of their staff designation, and whether the role was invested in one person or several. I was looking to see how far keyworkers had an individual, personalised relationship with their 'key' residents that promoted quality of life. I then reanalysed the interview responses from residents about keyworking and care

planning, in terms of their awareness, both of the purpose of each as defined in the professional literature on 'good practice' and their expectations and experience, if any, of the relationship and the care planning process. I wanted to discover whether the staff who helped residents with personal care were the same as those who undertook counselling and quality of life activities with them and whether they were senior staff or care staff, or a mixture. I was also looking for possibly differentiating patterns between the three provider sectors.

For the case study of the private home, I first investigated the sociology of hotel-keeping. I then drew up a schema of the public sector model and the hotel model of home, identifying ten aspects on which they differed in their attitudes and practices in relation to such concepts as risk, choice, flexibility, autonomy, ethic, orientation, etc. I compared the free text answers to the postal questionnaire given by residents in this home with the responses in the other five homes. These had given residents the chance to say what they liked, disliked and wanted to change about their residential home. I then did the same exercise with the interviews, highlighting similarities and differences between the case study home residents and residents in the other five homes.

As a result of my reading and reanalysis, I concluded that, unlike those of other groups experiencing discrimination, such as black people, people with learning disabilities, or with mental health problems or physical disabilities, senior citizens' voices and views about quality of life and support and services available to them, particularly residential services, were seldom heard. The Gray Panther self-advocacy movement of senior citizens started by Maggie Kuhn in 1970 in the United States (Bytheway 1995) has been weakly emulated in Britain. Elderly fora have been established in parts of Scotland led by senior citizens themselves as a means to get

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their voices heard by government with some success (see Henwood and Wistow 1999:44). Until relatively recently, senior citizens' views and concerns tended to be represented for them by voluntary organisations. The stereotype of senior citizens as 'dependent', requiring help and assistance from welfare professionals to articulate and meet their needs is well demonstrated in the titles of the two most prominent voluntary organisations concerned with senior citizens, i.e. Age *Concern* and *Help* the Aged (my italics). These organisations enjoyed a far higher public profile than the elderly people's fora which tended to reinforce the widespread perception that senior citizens were incapable of speaking on their own behalf.

I realised that senior citizens' views about care were hard to find, although less so than when I started my research. I debated whether this indicated a reluctance to voice their opinions, particularly if they are negative. Alternatively, was it that their views were rarely sought by policymakers and researchers and if so, why was this? Have we been asking the 'wrong' questions about residential care as far as senior citizens are concerned? I concluded that the concept of quality of care was too narrow as far as senior citizens were concerned and that their preoccupations were around their whole life experience in residential homes, not just the part with which they needed support and help.

My own experience of interviewing in residential care homes raised a number of issues about their participation in research which I pursue in the next section of this chapter. I discuss my own approach to interviews in my research and the influence of my professional background in social work. Over the years of researching, reading and thinking about senior citizens and residential care, I have been increasingly persuaded that the subject has to be studied and understood in terms of the broader context of ageing generally and wider social processes.

What is an interview?

The interview is a key method of researching the attitudes and beliefs of social groups. It has a central role in a range of research designs (Fielding 1993) and is a very widely used method of research. However, there are considerable philosophical differences among researchers as to the form interviews should take and the status of the information thus gathered.

Interviews can take a number of different forms, depending on the approach adopted in the research. Bryman (1988) gave a concise definition of what is generally understood to be the main characteristics of quantitative and qualitative research. 'Quantitative research is typically taken to be exemplified by the social survey and by experimental investigation. Qualitative research tends to be associated with participant observation and unstructured, in-depth interviewing.' (1988:1.) The philosophical, rather than technical debates about the respective merits of these two different approaches have hinged on whether a natural science model of investigation is an appropriate methodology for studying people and their social world (Bryman 1988). Qualitative researchers have argued that a scientific approach fails to take account of the differences between people and the objects of study of interest to the natural sciences (Bryman 1988).

The normal way of differentiating between these different forms of interview is by the extent to which they adopt a structured format (Fielding 1993:136). However, this is not a view shared by Hammersley and Atkinson (1995) when discussing the difference between survey and ethnographic interviews. Rather than structure being the differentiating factor, they maintained that the more important distinction was between standardised and reflexive interviewing (Hammersley and Atkinson 1995:152). In ethnographic interviews the emphasis is on flexibility; the exact

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questions to be asked are not decided in advance, nor is each interviewee asked exactly the same questions and the approach may be directive or non-directive within different parts of the same interview. Ethnographic interviews are more like conversations than survey interviews but the ethnographer has an agenda to follow, nevertheless and 'must retain some control over the proceedings' (p.152).

May (1997) has identified four broad types of interview used in social research; structured interviews, semi-structured, unstructured or focused interviews, and group interviews. In the studies that inform this thesis, I used semi-structured or semi-standardised (Fielding 1993) interviews.

Structure and standardisation are two elements strongly associated with a positivistic approach to social research (Benney and Hughes in Bulmer 1977, Gilbert 1993, Silverman 1993). However, Mason (2002) also called for qualitative research to be rigorously and systematically conducted, whilst distinguishing this from a rigid or structured approach, 'which is usually not appropriate for qualitative research' (2002:7). This lends some weight to writers who have suggested that the distinction between quantitative and qualitative research has been exaggerated (see Burgess 1988).

Predicated on the methods of research adopted by the natural sciences (Arksey and Knight 1999), the logic of this epistemological approach to interviews concerns a belief in objective 'facts' or an 'external reality' that can be measured (Fielding 1993). Discovering these 'facts' can only be achieved in interviews by adopting the scientific approach to the phenomenon, even when this phenomenon is a human being, being studied as 'object' (Arksey and Knight 1999). This requires the interviewer to maintain a neutral, distancing stance in interviews. The method puts great emphasis on rigour, both in terms of the questionnaire that is the research

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instrument and how it is administered. The aim is to 'generate data which hold independently of the setting and the interviewer' (Fielding 1993:151). Each questionnaire must be administered in exactly the same way to each 'respondent' (rather than 'subject') so that any differences in answers to questions are 'held to be real ones rather than the result of the interview situation itself'(May 1997:110).

A semi-structured interview was characterized by Fielding (1993:136) as one in which 'the interviewer asks certain, major questions the same way each time, but is free to alter their sequence and to probe for more information'. Asking open-ended questions opens the possibility of the interviewee responding more on their own terms than a standardised interview would allow, whilst the more structured format of this type of interview over the focused interview, makes comparability easier (Silverman 1993). This is probably the nearest of the four types of interview described by May (1997) to the style of interviewing I adopted in my research. As Hammersley and Atkinson put it, '…a distinctive feature of social science [is] that the 'objects' are in fact 'subjects', and themselves produce accounts of their world' (Hammersley and Atkinson 1995). Many writers have stressed that qualitative research interviews 'attempt to understand the world from the subjects' points of view, to unfold the meaning of peoples' experiences and to uncover their lived world…' (Kvale 1996). I find Kvale's definition of the research interview as a 'professional conversation' (1996) a helpful way of characterizing my own approach to carrying out research interviews.

Interviews in social work

My professional background in social work meant that I approached the conduct of interviews in a way that is not adequately captured in the descriptions of semi-structured interviews that I have read in the research literature. Although social work

interviews are conducted with a wide range of people, in a multitude of different settings and circumstances, there are core expectations about the professional approach that practitioners are expected to take towards their 'clients'.

Social workers are expected to practise against an explicit set of principles or values. These include respect for all human life, optimism about human nature, sensitivity in all social relations and a readiness to use 'the self' to reconcile the often conflicting interests of what Davies (1985) called 'marginal individuals' (p. 181) and the state. These principles demand a more personal involvement from the social worker in his or her working relationships with people using social services than that described by either Fielding (1993) or Silverman (1985) in their discussions of semi-structured interview methods in research. Rather than 'probing' in interviews to elicit more of the interviewee's perspective I would describe my attempts at getting the person to explain or enlarge on their views in more detail as 'encouraging' or 'prompting'.

It is, perhaps, the reconciling role of the social worker mentioned by Davies (1985) that provides a clue as to why I find the philosophical epistemological debates about quantitative and qualitative approaches to social research difficult. Social workers who practise in the public sector (as I have done) operate within a statutory framework or structure. The powers and duties they exercise are established by legislation. Yet our professional principles oblige us to uphold and respect the unique value of all human beings. We have a concern with the individual as well as his or her relationship with society. When relationships go wrong, whether from the perspective of the individual or the state, social workers are expected to try to help to put them right.

In research interviews, the purpose behind the interview is different from practice interviews. The social work researcher is not undertaking the interview in the role of

'the helping person' (Compton and Galloway 1975 cited in Davies 1985). I found this aspect of research interviewing personally challenging in the first research study particularly because my role in interviews was confined to that of empathic listener to many peoples' difficulties and distress.

Social work practice requires us to operate flexibly within a broadly structured framework. Social workers may conduct all four of May's (1997) types of interview in the course of their work but the professional principles or values they operate from should remain the same. This is at variance with the research literature's description of how structured interviews should be conducted, the need to maintain uniformity of approach and 'the detached, observer status of the natural scientist' (Arksey and Knight 1999:10). This is the complete antithesis of how social workers see their work. The whole emphasis is on the quality of the 'professional' relationship social workers make with the people with whom they work. As Howe (1987) put it 'if nothing else, social workers should be able to 'relate' to people' (p.113). Davies (1985) suggested that the key to the social work identity lies 'not in *what* is done but *how* it is done' (p.181). In other words, when measures of social control have to be applied by a social worker, these should be carried out in ways that continue to value and respect the individual. This is not a claim for some special virtue among social workers but rather to make the point that as professionals we are expected to conduct ourselves in a particular way.

I conducted my research interviews against the background of the ten principles of interviewing for social workers, developed by Jamieson (1978) and discussed in Davies (1985). These principles included adopting a sympathetic, empathic and non-condemnatory approach, asking neutral, open-ended questions and not probing too deeply too quickly in an interviewing relationship.

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In both social work interviews and qualitative social research interviews, the way the person conducts the interviews is important. Contrary to the tenets of the quantitative method's insistence on eliminating the interviewer effect (Hammersley and Atkinson 1995), in qualitative research interviews it is the researcher themselves that is the research instrument *par excellence* (Hammersley and Atkinson 1995:19).

Research texts emphasise the importance of establishing trust, understanding and respect between the interviewer and the interviewee as part of a strategy for 'inducing positive feelings' during an interview (Arksey and Knight 1999). In social work, the emphasis is on making relationships with 'clients' in order to gain 'an understanding of the meaning which people give to their experience' (Howe 1987:114). In 'client-centred approaches' (Howe 1987) key factors employed by social workers are their intuition and their ability to make 'use of the self', which has been described as 'crucial' (Davies 1985:182, England (1986) quoted in Howe 1987).

The social worker has to acknowledge key aspects of 'the self' as qualities or deficits with which they have to work; their own strengths and weaknesses and other personal characteristics, including their age, sex, ethnicity, energy and prejudices (Davies 1985). In order to help people, social workers must be aware of their own thoughts and emotions generated in their relationships with their 'clients' and be prepared to use these (Howe 1987) in developing their understanding. This self-awareness that is a key requirement of the 'client-centred approach' to social work relies on the worker's use of their intuition, defined by Howe (1987) as 'a natural ability, if we allow it, to appreciate the thoughts and feelings of others' (p.111). Some writers go so far as to see intuition as 'the essence of social work' (England, cited in Howe 1987). This intuition is used to help the social worker understand subjectively the meaning which people give to their experience.

In my reading about different qualitative approaches, I found much in common between the social work principles and values to which I subscribe and those adopted by researchers taking a feminist approach. Both approaches acknowledge an awareness of oppression among certain social groups. Where the social work approach emphasises the intrinsic worth of all individuals, irrespective of their gender, sexual orientation, race or age, the feminist approach is concerned specifically with the oppression of women. My own approach to this research and my concern to give expression to senior citizens' voices and views on residential care is similar to that of some feminist writers. Their commitment is to 'tackling the invisibility of women in sociological enquiry' (Roberts 1981:7) and to 'understanding the experience of women from their own point of view' (Reinharz 1992:52).

The research literature testifies to the many effects the interviewer's race, age, gender, social class and religion may have on what the person being interviewed says, or feels able to say (Fielding 1993:145, Silverman 1993:35). How the interviewer behaves and conducts themselves has also been found to affect people's responses to interviews (Fielding 1993). Kvale (1996) emphasised that the outcome of an interview depends on personal attributes of the interviewer – their knowledge, sensitivity and empathy. In one study (Shapiro and Eberhart 1947) aggressive interviewers and a willingness to probe resulted in greater interviewee 'verbosity' and more information being volunteered (Fielding 1993:145). The extent of the interviewer's experience has also been found to affect response rates and extensiveness of response (Bury and Holme 1990:137, Fielding 1993:145).

The impact of a social work approach

A background in social work can have both positive and negative implications for research methodology. On the plus side, is the already acquired skill to interview

people sensitively about what may be difficult topics for them to address. Knowing the value and importance of being an attentive listener allows one to pick up on voice tone, nuances in meaning and non-verbal elements of communication. There is the possibility of getting close to what the person is wanting to convey.

An awareness of the implications for interviewing of a particular physical or sensory impairment meant that I took pains to check with individuals their ability to hear me by asking where they preferred me to sit. I made a point of extending a handshake to people with impaired sight and letting them choose our respective sitting positions. In the first study, I interviewed a woman with total hearing loss. After one or two experiments, we concluded that the optimum means of communication was for me to write my questions down so that she could then speak her answers. So the hearing person (the researcher) was silenced and the impaired person spoke – an interesting juxtaposition that worked well. The reaction of fellow residents to her hearing loss left this woman extremely isolated and lonely.

Interviewing as a practising social worker and as a social work researcher are different activities. Although prior background knowledge of the subject area is often cited in research texts as an advantage (Arksey and Knight 1999), I found this same familiarity was an impediment to my first research study. It took me a while to look with a more critical researcher's eye at taken-for-granted phenomena, such as the regimes in residential care homes, that I had been unquestioningly familiar with as a practitioner.

In that study, I had previously worked in the local authority as a social worker. My change of role to academic researcher was not always clear to staff in homes, which sometimes caused difficulties when residents were being invited to take part in interviews. Some residents were invited to 'come and tell Mrs. B. all your wee

problems'. Some residents reacted to my approach by asking whether I had come to 'put them away' – described by some researchers as 'the biggest fear of elderly people and the greatest concern of their relatives' (Finch 1989a, cited in Arber and Ginn 1991).

My first task, then, was to dispel the anxiety and misunderstanding of why I was there, in the home. I clarified that as a researcher I had no influence over their continued residence and stated the purpose of my research. This was a salutary reminder to me of how insecure some residents felt about their ability to remain in a particular home, and how threatening a social worker's presence can sometimes be. My arrival to some people was associated with the possibly unwelcome exercise of authority over their lives in the residential care home. This highlighted the fact that where people consented to be interviewed, their consent was not well informed. In a research interview, the interviewee should be a willing participant who has given their informed consent to take part in the research (Kayser-Jones and Koenig 1994). I tried to remedy this lack of information at the outset of each interview, offering the person a second opportunity to decline to take part, if they wished. Ten people told staff they did not wish to participate in the first interview and five people did so at second interview.

In the second study, I went to considerable lengths to try and ensure that consent to take part in the research was properly informed. I had tried this out by writing to each person living in the home individually in the pilot study. The useful feedback from residents was that the letter and questionnaire presented no problems of understanding but that the typeface could usefully be larger and darker. In phase two, larger type letters and questionnaires were sent, setting out the government's wish to elicit senior citizens' views about their experience of care. The interview group was selected

randomly. People with dementia and any refusals were substituted similarly. Again, at the start of each interview, I referred to the postal questionnaire, the purpose of the research and stressed that participation was entirely voluntary. My sample number was thirty-seven rather than thirty-six because one lady asked specifically to be included in the interviews.

One advantage of my practitioner background as far as access to records in the first study was concerned, was that there was never any hesitation in allowing me to read individual residents' case records and care plans. On the other hand, staff tended to maintain a professional relationship with me, perhaps somewhat anxious and distrustful initially of what impact the research findings might possibly have on their jobs. Written care plans, where they existed, were readily made available in phase two of the second study, perhaps helped by the knowledge that the participating homes knew that they had come out well in the first phase.

In the interviews I had to establish that I was trustworthy and that what residents chose to say to me was confidential and would not be fed back to staff or reported in any way that was personally attributable to them. It is possible that some people were not sufficiently reassured to feel able to express their views frankly to me. For the most part, this did not appear to be the case.

Having considered the effects of my social work background, I now want to move on to consider the importance of the context in which interviews with senior citizens in residential care homes are conducted.

The importance of context

In this part of the chapter, I examine the influence of context on my research at three levels, the interpersonal, the institutional (the care home) and the (broader) social context.

The interpersonal context

In the interpersonal context of residential care interviews, the use of language and vocabulary between the researcher and the person being interviewed can facilitate or inhibit communication. My commitment to giving senior citizens the chance to express their views in their own words rather than responding to my suggestions resulted in my asking the people in the pilot study of what elements they thought 'quality of care' should comprise. However, this was not a success as none of my interviewees could readily produce a list of key factors. This is hardly surprising. I learned from this that it is not easy to translate grounded experience into abstract concepts for the purposes of discussion at a moment's notice. When I embedded the question in concrete examples of what might be regarded as key elements of care quality – the very action I had been trying to avoid of putting words into peoples' mouths – people responded animatedly. I surmised that this was because I was now talking in terms that resonated with their daily life experience. So, in this instance, I concluded that the unfocused approach to interviewing was not likely to be very useful in this area of research and abandoned it for the semi-structured format in the phase two interviews. Interestingly, Raynes (1998) had considerable success with her question 'what makes a good residential care or nursing home' when it was posed to focus groups of senior citizens living in residential care homes. Perhaps the fact that these groups of people met several times, away from the homes and from staff to discuss this topic and had the support of the group itself made the difference.

Researchers forget, at their peril, the importance of using language and vocabulary that is familiar to their interviewees. Social work jargon such as the phrase 'key worker' and 'care plan' either had no meaning for some of my interviewees or very different meanings. I dealt with this by using the phrase first, without explanation, but making it clear that I did not necessarily expect the person would know what I was talking about. This was essential to avoid making the person feel uncomfortable or incompetent and also because some of the homes did not operate a key worker scheme or have care plans as defined in the 'good practice' literature. Some people offered a definition of what they thought these phrases might mean in their own experience, which was interesting and varied. Where people did not know what I was talking about, I offered them a brief definition for each term.

The element of compulsion behind many admissions to care is not an issue that is discussed in methodological texts so far as interviewing senior citizens in residential care homes is concerned. There is some acknowledgement that 'senior citizens living in institutions…may already be subject to invasions of their privacy, and an undermining of their autonomy' (Butler 1990:170) and that the need for researchers to behave ethically is all important. Some people did choose to move into a care home but they were a minority, according to the people I interviewed (see also Willcocks et al. 1987, Sinclair 1988, Phillips 1992, Oldman and Quilgars 1999). Although I knew this from my previous practice, I was still unprepared for the extent and depth of emotional reactions to my question 'was it your own idea to come and live here' in the first study. This question was initially asked in the preliminary demographic part of the interview but I moved it to a position later in the interview, so that the relationship with the older person was more established and the more straightforward questions were out of the way. Given the sensitivity of the circumstances surrounding

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the person's move, and the likelihood of their being distressed when discussing these circumstances, I was very careful to let the person themselves control the pace and extent of the information they revealed. I was also concerned that the interview should be concluded only when the person had recovered their composure, if they had been tearful, and after we had discussed other, less emotive topics.

A second possible area of sensitivity is how to undertake interviews with senior citizens who have learning difficulties or mental, physical or sensory impairments. I have already discussed my strategies for facilitating interviews with people who have sensory impairments. In the first study, quite a sizeable minority of the people I interviewed had come to the residential care homes from a long stay learning disability hospital. The range of their capacities to take part in the interviews was considerable. Here the issue of informed consent to taking part in the interviews was of concern and I attempted to implement this by explaining the purpose of the research before beginning each interview. In the course of the research, I learned that many of these people had originally been hospitalised for social reasons, such as unmarried pregnancy or 'wild behaviour' rather than degree of impairment. Researchers therefore need to be aware that the labels attached to people do not necessarily correspond with their ability to take part in research interviews.

Physical impairment may sometimes make it difficult or painful for people to move easily around the home, so the desire for privacy in interviews may have to be weighed against the physical distance of bedroom accommodation from public lounges, where most residents spend much of their day. Some senior citizens are frail and cannot comfortably sustain a long interview. I found it valuable to check individuals' level of comfort from time to time, so that the interview could be speeded up or shortened if need be but none were curtailed (Phillips in her residential care

research found the length of the interview was 'crucial'. She also found it was important not to underestimate interviewer fatigue, 'particularly when interviewing people who are depressed or going through a bereavement' 1992:71).

Estimates of the proportion of people with dementia in residential care homes vary greatly. Some residential care homes offer a service specifically to people with dementia. As many as one third of senior citizens living in residential care homes have been diagnosed as depressed (Murphy 1993), although this receives much less attention in the literature. More recent research claims that the incidence of depression among senior citizens is far higher in care homes than among those living in the community and stresses the importance of detecting and treating depression as well as staff training to change attitudes (Leason 2005). The idea that people with dementia are capable of taking part in research interviews was not current when I carried out the first study and although I did interview some people who were said by staff to be 'confused', my attempts were not very successful.

In the second study, we recognised our limitations in time and expertise and deliberately omitted people identified by the homes as having dementia from the interviews, whilst acknowledging that this limited the scope of the study. In the first study, I did interview a significant minority of people who had come into the residential care homes after living for many years in long stay psychiatric hospital. One of my concerns with this institutionalised group of people was to establish their informed consent to taking part in the research at the start of each interview. I was also concerned to minimise any potential harm or 'costs' such as 'the provocation of anxiety, embarrassment or some other form of mental anguish' (Butler 1990:168).

A third key factor in the interpersonal context of interviewing is the low expectations that have generally been imputed to senior citizens in residential care homes by

researchers (Hughes and Wilkin 1987, Booth 1985, Peace et al. 1997). This is but one example of a tendency to homogenise senior citizens into one undifferentiated, ungendered group (see Morris 1993). It is obvious, as soon as one starts interviewing people that 'elderly people as a single, homogeneous group do not exist' (See Phillips 1992:70, Willcocks et al. 1987). People in residential care homes come from widely different social and economic backgrounds, so their expectations are similarly varied. The experience of living in a care home is a highly gendered experience, with different implications both for the female majority and the male minority of residents (Office of Fair Trading 2005). The staffing of residential care homes is also highly gendered, with few men employed (SSSC 2004). As a woman, I felt my gender was an advantage in that most of the people I interviewed, whether residents or staff, were women also.

I concluded from my first study interviews that most people moving into residential care homes knew very little indeed before doing so and therefore did not know what to expect. I subsequently wrote a small book (Bland 1987) that set out information for senior citizens about residential care and a second book was commissioned later, setting out the choices available within the broader context of community care (Bland 1997). Rather than a question of senior citizens having low expectations then, it may be more a question of them not knowing what their expectations of a care home could reasonably be. Very few senior citizens are familiar with what residential care homes offer or are supposed to provide before they move into one (Shaw and Walton 1979, Sinclair 1988, Booth 1995, Office of Fair Trading 2005).

The belief that senior citizens have low expectations has allowed researchers to be very critical of some aspects of residential care. However, there is a danger that the researcher's own social background, particularly their gender, age, social class and

ethnicity, may cause them to react negatively to features of homes which residents do not necessarily find the most unsatisfactory or problematic (see Sinclair 1988). There has been a danger, then, that in the absence of senior citizens' articulated views, those of researchers, commentators, policymakers and others may have dominated the predominantly negative views about ageing and residential care and prevented senior citizens influencing policies, services and practices that affect them.

I now discuss the influence of residential care as the context for interviewing senior citizens.

Institutional context

Timing of interviews in residential care homes has to be fitted around the home's regime. The day is divided up by refreshments being served mornings and afternoons, and by mealtimes. In all the homes I visited, the main meal was served at lunchtime around 12.30 and 'high tea' was between 4.30 and 5.00 p.m. It was important to ensure that taking part in the interview did not mean that the person missed their coffee or tea or was late for lunch or high tea. In some homes, people were anxious that their meal would not be kept for them if they did not appear in the dining room on time. After lunch, many senior citizens took a nap, so the window of opportunity for interviewing throughout the day could be relatively narrow.

Life in many residential care homes, particularly in large homes, was lived largely in public (see Willcocks et al. 1987). Although lip service was paid to the importance of the individual right to privacy, shared accommodation, the lack of locks on bathroom and bedroom doors made this difficult to guarantee in practice. Moreover, the perceived need for staff to keep residents under surveillance, particularly people with dementia, resulted in resident privacy sometimes being seen as undesirable. This had implications for researchers trying to secure privacy for interviews. In the first study

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particularly, a high proportion of residents shared bedrooms. This meant negotiating the use of the visitors' room, or the manager's office was sometimes made available. This meant that the person was not being interviewed 'on their own territory' and occasionally the interview would be interrupted by another resident wandering into a sitting room, or by someone coming in to answer the office telephone.

Where the resident had their own room they almost always suggested the interview take place there. A personalised bedroom with photographs and memorabilia was helpful in gaining a sense of the individual. However, I was again reminded how abnormal care home life is when one interviewee stated how much she disliked having to entertain visitors in her *bedroom* (which was smaller than the 1973 Building Note recommended minimum of 10.25 sq. m.). rather than in the sitting room, as she would have done at home.

I learned from many visits to residential care homes that staff were understandably keen that visitors should leave with a good impression of their work. They not infrequently illustrated this by identifying 'good residents' for interview. These residents tended to be people who had settled well into the care home, had personalised their bedroom and were leading a full life there. I deliberately chose to sample the residents in the national study randomly to try and get a mix of interviewees in terms of their disposition towards their residence and length of stay in the home. The only substitutions were for people whose dementia was too severe to allow them to participate or because the person refused. The wisdom of doing this was confirmed when more than once, the home manager said that they would not have recommended a particular person, selected randomly, for interview. I was cautioned before interviewing one man who was described as aggressive and liable to hit out with his stick.

It was important to be aware that when an older person has moved into a residential care home, particularly a public sector home, they may have been expected to relinquish control over key aspects of their life. Apart from losing control over the move itself in many cases, which I have already discussed, the person, particularly if they were state funded, may have had to share a room, with the consequent loss of privacy. They may have given up control of their finances to the local authority and have had only the statutory 'personal allowance' as income. The care home may have assumed control of any medication the resident may have been taking and the person may have been supervised by staff when bathing or showering. Many senior citizens did not realise that they had the right of choice about some of these care decisions. Questions about these areas of life in residential care homes may elicit anger or distress in interviews. Such restrictions on residents' autonomy and privacy have to be understood in the wider social context of attitudes towards and treatment of senior citizens generally.

Wider social context

I have already discussed the social attitudes and theories around ageing and their influence on senior citizens and their support and care in Chapter Two. In this section, I want to refer specifically to those aspects of statutory health and welfare provision which influence moves to residential care homes.

Many people who move into a residential care home do not visit it beforehand (Willcocks et al. 1987, Sinclair 1988, Booth 1993). The reality of making a personal choice of home may be constrained by frailty or illness, professional or family involvement, or income. The move may come about as the result of a health crisis and be unplanned. A high proportion of residents move direct from hospital to a care home, without returning home again (Bland and Bland 1985, Willcocks et al. 1987,

Phillips 1992, CSCI 2004, OFT 2005). For some people, particularly people who have dementia, this may compound any confusion about their location caused by the illness.

The link between the health, welfare and social security systems can act against the interests of senior citizens as well as for them. This is particularly true of those senior citizens who are totally reliant on the basic state pension and social security system for their income.

In Chapter Four I have already discussed how other researchers have approached the study of senior citizens and residential care. I particularly identified how the adherence to quantitative methodologies in the majority of earlier studies had resulted in the voices and views of senior citizens not being elicited or not listened to. More harmful, I now conclude, have been the use of closed questions in these studies because the subsequent analyses of 'users' views' have only reported senior citizens' responses to topics and questions that policymakers or researchers consider important. For instance, the review of the literature conducted for the Wagner Committee (Sinclair 1988:268) reflected greater confidence in findings reported in large-scale, quantitative studies. This resulted in the findings from smaller scale studies that provided revealing insights into residents' concerns being given less weight (see e.g. Power et al. 1983). This led to one-sided and partial reporting of what senior citizens think and feel about their lives and left us uninformed about those matters that are of importance to them.

Since ageism is endemic in our society, research and researchers reinforce, knowingly or otherwise, the negative stereotypes about the process of growing older both in the topics they continue to research and in the methodologies they employ in their studies. The mistaken belief that moving into a care home is a common feature of later life

was reinforced by the fact that much research into ageing was carried out on the 5% of senior citizens living in long term care (Bland et al 1992:21).

My own conclusion after conducting a number of studies with senior citizens is, that it is essential to understand and be aware of how easily ageist beliefs and stereotypes can blind us as researchers to social realities for senior citizens. They are often quite different from how we think they are or how they are portrayed. Methodological texts have yet to give sufficient emphasis to the effects of age in social research, both the age of the researcher and of those being researched, in the way that social class, race, religion and gender have been discussed. The insidiousness of ageism makes it all the harder to detect but its pervasiveness is a serious threat to the right of people in later life to maintain control over decisions about their futures, particularly if they need support to maintain their autonomy (JRF Task Group 2004).

Conclusion

In this chapter, I have discussed how previous research with senior citizens caused me to question the rationale behind 'good practice' in residential care. This led me to undertake further work to prepare this thesis, involving an investigation of the historical and policy development of residential care and how 'good practice' has been conceptualised and implemented. I noted the relative absence of senior citizens' views in residential research literature and criticized my own previous research methodology for its tendency to reinforce ageist attitudes about the assumed 'dependency' of senior citizens, particularly those living in residential homes. I discussed the philosophical differences about the nature of interviews in social research and attributed my particular difficulties in this respect to my background in social work. Finally, I discussed the importance of understanding the implications of the residential home as the context within which research interviews are conducted

and how this may affect the questions asked and answers given. I noted the need to be very aware of ethical and other issues such as confidentiality when carrying out research with senior citizens living in residential care homes. I commented on the failure in many methodological texts to acknowledge or discuss the impact of age in research (both on the researcher and the researched) unlike its attention to gender, race, social class and religion. I concluded that researchers need to be aware of the insidious nature of ageism in order to guard against accepting or perpetuating the pessimistic and negative stereotypes that surround ageing. Failure to be aware of this danger can prevent researchers exploring the social realities for senior citizens that may be at variance with how they are portrayed.

In the first four chapters of the thesis I have examined how beliefs about ageing have been expressed in social attitudes and social policies towards senior citizens and have been predominantly pessimistic and negative. Rather than being seen as a cause for rejoicing, increased expectation of life has been regarded as problematic, both personally and socially. The 'good practice' solution to the 'dependencies' of ageing has been residential care. However, beliefs that attributed the causes of poverty and ill health in later life to individual improvidence or failure of family support, led to residential care being seen as a stigmatizing solution to people's needs. The development of hospitals and medical interest in conditions that were curable led to the exclusion of people with chronic illness or disability, many of whom were elderly, for whom residential care was deemed appropriate. Thus, the original purpose of 'good practice' in residential care to provide asylum to the destitute changed again, to provide long term care for senior citizens no longer deemed treatable by a health service focused on acute illness. However, the social disgrace and failure associated with entering residential care has remained in the public mind, reinforced by periodic

scandals and poor quality of care and practice in some homes. There has been a continuing failure to give senior citizens a statutory entitlement to residential care and to tackle low standards in homes through adequate additional investment and a trained workforce.

To advance the insights achieved in the policy analysis, the next three chapters draw on the empirical material of the thesis. In these chapters, I examine the interpretation of the philosophical ideas that have defined 'good practice' in residential care from the perspective of residents, the staff and the residential home. Firstly, in Chapter Six, I explore 'good practice' from the perspective of the senior citizens expressing 'voice' about their quality of life as residents and how far they felt able to exercise independence, choice and privacy. In Chapter Seven, I examine 'good practice' from the perspective and understanding of staff in homes, by drawing on evidence of their time use to establish how quality of life aspects were addressed with residents. I look particularly at how ageist attitudes among staff led to the incorporation of keyworking and care planning, core components of 'good practice', into the process of physical care rather than being the means of promoting individuality of care and quality of life. In Chapter Seven I move on to looking at what 'good practice' means in the context of a 'hotel' approach to residential care implemented in a private residential home, comparing it with the statutory model. I argue that the 'risk avoidance' philosophy of the 'social care' model is a major impediment to implementing 'good practice' and compare it with the 'personal service' philosophy of the 'hotel' approach and its attitude to 'risk management'. I focus on the opportunities and constraints these two approaches to 'good practice' presented to senior citizens as residents striving to maintain their independence, privacy and freedom of choice.

Chapter Six - The Residents' Experience

Introduction

This chapter marks the start of the empirically based section of the thesis. In Chapter Two I argued that negative attitudes towards ageing, disability and poverty and ageist social policies can undermine the ability and determination of senior citizens to retain their independence by defining them as 'dependent' and 'in need of care'. In Chapter Three I argued that despite policy initiatives and changes in the nature of provision, underlying ageist policies towards senior citizens have consistently been to encourage independence from the state, to emphasise family responsibility and to offer statutory residential care as the 'last resort'. The result of such policies is that residential care is seen as stigmatizing and entry as a sign of moral failure. In Chapter Four I argued that definitions of 'good practice' in policy guidance have been confusing and contradictory, emphasising independence within a dependency model of ageing, reflecting ambivalence towards senior citizens and a continuing uncertainty about the objectives of residential care. Professional definitions of 'good practice' have been expressed as principles such as independence, choice and privacy, whose meanings are debated and contested within therapeutic or emancipatory models of care. In Chapter Five I was critical of my own quantitative approach in previous studies and showed that this methodology has reinforced ageist perceptions of senior citizens as 'dependent' and has failed to give sufficient emphasis to their views and experiences, as competent adults, of 'good practice' in residential care. I argued that senior citizens are not passive or uncritical in their views of 'good practice' in residential care, as they are often portrayed by ageist researchers and practitioners. I argued that,

given privacy and confidentiality for the disclosure of their views, they can be, and are, critical of poor practice and low standards of provision in residential homes.

In this chapter, I begin by arguing that we still know relatively little about the views of senior citizens living in residential homes and review the relatively modest 'consumer' literature. I then explore how 'good practice' was implemented in the homes I studied and experienced by residents in terms of their quality of life, using the concepts of independence, choice and privacy. My evidence is drawn from interviews conducted in two studies I carried out between 1982 and 1992 in which I conducted some five hundred individual interviews with people living in residential care homes and from ninety-one responses to a postal questionnaire to residents in the second study. I have already discussed in Chapter Five the reanalysis of these resident questionnaires undertaken as additional work for the thesis.

I draw on my data to argue that social workers implement their principles of 'good practice' in terms of a functional model of ageing that tends to see senior citizens as vulnerable and 'dependent' people who need to be cared for. Social workers do not, I argue, see senior citizens as independent adults, capable of exercising autonomy and choice despite their disabilities but as 'vulnerable' and 'at risk'. I draw on my interview data to argue that senior citizens' efforts to maintain their status as independent adults may be compromised by the actions, inaction or poor practice of professionals or relatives, resulting in their move into residential care. I describe the various routes my interviewees had taken into residential care, highlighting the influence of ageist attitudes and policies in determining a residential solution to their 'needs'.

I then move on to discuss people's experiences of 'good practice' as residents in the residential care homes I studied and how these differed from the principles of 'good

practice' set out in policy and practice documents, which I have already analysed and discussed in Chapter Four. In this chapter, I am using evidence from my interviews to argue that, although practitioners define 'good practice' in terms of promoting quality of life, ageist social attitudes and policies respond to senior citizens as 'dependent' people for whom 'care' and protection from harm should be provided. I argue that the focus of staff implementing principles of 'good practice' in many homes reflected these wider social attitudes. They saw 'good practice' as providing physical care to 'dependent' people, ensuring their safety and avoiding risk.

I argue that this focus is at variance with how most senior citizens see themselves and with what most of them want from residential care. Most people look for support and help from staff to maintain their *independence* – whether in functional or moral terms – while others wish to be able to be physically or emotionally dependent without being denied their status as adults (Boaz et al 1999, JRF 2005). I argue that this is something that is very difficult for staff to do because having 'dependency' needs flies in the face of the cultural definition of adult status, which is physical independence.

I discuss the meanings of independence to senior citizens and the constraints that poor design, location and lack of amenity in homes can impose on maintaining their functional independence. I consider aspects of organisational policy and staff practice that, I argue, can undermine or promote residents' independence in terms of their autonomy as adults and their quality of life. I argue that despite these constraints, senior citizens in the homes I studied acted to assert their autonomy or independence in subtle ways, such as ignoring or breaking house rules, 'keeping themselves to themselves' or opting out of communal activities that they disliked.

I discuss how far 'good practice' enabled residents to make informed choices in regard to residential care, the particular home, their accommodation and their daily lifestyle in the home. I discuss the importance residents ascribed to privacy in terms of having their own room, since this enabled them to maintain important personal relationships and safeguard their dignity and bodily privacy in such matters as personal care. I argue that lack of amenities and poor care practices can deny or undermine people's privacy. Finally, I discuss the importance to residents of having a social life in homes and their very varied views about the kinds of entertainment and activities they enjoyed or wished to undertake individually or as part of the resident group.

I argue that staff understandings and definitions of 'good practice' in residential care resulted in them implementing a definition derived from a functional model of ageing that defines residents as 'dependent' people, in need of care and protection from harm. I argue, from my data and other research findings, that this is the antithesis of how most senior citizens defined 'good practice' for themselves. I argue that despite a model of 'good practice' that constrained the amount of independence, choice and privacy that senior citizens could exercise in terms of their physical care, they could and did exercise autonomy, choice and privacy in many, subtle ways.

The service user's view

As I have already discussed in Chapter Three, British research and policy interest in residential care of senior citizens has been considerable over many years and particularly since the 1980s. (See Ward, 1980; Hughes and Wilkin, 1981; Thomas, 1981; Clough 1981; Bland and Bland, 1985; Sinclair, 1988; Bland et al., 1992; Phillips, 1992, Booth 1985, Peace et al. 1997, Reed and Payton 1997, Oldman and Quilgars 1999, Kellaher 2000, Tester et al. 2004). The focus of interest in the earlier

studies was often topics that were of concern to policymakers. Much of the research was commissioned policy research. Topics varied from preoccupations with the built environment and residents' interaction with it – a topic of great interest to policymakers for a number of years – to preoccupations with resident populations and levels of 'dependency' as well as philosophical and sociological considerations of homes as instruments of social control.

The first explicitly 'consumer' study of residential care for senior citizens was completed in 1982 (Willcocks et al., 1982), although most previous studies had included interviews with residents as part of their methodology to a greater or lesser extent. (See Townsend, 1962; Evans et al., 1981, Allen et al., 1983, Power et al., 1983, Booth 1985, Bland and Bland 1985, Weaver et al., 1985, DOH/SSI, 1989, Hughes and Wilkin 1987, Bland et al. 1992, Allen et al. 1992). The idea that senior citizens' views of residential services might be used as the yardstick of quality in provision has yet to be accepted, although senior citizens are now being consulted much more (see Raynes 1998, Boaz et al. 1999, Scottish Executive 2001, Hudson et al. 2005, Robinson and Banks 2005). I have argued that in the absence of agreed professional objectives for residential care, 'good practice' has been defined by policymakers in terms of minimum standards, which are applied by practitioners in the light of their professional principles and values. Compliance with these standards is through the mechanism of registration and enforcement, which is undertaken by independent regulatory commissions in England and Wales and in Scotland, set up under legislation, which I have already discussed in Chapter Four.

The consumer study of old people's homes, one aspect of which I have already discussed in Chapter Three, evaluated aspects of homes which influenced resident satisfaction, with a particular focus on the physical environment (Willcocks et al.,

1982). The recommendations of the research were intended to inform new policy

guidance to local authorities on residential home design. In the event, no further

design guidance was issued. One development which policymakers at the time

thought very promising – residents living in small groups (and which I have already

discussed in Chapter 3) - turned out to be less popular with senior citizens - only one

third of them favoured it. Staff also disliked the model because it was predicated on

supporting residents to be more independent, which, I argue, undermined the staff's

perception of their role as providers of physical care (Willcocks et al., 1987). Senior

citizens placed greatest emphasis on being able to exercise their physical

independence, autonomy and freedom of choice in their immediate physical and

social environment (Willcocks et al., 1987).

I argue that, after decades of research information about what researchers,

professionals and policymakers think 'good practice' residential care should be about,

information about senior citizens' opinions of residential care is now gradually

increasing. In one study, senior citizens living at home and senior citizens living in a

home had different priorities for residential care (Counsel and Care, 1992). Non-

residents put greatest value on their quality of life by retaining their individual

freedom, having company and visits from family and friends (p.12). People already

resident in a home placed greatest emphasis on the quality of care received from staff,

the physical comfort of the home, its régime, and company (Counsel and Care,

1992:12). The Caring in Homes evaluation (Youll and McCourt-Perring, 1993),

aspects of which I have already discussed in Chapter Three, found that all people

using residential care judged its standards more by the quality of relationships and the

general climate of the place than in terms of the physical resources (p.159). Given the

heterogeneity of senior citizens, I argue one would expect a wide range of opinions

and priorities. However, much of the literature has tended to report more about peoples' reactions to the service currently provided than evidence of what they might prefer. In a more recent study of people's quality of life priorities should they need social care services in the future, respondents put high value on maintaining their independence and freedom of choice in the services they received (CSCI 2004).

Meanwhile, 'good practice', in its many definitions, already discussed in Chapter Four, continues to be promoted by professionals and policymakers and other 'experts', still largely uninformed by the views of the people who are using residential care (see Beresford 2001:507).

The *Caring in Homes* evaluation (Youll and McCourt-Perring 1993) explored good practice, quality of life, and quality of service with staff and 'wherever possible with residents themselves' (Youll and McCourt-Perring, 1993:5). As I have already discussed in Chapter Four, the authors had difficulty gaining access to individual residents to elicit their views. Care home managers and staff were cautious, some even refusing to allow residents to be invited to participate in the research (see also Abbott and Fisk 1997:10 who found some organisations 'over-protective' of their residents). Residents did not have the opportunity to decide for themselves whether to be interviewed or not. The researchers were told a number of times – in relation to senior citizens and people with learning disabilities in particular – that the residents would have nothing to contribute or that they would not understand (Youll and McCourt-Perring 1993:9). Most residents had experienced 'restrictions, frustrations and difficulties' in residential care which eroded their rights as citizens and 'fell short of a reasonable quality of life', across all service user groups. People using residential services described a 'general absence of feeling valued and special' (Youll and McCourt Perring 1993:158).

Senior citizens using residential care have only recently begun to be openly critical or demand a greater say in what is provided for them (see Rees and Wallace, 1982; Youll and McCourt-Perring, 1993, Youll and McCourt-Perring 1999, Audit Commissiion 2004, Hudson et al. 2005). It is young people in care (Page and Clark, 1977), people with a learning disability (CMH, 1972 and 1973a, in Fisher, 1983; Ryan and Thomas, 1987), users of mental health services (Chamberlin, 1988; Survivors Speak Out 1993) and adults with physical impairments (Glampson and Goldberg, 1976; Oliver, 1990, Devenney in Kelly and Warr 1992, Campbell and Hasler 2001) who have led the way in demanding a more equal relationship with social services and social work. Early initiatives for the empowerment of senior citizens in residential care tended to come from service providers through such strategies as charters of 'residents' rights' (Norman, 1980) and 'residents' forums' (Flowers, 1983). Now National Care Standards give residents the right to a written agreement setting out the terms and conditions of their residence and their occupancy rights (Scottish Executive 2001). However, I argue that these rights are still disregarded in some homes. Many senior citizens in UK care homes do not know if they have a written contract or statement of terms from the home (OFT 1998, 2005). Over a third of care home residents in Scotland do not know how to raise a complaint (Care Commission 2004:23).

As the framework for my analysis, I used the six principles[5] identified by the Social Services Inspectorate (DoH/SSI 1989) said to underpin quality of life 'for most people' (p.16), adopting a rights based, citizenship approach (see Morris 1993:32, Youll and McCourt-Perring 1993:195). I have focused particularly on three of these principles, namely independence, choice and privacy since these are highly valued by

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[5] The six values identified were privacy, dignity, independence, choice, rights and fulfilment (DoH/SSI 1989).

senior citizens themselves as well as being principles of professionally defined 'good practice'(Sinclair 1988, NISW 1988, Wagner 1988, Allen et al. 1992, Kane et al. 1997, Henwood and Waddington 1998, CSCI 2004). I argue that it is the anticipated loss of their much prized independence, freedom of choice and privacy that makes the majority of senior citizens reluctant to consider residential care (Salvage et al. 1989, CSCI 2004).

I argued in Chapter Two that the social construction of independence in the narrow terms of functional independence in health and social services has a disabling effect on people with disabilities, including senior citizens. I argued that senior citizens who unable to meet the medical goal of functional independence risk being labelled as 'dependent' and deemed incompetent to manage their lives (see Hudson et al. 2004, Audit Commission 2004, Robinson and Banks 2005). I supported Oliver's argument that independence is a broader concept than functional ability and encompasses autonomy, since impairment does not necessarily prevent a person's right or ability to make choices, decisions and to be in control of their life (Oliver 1993:54).

In this section, I have argued that although much previous research into residential care had included interviews with senior citizens, most studies have not focused on senior citizens' views as consumers of residential care. The social construction of them as 'consumers' of social services has led to a growing interest in finding out what senior citizens think about life in general and about life in residential care homes. I argued that there is still much about senior citizens' attitudes to residential care that we still do not know. I set out my own framework for analysing senior citizens' views of residential care, which is the investigation of how the implementation of 'good practice' by social workers and social care staff promotes the independence, choice and privacy of residents.

Independence or dependency?[6] *the key roles of professionals and relatives*

I have already argued that the right of senior citizens to their adult status and independence is compromised by negative attitudes to ageing, poverty and disability even before they move into residential care (see Audit Commission 2004, Hudson et al. 2005). Perceived as 'no longer adults', I argue that they have been ascribed a passive and dependent social role.

I argue that there is a strong belief that people moving into residential homes are an increasingly disabled population. With the continuing contraction in NHS long stay beds, people who would previously have been in continuing care wards now tend to be cared for in residential or nursing homes. Although the proportion of very physically or mentally disabled residents varies between homes and between sectors, significant proportion of people in most residential homes are still relatively functionally independent. (See Netten et al. 1998:48 where half the people admitted to local authority homes, 60% of those admitted to voluntary homes and just over half admitted to private homes were functionally independent or minimally dependent).

Our first research study (Bland and Bland 1985) found just one quarter of residents had very high levels of disability. The second study (Bland et al. 1992) found the same proportion of very disabled residents in homes in 1991. Although there were significant variations between the sectors in the proportion of very disabled residents, the level of disability in local authority homes in the two time periods was virtually unchanged. Booth (1985) who found similar results in his survey, also argued that the salary differential between classifications of local authority homes gave staff an

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[6] In this context, I am using Oliver's (1993:50) definition of dependency as 'the social construction of disability as a particular kind of social problem'.

incentive to magnify the infirmity of their residents and intensify concerns about 'rising' levels of 'dependency' (p.55).

The numbers of people who are going into care homes with some degree of cognitive impairment is increasing but a higher proportion of people in residential homes are depressed – 'as many as one third of residents in homes in Britain' (Murphy 1993. See also Llewellyn-Jones et al. 2001 who found depression in 27% of people living in residential care in an Australian study). I argue that this fact is not given the same prominence in the literature as dementia. Depression, I argue, seems to be regarded as a 'normal' part of the individual ageing process rather than a symptom of what is wrong with the social treatment of later life (Loo et al 2004, McCrae et al 2005). This, I argue, is further evidence of application of the pathologized model of ageing already discussed in Chapter Two. I argue that the higher chronological age at which people are going into residential care is too simplistically equated with higher levels of impairment. This is not always necessarily the case, as analysis of our voluntary home sample in the national study demonstrated. Residents were older but not necessarily more impaired (Bland et al. 1992). However, I argue that physical or functional independence is but one aspect of independence. Where the older person has relied socially, emotionally or cognitively on someone else, and this support is withdrawn, I argue that this renders them liable to being seen by professionals or their relatives as 'vulnerable', 'unable to cope' or 'at risk' and therefore 'in need' of residential care.

I argue that in order to put people's reactions to 'good practice' in residential care as residents into context, it is essential to understand the very varied backgrounds to their move and the way in which their independence became compromised. The people I interviewed in my two earlier studies had come into residential care through four

main routes; from their own home, from the home of a relative, from acute or long stay hospital, or from another residential or nursing home. The reasons for their moves varied but were not necessarily primarily due to poor physical or mental health. It was the person's social circumstances rather than their health that were more influential in determining their move into care. The availability or otherwise of family support was crucial. A small minority of people had come into care because they had been rendered homeless by relatives.

The largest single group, but not the majority, came into care from their own home, where they had lived alone, usually for a number of years. These people had remained independent with increasing difficulty, often because of a multitude of long-standing health problems, some of which, such as arthritis, had made them increasingly disabled. The vast majority of this group were women, a proportion of them single, divorced or widowed and childless. A sizeable proportion of them said they had applied for care on the advice of their general practitioner, with whom they had had prolonged and increasing contact. Where people had become gradually less and less able over a period of years and had been receiving increasing amounts of help from family members, a proportion of them had decided that rather than move to live with relatives, they preferred to be cared for in a residential home.

My interviewees varied markedly in the amount of formal services they had been receiving at home before their move into a residential care home. One third of those interviewed had been getting the maximum home care assistance available at the time of five days a week, while a further third had not been in receipt of any formal services. Less than one in five people admitted from a relative's home had been receiving a home care service there. This lack of support to relatives was important, because they were very influential in suggesting or in some cases 'pushing' the older

person to consider a move into a residential care home, particularly if the relative, typically a daughter, had been previously providing most of the support. (See also Neill et al., 1988, Allen et al. 1992 on local authority home admissions; Corden 1990 and Phillips 1992 on the influence of relatives in admissions to private residential homes; Office of Fair Trading 2005).

I argue that relatives were even more influential over the residential care decision where the senior citizen had given up their own home to co-reside with them. This move had often been at the son or daughter's suggestion, occurring typically on the death of a spouse. Nearly a quarter of all the people interviewed in the first study had come into care from the home of a relative. The reasons given for the arrangement breaking down varied from overcrowding to personal antipathy or disagreements about money. Often, it was a question of inadequate accommodation. Compromises made in a crisis by various family members, such as grandchildren sharing bedrooms, had become irksome or untenable over time.

In some cases, pre-existing poor relationships between sons-in-law or daughters-in-law and the senior citizen and living in close proximity for perhaps a longer period than was originally envisaged, renewed tensions. Sometimes the senior citizen admitted their previous disapproved of their son or daughter's marriage partner, not infrequently on sectarian religious grounds.

Some people blamed financial matters as another source of disagreement with relatives. Some interviewees felt they had been asked to make a disproportionate contribution to the running costs of the home or had been resistant to contributing all of their Attendance Allowance towards their upkeep.

A few senior citizens said they had sold their house and given their child or children the proceeds on the understanding that they would be cared for until they died. When the arrangement had broken down, the older person was not only homeless, but was also without the financial capital or the emotional energy to buy themselves somewhere else to live, and said they had no alternative but to accept residential care. These people were in a minority but they expressed some very bitter and unresolved feelings of betrayal by their relatives and appeared devastated by what had happened.

Sometimes conflicting inter-generational loyalties were given as reasons for the cessation of care and support. For instance, Mrs. W. had lived with her widowed daughter for many years, helping to raise the grandchildren. She went to stay with a son for a holiday and returned to find that a granddaughter whose marriage had foundered had moved back into the maternal home with her children. In these circumstances, the kin relationship between adult child and grandchild took primacy. The grandmother was rendered homeless and admitted to residential care as an emergency.

Similarly, co-residence of adult children with senior citizen parents in the parental home, I argue, was a 'risk' factor for residential care. A minority of senior citizens interviewed had taken adult children and their families into their home, often in an emergency, such as redundancy, eviction or house repossession. The elderly parent had given the house or assigned the tenancy to their adult child and had subsequently been evicted by the family, rendering them homeless and sometimes penniless too. In these cases, the senior citizens had experienced a double blow, losing a close, perhaps their closest, family relationship as well as their home.

Sometimes illness or exhaustion of a relative or spouse meant the senior citizen could no longer receive the care they needed. This was particularly true where the person

had developed dementia, according to case records. Some caring relatives had decided to move to live nearer a married child or sibling, and the caring arrangement had been terminated. A small number of bachelors in the homes described a characteristic pattern of support from a succession of female relatives following the death of their elderly parents. Sisters, sisters-in-law and nieces had successively provided them with a home for a number of years until finally, the supply of carers was exhausted and rather than set up home on their own, the person had applied for residential care.

A major route into residential care for senior citizens is, I have already argued in Chapter Two, via hospital. Just over half (52%) of residential care home admissions are now from hospital (OFT 2005:24). A sizeable proportion of residents (one third in the first study, just under a quarter of interviewees in the second study) had moved into the home straight from hospital. These people had mostly been admitted in an emergency, typically following a stroke or a fall, sometimes resulting in a hip fracture. Their move into care was therefore unanticipated and unplanned.

'I was in hospital because I broke my femur. I have osteoporosis. Then I went to A. for rehabilitation. My GP recommended this home. I looked at several. I saw one home with very small rooms'. WP6F.

A 1995/6 Personal Social Services Research Unit survey showed 18% of local authority, 16% of voluntary and 24% of private residential home admissions were from hospital (Netten et al. 1998:45). People in my previous studies who had lived alone, and particularly people who had no family support, had been assessed by social workers as 'needing' long stay care. They had not been offered additional formal support at home if they had only made a partial recovery, were left markedly impaired, or if their home was judged to be no longer suitable for them.

Other people had been admitted to hospital for 'social' reasons, such as the sudden death, illness or hospitalisation of the carer (particularly a spouse) on whose help they had depended, such as Mrs. S., a childless widow, who lived with her sister. She had developed dementia and was on the waiting list for psychogeriatric care. Her sister dropped dead one day while out shopping. An old friend stayed with Mrs. S. for some weeks until she was eventually admitted to residential care.

Yet others were hospitalised because they said they had become depressed. They had neglected their appearance or had failed to eat properly or care for themselves because their relatives could not or would not support them any longer. Not infrequently, the depression had occurred after a spouse died or other close relative such as an adult son or daughter, or a sibling. Mr. W., a widower with five adult children, who lived alone became depressed and began to neglect himself. He said he found running a house too demanding and he finally applied to a residential home where he hoped to find 'security and companionship'.

Some people had been in the care 'system' for a long time before moving to a residential home. Typically, they had been moved out of local long stay psychiatric hospital, learning disability hostel or hospital, sometimes after many years, due to improvements in their health, in drug treatments, changes in health or social policy or because they had reached statutory retirement age. For these people, the home represented an improved quality of life, after retiring from working in the hospital laundry or kitchen and gaining a room to themselves for the first time for many years. These residents were well settled in the home, presumably because they were used to communal living and as most of them were usually quite a bit younger than other residents and physically fairly fit, they mostly enjoyed greater freedom to come and go than they had previously.

Some of the women in this group had originally been institutionalised by their parents under mental health legislation for social reasons, namely because they had an illegitimate child, rather than because of a learning disability or a mental illness. A few people interviewed said they had chosen to move out of private or voluntary residential homes into a local authority home because they had been dissatisfied with the service provided, or had moved to be nearer relatives.

I argue that my interviews show how people's independence had already been undermined by a variety of circumstances before moving into the residential home. Firstly, where their independence relied on assistance from relatives which was precarious, a breakdown in the relationship or the health of the carer could render the senior citizen dependent on formal care, which was residential care. Secondly, independence was likely to be lost where health professionals' application of 'good practice' assessed them as 'dependent', unable to return home from hospital because of their levels of physical or mental frailty and the unavailability of suitable housing or support services. In a few instances, the older person themselves had decided that they no longer wished to remain living independently for various reasons, and knowingly traded their independence in order to be 'looked after' or 'cared for'.

> 'I didn't look at other homes – I was in N. hospital – the specialist suggested a home to me but I said no and went home. I was back in again in a month. The social worker brought a list of homes. B. was the nearest to my home. I didn't fancy another winter on my own' BVF1.

Some people, who were very disabled and could no longer manage to live alone, had decided to move into a home rather than live with a son or daughter in order not to be a further 'burden' on them. The levels of formal service support to people when at home had, for the most part, been non-existent or relatively low (see also Sinclair

1988). Only a minority of people said they had been getting help at home for up to five days a week.

I argue that the senior citizens interviewed in my research were almost all unprepared for life in a residential home. Few had visited before becoming residents (see Salvage 1989, OFT 2005), despite pre-admission visits being regarded as 'good practice' in social work (see Brearley et al. 1982) and did not know what to expect. For many people, the reality was a shock, not least, once they realised that their own home was gone. Most were not prepared for the loss of independence and control over their lives and the pervasiveness of the care environment. However, having moved into a residential home, people did not want to move again. They were quite clear that it was 'not like your own home', which had been given up, lost or relinquished by the time of the interviews. They nevertheless feared further involuntary moves elsewhere to a nursing home or hospital, if they became too frail for the home to care for them or their funds ran out (see Power et al., 1983, Abbott and Fisk 1997, Office of Fair Trading 2005:128).

I argue that the residential care home had become the person's *de facto* home and having accepted this they expected and hoped to end their days there. This resulted, I argue, in people taking a much broader view of the home, namely as a place to *live*, rather than as a place to stay briefly while receiving treatment, as in hospital. I argue that this was a quite different focus from that of staff. The *raison d'etre* of the home as far as the staff were concerned was much narrower, namely to provide physical care. Physical care tended to dominate staff priorities and activities and the way the home was run, although it only made up part of the residents' daily lives (see also Willcocks et al. 1987:130, Peace et al. 1997:117, Youll and McCourt Perring 1999:379).

In this section, I have discussed how the social construction of ageing as 'dependency' undermines many senior citizens' efforts to remain independent and puts them 'at risk' of being moved into residential care involuntarily. I also identified the minority of people who have actively chosen to move into residential care and their reasons for doing do. I argued that there are four different routes by which people may find themselves in residential care, pointing out that half of all admissions are now from hospital. I argued that relationships with relatives and the actions of professionals are extremely influential in decisions about senior citizens moving into residential care.   I argued that social as well as medical reasons lay behind most people's admission, in particular, the unavailability or collapse of people's informal support, combined with a degree of disability, and limited formal 'community care' services.

In the next section, I move on to discuss how senior citizens aimed to maintain their independence as far as possible when they became residents and how this could be frustrated by the physical environment and the understandings and implementation of 'good practice' as physical care and protection, by staff.

Maintaining independence as a resident

I argue that when senior citizens talked of their fear of losing their independence by moving into a residential care home (Salvage 1986, Counsel and Care 1992, Hayden et al 1999), they were not talking about their functional independence but the broader meaning of the word. Their meaning, I contend, was in terms of their ability to remain in control of their lives, as autonomous adults (Harding 1997 in Harding 1999:43). Likewise, when professionals and disabled people talk about 'independence' as a goal they are not talking about the same thing (Oliver 1993). Professionals tend to define independence purely in terms of an ability for self-care

without assistance (Oliver 1993, Fine and Glendinning 2005), whereas disabled people have defined it more broadly as 'the ability to be in control and make decisions about one's life' (Oliver 1993:54). Senior citizens see living in their own home as an integral dimension of their independent self and the means of retaining their sense of personal integrity (Sixsmith 1986, Hayden et al. 1999, Secker et al. 2003). For these senior citizens, independence means being able to do what they want, to do things for themselves and not being beholden to anybody (Sixsmith 1986, Hayden et al. 1999), irrespective of disability. There is evidence of staff uncertainty about their role in relation to residents and their independence. In one study, promoting resident 'independence' within a functional model of ageing as 'dependence' was understood to mean the need to be 'keeping people going physically, irrespective of what they wanted (Dixon 1991:91) rather than allowing their right to autonomy and self-determination. There is evidence that staff are unclear about the job they are required to perform and have difficulty in understanding and implementing the philosophical shift away from a medical model of long term care towards a social model that emphasises respect for residents' values and preferences (Moniz-Cook et al 1997, Eales et al 2001).

I argue that the research literature on residential care homes has tended to focus on a number of key aspects when discussing the functioning of residential. Analysis has tended to concentrate on the physical and cognitive 'dependency' of the resident population, the suitability of the buildings, the lack of staff training and the attitudes and behaviour of staff (see Townsend 1962, Davies and Knapp 1981, Booth 1985, etc.) Why some staff behave in the ways that researchers have observed and commented on has been variously interpreted (see Clough 1981, Davies and Knapp 1982, Willcocks et al. 1987, Dixon 1991, Peace et al 1997). I argue that what is

crucial to residents' experience is not only *what* staff do or do not do when assisting them but also *how* they provide the assistance. In other words, the beliefs and attitudes of staff about ageing and senior citizens and the nature of their task influence staff behaviour towards residents.

In my research, I argue that residents' independence was influenced by their degree of disability and the design, location and facilities provided by the home, as well as the attitudes and behaviour of staff. Residents' impairments, their attitude to them and the design of the building had a profound effect not only on their functional independence but also on the degree of autonomy they enjoyed. The design of recently built, single storey, grouped unit style homes was more likely to enable residents to be physically independent. Some homes built in the 1960s were multi-storey, presenting disabled residents with barriers to movement between floors and dependent on staff to assist them. A design feature of these homes was long corridors separating bedrooms and bathrooms from daytime accommodation. Residents found these corridors, steps and stairs and the lack of ramps made it difficult for them to move about the home independently. The tendency was for them to be escorted to the lounge by staff for much of the day rather than return to their room because of the distance involved or because of the need for staff assistance to do so. Older, adapted homes in former private houses presented people with similar difficulties, particularly small homes on several floors. Respondents to the postal questionnaire wanted homes to be more compact, so that long corridors did not act as barriers to their mobility and therefore their independence. Residents were critical of the call systems in some homes on grounds of insufficiency of call buttons or cords or because the system only operated in one part of the home. I argue that residents highlighted aspects of the

homes that militated against them maintaining their functional independence, privacy and self-respect.

One aspect of individual control in residential care homes investigated by the first consumer study related to heating and ventilation in residents' rooms (Willcocks et al. 1987). What constitutes a comfortable level of heating and ventilation is a very individual matter. Senior citizens who have difficulty with their mobility or who spend much of the day sitting still are more likely to feel the cold. In my postal survey of residents, three quarters of them said they were satisfied with the heating in the home. Heating in the case study homes varied considerably. Several residents in one home found the heating hard to regulate and sometimes it was too warm. Residents of another home who complained that they frequently felt cold in the lounge thought the offer of knee rugs by the home owner was an inadequate response. Several residents in this home felt that it was not kept warm enough.

I argue that respondents to the resident survey emphasised 'hotel' rather than 'care' aspects of homes that they wanted to change, pointing out more faults with the building than any other feature of home life. The features they identified were aspects of the building that limited or undermined their functional independence and their privacy. Above all, people who shared a bedroom wanted single rooms to be provided for everyone - a demand echoed by their relatives and residents in innumerable other studies (see Willcocks et al. 1987, Sinclair 1988, Counsel and Care 1991, CSCI 2004). Some people had to wait a considerable time, probably for the death of another resident, before getting a room to themselves.

'I shared for over a year. I've had my own room for the past six weeks. I don't think I knew I'd have to share' BLA1F.

Others, forced to share with an uncongenial person had their independence of action compromised.

'I don't believe in shared rooms. I find my room-mate aggravating' CV2F.

People in residential homes also wanted to be able to control ventilation (Willcocks et al. 1987). A quarter of respondents to my survey could not open their bedroom window, several of them blaming this on their own impairment, rather than defects with the window. Adapted homes often had sash windows that were heavy and difficult to open (see Weaver et al. 1985), so were less than ideal for people who were disabled and who were therefore dependent on staff to open and close windows for them. People in the 'consumer' study rated having windows that they could open themselves second out of a list of thirty-five desirable architectural features of homes (Willcocks et al. 1987).

In this section, I have discussed how physical constraints and their own disabilities challenged residents who tried to retain their functional independence in residential homes. The next section looks at how administrative and caring practices could undermine residents' status as adults and their ability to act autonomously and retain control over their lives.

Independence as autonomy

Autonomy has been closely linked to adult status and independence in terms of freedom to act and be responsible for oneself (Hockey and James 1993). McCormack (2001) has argued that there is a conflict between this individualistic understanding of autonomy and 'person-centred practice'. She argued for an alternative view of autonomy based on 'interconnectedness' as a framework for negotiation between nurses and patients over care decisions (McCormack 2001). I have already argued

that when senior citizens move into residential homes they may already have had their adult status eroded, particularly in terms of their autonomy. This is illustrated in areas of life where adults usually act autonomously, such as controlling their money and financial affairs, their medicines and their smoking and drinking habits.

In my first study, a high proportion of senior citizens had surrendered their financial autonomy by handing their pension books to the local authority on taking up residence and received their 'personal allowance' (previously known as pocket money) from administrative staff weekly, in a brown pay packet. In my second study, one or two people expressed resentment in the postal questionnaire responses that the personal allowance was so small (less than twenty pounds per week). This made it impossible for them to maintain the leisure activities that they had previously enjoyed, such as smoking, going out to the pub or going on holiday.

'I missed out on holiday this year because of lack of funds' BLA5F.

The responses from some people about their financial situation were clearly incorrect and raised questions about possible mismanagement of people's funds by homes.

'Mr. C (proprietor) holds my money for me. I don't get a personal allowance'.NP2F.

A respondent to the postal questionnaire expressed concerns that the home owner held the personal allowance on behalf of some residents but was not accountable for how it was spent. Another was unhappy about the owner's management of his pension.

'Many of us here have handed over our pension books to the owner who makes the withdrawals every week so we don't know wher (sic) we are regarding what we are paying etc. I feel that each resident or his relatives should receive a monthly or yearly statement' WP3M.

I argue that no-one interviewed appeared to have challenged the request to relinquish control of their finances, whether to the home owner or the local authority. There did not seem to have been any choice but to agree. I argue that the failure of many homes to provide locks on bedroom doors or lockable storage within bedrooms made it difficult for residents to retain possession of their money with confidence.

> 'I was asked to give my pension book (to the home). I get my personal allowance in an envelope'. CV6F.

Some residents deemed unable to manage their own money had part or all of the personal allowance held by the home on their behalf, staff buying toiletries and other sundries for them as needed. As I have already discussed, a few people had their finances managed by their solicitor or a family member, as in the second study. A few people remembered getting a letter notifying them of the charges. Residents varied in how far they were aware of or fully understood the financial implications of moving into residential care (see also OFT 2005). I argue that there was some evidence that if they had known beforehand, some interviewees would have been resistant to the move.

> 'They asked to see my bank books. I had no letter saying what the charges would be in advance. I would have been resistant if I'd known'. ALA1F

Some people remembered being told what the charges would be. Some people had no idea what their care was costing or how it was being paid for. Relatives had often taken over management of their financial affairs for them and one resident had adopted a 'just trusting to luck' attitude. A high proportion of local authority home residents who had relinquished control of their finances was no longer concerned about the costs of care. A few male residents, who had an occupational as well as a

state pension expressed resentment that their care was costing so much, leaving them with little money for themselves.

I argue that another adult activity which is often constrained in residential homes is smoking. Residents who thought there were no rules in the homes where they lived were immediately able to identify that there were rules after all when asked about smoking. Most homes restricted smoking to one or two rooms only and all but one home forbade it in residents' bedrooms. During the interview visits in the second study, I encountered three very different attitudes to smoking in homes. Residents could not smoke anywhere inside one home and were told to use the summerhouse (a wooden construction in the garden). At the time of the research visit, a new resident in this home had just broken the home rule by smoking in her bedroom, accidentally setting her waste paper bin on fire. In another home, a male resident who was paralysed down one side after a stroke was not allowed to have matches or a lighter and was dependent on staff when he wanted a smoke.

'I'm not allowed matches or lighter – very aggravating. It makes me feel so useless. I had a first stroke and then my wife died. She was better off than I am. Life has nothing to offer me, nothing.' NP6M.

This man conveyed his sense of frustration by hitting out at staff with his stick but during the interview he wept. In the case study private home, residents did not have rules about smoking imposed on them because the home owner had taken advice from the local fire master and had instituted a number of measures to minimise the risk. Only in this home were residents able to smoke where they wished. I discuss this home's relationship with its residents further in Chapter Eight.

I argue that staff attitudes to alcohol use by residents also varied among homes. Some homes tended to store a bottle of sherry or whisky in the manager's office for individual residents, who could ask for a drink when they wished. Some residents kept their drink in their rooms. Male residents who were able went out to the pub, when they could afford it. Sometimes home staff organised sherry and singsongs at the weekend, or offered a drink before Sunday lunch or in the evening. Birthdays and public holidays were usually occasions for a cake or offering a drink to residents. Many residents mentioned special celebratory parties at Christmas and one home 'allowed' residents to invite two guests each to lunch on Christmas Day.

In the second study I attempted to discover how far residents felt their autonomy in the home was impeded, by asking them about rules and regulations. When asked what rules and regulations applied in the home, one resident, a veteran of fourteen years' living in various residential homes replied,

'I don't know because I am so used to homes. I don't do anything I shouldn't, I know' CV2F.

I argue that most of the rules mentioned by residents put limits on their autonomy as adults. For instance, one rule volunteered by a resident concerned limits to watching television.

You're not supposed to have the television on after 10 p.m. I watch the late film, provided I keep the sound down' CV3M.

Other residents were less compliant or admitted that some rules were often breached.

'You're not supposed to smoke in your room but I do. I haven't been caught yet' BLA6M.

I argue that this is an example of how, despite the over-protectiveness of staff practice in some homes, residents still managed to assert their independence, albeit in subtle, inconspicuous ways. Some interviewees in homes that used coffee or alcoholic drinks in the lounge as inducements to residents to socialise more with each other said they deliberately stayed away. Others avoided communal activities such as 'sing-songs' by going to their room. Others boycotted staff/resident committees, regarded as 'good practice' because they enabled resident participation in the running of the home, seeing them as tokenistic and pointless.

'It's a load of rubbish – I was on it before. The meetings only last ten to fifteen minutes! BLA3M.

Another resident thought there were rules about not helping others.

'You're not supposed to help residents into their chairs – but it's [the rule] often broken. The fire doors are kept open and they shouldn't be' CV4F.

One resident, untypically, was able to cite three house rules without hesitation.

'You must be in the lounge for morning coffee – you don't get it otherwise. No smoking in the house at all. If you're going out you leave a card in the hall to say so' BV2F.

A respondent to the postal questionnaire in one home was critical of the authoritarian manner of a senior member of staff, which she implied, intimidated residents.

'The attitude and manner of the assistant matron …left a lot to be desired. This affects quite a few of us who, unfortunately, are afraid to say anything' CVF15.

This section has argued that the focus of 'good practice' on safety and the avoidance of risk undermined residents' adult status and could prevent them retaining control over their lives and pursuing normal, adult activities. I also argued that some

residents still acted, within these constraints, to assert their adult independence, in subtle, inconspicuous ways. I argue that staff attitudes and practices, particularly with regard to activities such as smoking, increased rather than reduced the likelihood of serious consequences, a matter that I shall pursue further in Chapter Eight, in relation to the case study private home.

The next section examines the reality behind the 'good practice' principle of choice for senior citizens about entering residential care and the social constraints that can prevent it being a 'positive' choice. I then discuss the extent of choice available to people as residents.

The lack of choice

'Homes are for Living In' (1989) defined choice as the 'opportunity to select independently from a range of options' (p.16). I have already described the route into residential care taken by people whose independence, I argued, became compromised by deteriorating health, homelessness or the loss of support from relatives. I now discuss how far this move was the result of individual informed choice of a particular home or was taken in the knowledge of possible alternatives. Later, I discuss the evidence from the interviews of daily choices withheld or available once people had moved into the residential home. These included evidence of 'good practice' principles being implemented in a way that allowed residents a measure of self-determination about basic matters like when to get up or go to bed, or go out. The Wagner Committee (Wagner 1988) recommended that people needing assistance in caring for themselves should 'be able to exercise a positive choice over the combination of accommodation and personal services which they require' (p.26). In order to make such a choice the Committee realised that people would need adequate

information about their options and realistic alternatives to choose from (Wagner 1988:26. See also Audit Commission 2004, OFT 2005).

The majority of people I interviewed felt there had been no other option but to accept residential care, albeit very reluctantly in some instances. Only a minority of people in either study had made the choice themselves – more of those people who had been living at home than those who had been in hospital. *Caring for People* (DHSS 1989) and the subsequent NHS and Community Care Act (1990) emphasised the centrality of senior citizens' involvement in the assessment of their needs. The service response was supposed to reflect the person's needs rather than the availability of a particular service. The person was to be given a choice of care home, if that was to be the solution to their needs. The same emphasis on choice was not extended to people who, although assessed as needing residential care, wished to be supported to stay at home, although there are now signs that this may be changing (Department of Health 2005).

Our two research studies were carried out before the Community Care legislation was fully enacted in 1993, so the philosophy of needs-led rather than service-led responses had not yet been articulated in policy documents. When the earlier study took place, the independent sector was small and most residential care was provided by local authorities. A small minority of people interviewed had chosen their particular home in anticipation of growing frailer, applying for a place before the home opened.

Most people said they had not chosen the home where they were living and for some, particularly those people who had been admitted in a crisis or from hospital, they were sometimes 'put' into a home in an unfamiliar area, which caused difficulties for them and for their visitors.

The mixed economy of care was well established by the second study and there was some small evidence of choice, in that four of the people I interviewed had visited at least one other home before making a decision. However, for most people, I argue that there was no choice, because they lived in an area where there was only one local home, or there was only one vacancy when they needed care. People who needed local authority help with private or voluntary home fees were theoretically offered a measure of choice, albeit restricted by the locally approved fee level and the availability of a suitable vacancy when needed. Most authorities were reluctant to pay fees to an independent sector home if there was a vacancy in their own residential homes.

For self-financing people who had been in hospital, a relative had often looked at a number of homes on their behalf and then taken them to see the home they thought most suitable.

> 'I was from F. originally but latterly lived in D. I was in hospital in D. My niece who lives here in C. is my only relative. She told me I was to go into a home and she fixed this home.' WP3F.

Sometimes the move was suggested by relatives when the formal support provided was no longer enough to meet the person's needs.

> 'My niece and sister suggested a home to me. My niece got brochures. I had had home help five days a week and an hour on Saturday and Sunday but it wasn't enough. I looked at one other home – I forget the name. I saw B. first and preferred it. I came for the day and then for a week. The lovely garden and nice house sold the place to me'. BV5F.

For some of the most disabled residents, or where the move had been in a crisis, such as being rendered suddenly homeless, even this initial visit had not been feasible and they had come straight from hospital or home.

> 'I fell out of bed one night and lay until neighbours came in next day and then I was in hospital in O. My son made the application for me. I was fortunate to get in here' ALA6F.

In a study of private residential care, when a close relative had chosen the home for them, the senior citizen usually felt that the choice made reflected their own wishes and tastes (Phillips 1992).

Despite the rhetoric, I argue that most people in my studies had not been able to exercise choice either about whether or not to move into care, or about moving to a particular home. The extent to which this was a source of grief to people varied. Once the major decision had been made to move into a home, which home that was apparently seemed less important for most people. Very few people in residential homes moved back into their own home again. During the first study, only two people moved out of residential care other than by hospitalisation or through death. One person married and the other secured himself a sheltered housing tenancy.

I argue that most senior citizens moving into residential care do not know what to expect of homes because they have little or no information beforehand (OFT 2005). Location is an important factor in choosing a residential home, particularly its proximity to friends, family or the individuals' previous home (OFT 2005:56). Several of the homes in my studies were in rural areas where people often opted for the one, local home.

'I lived in the village. My husband managed the pub. My family urged me to come in. I came in right away. I had to make the best of it.' NP2F

Some people initiated the application for residential care themselves.

'I didn't look at other homes because I am a local. I have family here but I wouldn't stay with them. I wanted to retain my independence. I heard it was quite nice. I knew some of the staff well enough to find out about it [the home]. I didn't try it out. I applied and got in quite quickly, only a few weeks. I didn't like staying alone. I was lonely. My four children are all married. It's a homely place. I knew some of the residents as acquaintances in the street only.' ALA2F

Others, I argue, were directed by professionals, such as their GP, towards a particular home.

'I lost my husband six years ago. I couldn't stay on my own because of my nerves. I didn't look at other homes. Dr. W. [her GP] said I was to come here'. BLA4F

'I was bulldozed into this. I was living in sheltered housing in P. My GP decided on this home – I wanted to be independent. I used to work in hotels. I got the sack from a family run hotel when I was seventy-two. At first it was terrible. I am accustomed to younger people' CV3M.

In another case, the choice of home was made by a social worker.

'I didn't look at other homes. I came for two weeks against my will, a bit. I went home for another six months or so. I had a home help latterly. Previously I was able. I suppose it's their job. You make yourself sociable' ALA3F.

Although it was 'good practice' for social workers to assist potential applicants to visit residential homes before moving, or for home staff to visit applicants in their own homes (see Brearley 1982), few of the people I interviewed had visited or been

visited before their move. Not only had most people not looked at other homes, most

of them had not previously contemplated residential care. Most people had not seen a

brochure or any written information about the home they moved into (This is still

true. See OFT 2005:4). They were essentially 'buying in' to an unknown entity.

This had repercussions for people in a number of ways.

> 'I didn't see a brochure. Maybe my sister-in-law (who secured the place for her)
>
> did. I wouldn't have come if it meant sharing'. BRV3F.

People did not know the basis on which they had been offered the vacancy in the

home. They were unaware whether they had a contract with the home, although some

people in the private and voluntary homes thought a relative might be holding a

contract on their behalf (see also OFT 2005).

Sometimes it was the person's lawyer who arranged the move into care.

> 'I don't think so. It was all done through the lawyer' BRV3F.

Where the person was childless, nieces and nephews were often involved in making

arrangements for the move and were thought to have the contract.

> 'I know nothing about it. My niece handles the financial side'. WP3F.

> 'I think I gave it to A. (her son). He applied to the DSS'. BRV4F.

Whilst National Standards now require care home providers to give residents a

contract setting out the terms of residence, few local authority homes provided this to

residents at the time of the second study. Where the authority was contributing to the

care costs for someone in a private or voluntary home, regulations prescribed that the

contract for care was between the local authority and the home, not with the

individual resident, further undermining their status as a competent adult, party to a

contract. It is not surprising, then, I argue, that most of the people I interviewed did

not know about the contractual basis of their care. A recent study has shown that less than half (49%) of care homes in England and Wales provide a written contract or statement of terms and conditions (National Care Standards Commission 2004:10). In Scotland, a local authority making arrangements for residential or nursing care is responsible, under the Social Work (Scotland) Act 1968 for the full cost of accommodation and must contract with the care home (OFT 2005:96). Where someone is paying a top up to enable a senior citizen to stay in a more expensive home than the local authority is willing to pay for, that person can make a separate contract for that part of the home fee (OFT 2005:98).

In the first study particularly, residents expressed fear of being moved involuntarily, whether to another home or to hospital, if they became frailer. Not infrequently, I was greeted at first interview by the disturbing question 'you're no goin' tae put me away, are ye?' Residents who felt they had been tricked or misled about their original move into the home (see Meacher 1972), whether by relatives or professionals, had had their sense of security and control over their lives severely undermined. Researchers long ago identified that, unsurprisingly, people who moved voluntarily into residential care and who felt in control of the decision to do so were most positive about it and 'adjusted' most successfully (Schulz and Brenner 1977, Weaver et al., 1985, Allen et al., 1992, Reinardy 1995). However, Lee et al (2002) argue that there is a lack of literature on the actual experiences involved as people make the day to day adjustment to living in residential care.

As I have already discussed, one of the most important aspects to senior citizens of moving into a residential home is having their own room (CSCI 2004). My research showed that few of my interviewees knew before they moved that they would have to

share a bedroom. There was no question of them exercising informed choice in this respect.

> 'I share a room. I didn't know beforehand that I would have to share. I've been promised a single room eventually' CV5F.

I argue that it is regarded as 'good practice' to offer people moving into residential care the choice to furnish and personalise their rooms with their own furniture. How far this is practicable depends on the furniture, the size of the room and whether it has any fitted furniture. People varied in the importance they attached to having their own furniture in their rooms.

> 'I brought a bureau. There was no more space in the room'. CV4F.

I argue that a number of my interviewees were denied this choice because they were not informed by the home of their right to bring their own furniture before they moved.

> 'I wasn't told about bringing furniture. Mr. B (the manager) said to bring photos and things. He didn't mean furniture.' ALA1F.

> 'I wasn't invited to bring in furniture. I told my son to take what he wanted and to give the house up'. BLA3F.

Some people deliberately chose not to bring furniture into the home. Their inability to secure precious belongings in their room was a factor for some people.

> 'I sold my furniture when I left D. I brought my own television and radio. There's nowhere to keep possessions secure'. NP7F.

'I had none really to bring in, although I could have done' CV3M.

Most people had only brought in one or two small items because of restricted space or because they had disposed of their furniture to relatives. A quarter of the people interviewed in the second study did not know before moving that they were 'allowed' to have their own furniture in their room. Seven people knew they could but chose not to do so. Some people had bought odd items of furniture since moving in, most commonly a television set. People who had moved in straight from hospital were particularly dependent on relatives to transport items of furniture from home for them. People without involved relatives were even more likely to be denied this important choice.

Exercising choice about ordinary, every day such as what time to wake up, get up and go to bed are, I argue, basic freedoms that most adults take for granted. However, securing such freedoms can be difficult for disabled people who may require assistance (see Dartington et al. 1981 who talk about 'having to move heaven and earth to secure such freedoms' p.64. See also Parsloe 1997, Oldman 2002, Rummery and Glendinning 1999). I argue that none of the residents living in four of the thirteen homes in the first study could choose when to get up, irrespective of their abilities. In the majority of homes, people who needed staff help most tended not to be offered a choice. Night staff were expected by day staff to get residents up and dressed before the shift changeover at 8 a.m. As a result, most people were wakened with a cup of tea and 'got up' between 6.15 and 7 a.m. Only three people claimed to still be in bed after 8 a.m. Staff that I interviewed varied in their attitudes about people staying in bed. Some felt that certain residents would 'never rise' if allowed to decide for themselves, an attitude also shared by staff in Dixon's research (1991).

Overall, half the residents I interviewed in the first study said they were wakened in the morning by staff. Breakfast times were said by staff to be flexible in seven

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homes. One home attempted to introduce flexibility – described by the manager as 'a staggered breakfast' – but residents were not in favour of the change and continued to appear at the original set time until the experiment was abandoned. Not surprisingly, people who were early risers were for the most part also early to bed. Staff in three homes in the first study said they did not give residents a choice about bedtimes and most of the residents said they were in bed, or in their bedrooms, by 9 p.m. People who shared rooms said they had their choice of bedtime constrained by their roommates. More than one person who wanted to read in bed was unable to do so because the light was said to keep their roommate awake. One person had to resort to doing her nighttime reading on the landing.

In the second study, residents were still being wakened in the morning by staff, between six and seven o'clock, sometimes with a cup of tea. A resident in one home identified this early call in the postal questionnaire as an aspect of life that they disliked.

In this section I have discussed how far staff implementation of 'good practice' enabled senior citizens to exercise choice about their move and aspects of daily life once they became residents. In the next section, I discuss an aspect of choice which the literature has given relatively little attention to but which, I argue, mattered a great deal to many of my interviewees.

The importance of food and mealtimes

An area of life where people usually expected to have a degree of choice was over what they had to eat and when and where they ate it (Homes are for Living In 1989:92). In residential care, I argue, responsibility for the quality of food and meals lies with the management. Residential homes are expected to offer more than 'merely

housing people and keeping them clean, safe and well nourished' (DoH/SSI 1989:3, Scottish Executive 2001). Malnutrition or 'under-nutrition' is widely acknowledged to be a problem in long term care institutions (West et al 2003,Woo et al 2005, Evans and Crogan 2005) – occurring in two residents out of five in nursing homes and adversely affecting their health and quality of life (Evans and Crogan 2005). An audit of nutritional standards in Scottish residential homes, nursing homes and hospitals in which more than one fifth of residents were found to be 'undernourished', provides evidence of similar problems in this country (Marshall 2001:6). Here again, I argue, the influence of the medical model of ageing is reflected in the language used, where the normal word 'food' becomes 'nutrition' in the medical vocabulary and the dependent, 'patient' status of ageing citizens is reinforced. The danger of adopting a narrow, biomedical perspective is shown by the acceptance, until recently, that weight loss was a symptom of dementia rather than an indicator of 'less than optimal nutrition' (Marshall 2001).

I argue that the staff emphasis on 'good practice' as physical care results in the cultural and social importance of meals and mealtimes to residents often being overlooked or denied in residential homes (see Donovan and Wynne-Harley 1986:12, Abbott and Fisk 1997, Abbott et al. 2000). Meals and mealtimes become just another part of the daily caring routine rather than important breaks in the day and potential occasions for enjoyment and socialising. One of the residents interviewed in the second study, whose wife had dementia, thought food was very important, particularly for her.

'The social part of meals is very important. The mentally frail gauge their day by mealtimes' WP1M.

In another study, residents in private homes appreciated the 'hotel-style menu, opportunities for choice and attention to detail which showed attempts to cater for individual preferences' (Donovan and Wynne-Harley 1986:12). Senior citizens interviewed in a study of Independence and Involvement for the Abbeyfield Society commented unfavourably on the restrictiveness of 'compulsory' attendance at communal meals and the early timing of lunch and supper (Abbott and Fisk 1997:27). Residents criticized the lack of variety of food provided and some expressed preferences for what they called 'old-fashioned food' such as sponge and custard (Abbott and Fisk 1997:28). (See also Kellaher 2000:42 where residents resented their monthly compulsory rotation between tables at mealtimes).

In the second study, we sought the views of residents about food and mealtimes as part of our exploration of the reality of choice, through the postal questionnaire and individual interviews. The postal questionnaire asked residents to rate their happiness with the food provided by the home on a three-point scale. In only two of the six homes, did all the respondents declare themselves 'happy' with the food, although high levels of satisfaction were expressed by the majority of residents who responded. (See also Evans and Crogan 2005, where half the residents hated their food but 65% made no complaint about it and Ekberg et al 2002, where 84% of residents with swallowing difficulties thought eating should be enjoyable but less than half (45%) found it so.) In one home in my study, nearly one third of respondents said they were neutral or unhappy about the food. This home spent the least amount of running costs on food, just five percent of its costs (Bland et al. 1992:114), lending further weight to a likely connection between quality and expenditure on food.

Key factors highlighted by residents were the quality, content and variety of food in homes and the timing and location of meals. I argue that resident opinion about the

quality of the food varied enormously – from poor to extremely good – within the same home. Many residents commented on the lack of choice at mealtimes and the lack of variety in the food provided (see also Abbott and Fisk 1997:28). I argue that food was more important to some people than to others. People had different standards and expectations about meals. Cooks were more skilled in some homes than others. Meal quality was said to vary at weekends, when the cook was normally off duty and other staff members, often unqualified, took over meal preparation, with varying degrees of success. Several homes provided a cooked breakfast and a roast lunch on Sundays. Sandwiches were unpopular as the main component of the evening meal because some people thought they were inadequate or they found sandwiches difficult to chew. A respondent to the postal questionnaire criticized

'the poor meals at 5.30 p.m., for example three small lettuce sandwiches with as sweat [sic] one cheap wrapped choc-ice' WP3.

One of the voluntary homes was highly rated by the residents for the quality of its food, several people mentioning the food as one of the three things they especially liked about the home. One person praised its

'excellent variety and choice for the meat course. It's beautifully prepared and beautifully served' CV5F

and another resident commented:

'One is well fed. The food is marvellous'. CV21.

All six homes made lunch the main meal of the day – usually consisting of two courses – which seemed to suit most residents. Although alternatives were always available, only two of the six homes actually offered a choice of two hot dishes at lunch-time. A few people suggested that high tea, the last substantial meal of the day,

which was served any time between four-thirty and five-thirty p.m., should be served later, not least because it made the afternoon short and the evening particularly long (see also Abbott and Fisk When1997). Most homes offered 'supper', usually consisting of a hot drink and a biscuit later in the evening, after which most people went to bed.

Residents in some homes were encouraged to make suggestions about menus. In one home where the cook had invited menu suggestions from residents, one interviewee said

'I gave one or two ideas but we haven't had any of them yet' CV4F.

Although only one home said that staff planned the menus without either consulting residents or inviting them to make suggestions, people interviewed did not appear to think they could influence the content or timing of meals. In some homes, menus were made up a month in advance. In others it was on a seven-day rotation, the same food being offered on the same day each week. A few homes made attempts to address the social aspects of meals by offering residents sherry in the dining room before lunch and an a la carte menu every three weeks instead of the usual set menu. Another home offered its residents morning coffee only if they came to the lounge for it, as an encouragement to socialize, which some people resented.

A few residents made unfavourable comparisons between food in the residential home and the food they had been used to in their own home, particularly criticizing the use of dried egg, tinned vegetables and tinned soup.

Analysis of the 100 homes surveyed showed that staff in the private homes were most likely to give residents the choice of taking their meals in their room and voluntary homes least likely to offer this opportunity. Whether the reasons for these differences

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between sectors were attributable to aspects of buildings or staff interpretation of 'good practice' principles was unclear. All six case study homes had claimed that residents could eat in their room if they wished, one of the local authority homes qualifying this by adding 'although we don't really encourage it'. A resident in one of the private homes gave an example of how a change of management can alter the regime.

'I have tea in the little sitting room. I used to have breakfast there but the new matron makes me have it in the dining room. They're no keen on you lying in bed' NP1F.

This section has considered the importance senior citizens attach to choices about meals and food and where and when they eat. I argued that senior citizens have higher expectations of residential care homes than researchers often give them credit for, making unfavourable comparisons with the standards of food they had been used to in their own homes.

The next section examines the third 'good practice' principle that is very important to senior citizens, namely privacy. Again, I argue that there are physical as well as organisational constraints on residents exercising a right to privacy, not least the staff interpretation of 'good practice' as ensuring safety and avoiding risk. Keeping people safe and preventing them from perceived 'risky' behaviour requires staff being able to see them and supervise them in undertaking 'risky' activities which can undermine the 'good practice' principle of privacy.

Residents and privacy

The loss of their privacy is one of the key factors senior citizens raise when explaining their lack of enthusiasm for residential care (Salvage 1986, Sinclair 1988,

Phillips 1992, Peace et al. 1997, CSCI 2004). Privacy has been defined as 'access of residents in communal living settings to private space' (Counsel and Care 1991:). In their manual of 'good practice' for inspectors, The Social Services Inspectorate (1989) defined privacy more broadly as 'the right of individuals to be left alone or undisturbed and free from intrusion or public attention into their affairs' (p.16). I argue that residents have to share the residential home with people who are initially strangers and perhaps not to their liking. I argue that their right to privacy becomes all the more important where much of daily life is unavoidably lived in 'public' areas of the home. Being able to receive visitors in private is very important to people living in residential homes (CSCI 2004). Two homes in the first study had nowhere for residents to see visitors in private and a large proportion of them shared bedrooms. In the second study, one resident in the postal survey said they could not entertain visitors in private and three people said they could not use their rooms whenever they wished. These three people were resident in one of the voluntary homes that discouraged people from going to their rooms between breakfast and lunchtime to facilitate cleaning.

I argue that privacy in residential care can be violated in very many ways. Bodily privacy involves issues of nudity and how far residents wish staff to be involved in intimate personal care activities such as using the toilet or taking a bath or shower . It also extends to the right to privacy of information held on the resident by the home. As my interviews showed, many residents were unaware of records and care plans and were not made aware that they had a legal right to see these records. These records, then, were largely kept private from residents rather than staff.

Privacy of communication is a taken for granted right of adults but this was not necessarily so, I contend, in the residential homes I researched. In the first study,

some homes had no public telephones for residents' use or those that did, did not enable calls to be made in private. Most homes in the national study did have telephones for resident use and a few people had had a telephone installed in their room but they were exceptional. One person I interviewed had tried to get their own telephone installed but had been refused permission by the owner. Perhaps the mobile phone will make privacy of communication accessible to more residents.

Dignity is a core underlying value of 'good practice' in residential care (DHSS 1989) and one way of preserving dignity is by enabling people to secure their privacy, I argue, particularly where intimate personal care is concerned (see Woolhead et al 2004). How staff react to people who are incontinent is crucial, I argue, to a person retaining or losing their sense of dignity and self-esteem. A young male care assistant I interviewed, spoke with emotion about his feelings of embarrassment, disgust, ineptitude and lack of training and skill when helping someone who had been incontinent in the sitting room two days after he starting work in a residential care home. He felt that his inexperience had made a difficult situation for the resident worse and had seriously contemplated resigning. Two respondents to the postal survey suggested individual en-suite toilet facilities would be an improvement to the quality of accommodation in homes, as have residents in other studies (Parkinson and Buchanan 1996, CSCI 2004).

Residents who had to share rooms found it difficult to safeguard their privacy, dignity and exercise choice (Counsel and Care 1991). When senior citizens have been asked about their priorities in care, not having to share a room has been high on the list (Willcocks et al. 1987, Peace et al. 1979, CSCI 2004).

I argue that residents in some residential and nursing homes had great difficulty securing their right to be left alone and not be intruded on by staff. A study of privacy

in private and voluntary residential and nursing homes in Greater London found that on a number of indicators larger homes seemed to offer better standards of privacy than smaller homes (Counsel and Care 1991). The study also established a link between poverty and the right to privacy, in that residents on state funding were more likely to be in shared rooms. Very few residents in the Counsel and Care study homes could lock or had keys to their rooms (1991). Most homes (80% of nursing homes and 67% of residential homes) expected residents sharing a bedroom to use a commode, nearly a quarter (24%) expecting them to do so even where there were no curtains or screening to preserve a modicum of privacy (Counsel and Care 1991:16). The researchers at the time were disturbed by the indifference of homes to resident privacy and by the generally low expectations of residents and lack of protest by them or their relatives about 'what most citizens would regard as intolerable and avoidable invasions of their privacy' (Counsel and Care 1991:24). I argue that senior citizens in residential and nursing homes have not been regarded or treated as 'most citizens', highlighting once again the dominance of ageist attitudes towards later life (see Woolhead et al. 2004).

I argue that managing and maintaining continence, although hardly discussed in the literature is extremely important to senior citizens in maintaining their self-esteem and independence (Wilkin and Hughes 1986, Featherstone and Hepworth 1989). Featherstone and Hepworth have argued that enjoying competent adult status depends on the capacity to control urine and faeces (1989:148). Key to maintaining this status are the location, availability and suitability of toilet facilities (Neill et al. 1988, Willcocks et al. 1987). It is not surprising then, that residents in my second study criticized the inadequacy of toilet provision on grounds of numbers, size and privacy afforded in cubicles. One home had toilets with sliding doors that had no locks.

Narrow toilets made it difficult or impossible for people using walking frames or wheelchairs to use the toilet independently and in private. Not only were the numbers of toilets provided for residents' use insufficient, they were also poorly located, particularly in relation to dining rooms and lounges (Barrett quoted in Willcocks et al. 1987).

One respondent to my postal questionnaire highlighted how the inadequacy of toilet facilities made life difficult for her.

'The toilets are too small. I have no bell near me in the lounge, so when I require the toilet I have to shout out for help, and this can take some time. I would like a larger toilet nearer the lounge and a bell near my seat in the lounge'. CVF.

Some homes had unisex toilet facilities which residents disliked and wanted to change, highlighted as a cause of concern and embarrassment to residents in other studies (Willcocks et al. 1987, Counsel and Care 1991).

In contrast to the inadequacy of the facilities, the attitudes and behaviour of staff in assisting residents with personal care showed respect for their dignity and their privacy and were applauded.

'Oh yes, we had an old man of ninety-six and they did everything for him. They give you good attention' ALA6M.

'Oh yes. The staff here is a hundred percent' BLA2M.

'They're very good. We used to have one resident who made a wee puddle' BRV6F.

Some people obviously spoke from personal experience.

'They were very, very nice to me. I was terrified she would throw me out'

BRV4F.

Although privacy is a key value supposedly underpinning 'good practice', I argue that
this is an aspiration rather than an experience for people who have to share a
bedroom. Willcocks et al. argued that the single most important determinant of
'environmental control' in a residential home was access to secure personal space
(Willcocks et al. quoted in Booth 1985:114). I argue that this necessitates all
residents being offered a bedroom to themselves, preferably one they can lock (Booth
1985, CSCI 2004). Almost all the people I interviewed or surveyed put a premium on
having their own room. Two people in one home specifically complained about not
having anywhere to lock away their possessions. Several respondents to the postal
questionnaire specifically mentioned privacy as a feature of the home that they
appreciated. A small minority interviewed in the first study said they liked sharing a
room as they found it comforting to have a roommate who could call for assistance if
they were unwell during the night. One interviewee in the second study who knew
before moving in that she would have to share, had since been offered a single room
once or twice but

'I refused it because I get on very well with my room-mate' ALA3F.

In the postal survey, privacy was explored by asking about entertaining visitors. Not
all respondents were able to receive visitors in private. Residents in half of the six
homes who shared rooms found this difficult. Not all homes offered alternative
private space for residents who shared bedrooms to receive their visitors. As most
residents had visitors at least weekly, and a few daily, the ability to make visits in
private was important both to the visitors and the residents.

I argue that most people enjoyed the freedom to use their room and be private whenever they wished, but not all. People who had difficulties with mobility tended to be installed in lounges for most of the day and were reliant on staff to assist them back to their room.

'I go to bed at ten to seven. They just come for me' NP2F.

One resident who had become more disabled since moving into the home was afraid she was going to have to move to a ground floor bedroom.

'They want me to come downstairs now – I love upstairs. It would be a wrench.

I'm not allowed to go upstairs alone. It's a long, long day' NP1F.

I argue that another area of life that impinges on people's independence, privacy and dignity is bathing. To paraphrase Twigg (1997) bathing in institutions 'is part of a rite of passage, with the residential home bathroom representing an imposed liminal state between life outside as a citizen and inside as a resident' (p.220). (See also Twigg (2000).) Bathing is something that is done *to* people and as such involves aspects of a power relationship, whereby the individual resident can be made subject to the rationale of the institution (Twigg 1997:221).

In the first study, just over half the people interviewed reported no longer bathing independently at home before their move. Some had received a weekly bath assisted by the community nurse or by a relative. Others said they had given up using the bath altogether when they no longer felt safe and gave themselves a 'strip wash' (see Avebury 1996:49) instead, washing their top half at the washbasin and sitting down to wash their legs and feet in a bowl on the floor. I argue that this alternative strategy enabled them to maintain both their independence and their privacy by concealing

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their difficulty from professionals and not having to depend on relatives for assistance.

I argue that in residential homes, bathing is regarded as a risky activity and policies on bathing usually state that all residents should be assisted or supervised by staff. Thus does a very private, intimate activity become a much more public one. Very few people that I interviewed bathed unassisted. The picture that emerged was that frequency and timing were not under the residents' control.

'There's a bath book. Quite a few need help. You look up when you're due' CV6F. (see also Willcocks et al. 1987:59).

'Different girls help me. Two give me a shower. I prefer a bath, at night' NP1F.

'Things have improved vastly since the new manager came. Now we're able to bathe in the mornings' BRV1F.

'I used to bath myself. They won't allow me now because of my age' BLA1F.

How far people experienced choice of time, frequency or assistance when bathing varied between homes. In five of the thirteen homes in the first study, no residents were offered a choice, according to staff. Only a quarter of people interviewed said they had a choice about timing and only a fifth had a choice of assistant. The frequency 'norm' for bathing across the homes was once a week, unless the person had incontinence problems, when it was more frequent. The same norm persisted in the second study.

'Lists go up at the beginning of the week when the bath is. You don't choose when. There's one a week for those who need help' CV2F.

This, people said, did not necessarily match their previous bathing habits at home.

'I have a bath once a week. I get help. Nobody bathes themselves alone here.

When I was at home I had more baths but here there are so many [residents]'

ALA2F.

In one home, a resident felt that the facilities for showering and bathing were

unsuitable.

'The shower is not safe here. I am bathed once a week. Baths are so deep here,

it's hard to get in and out' ALA3F.

Residents who 'needed' help with bathing (almost everyone, I argue, because of the

home's policy – see also Willcocks et al. 1987:41) had to take their bath when there

were sufficient staff available, which tended to be in the morning rather than the

evening but there were exceptions.

'We only get one bath a week. The home is short staffed in the morning and at

night' ALA1F.

A resident in a private home who used a wheelchair could not get a bath at all because

the home had no hoist.

'The baths would have to be moved to the middle of the room [to use a hoist]'

NP4F.

In my second study, one resident commented on her dislike of getting dressed for

breakfast, which was an effort for her, and then a short while later having to get

undressed again in order to go for a bath. One home had got round this difficulty by

'allowing' residents to have breakfast in their dressing gowns. Although most of the

local authority homes in the first study had showers, these tended to be used for

storing equipment, such as hoists or wheelchairs. Residents were said not to like

showers, being unused to them, apart from those male residents who had worked in

the local coal industry (see also Willcocks et al. 1987). This may well be true. I omitted to ask the residents themselves. Having the choice of a shower, which policy guidance advocated as long ago as 1973 said should be available to residents and which I have already discussed in Chapter Four, might have enabled an older person to manage their toilette independently. This might have been particularly appealing, perhaps, to people who had adopted the 'strip wash' strategy at home. However, use of showers may be perceived by staff as being less under their control and therefore involving greater 'risk' to residents and so undesirable. All the rooms in one private home run on 'hotel' lines had en-suite facilities with alarm pull cords and residents decided whether and how much assistance they wanted from staff when taking a bath or shower. This home's attitude to independence and risk is discussed further in Chapter Eight.

In this section I have argued that privacy, particularly for most people the privacy of their own room, is crucially important to their quality of life in residential care. I have discussed the environmental barriers in homes to residents being able to secure their privacy and I have argued that staff attitudes to safety and risk-taking can result in them overriding or ignoring the 'good practice' principle of privacy.

In the next section, I discuss 'fulfilment', which was a core principle of 'good practice' enunciated in *'Homes are for Living In'* (DoH/SSI 1989) and which residents raised in my research as 'activities', as being of great importance to some of them. The definition of activities covers a very wide range, as, I argue, do people's aspirations. Some people said they were keen to pursue hobbies on their own but lacked equipment. Others needed assistance from their keyworker or other staff member that they could not secure. Generally, there was an impression, I argue, that most people felt they did not have enough to do with their days. I argue that social

activities and hobbies are a key distinguishing factor between quality of *care* and quality of life for senior citizens (see Gabriel and Bowling 2004). I have already argued that because the focus of staff in many homes is on the former, the latter tends to be regarded as less important and as a desirable 'extra' only if time and energy permit.

Fulfilment: the importance of activities

Fulfilment has been defined as 'the realisation of personal aspirations in all aspects of daily life' (DoH/SSI 1989:112). It has been suggested that activities may influence the quality of life of senior citizens as much as their health status (Wilhelmson et al 2005). I explored how far residents had a fulfilling life in homes by asking about entertainment and activities provided, in the postal questionnaire and in the interviews.

I argue that many people in residential homes spend much of the time feeling bored (Wilkin and Hughes 1987:180, Oldman and Quilgars 1999), particularly those who are not very mobile and heavily reliant on staff help to get about. Residents in my interviews, who were fitter, said they took themselves out for walks when the weather was reasonable and one person said

'I garden. I couldn't stand it otherwise' NP7F.

'We have exercises. Every Saturday night a concert party – a lad comes in with his squeezebox. Outings? Yes, I had a wonderful holiday on A. We stayed in a bungalow. Six people and two staff went' ALA5F.

'None. I certainly don't want trips. I miss knitting. I had a gadget in A. Hospital and I miss is terribly. The Occupational Therapist at A. got it for me but I don't

have it here now. I'm hoping to go back to A. Day Hospital to re-learn how to walk' NP4F.

Frailer residents said they tended to spend their day in the public rooms, often under-occupied, as several researchers have noted (Godlove et al, 1982, Peace et al. 1997). However, some people over seventy-five living in their own homes said they spent up to two hours and more a day 'just resting' (Abrams 1980), so researchers need to be careful not to project their own prejudices onto what they see. Some respondents to the residents' survey wanted more activities to be available in homes (see also Raynes 1998) as well as occupational therapy.

'More entertainment would help. We just sit' NP2F.

'Not really [enough activities], no. It may be different in winter. There are games available' WP2F.

Residents varied in what they said they wanted. Some people said they 'joined in everything'. Others said they preferred a quiet life.

'I don't really attend them – it depends what it is. I like to get upstairs to get peace and quiet. I go on occasional outings but I feel out of it when I can't see. They used to have muzak in the bus. It was awful. It's stopped now' CV4F.

Some homes had their own minibus for outings, which some residents said they relished but others avoided. One home used volunteers with private cars to take residents out for a run. Homes made particular efforts to arrange trips out during the summer but said they found it harder to arrange entertainers to come into the home during the winter. I argue that the location of the home could make a great difference to residents' access to outside entertainment, such as cinemas and theatres. One voluntary home was well served in this respect as it had a theatre nearby. I argue that

at the time of my study, finding interesting ways of occupying themselves was hard

for residents with impaired sight or hearing, particularly if they had previously

enjoyed hobbies such as reading or knitting. A blind resident, who had newly

acquired a talking book, was full of enthusiasm for it.

> 'I was always very fond of reading. My talking book is upstairs. I would prefer it
>
> downstairs. My nephew offered me a cassette player but I refused it. After
>
> breakfast I talk to my neighbours or sit in the duty room. The forenoons are quick,
>
> the afternoons very long. Sometimes ladies from L. bring a tape of songs. I go out
>
> for a walk, if possible alone. I'm a outdoor person' ALA3F.

In this section, I have argued that the experience of 'good practice' of many people

for much of the time in residential homes is boredom. This, I argued, is because there

are not enough activities to keep people stimulated (Oldman and Quilgars 1999).

Residents may be unable to pursue individual hobbies due to lack of materials or

available help from staff, or there may be aspects of their own disability, such as

sensory impairment, which make it impossible for them to pursue their former

pastimes. I argued that the great diversity of residents in my research studies is

reflected in the very diverse kinds of activity that they did or did not like and the

activities that they wished to pursue, on their own, or in the company of fellow

residents.

Conclusion

In this chapter, I have examined how social workers and staff in residential homes

implemented their definitions of 'good practice' in relation to senior citizens. I drew

evidence of how the definition of 'good practice' as independence, choice and privacy

was implemented by practitioners and staff from the experience of residents in terms of the effect on their quality of life.

I examined the relatively sparse state of research knowledge about the views of senior citizens about life in residential care. I argued that this was due to researchers' own ageist attitudes to senior citizens, which reinforced social perceptions of them as 'dependent' people for whom the definition of 'good practice' as physical care and protection was the appropriate response to their 'needs'. I argued that social work definitions of 'good practice' in their assessment and preparation of senior citizens for a move into residential care were based on a functional model of ageing that saw senior citizens them as 'vulnerable' and 'at risk' and 'in need of care'. I argued that senior citizens' efforts to maintain their independence and adult status were compromised by actions, inaction or poor practice by professionals or relatives. I argue that this was due to widespread ageist attitudes towards senior citizens and an understanding of ageing as a physical process of deterioration that results in 'dependency' and a 'need' for protection and care that is met by residential care. I argued that the focus of staff implementing principles of 'good practice' in many homes reflected these social attitudes. I argued that this resulted in staff defining 'good practice' in terms of providing physical care and protection from harm to residents as 'dependent' people, for whom they were responsible.

I argued that this definition of ageing and of 'good practice' is at variance with how senior citizens viewed themselves, and with what most of them wanted, in residential care. I argued that most residents looked to staff to support them in maintaining their independence or in being dependent without denying them their status as competent adults. I argued that this was difficult for staff to do because of their understanding of ageing as physical dependency but also because adult status was defined in terms of

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physical independence. Residents who were disabled were, by definition not seen as independent adults by staff, I argued.

I discussed the meanings of independence to senior citizens and identified the constraints that poor design, location and lack of amenity as well as staff practices imposed on maintaining functional independence. I argue that these constraints were due to ageist minimalist policies towards residential care that put greatest emphasis on keeping down costs and the ageist attitudes of staff for whom 'good practice' was defined in terms of physical care and protection. . I argued that despite these constraints, senior citizens asserted their autonomy and independence in different, sometimes subtle and potentially hazardous ways. I argued that staff failure to treat residents as adults by preventing or restricting normal activities, such as smoking, sometimes posed a greater rather than lesser risk to residents. I shall pursue this theme further in Chapter Eight.

I discussed residents' experience of the implementation of choice by social workers before they moved into residential care and by staff in terms of their accommodation and their lifestyle once in the home. I argued that social workers' understanding of ageing as physical dependency resulted in them defining 'good practice' with senior citizens as a 'need for care' to be met in residential care, overriding the professional principle of choice for senior citizens.

I discussed privacy as a principle of 'good practice' and how it was implemented in terms of accommodation and staff practices. I argued its cardinal importance for most residents in terms of having a single room, which, in some homes, is still not available to all residents. I argued that lack of amenity and care practice by staff that was focused on the avoidance of risk in activities such as bathing, could undermine

residents' attempts and desire to retain their privacy, particularly in aspects of personal care.

Finally, I argued that although 'fulfilment' is a principle of practitioner defined 'good practice' in residential care, senior citizens' experience was frequently one of boredom and inactivity, which was at variance with what they wanted. I argue that activities were not a priority of 'good practice' for staff because they defined 'good practice' in terms of giving physical care to residents and keeping them safe. Staff focus was on the quality of care provided to residents rather than quality of life, I contended.

In Chapter Seven, I discuss my comparison of the theory and philosophy of keyworking and care planning, two core activities of professional definitions of 'good practice' in residential homes, with how they were understood and implemented by staff. I draw on the responses of staff in one hundred homes to a postal questionnaire in the second study about their use of time at work in residential care homes as well as the research and practice literature. I argue that the potential of keyworking and care planning to promote quality of life for senior citizens remained unrealised in residential care due to staff understandings of ageing as physical dependency and definitions of 'good practice' in terms of physical care.

Chapter Seven - Keyworkers, Care Plans and Good Practice

Introduction

I argued in Chapter Four that 'good practice' has been defined in many various and conflicting ways by policymakers and practitioners. Varying definitions of 'good practice' in residential care have been contested and debated over time. In Chapter Six I discussed how senior citizens in residential homes experienced 'good practice' in terms of their quality of life, focusing particularly on how far the implementation of 'good practice' by staff enabled residents to be independent and enjoy freedom of choice and privacy.

In this chapter, I use a detailed analysis of keyworkers and care plans, which are highlighted in the social work and social care literature as core exemplars of 'good practice', to explore how far staff implementation of 'good practice' reflected the definitions of policymakers and practitioners. We included keyworker systems and care plans as indicators of quality in homes in our second study (Bland et al. 1992, Cheetham et al. 1992). Key workers and care planning had been increasingly included in professional definitions of 'good practice' since the 1970s (RCA/BASW, 1976; Barclay, 1982; Wagner 1988, DoH/SSI 1989, DoH/SSI 2002). However, staff responses to the Time Use questionnaire in the survey and my later interviews with residents in the case study homes, raised doubts about the effectiveness of the keyworker role and care plans, as applied in these homes, in promoting quality of life for residents. As I said in my Introduction to the thesis, these doubts fuelled my curiosity about the theory and meanings associated with the principles of 'good practice' and their implementation in residential care. I argue that 'good practice' is a taken-for-granted concept that is widely, often unquestioningly, used in social care

and other fields. As I have argued in Chapter Four, in residential care of senior citizens it has had many definitions and has been subject to change, dispute and contradiction. I also argued in Chapter Four, that in my analysis of policy and practice documents and reviews concerning 'good practice', the views expressed were those of professionals and 'experts' of what they thought 'good practice' was, or should be. They were not the views of senior citizens who had not been involved in defining 'good practice'.

I begin this chapter by analysing the origins of the concept of the keyworker role This is followed by a discussion of the emergence of consumerism and empowerment of staff and residents as bases for developing 'good practice' in residential care. I then trace the development of the keyworker role, its endorsement by policymakers, professionals and training organisations and then analyse its potential for developing quality of life for senior citizens in residential care.

I argue that my analysis of the origins and theory behind the keyworker and the association care planning role and my interviews with residents revealed variation and confusion in how the role has been interpreted and implemented by staff in homes. These variations, I argue, reflected the ongoing debates about the objectives of residential care for senior citizens and conflicting definitions of 'good practice' in residential homes. The various models of keyworker are then discussed in the context of my study findings. I argue that the variation and confusion around definitions of 'good practice' that I identified in the literature was reflected in the different patterns of practice and implementation of keyworking and care planning I found in public sector and independent sector homes in my research. I argue that staff use of their time in residential homes and the focus of 'good practice' were on giving physical care rather than undertaking activities associated with the quality of life. I argue that

this was further reflected in the varied understandings and experiences of keyworkers and care plans reported by the residents in my study.

I argue that ageist social attitudes, reflected in social policy by the marginalisation of residential care at the level of policymaking and ongoing, unresolved debates between professionals and practitioners about the objectives of residential care and the definition of 'good practice', have hindered its development in residential care. I argue that disputed definitions and confused understandings and implementation of keyworking and care planning have hindered their potential to enhance residents' quality of life in terms of promoting their independence, freedom of choice and right to privacy.

Historical background

The 'key worker' role in residential care was devised in the late 1970s, as a potential solution to poor co-operation between social services residential and fieldwork staff. The lack of co-operation was seen as having a negative impact on the service provided to social work 'clients' (RCA/BASW, 1976). The keyworker was defined as the person who was most appropriate to take primary responsibility for co-ordinating and planning care 'based on a close relationship between the worker and the service user' (Mallinson 1995:4). However, as a review in 1984 of the keyworker principle later admitted, the needs of clients were the secondary rather than the primary focus of the initiative (Hopkins et al. 1984).

After the Hopkins review, it was the organisational potential of the role that tended to dominate much of the discussion (see Mallinson 1987, 1989). Nevertheless, the keyworker continued to be endorsed by various enquiries and policy documents for use in a variety of settings (Barclay, 1982; Wagner, 1988; DoH/SSI 1989). It was

employed and encouraged in the context of child protection (Rodway 1979, Hopkins et al. 1984) as well as in non-residential community services for senior citizens (Challis and Davies 1986, Dant et al. 1989). Other services in which keyworking was encouraged include mental health services (Bulmer 1987, Dant and Gearing 1990, HMSO 1995) and in co-ordinating child abuse investigations (Mallinson 1995:4). In the community care context, similarities were drawn between the keyworker and the care manager role, since co-ordination of social care was a prime function of each (Challis and Davies, 1986; Dant and Gearing, 1990).

The keyworker role and the importance of care planning have been given renewed emphasis in the National Care Standards for Older People and by the independent Care Commissions established in England and Scotland in response to the Royal Commission on Long Term Care of Older People Report (Sutherland 1999). I shall discuss how these bodies visualised the development of the keyworker later in the chapter.

The development of consumerism and empowerment

As I have already outlined in Chapter Four, one of the stated aims of the NHS and Community Care Act 1990 was to give people using social services 'more say in how they live their lives and in the services needed to help them to do so' (DHSS 1989:4). The Audit Commission had previously called for social services to change their focus to the service user rather than focussing on the service itself (Audit Commission 1986:73). The strategy adopted by the government for achieving this 'greater say' was through consumerism.

People using social services were no longer 'clients' but 'consumers' with the supposed power of consumers in the wider commercial marketplace. 'Subject to the

availability of resources' people moving into residential or nursing home care should 'be able to exercise the maximum possible choice about the home they enter' (HMSO 1989:27).

The rationale for this reorganisation was 'the empowerment of users and carers' by creating a new organisational culture in social services departments (SSI/SWSG 1991:9). This posed a powerful challenge to practice, which had tended to focus more on criteria of eligibility and suitability for services than on establishing the needs and wishes of potential service users and their families. Again, there was the emphasis on the need to change the approach to people's needs from a service-led response to one that more nearly matched those needs. This consumerist approach was primarily directed at community care services. Ways of improving quality of life for people in residential care were tested and evaluated by The *Caring in Homes* Initiative, the government response to the Wagner Report (1988) which I have already discussed in Chapter 4 and Chapter 6. The evaluation of that Initiative showed how resistant the culture in residential care homes was to change.

The literature on residential care at the time of our studies, abounded with evidence that social care staff, particularly those working in the statutory sector, had low status (CCETSW evidence to the Wagner Committee, 1988; Wagner, 1988; Youll and McCourt-Perring, 1993). They felt isolated, lacked autonomy and had a very real sense of powerlessness in terms of planning and implementing care (Payne, 1989, Potter and Wiseman, 1989; Baldwin, 1990). There is little evidence that this has changed. This sense of powerlessness was compounded by their lack of training, particularly in residential homes for senior citizens (Wagner, 1988; Howe, 1992; SCA Education, 1992, SSSC 2003, SSSC 2004). Stevenson and Parsloe suggested that workers who sought to empower the people with whom they worked were more likely

to succeed in organisations that also empowered them (1993:9). Given the sense of powerlessness and low self-image in residential care, it is not very surprising that staff working in residential homes did not find it easy to allow senior citizens to exercise their autonomy (see Dixon, 1991; Potter and Wiseman, 1991).

Staff working in residential homes found it hard to acknowledge that they did exercise considerable power over residents. It was therefore essential to consider their views and the implications for their sense of professionalism in sharing that power with residents and how this could be reconciled with the physical, social and emotional risks which may sometimes be involved (Stevenson and Parsloe 1993). I now explore how far the role of keyworker in residential care was seen as a power-sharing role with residents in terms of determining how their individualised care and quality of life could be promoted.

The keyworker role

In Chapter 6, I discussed the lack of choices available to senior citizens both before and after their move into a residential care home. In theory, the keyworker had the potential to be a means of empowering people in residential care homes to exercise choice in their daily lives, since helping them to do this was said to be at the core of the role (Mallinson 1989). A number of claims have been made for the keyworker role. Keyworker systems in homes have enabled people to participate more in their care Mallinson 1991). The role could act as a basis for managing the tension between individual care and group living (Mallinson 1992), and could provide a relationship within which individual wants and preferences could be addressed. However, as I have already shown in Chapter 6, the way in which the keyworker role was implemented and understood in residential homes varied considerably, with

repercussions for its effect on residents' quality of life. Davies (1985) saw the keyworker role as a good idea that had never been properly tested.

The keyworker role developed in the 1970s out of a need for residential and field social workers to resolve practice difficulties between them. Representatives of field and residential social workers met to examine their respective roles in an attempt to improve practice and the standard of service to people using social work (RCA/BASW 1976:1). I have already argued in Chapter Four that disputes about the relative status of social workers and social care staff, have been an impediment to the contribution of staff to the development of theory and 'good practice' in residential care for senior citizens. The shortcomings in services identified by the joint representatives revealed that this was a dispute about status and power within social work rather than a critique of poor services to social work users. Residential staff resented not being involved in admissions and discharges from care, which were usually arranged and controlled by field social workers. The loss of social worker contact after admission to residential care for some users, particularly senior citizens, implied that no-one had the responsibility for developing, implementing and monitoring a care plan with them. There was resentment that it was the field social worker who, despite their infrequent contact, retained responsibility and power for making decisions about the person's future although the residential care worker who was in daily contact was better informed about the person's conduct and welfare.

Defining the role

The RCA and BASW representatives finally agreed that either a field or a residential social worker could be responsible for decisions about moves in and out of residential care, and adopted the term 'key worker' (sic) to describe the role. The main focus of these discussions was statutory residential care for children rather than care for adults.

There was no acknowledgement that the relationship between an adult service user and their keyworker might, or should be different. The appropriate person to take on the role of keyworker would depend on the worker's experience and the needs of the service user, the final decision being made 'within the first three months after admission' (RCA/BASW 1976:5). This solution did not resolve the problem because the disparity in education, training and experience between field and residential workers remained.

A subsequent paper reflected determined attempts by the Residential Care Association to develop the professional role of residential workers who saw themselves as having responsibility for 'the more mundane, less demanding and less satisfying tasks' in relation to service users (BASW/RCA 1976:3). The paper identified five functions for which the keyworker should be fully accountable;

> a. drawing up, implementing, monitoring and updating individual care plans
>
> b. calling reviews after three months and subsequently as appropriate
>
> c. maintaining an appropriate working relationship with the service user
>
> d. maintaining adequate records
>
> e. ensuring appropriate arrangements for social work help on discharge from residential care (RCA\BASW 1976).

These proposals about the keyworker role had implications for how local authority departments were organized, as well as for residential staff training (RCA/BASW, 1976). Rodway (1979), a director of social services and a former residential worker who supported the keyworker concept, highlighted the structural difficulties in authorities where residential care and field social work were separately managed, particularly for ensuring keyworker accountability and supervision. Rodway also

stressed the importance of the service user's perceptions and views about keyworkers, emphasizing the need for clear explanation and discussion in helping the person to reach conclusions about the value of the role. Acknowledging that the views and opinions of residents are often not sought or are ignored, particularly in residential care homes for senior citizens, Rodway emphasized that the ultimate objective of the keyworker role should be to improve standards of service to users (Rodway 1979).

In Chapter Four, I demonstrated how the numerous committees and working parties that met to consider the future of residential care for senior citizens in the 1970s, 80s and 90s did not have any direct representation from senior citizens. Policymakers and practitioners were in no doubt that keyworking improved standards of service but confirmation of this had not previously been sought from the service users.

Reviewing progress

By 1980, these two very different rationales for developing the keyworker role emerged more clearly. Some writers criticised the apparent failure of many social services departments to use residential staff as keyworkers, whilst acknowledging that there had, in one sense, always been a 'keyworker' - the field social worker (Douglas and Payne 1980). Elliott's review reported that several studies had had some success in expanding the role of residential staff as originally proposed (Elliott in Walton and Elliott, 1980). However, she also noted that the keyworker concept had generated very little public debate, 'despite its importance for the changing role of the residential worker' (Elliott in Walton and Elliott 1980:15).

The progress of the keyworker in straddling the boundaries between residential and fieldwork was almost invariably charted from the residential worker's rather than the resident's point of view (see Davis 1978, Douglas and Payne 1980, Payne and

Douglas 1983; Hogan 1988; Mallinson 1989, 1991). Young people in residential care said they wanted 'a special person to whom they could talk about things which really mattered to them', so it is surprising that residential staff never used that need to support their argument for developing the keyworker role in residential child care (Page and Clark, 1977). It suggests that the debate was focused on improving the status of residential staff rather than the service to the residents, whose views were seen as of low priority.

Latterly, the keyworker role was given a further interpretation: that of care co-ordinator in field social work. This led to its being likened to the role of care managers in long term community care, who were responsible for assessing need, planning care, implementing and monitoring that care (see Challis and Davies, 1986; Dant and Gearing, 1990; Mallinson and Kelly, 1990). Dant and Gearing saw the keyworker as the basis for a relationship with the service user that offered personal support and someone to whom the person could address their needs and concerns, a much less dependency-oriented definition (1990:333).

Despite these varied interpretations, the incorporation of keyworking into definitions of 'good practice' in residential care can be found in policy documents and professional practice manuals and reports from the early 1980s onwards. The vast majority of these documents continued to address the issue of residential care from the staff rather than the service user's perspective.

The Barclay enquiry (Barclay, 1982) gave 'unqualified support' to the concept of the keyworker, considering it a 'manifestly appropriate role' (Barclay, 1982, p. 69) for social workers in day or residential services. However, it is not clear which interpretation of the role identified (Douglas and Payne 1980, Hopkins et al., 1984) the committee had in mind. The Wagner Committee (Wagner 1988) saw the

'residential key worker' as one way of achieving and encouraging continuity for people in care, although it did not give any examples of how it might be developed and the SSI in *Homes are for Living In* (DOH/SSI, 1989) endorsed the keyworker as part of a system to promote residents' 'independence' (sic) (DOH/SSI, 1989:72).

The Code of Practice (Avebury 1984) published as part of the implementation of the Registered Homes Act (1984) identified the need for people moving into residential care to have a 'key supporter'. This was likely to be a relative, friend or field social worker -someone to act in the role of advocate for the person taking up residence but deliberately not a member of the residential staff. Only from this point on did the possible need for resident advocacy start to receive serious consideration.

Homes are for Living in (1989) invoked the keyworker as a system with duties to promote 'independence' and raised the possibility of residents having a choice about who their keyworker should be. In exploring the principle of fulfilment, it asked how homes planned to meet residents' needs and ensure that their wishes and aspirations were known (p.116). It discussed the idea of written care plans and the areas of the resident's life that these might cover, such as how their physical as well as emotional and spiritual needs were to be met. It raised the question of whether care plans meant anything in practice and whether they were pursued with enthusiasm and ever reviewed. In the absence of care plans, the model sought other evidence of a home's efforts to plan for individuals.

The Howe Inquiry report (1992) on quality of care and staffing in local authority residential homes revealed that the unequal status of field and residential social workers had not improved. The views of the field social worker still prevailed over those of the residential keyworker (Howe 1992:24) which undermined the self-perception and status of residential staff who saw themselves as 'at least of an equal

standing with field workers' (p.25). The report recommended that local authorities develop close links between residential and field workers to enable each group to better appreciate the other's contribution to the 'continuum of care' (p.31). Training and staff development were highlighted as one of the key areas affecting the quality of service and the status of residential care (p.51), and the report called for a comprehensive qualification framework for residential care (p.53).

A different emphasis from the 1984 code of practice was put on the keyworker by Avebury's *A Better Home Life* (1996). Avebury (1996:48) now saw the keyworker as a member of the home staff rather than the independent resident advocate endorsed earlier. The keyworker's responsibility was to see that individual residents were looked after in accordance with their particular needs, as laid down in the care plan.

In its Introductory Guide to keyworking in social care, the Social Care Association defined a keyworker as 'an individual named worker that a particular service user may relate to in daily living on a personal basis'(SCA 1991:3). It set out three main principles for keyworking: to individualise social care, to be a system for managing social care and a means for care planning (SCA 1991). Activities in which keyworkers were likely to be involved were very wide-ranging, including physical care, assessment, advocacy, counselling, arranging activities, shopping and liaising with relatives. More importantly, the document gave the keyworker responsibility and accountability for the care of the service user. The emphasis throughout the document was on the keyworker role in relation to care procedures and processes rather than developing a relationship with individual residents to promote their quality of life.

The Residential Forum's *Creating a Home from Home* (1996) described the keyworker as a system 'that has become familiar and accepted within social care as a

positive development… that takes many different forms in practice' (p.33). The purpose was to provide individualised care to a number of residents, who should be able to change their keyworker if they wished.

A Counsel and Care guide to care planning defined the key worker as a member of the care staff whose role was 'to carry out specific personal tasks and to form a special relationship of trust' (p.38). Key workers in the study carried out by the authors were the people who carried out direct and indirect care tasks for residents, bathing, dressing and shopping for their nominated residents and helped to 'clarify the process of objective setting for the resident's care' (Coleman et al. 1999:39). Key workers were seen as central to implementing 'the strategies that have been agreed as necessary to achieving the set objectives' (Coleman et al. 1999:39). Not all key workers in the homes visited were allowed to make entries into residents' records and had to be content with verbal reporting, which senior staff, sometimes nurses, subsequently entered into residents' records. The guide recommended that key workers should be matched with residents as far as possible and that ideally, residents should be able to select their own keyworker, with a right to veto a key worker with whom they felt uncomfortable. Like many of the people in my own studies, people interviewed were unfamiliar with the keyworker concept and either did not know they had a keyworker or did not know who their keyworker was (Coleman et al. 1999:55) which raised questions about the existence and quality of the relationship.

Care plans

In residential care homes, the care plan is the document that is drawn up by the keyworker with the resident that details agreed goals and individual arrangements for meeting the person's needs. Its focus should be on the person's lifestyle and on enabling them to exercise choice (Residential Forum 1996:33).

Mallinson's research found that the practice of care planning was quite different from the theory (Mallinson 1995). 'Good practice' principles such as involving the service user in decisions and the shared goal of achieving maximum possible independence were far from being realities in practice (Mallinson 1996). Staff were concerned to complete everyday tasks rather than jointly identify needs and goals with residents. Relationships with residents were 'at best paternalistic and benign' but in some situations could become rigid and routine with care being 'done to people' (Mallinson 1996:136). Care planning was undertaken solely by managers because they were the only staff who were trained (Mallinson 1996). Mallinson concluded that the attitudes of managers were crucial to realising the principles of self-determination and choice for residents. Without a managerial commitment to service users' rights to make their own decisions and determine their own futures and everyday practice, residents might find their freedom curtailed by a management culture of 'play safe' in which care staff had little option but to collude (Mallinson 1996:136).

Mallinson carried out a more detailed exploration of care planning within three homes from his census sample and concluded that 'poor practice may be the norm in Scotland and possibly elsewhere in the UK' (1996:60). He found that care planning in these homes had become a means for establishing routines and functions in homes, addressing the agendas of staff rather than those of residents (Mallinson 1996:115).

The Counsel and Care guide to care planning in residential homes (Coleman et al. 1999) drew heavily on medical, nursing and hospital models of care and the biomedical model of ageing in its discussion. It started from the assumption that care homes accept responsibility for residents who have moved there 'precisely because they need to be looked after' because they could not cope satisfactorily alone (p. 11). As I have already discussed in Chapter Six, and as the Care Planning Guide reiterated,

decisions about a move into residential care were often taken without the senior citizen being fully consulted (Counsel and Care 1992). The guide warned that care planning can continue this pattern of removing responsibility away from residents if carried out insensitively (p. 53). During the research interviews on which the guide was based, many residents said they saw little point in planning their care, suggesting managers 'do whatever you think best' or using their age as a reason for not wanting to become involved (Coleman et al. 1999:52). Residents were often unfamiliar with the term 'care plan', although they remembered being asked 'lots of questions' and some people were aware that the home kept papers about their care.

The study authors were surprised to find great variation in local authority inspection units and inspectors 'seriously divided' about the format they would expect homes to adopt for care planning. Some units were highly prescriptive, distributing forms for homes to use while others left it to home managers to decide how care plans were recorded (Coleman et al. 1999:60). The study found a diversity of practice in record keeping and an absence of consensus on many key issues.

The consumer study of residential care (Willcocks et al. 1987) which proposed the residential flatlet as the physical prompt for redefining the residential care task, suggested that making keyworker schemes routine might be a prerequisite for achieving such a redefinition. They saw keyworker schemes as a potential means of assisting residents to greater autonomy and for the reconstruction of care in terms of individual need rather than as a generalised response to the demands of the residential population as a whole (p.136). Peace et al's re-evaluation of residential care (1997) noted that there had been changes in practice in some homes, typified by the introduction of keyworker systems and care planning programmes that aimed to support residents as individuals, and enable them to participate in home life (p.51).

A study of quality of care in residential homes evaluated care plans along the dimensions of physical, emotional, social and cultural care (Schneider 1997). The study concluded that emotional and cultural aspects of the resident's life were relatively neglected in care plans (Schneider 1997). Yet these were just the aspects of life that people receiving care services at home and in residential homes wanted more help with from their paid carers (Oldman and Quilgars 1999:379). Some people in Oldman and Quilgars' research were sceptical about the introduction of key working, describing it as 'a bit of a farce' because staff had no extra time allotted to provide the support residents wanted (Oldman and Quilgars 1999:380).

The National Minimum Standards for care homes for older people (2003) for England, that came into force in June 2003 set out for care home owners the standards to be met and facilities to be provided for people in care homes. Each of the standards is prefaced by a statement of 'good practice' which is the rationale for that standard. The National Minimum Standards refer to two kinds of plan. The first is the care plan produced for care management purposes, a summary of which should be given to the registered person running the residential home (p.3). The service user plan, Standard Seven, sets out in detail the action needing to be taken by care staff to ensure that all aspects of the health, personal and social care needs of the service user are met (p.10). This plan, which is drawn up with the involvement of the service user and signed by them, has to meet relevant *clinical* guidelines (my emphasis) concerned with the care of senior citizens and should include a risk assessment, with particular attention to the prevention of falls. This plan is supposed to be reviewed and updated monthly.

Evidence continues that care plans for senior citizens are still inadequate. An overview of performance by local authorities in England (Bainbridge and Ricketts 2003) found that nearly a third of cases had 'mostly or totally unsatisfactory' care

plans. Needs and objectives needed to be clarified, plans needed to be linked to strengths and peoples' support networks and residents needed to be given copies in accessible formats (p.36). The Inspectorate emphasised the potential of care plans to promoting independence and the need for them to be reviewed, as people's needs changed (Bainbridge and Ricketts 2003:21). Other work by the SSI identified care plans as continuing to be service-led rather than needs-led and there was little choice in the range of resources available (Little 2002:28). The Inspectorate found that few councils had provided training to staff in designing care plans to maximise independence (p.31).

The National Care Standards for Older People (Scottish Executive 2001) are written from the point of view of people who use the service and describe 'what each individual person can expect from the service provider' (p.5). The Standards are set out in a way that discusses the role of the keyworker as part of the process of moving into a residential home. According to Standard Seven, the new resident will have a named member of staff assigned to them, a keyworker, who may be a nurse if they are receiving nursing care. The keyworker will draw up a 'personal plan' with the resident and stay in regular contact with them and others involved in their support and care. The keyworker is the person with whom the resident can discuss their needs and any concerns (p. 29). Standard Nine discusses safety and security and leaves the resident with responsibility for their own actions and active involvement in their risk assessment. The emphasis is on achieving a balance between reasonable risks that the resident might wish to take and the safety of the staff and fellow residents (p.31).

In this section, I have reviewed the definition and implementation of 'good practice' in regard to keyworking and care planning in residential care homes for senior citizens. The pattern of uncertainty, confusion and conflicting definitions that I

argued in Chapter Four has typified debates about 'good practice' is reflected again in this review. The unresolved question about the unclear objectives of residential care continues to bedevil attempts to clarify what 'good practice' should be and how it should be implemented. The emphasis in many documents is on physical care, its imputed associated risks and the responsibilities of staff for residents.

In the next section, I discuss the patterns of implementation of keyworking and care planning encountered in the homes in my second, national residential care study and how residents understood and benefited from them.

Staff as keyworkers – the quality of care study

When I reanalysed the survey findings in preparation for this thesis to determine which staff carried out keyworker tasks with individual residents, it became clear that these activities were performed by various grades of staff. However, care planning - the prime keyworker task - was carried out by managers in independent sector homes and predominantly by managers in local authority establishments. This was similar to the findings of Mallinson, which I have just discussed. I subsequently elicited the views of senior citizens about keyworkers and care planning in individual interviews in the six case study homes.

The staff in our original sample of one hundred private, voluntary and local authority homes in Scotland had completed individual questionnaires about their activities and time use at work. Analyzable data were returned by the staff in more than three quarters of the homes – some 1600 questionnaires. The extent to which keyworkers and care plans were in use varied markedly between the sectors, as Figure 1 illustrates. Whilst the vast majority of local authority homes had both keyworkers and care plans in operation, only one third of the private sector homes had keyworkers and

just over half had care plans. Less than half the voluntary sector homes had

keyworkers and around two thirds had care plans for residents.
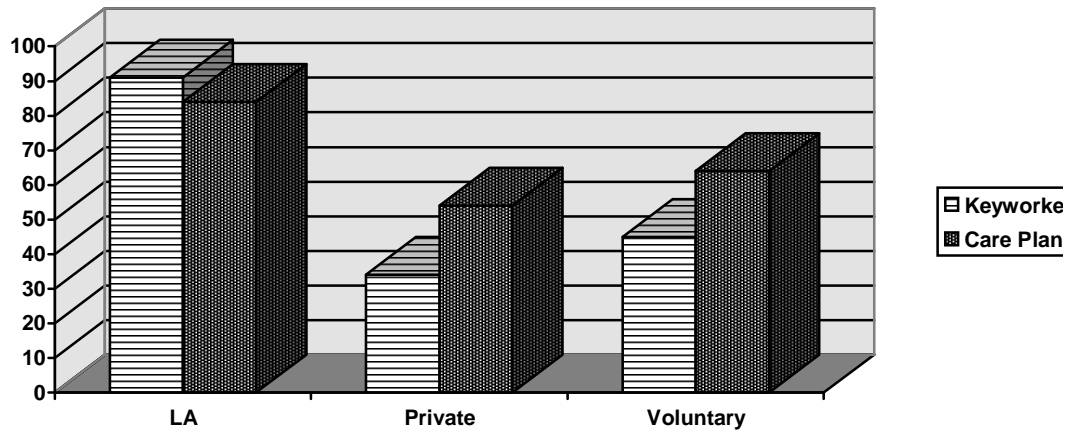
Figure 7.1: Use of Keyworkers and Care Plans by Sector (100 Homes)

Mallinson reported similar sectoral differences in the use of keyworkers in a postal

survey he conducted in residential homes for senior citizens in one region of England

(Mallinson, 1992).

I analysed the Staff Time Use questionnaires in order to discover how much time was

given to activities associated with promoting quality of life for residents. I used the

following six categories of activity, three of which focused on activities with residents

and three on aspects of home administration:

   i. physical care;

   ii. promoting psychological welfare;

   iii. informal recreation

   iv. household maintenance

   v. staff interaction

   vi. administration

The results showed wide sectoral variations in how staff used their time.

A total of 126 individual activities were identified under these main headings. In all three sectors, care staff spent most working time in the three resident-centred categories of activity: giving physical care, promoting psychological welfare, and providing recreational opportunities. The greatest amount of time was given to physical care - 13 hours per bed per week, on average. However, there were marked differences between the sectors with care staff in private homes spending 17.6 hours on average giving physical care, compared with 12 hours in the local authority homes and 8.8 hours in the voluntary homes. By contrast, the average time devoted by care staff in all three sectors to activities to promote residents' psychological welfare (in which we included drawing up, monitoring or reviewing care plans) was just 12 *minutes* per bed per week. On average, care staff spent just 1.4 hours per bed per week on informal recreation with residents. The average amount of time spent by care staff per bed per week across all activities varied markedly between the sectors. In local authority homes, an average of 26.1 hours was spent per bed; in private homes it was an average of 36.4 hours and in voluntary sector homes, the average care staff time spent per bed was just 18.0 hours – half the average time of the private sector homes. The average time spent by managers on activities to promote residents' psychological welfare was the same - just 6 minutes per bed per week - across all three sectors. This reporting appeared to confirm that care staff spent most of their working time giving physical care, leaving very little time available to develop or implement care plans with residents - a potential means of enabling them to exercise choice over their daily lives.

I undertook further analysis to see which staff in the homes usually performed tasks which might be associated with being a keyworker or a 'key person' (Douglas and Payne, 1980). I did this by reviewing the data on a number of tasks involving

personal care, promoting psychological wellbeing, and informal recreation with residents. The personal care tasks I chose were bathing, hair washing, cutting fingernails or toenails, and escorting the resident about the home. I looked at three activities concerned with promoting residents' psychological wellbeing: compiling, reviewing or changing a care plan with a resident, counselling, and visiting residents in hospital; and six activities associated with informal recreation on an individual basis with a resident: taking them shopping, writing letters for them, reading to them, taking them to visit a friend, out for a walk, and conversing with them. The picture that emerged was mixed, as Table 7.1 illustrates.

Activities usually carried out	MANAGERS %			CARE STAFF %		
	LA	Private	Vol.	LA	Private	Vol.
Assist with bathing	1	32	23	71	60	75
Escort within Home	3	30	11	32	8	20
Wash hair	0	16	14	39	27	37
Cut toe/fingernails	3	37	19	91	31	39
Devise care plans	63	44	43	16	3	23
Counsel	66	45	40	13	5	16
Visit in hospital	30	41	40	15	3	9
Take shopping	12	32	16	21	5	19
Take for walks	7	18	14	26	20	25
Take to visit friends	4	10	5	6	0	5
Chat	78	68	79	79	72	74
Read	10	18	9	17	6	14
Write letters	23	33	38	29	14	22

Table 7.1 Selected resident-centred activities usually carried out, by staff grade (all 100 homes).

I found that across all three sectors, personal care tasks were usually carried out by the care staff. Only in the private and voluntary sectors was a minority of managers likely to perform personal care tasks such as assisting with bathing. Activities associated with promoting psychological wellbeing showed less uniformity. Care planning was more usually carried out by senior staff in all homes, although a minority of care staff in local authority and voluntary homes also reported usually

doing this with service users. Virtually no care staff in private homes reported involvement in constructing or revising care plans, visiting residents in hospital, or counselling them. Some of the recreational activities were performed predominantly by care staff in all sector homes, but a mixture of staff said they wrote letters and took residents to visit friends. Large numbers of staff of all grades in all homes said they usually chatted to residents. This activity apart, relatively few staff of any grade said they usually carried out activities with residents that might be regarded as potentially quality of life or morale enhancing.

The survey showed that senior staff devoted 6 minutes per bed per week, on average, to the formal promotion of residents' psychological welfare, which supposedly included care planning. It is therefore not surprising that residents who were unsure about who their keyworker was when I interviewed them, hazarded a guess that this might be the person most involved in their physical care - a member of the care staff.

In the original survey interview with managers, five of the six homes later used as case studies in the second phase of the research study had claimed to use the keyworker role (apart from Home E - see Table 2 below) and all six said they devised care plans with residents. The subsequent resident interviews revealed a lack of understanding or limited experience on their part of care planning in some homes, particularly in some of the independent sector homes, as might have been expected. Table 7.2 summarizes the residents' responses.

		Local Authority		Private		Voluntary	
		Home A	Home B	Home C	Home D	Home E	Home F
Do you have a Keyworker?	Yes	6	6	-	1	-	4
	No	0	0	0	3	6	0
	Unsure/Don't Know	0	0	7	2	0	2
Do you have a Care Plan?	Yes	2	2	0	3	2	0
	No	4	4	0	3	4	6
	Unsure/Don't Know	0	0	7	0	0	0
(N interviewed)		(6)	(6)	(7)	(6)	(6)	(6)

Table 7.2. 37 Residents' awareness of their keyworkers and care plans in 6 Case Study Homes

Some people used the residents' postal questionnaire to register their desire to see more of their keyworker or to complain that staff seemed to have to work too hard. In the local authority home interviews, it became clear that users knew who their keyworker was and that, on the whole, they appreciated them. In the first home, all six interviewees spoke warmly of their keyworkers as individuals. Four of the six residents spoke spontaneously about the relationship in terms of keyworkers assisting them with physical care - bathing or showering on a weekly basis.

'Oh yes. She comes to see me and we have a bath. Anything we need we do it through her' ALA6M.

'She comes to see me and we have a bath. Nobody bathes themselves alone here' ALA6F.

One resident who had bilateral cateracts needed more support than her keyworker felt able to give her.

'My keyworker reads letter for me but she's not keen to write for me to my sister as she has four residents. I can't see to read or even to eat my food. It's terrible. I have a talking book but I don't know how to operate it myself. My keyworker is too busy to show me how' ALA1F.

Others seemed content with the amount of contact they had with their keyworker. One person saw the keyworker acting in a liaison role with senior staff.

'Anything we need we do it through her' ALA4F.

'I quite like her and she does any jobs for me' BLA4F.

'She's very nice – couldn't be nicer. I can depend on her' ALA4F.

In the second local authority home, views about keyworkers were far more mixed. One resident said he did not have a keyworker.

'No – just anybody. A waste of time. Not necessary' BLA1M.

Only one person in that home mentioned the keyworker in terms of receiving assistance with bathing. Three people appeared to have little contact with their keyworkers. One person 'thought it was a good idea' and another that 'they're a very good help if you need it'. A third person responded by saying 'I'm fit and well. I'm

all right', which seemed to imply that keyworkers were seen as only working with people who were disabled or ill.

Although most residents in the local authority homes could talk about their keyworker knowingly, only one third of interviewees thought they had a care plan that had been worked out with them. Several people said the phrase 'care plan' had no meaning for them. One person remembered being asked questions but did not recall a care plan being drawn up. One person remembered a plan being constructed but it had never been reviewed.

> 'I did [have a care plan] to start with. Now I have very poor sight. I used to do a lot of knitting. I've had cataract operations. My sight is improving, hopefully. I just sit and talk and make friends with them all' ALA5F.

For some interviewees, the phrase 'care plan' was completely new, yet associated with needing help with personal care, such as bathing.

> 'I've never heard of the phrase [care plan]. I'm not aware of it. I don't need help with the bath or anything' BLA6M

In the private sector homes there was greater uncertainty about both keyworkers and care plans. Nobody in Home C was aware of the keyworker system and, in Home D, only half the residents interviewed thought such a system might exist there.

> 'Not really. I came in at a bad time a year ago. Mrs. C. (deceased wife of the owner) got ill and died. That knocked me' NP3F.

> 'I don't remember that [care plan]' WP4F.

One person thought that all staff acted as keyworkers. In Home E, residents were (quite correctly) definite that there were no keyworkers. In that home, a house committee of volunteers provided recreational opportunities for residents that took

place outside the home, and the committee was also the means of addressing and remedying any complaints. Care plans were said to be completed only sometimes by the depute or assistant manager, never by the manager. In Home F, which had a well-established keyworker system, two people interviewed were uncertain whether they had keyworkers or not, which rather defeated the object in terms of their benefit.

In the voluntary sector homes, many interviewees asked for a definition of 'keyworker' before they could identify whether they had one or not.

'Maybe I do. One of the care assistants makes an effort to say good night' WP3F.

Other residents were more definite about the relationship.

'Yes I do. Any complaints, she'll sort things out. I think it's a good idea'. CV3F.

When asked about care plans, interviewees were more uncertain. Several people remembered discussions with the owner or manager on admission about their likes, dislikes and wishes about how they should be supported but none of them appeared to be aware that a personal care plan existed as a written document. Nobody could recall their care plan ever being reviewed with them or changed.

'Nothing was written. They told you mealtimes and unpacked my case for me, which I prefer to do myself. For three days I sat and looked at the carpet and then I hit on the knitting' CV3M.

'No care planning was done. I was told when I applied that I would have to share' CV6F.

This may be readily understood in the case of private Home C, where the care plan was said by the manager to be verbal only. It is less understandable in the other homes (particularly A, B and F) where the system was, as far as the managers were concerned, an important and established part of the organization of care in the home.

Devising, implementing and reviewing care plans was a major part of the keyworker role in the original RCA/BASW paper (1976). The limited definition of keyworker offered to me by a number of residents as 'the care girl' or 'key lady who helps me bathe', is understandable in the light of this evidence.

Conclusion

In this chapter, I have drawn on an analysis of the origins and theory of the development of the keyworker role and care plans as core exemplars of professionally defined 'good practice' to investigate their implementation by staff in residential care of senior citizens. The focus was in terms of the philosophical potential of keyworking and care planning to enhance and individualise residents' quality of life.

I argued that my analysis of the origins and theory behind the development of the keyworker showed variation and confusion, reflected in the different ways that it had been understood and implemented by staff and experienced by residents in the homes that I studied. I argue that this variation and confusion reflected the varied and conflicting definitions of 'good practice' by practitioners, which I discussed in Chapter Four and in Chapter Six. I argued that the variation and confusion around definitions of keyworking and care planning I identified in the practice literature, was reflected in the different patterns of implementation and understanding of keyworking and care planning between public sector and independent sector, particularly private homes in my study. This, I argue, reflected unresolved and ongoing debates about the definition of 'good practice' in residential care. I argued that my finding that keyworking and care planning had become incorporated into the routine process of giving physical care rather than promoting individual quality of life was due to the confused and debated definitions of 'good practice' among practitioners and staff understandings of ageing as physical 'dependency'. I argued that other sector homes

had understood and implemented the keyworker and care planning variously, in the light of their definitions of 'good practice' and of the objectives of residential care for senior citizens. I argued that these varied definitions of 'good practice' were reflected in the understandings and experiences of keyworkers and care plans reported by the residents in my study.

In the six case study homes, most people in three homes - two local authority and one voluntary - knew their keyworker and could name the member of the care staff. I argued that for the most part, their understanding and experience of the keyworker role reflected what the staff time use survey had revealed, that it was primarily associated with everyday physical assistance with personal care, particularly bathing.

I argued that the vagueness of residents about the existence of care plans and what their purpose and function might be because it was senior staff who said they compiled care plans 'with' residents. Senior staff were not associated by residents with their keyworker because they were not the person that assisted them with personal care. The model of keyworking identified in the study appeared to be the 'mixture' identified by Douglas and Payne (1980). In that model, the head of home or senior staff held the responsibility for care plans but the title 'keyworker' was vested in care staff who functioned as the 'key person' identified by Hopkins et al. (1984). As a result of this splitting of the role, both staff and residents had a generally undeveloped and unclear understanding of the roles the keyworker was supposed to undertake. SSI Inspection reports on local authority residential homes for senior citizens have described the staff in some homes as 'rather hazy' about the concept of key working (SSI 1995:15), so a lack of understanding among residents of keyworking and care plans in these homes is not surprising.

In the earlier part of the chapter, I discussed the origins and development of the keyworker in residential settings as a means of resolving boundary disputes between residential and field social workers. I argue that its secondary purpose of improving the quality of life of residents in residential care homes remained largely undeveloped because the staff emphasis of their role was on giving physical care. I argue that, like other elements of 'good practice', the overriding preoccupation with physical care has resulted in the keyworker being defined in terms of responsibilities for giving physical assistance to a specific group of residents. Its potential as means of giving residents the individual attention they wanted and enabling them to enjoy a satisfying quality of life in a way of their choosing was not realised.

Care plans have not yet achieved their potential and have largely remained as records of the physical care routines applied to individual residents, few of whom, in my study, were aware of their existence. I argue that an SSI inspection report of local authority homes showed the influence of biomedical models of ageing on residential care. The definition of 'good practice' in homes had been narrowly interpreted by staff in terms of giving physical care to people who were seen as 'dependent' and incapable of acting independently. Inspectors found care plans 'relatively undeveloped' in homes. Homes frequently blamed this lack of development on the level of staff literacy (SSI 1995:14, see also Coleman et al. 1999:38). Residents' files were described by inspectors as more generally containing 'a hotchpotch of papers relating to financial, legal and health matters together with extensive day to day reports of the resident's [physical] functioning' (1995:14). The involvement of the resident in compiling care plans tended to be minimal.

I argue that although the keyworker role was recommended in a number of policy documents and reports, it remained, like other features of 'good practice', poorly

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understood, under-theorised and under-used by providers and practitioners and has developed haphazardly as a result. It has yet to be demonstrated whether implementing a keyworker system in residential homes for senior citizens is experienced as quality of life-enhancing and enabling for those who live there. My research revealed keyworking as very much associated with physical care. I argue that the potential of keyworkers and care plans to enhance the quality of life of senior citizens in residential care by promoting their independence, choice, privacy and fulfilment through activities remains largely unrealised. I argue that this is because professional definitions of 'good practice' are confused and conflicting and because staff hold the same ageist attitudes that exist elsewhere.

Where homes implemented keyworking and care planning, these tended to be incorporated into the process of physical care-giving rather than addressing the social and emotional aspects of life which residents valued. It is these aspects of life in homes that were missing from residents' lives and which they raised during the interviews and which Schneider (1997) also highlighted in her study, as already discussed. Residents expressed quiet resentment that they were unable to persuade staff to make time to pursue ordinary, recreational activities with them. Such activities were seen as peripheral and expendable in a regulatory approach to care that attached greatest importance to ensuring residents' 'safety' and meeting their physical care needs. Our time data, provided by staff themselves, clearly showed how little working time was spent pursuing those activities with residents that could enhance their quality of life. This did not stop some writers making large claims about the positive effect of keyworking on service users' lives (Mallinson, 1987; 1991).

On the basis of more recent work and the evidence presented here, with an admittedly small sample of service users, I argue that keyworking, as it was implemented, was

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not necessarily an indicator of 'good practice' in homes for senior citizens. The keyworker reinforced staff responsibility for a group of residents rather than being a vehicle for negotiating individually with residents how they wished to be supported in the home. It is salutary that many of the people I interviewed associated a relationship with a particular member of care staff with the receipt of physical care, predominantly being given a bath. If the keyworker role is to become a means of enhancing the quality of life of residents as it could do, its primary purpose and function needs to broaden and change. As practised in the homes we visited, it had become an organizational tool for staff that reinforced the 'dependency' rather than enhanced the independence of the people with whom they worked.

Having investigated how the philosophical principles of independence, choice and privacy in 'good practice' were interpreted and implemented by staff in two core activities with residents, I move on in Chapter Eight to compare the social care model of 'good practice' with an alternative model of residential care. This model, adopted by a private home among the six case study homes, centred on defining 'good practice' as a 'personal service' that was not solely concerned with the physical care aspects of residential life. In the next chapter, I argue that the 'personal service' definition of 'good practice', based on the concept of hospitality on which this home operated, had the potential to fulfil the professional definitions of 'good practice'. This home, by defining 'good practice' in the way that it did, was able to give senior citizens in residential care homes the independence and quality of life they were seeking.

Chapter Eight - Two Contrasting Approaches to 'Good Practice'

Introduction

Up to this point, the thesis has explored and analysed the development of 'good practice' in the statutory model of residential care, focusing on its ability to promote the quality of life of senior citizens as residents. I have used three principles of professional definitions of 'good practice'- independence, choice and privacy – to examine how it is experienced by senior citizens as residents and how the implementation of 'good practice' by staff affects promotes residents' quality of life.

In Chapter Seven I examined the philosophical and theoretical intentions behind the development of the keyworker role and the development of care plans. I argued that they were often narrowly interpreted by staff in terms of the core activity of physical care-giving and are often poorly understood by residents as a consequence. These two examples illustrate how the policy philosophy to promote quality of life in homes through 'good practice' can become subverted when the principles are at variance with a regulatory and risk-aversive approach that puts greatest emphasis on senior citizens' 'dependency' and need for physical care.

In this chapter, I compare and discuss an alternative approach to 'good practice' adopted by one private home in our case study sample of six homes. I subject this home and its approach to similar analysis and compare it with the 'social care' approach of the statutory model. I conclude that the approach of this home, based on the concept of 'hospitality', with its hotel background, was more successful than homes operating the 'social care' approach in achieving the core principles of 'good

practice' to enhance the quality of life aspirations of its residents. I argue that this success was due to the owners' attitude to risk, privacy, residents as customers and their focus on hospitality rather than care.

The social care approach

The social care approach adopted in public sector residential homes reflects their statutory duty to provide a care home service, consisting of 'accommodation, together with nursing, personal care or personal support for persons' who are vulnerable or in need (Regulation of Care (Scotland) Act 2001). It incorporates policy guidance, local procedures and the accumulated 'practice wisdom' of inspection and residential care staff. Local authority homes vary considerably in size and design. Some are adapted former private houses, others have been purpose-built at different times and reflect the changing fashions and philosophies about desirability in terms of size, layout and design that I have already discussed in previous chapters. I have already demonstrated that the persistent failure at policy and practice level to define the objectives of residential care for senior citizens has resulted in uncertainties about what 'good practice' should be. Residents are unsure what to expect of life in homes and staff are left to carry out the unspecified residential task in the way they think best (Clough 1981, PSSC 1977, Booth 1985, Atherton 1989, Brearley 1990, Clough 1998, Sutherland 1999). The conflicts care staff experience in providing care and support to people whilst recognising their right to self-determination as fellow citizens have been highlighted in a number of studies (Dixon 1991, DHSS 1979, Dartington, Miller and Gwynne 1981, Goldberg and Connelly 1982, Youll and McCourt Perring 1993, McCormack 2001, Eales et al. 2001,Secker et al 2003).

In the 'social care' approach to 'good practice' staff assume responsibility for residents' welfare because they are seen as no longer able to manage it for themselves

(see Coleman et al. 1999, Peace et al. 1997). By applying for residential care or, more typically, being referred for care by professionals or relatives, senior citizens are defined as 'socially incompetent' or incapable of remaining 'independent'. Social workers use assessments of peoples' physical, mental, social and emotional 'needs' to determine their eligibility and priority for the services available to meet those needs. Thus is the person's physical and social 'dependency' constructed and their 'need' for care confirmed (see Chapter Two, Walker 1982 and Dant 1988 for a fuller discussion of how 'dependency' is socially constructed). People are rewarded for becoming and remaining 'dependent' because this is the way to get help (Browning 1999:123). As the age of entry to residential homes rises, the need for physical assistance obscures the fact that most people have continued to make decisions and exercise control over their lives to a greater or lesser extent up to the time of their move. Most remain keen and able to do so. This is particularly true where loneliness or loss of confidence rather than physical or mental impairment have been the prime reasons for the move.

As I have already illustrated, the social care approach may assume total responsibility for senior citizens in a number of ways when they move, are 'admitted' or 'put' into a home, such as assuming management of their finances and their medication. Although local authorities paid lip service to the importance of giving residents privacy, their former local registration and inspection units varied greatly in the percentage of single rooms (20%-100%) they expected homes to provide (Day, Klein and Redmayne 1996). Variations in registration requirements have now been removed by the development of National Standards for residential care and nursing homes. In England the Commission for Social Care Inspection uses the National Minimum Standards under the Care Standards Act 2000. Although new build, extensions and first time registrations of homes must now provide all single rooms,

pre-existing homes can continue to offer 80% of single rooms or less. In Scotland, independent inspections are conducted by the Scottish Commission for the Regulation of Care (The Care Commission) under the Regulation of Care (Scotland) Act 2001. The National Care Standards for Care Homes for Older People have finally given senior citizens the right to the privacy that they want. By 2007, residents in all care homes in Scotland will be able to have a single room if they wish it (Scottish Executive 2001:20). A couple wishing to share will be offered two rooms.

As I have already discussed in Chapter Four, risk assessment is part of social work assessment of need and is at the heart of social care (see Wenger 1997, Parsloe 1999, Taylor 2004). Attitudes to safety and risk in residential homes can restrict residents' autonomy and quality of life (DoH/SSI 1989, Parker et al 2004). It has even been suggested that residential care is primarily used as a resource to manage risk (Brearley 1990:97). Taylor (2004) found that professional approaches to risk varied from risk averse (particularly in home care services) to risk taking (in rehabilitative and hospital discharge settings). In Chapter Four I discussed a number of policy and practice documents (Avebury 1984, DoH/SSI 1989, Avebury 1996, Residential Forum 1996) which were published around the time of my original research studies. These documents stressed the importance of allowing people in residential care to take risks. These reports linked responsible risk-taking with independence and pointed out that excessive paternalism and concern with safety could lead to the infringement of individual residents' rights (Avebury 1984, Counsel and Care 1992, Parker et al 2004).

The Centre for Policy on Ageing studied the attitudes of senior citizens to risk and safety, interviewing people living in their own homes, in sheltered housing and in residential homes (Wynne-Harley 1991). Interviewees frequently expressed the view

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that 'in the Third and Fourth Ages, they can afford to take risks' (1991:29). The report asserted that the right of senior citizens to choose to take informed risks was indisputable. 'When risk-taking was not informed or considered, then the concern of the community might be justified and efforts made to reduce the risk but preserve the lifestyle' (p.29). Risk-taking involved balancing the freedom and safety of the individual and the whole group (Brearley 1990). However, because the social care approach assumed that the overall responsibility for residents' safety, security and welfare lay with staff, there was a tendency to try to avoid risk rather than manage it (see Residential Forum 1996).

Risk management at the level of the individual home has to be supported by external managers. Even then staff might not be confident that responsible risk-taking would be supported in the event of an accident (see Youll and McCourt-Perring 1993:207). Crump identified a similarly based reluctance among nurses to let senior citizens take risks and suggested that there were greater risks from inactivity than from activity (quoted in Hockey and James 1993:49). Fears of adverse publicity, media distortion and potential litigation combine to militate against policies that encourage responsible risk-taking. Although staff might pay lip service to the core values of independence, privacy, rights and choice for residents, the extent to which residents were able to exercise these rights depended on the staff assessment of the risk involved. Thus in some homes in my research, staff checked on residents regularly throughout the night, assisted them routinely when bathing or showering irrespective of the resident's preferences, and restricted their freedom to smoke or take a drink, which I have already discussed in Chapter Six (Hockey and James 1993:31).

Having discussed the social care approach to 'good practice' of the public sector, I now want to consider the approach to 'good practice' taken by the owners of the

private case study home, who were former hoteliers. I begin with a discussion of the philosophy and functioning of hotels, looking in particular at their management of privacy and risk within a context of hospitality.

The purpose and function of hotels

The available social science literature on hotels at the time of our research studies (Wood 1994) did not indicate any of the ambiguity or uncertainty of purpose that I have argued surrounded residential care. Hotels have been characterised as public organizations that offer an individualized service in return for payment (Mars and Nicod 1984). In complete contrast to the stigmatizing pauper origins of residential care homes, early hotels were modelled on elitist, aristocratic lifestyles. Only people from upper and middle class backgrounds originally used hotels. Increasing affluence has enabled people from a wide range of social backgrounds to use hotels. Like other forms of institution, hotels could be seen (Wood 1994) as agents of social control in their attempts to maintain their exclusivity. Over time, hotels have changed the services they offer to guests. For instance, self-service has increasingly replaced personal service rituals, through the use of technical devices such as buffets and drinks machines. Sociological commentators have been divided on whether these changes reflect a process of proletarianisation (Riley 1984), domestication, rationalisation of management or a desire to provide environmental continuity between home and hotel for guests (Wood 1994). Technical devices can certainly reduce staff costs and increase profitability.

The commodity that hotels of all kinds trade in is 'personal service' (Wood 1994). The stratification in the hotel industry only serves to create 'different expectations of the extent and quality of [that] personal service' (Wood 1994:70). Whether hotels meet their customers' expectations or not is a crucial element of satisfaction. Elias

(1983) described the way in which private and public social behaviour had been and still was constantly changing and being refined as the 'civilising process'. Expectations of interpersonal relations between guests and between hotel managers and guests changed towards greater self-control and rising standards of shame and embarrassment (Rojek 1985). This is reflected in the accommodation provided by hotels. The change from shared to en-suite bathrooms is one example of this trend. In the thirteenth century sharing a bed with a stranger was regarded as socially acceptable. Contemporary hotel guests do not expect to be asked by the management to share a bedroom, let alone a bed, with a complete stranger because it would be 'indecorous' to do so and therefore socially unacceptable (Wood 1994:72). Why sharing a bedroom with a stranger became socially unacceptable for hotel guests long ago but is still regarded as acceptable for some people living in residential care homes I shall explore later in the chapter.

Other research has confirmed that managing privacy can be a problem not just for large tourist organisations like hotels. It is even more problematic for bed and breakfast establishments, where the boundaries between public and private areas are much less clearly defined and not necessarily shared or mutually understood. Landladies running bed and breakfast businesses in their homes have found managing privacy especially difficult because expectations may differ between them and their guests about which parts of the house are private and which are available to guests (Stringer 1981, Bouquet 1984).

Hotels act to control their clientele in two ways; firstly by targeting potential customers, and secondly by managing guests' behaviour once in residence (Wood 1994). When devising their service model, hotels have used the mechanism of market segmentation to make crude assumptions about what different income and

occupational groups want by way of accommodation, food, drink and entertainment. The star ranking system of classification guides potential customers towards the model of hospitality they find attractive in terms of price, facilities, implied dress codes, food service rituals and the types of cuisine offered (Wood 1994).

Hotels have acted on the assumption that the guest or customer is a self-determining person who can do what he or she likes, and will not be considered a nuisance to other guests until proven otherwise (Atherton 1989:69). In part, this view of the guest stems from the fact that he or she is paying for the privilege. In many of the residential care homes I studied, I argued, the situation of a senior citizen was entirely different. The assumption was that the resident was not a self-determining person and could not do what he or she liked because they were no longer capable of self-determination, having been assessed as 'dependent' and in need of 'care', they had become the responsibility of staff. At the individual hotel level, hospitality is 'managed' in order to maintain the decorum and privacy that underlie acceptable social relations in public (Wood 1994). The normal conventions of privacy in the social care model of residential care were not mutually understood and applied between residents and staff because the culture of 'care' put a premium on safety and risk avoidance and the need to keep residents under surveillance (see Parker et al 2004). Guests expect hotels to treat them as *private* individuals. The challenge for the hotel lies in meeting this expectation whilst continuing to operate a generalised business function to *sets* of individuals (Wood 1994).

Like other institutions, hotels have been said to have an external appearance and a (different) internal reality known only to staff and permanent guests (Hayner 1936). The division between the public and private areas of a hotel preserves the expectations of management and guests about the form of hospitality being provided.

When not using public areas, guests are expected to use their bedrooms which, along with the staff quarters and the kitchens are 'back regions' (Goffman 1959:112), where guests and staff are protected from each other's intrusion through the mutually understood convention of privacy. Although staff have master keys, hotels enable guests to safeguard their privacy and control access to their rooms by providing keys and printed signs to indicate when it is convenient for staff to enter or when the guest does not wish to be disturbed.

Modern hotel bedrooms are increasingly furnished like domestic bed-sits, providing items such as sofas, easy chairs and coffee tables as well as tea and coffee-making facilities, telephone, television, video and mini-bars (Wood 1994). 'Domesticating' bedrooms in this way is said to encourage guests to use them more during the day and is part of the strategy to manage behaviour and maintain harmony between strangers (Wood 1994). This contrasts with the 'good practice' emphasis on encouraging a spirit of communality in residential homes. However, the growth in popularity of self-catering accommodation may indicate customers' rejection of this trend towards 'pseudo-domestication' by hotels. Self-catering may be preferred because it imposes fewer behavioural and social constraints on families (Wood 1994) and because it is usually cheaper. A parallel could be drawn here with the greater popularity among senior citizens of housing based models with care as solutions to their need for increased support rather than residential care (Thompson and West 1984, see also Fisk 1986, Clough 1998, Oldman and Quilgars 1999). In both self-catering accommodation and sheltered housing, occupants can conduct their lives and behave as they wish within a private rather than predominantly public context and control over everyday life remains with them rather than the provider of the accommodation.

Having described the purpose and function of hotels I now move on to consider how far this way of operating is replicated in private residential care homes.

Private residential homes

Most private residential care homes, like small private hotels, are run by individuals, families or couples rather than companies, although the market share of the top ten providers increased from six per cent to about 22 per cent of the total between 1993 and 2004 (Laing and Buisson 2004). Homes tend to be run as small businesses and reflect many of their characteristics, being predominantly family run enterprises, jointly owned and managed and having little capital (Scase and Goffee 1980, Phillips et al. 1988, Argyle et al. 2000:71).

The background of private homeowners has been shown to be gender-related. At the time of my second study, women homeowners were more likely to have a nursing background (Phillips 1992), whereas men tended to have small business or self-employment experience (Phillips 1992, Phillips et al. 1988). The incidence of owners with a background in social work or social care tended to be much lower. It was not unusual to find both nursing and business skills among partners. The partner with the nursing skills managed the day-to-day running of the home, and the spouse or partner with business experience taking responsibility for the upkeep of the building and the financial aspects of the enterprise. Only a minority of private homeowners came into the residential care business from a hotel background.

In some areas, particularly former coastal holiday resorts, the same owners may have changed the function of the property from that of hotel to residential or nursing home in response to changing leisure patterns and demographic trends (Phillips et al. 1988). Some large hotel chains also moved into the care business, predominantly the nursing

home sector, setting up subsidiary companies to do so. This reinforces the proposition that the two kinds of enterprise have aspects in common.

Some private homes emphasised hotel aspects in their brochures such as the desirable location, architectural merits of the building, the facilities and amenities provided and the flexibility and range of choices available to residents. Others emphasised a 'homely' and informal approach to care. Owners with a nursing background might emphasise a medical model of care, highlighting therapeutic and rehabilitative elements of the service they provided. In areas where there was keen competition between homes for residents, there was a need to 'sell' a distinctive model of care or to target a segment of the care market, such as senior citizens reliant on local authority funding or those able to pay higher fees themselves.

Relatives often play a key role in choosing a private residential home for an older person (Sinclair 1988, Phillips 1992, OFT 2005). They tend to place importance on security, privacy, a home's atmosphere and its ability to cater for individual tastes (Phillips 1992, OFT 2005). Some of these features are at the heart of the 'individualized service' offered by hotels. Whilst senior citizens themselves share most of these aspirations, they want more independence and consequently more risk taking rather than the security sometimes emphasised by their relatives (Phillips 1992, Joseph Rowntree Foundation 2005).

The case study home

As I have already discussed in Chapter Five, one of the private homes visited in the second phase of the national research project (Bland et al. 1992) impressed us all as qualitatively different from the other five homes we visited. Each of us later described this difference as being 'more like a hotel than an old people's home'. I

wondered whether some of this difference might be attributable to the hotel background of the owners and I subsequently, as part the work for the thesis, researched the sociological literature in order to understand the conceptual framework for hotel keeping.

The husband and wife couple who ran the private residential care home spent a great deal of time there - between sixty and seventy hours a week - to ensure that the staff were delivering the care service to residents in the way they wished. It is not unusual for owners of small, private homes to work such long hours to keep down staffing costs. In this home, the owners were performing a largely managerial and supervisory function (although the wife cooked at weekends) and said they did not find the long hours a problem.

The residential care home was a large, detached, two storey Victorian house with a modern, single storey extension, standing in its own grounds in a quiet residential area near the centre of a small seaside town. The home was attractively furnished and had a spacious hall, sitting room, television lounge, conservatory and dining room. Each of the eighteen bedrooms had en-suite bath or shower, television and tea-making facilities. Previous owners had installed a jacuzzi which was said to be very popular with residents, although none of them mentioned it in the interviews. A resident-operable chair-lift provided access to the upper floor of the house for residents unable to climb the broad, sweeping staircase.

Each resident had their own room, apart from a married couple who shared. Residents varied in their levels of physical and mental disability. A number used walking frames, one resident was bedbound and visited by the community nurse twice a week. Three people had dementia. The home's approach to its residents resembled the personal service orientation of hotels. There was a sense that residents expected

to be and were treated by the owners as adults and as individuals. There was no obvious emphasis on 'the resident group' or any sign that the home functioned as the surrogate community identified by Davies and Knapp in local authority homes (1981).

The residents appeared to have retained a considerable measure of independence, control and privacy in their lives. We sent individual residents a brief postal questionnaire about aspects of their care and used subsequent individual interviews to find out how far our impressions of the home as researchers matched their experience as residents. I have already discussed the topics addressed in the questionnaire in Chapter Five, which previous research had identified as important to people in residential care. All the residents who responded to the survey replied affirmatively to the questions.

The questionnaire also invited residents to identify up to three aspects of home life that they particularly liked, disliked or would wish to change. Most people appeared to find it easier to say what they liked about the home rather than what they disliked or wanted to change. People identified many aspects of the home that pleased them, particularly the atmosphere, the relationships between the staff and residents, physical aspects of the home and the services it provided.

'The beautiful, spacious well-kept garden (back and front); knowing that help is at hand whenever needed; being able to have my dog with me – a very dear pet, who died a few months ago, aged nearly 15'. WP7F.

'The loving care of owners and staff; visitors being offered tea or coffee; having one's own toilet, wash hand basin and shower and TV'.WP5F.

The care provided by the caring staff both day and night. The free and easy atmosphere with residents and care staff'. WP3M.

'A. and C. are very good; the staff are excellent; privacy and freedom, comfort and cleanliness'. WP2F.

'Cleanliness; Friendship; Homliness (sic)'.WP1F.

'Nice residents, easy to get on with; the staff are very pleasant; breakfast in bed'. WP9F.

Three people mentioned aspects they disliked about the home, including one person who mentioned its relatively high costs.

'The home is expensive'. WP11F.

One resident held very different views about the food from most of the other respondents, highlighting the different expectations people have of residential care:

'The penny pinching with regard to food; the way the staff are treated; when profit comes before comfort'. WP3M.

Residents wanted to make changes in the home by improving the food and arrangements for dealing with soiled laundry. They also wanted greater accountability from the owner of his handling of residents' financial affairs.

'Two of the residents here smoke and as they are not quite bright their cigarettes are supplied to them by the owner, both are light smoker and use approx two packets per week. They never recieve (sic)' one penny of pocket money which should be about £8 left after the cigarette are paid for (wher (sic) is it going). WP3M.

One person was critical of staff and three people criticised both the quality and quantity of the food and found the heating inadequate at times. Most positive comments were made about the owners, the care staff, the services and the

atmosphere in the home. This was the highest level of endorsement from residents in the six homes. All twelve residents in the case study home who returned questionnaires responded positively to six of the nine questions about life there. Although residents of this home were largely positive about it, they nevertheless saw it as qualitatively different from their own home.

'It's important to be tolerant and not expect it to be exactly like one's own home'. WP4F.

'It's not like home. The surroundings are pretty. They try to make you feel at home'. WP6F.

'It's not home'. WP1M.

These spontaneous statements from residents show that, despite high levels of satisfaction with the residential care home, it was not and could not ever feel like their own home. What the owners did was try to make their residents feel 'at home' which is different. Policy guidance to public sector homes with its emphasis on 'domesticity' and the Group Living model of care, already discussed in Chapter Four, was predicated on residents living in 'pseudo-family' groups proved unpopular with residents and staff alike. The private sector home did not pretend or try to be a domestic home. It modelled its care on an institutional form in which its owners had expertise, that of the hotel, with the owners acting as hosts rather than in a paternalistic or parenting role towards residents.

In the subsequent individual interviews, two interesting differences with public sector resident interviews emerged. Firstly, the private home residents expressed particular appreciation of the owners' flexibility and attention to them as individuals, giving numerous examples. These included providing vegetarian meals made from home

grown vegetables for one resident; and accepting another resident's grand piano, which enabled her to continue giving music lessons. Public sector residents were appreciative of staff in general rather than commenting about the quality of their relationship as individuals with the homes' managers. Secondly, the case study home residents responded confidently to questions about the way dissatisfactions or complaints were handled.

'A. said to complain directly to him, not sit and discuss it in the lounge'.

'I complain to Mr. S. He takes action immediately'.

'They are always attended to, Mrs. S. particularly'.

This readiness of the owners to address residents' dissatisfactions gave them three important messages. Firstly, that the owners recognised that there would be elements of home life which would displease individual residents from time to time; secondly, that residents had a right to voice their complaints and thirdly, that complaints would be responded to. Half the residents interviewed had made a complaint at some time and declared themselves satisfied with the owners' response. It was interesting that residents who expressed dissatisfactions with the lack of financial accountability in the questionnaires apparently had not complained to the owners. This contrasted with the public sector homes residents' awareness of how to go about making a complaint but their general lack of experience of actually doing so, despite expressing some dissatisfactions with aspects of their care during the interviews. Research by the Office of Fair Trading (2005) found that more than a quarter of care home residents interviewed had been dissatisfied in the past. One fifth had gone on to make a complaint and eight per cent decided not to (p. 118). In Scotland, 1,285 complaints were made to the Care Commission in 2003-4 about care services (Care Commission

2004:14). Two thirds (64%) of these complaints, mostly made by family and friends rather than residents, were about care homes. The highest number of complaints was about the services being provided and the behaviour of staff providing care (Care Commission 2004:14). In their survey of care homes, the Care Commission found that over one third of residents did not know about the procedure for making complaints (p. 23).

Relatives of residents in the six homes in our second study were also asked to complete a brief postal questionnaire on aspects of home quality. They showed similarly high levels of satisfaction with the case study home. All relatives enjoyed privacy on visits and knew where to address complaints. The vast majority of those who responded did not want any changes to the way the home was run. This was the strongest expression of relatives' satisfaction across the six homes. Again the largest number of positive comments from relatives were about the owners and the staff (more than in the other five homes) and the atmosphere in the home. The questionnaire responses from residents and relatives supported the home's high scores in the survey phase of the research and our impressions during the field visits.

Aspects of the personal service approach

I now want to examine how the private home's approach to the care of its residents differed from the social care approach in certain key aspects of 'good practice'; notably in the home's attitude to residents' independence, freedom of choice and privacy, and its management of risk. I have already argued throughout the thesis that the social care approach has been based on a medical model of ageing as disease and dependency. Resident independence has tended, therefore, to be interpreted narrowly by staff in some homes in terms of maximizing functional ability to perform daily living activities, an interpretation shared by some researchers (Sinclair 1988:269,

Coleman et al. 1999). As I have already argued in Chapter Six, the extent of choice and privacy available to residents may be subject to staff judgements about the level of 'dependency' and associated risk (see Fine and Glendinning 2005).

Managing risk is part of the process of hotel keeping. In the 'personal service' approach, the relationship between the case study home and the residents was more like that of hotel manager and guest. The resident was a 'customer' buying an individualized service who expected to be treated as an adult and as a private individual. The personal service approach strove to match the residential care product it was offering with the expectations of its customers, the residents. In the social care approach the expectations of residents about how they would be treated was irrelevant, since they were not seen as customers who had to be satisfied. As 'dependent' individuals the regime to meet their assessed 'needs' was determined by staff (see Sinclair 1988:267, DoH/SSI 1989:13, CPA 1996:24).

As I have discussed earlier, senior citizens have identified the anticipated loss of independence and lack of privacy as reasons for their reluctance to contemplate residential care (Salvage et al. 1989, Sinclair 1988, CSCI 2004). I have also argued that their understanding of the meaning of independence is broader than the narrow, functional one often applied in the social care model. The private home did not operate from a therapeutic or 'needs' basis but from that of 'hospitality', offering a 'personal service' which allowed individual residents to choose the help they wished in managing their daily lives. As a result, the quality of their lives was more under their control than for people receiving the social care approach, which focused on a 'dependency' model of ageing necessitating physical care and which resulted, I argue, in reduced quality of life.

Privacy and choice

According to Goffman, an 'individual's sense of privacy, control and self-respect is tied to the control he (sic) exerts over his fixed territories' (Goffman 1971:338). This is why the provision of private accommodation for residents, and staff who respect residents' right to privacy are key components of good quality care (Harris, 1977, DoH/SSI 1989, CSCI 2004). If privacy is afforded to them, people are able to exercise choice over what they do without encroaching on other residents. They are able to safeguard their dignity because intimate, personal activities such as bathing or assistance with toileting remain private activities and people are better able to preserve their sense of self-respect and social competence among fellow residents.

The case study home provided residents with individual, lockable bedrooms, all with en-suite facilities; it was the only home in the area offering such a high level of amenity when it had opened three years previously, a level still comparatively rare in residential care homes. The postal questionnaire had asked residents about their freedom to use and secure their privacy within their bedrooms. All twelve respondents replied positively to these questions. GP visits took place in the person's own room and a member of staff was present only if the resident wished. The home accorded residents their privacy by providing them with private accommodation and by applying the normal social conventions of privacy between strangers, as hotels do, and by transmitting these conventions to the care staff. Residents in turn respected the staff's right to privacy by not going into the kitchen. The owners discussed with each resident on moving into the home, what help they required. Residents were asked whether they wished to be helped with bathing and whether they wanted to have breakfast in bed. This discussion was the basis on which individualised care was provided.

The social care approach did not adhere to the normal social conventions of privacy between strangers in public places because these conventions differed from the conventions about privacy in two settings that it tried unsuccessfully to combine in residential care homes. These were the hospital setting, where patients temporarily forego their normal, conventional expectations of bodily privacy before strangers in pursuit of treatment and cure, and the domestic home, which is quintessentially private. Family members are not strangers and expectations of privacy are governed by norms and taboos of behaviour between kin that are individually determined. The attitudes of staff implementing the social care approach to privacy were therefore governed by a social construction of the resident as 'patient', 'family member', even 'child', (see Hockey and James 1993, Clough 1998). In any of these roles the conventional right to privacy that operates between strangers may not apply. The prime function of the residential home was 'to care', that is to take responsibility for or take charge of people deemed unable to care for themselves, an ideology of caring which Morris has said underpins practice in both health and social services (Morris 1993). Normal social conventions surrounding privacy are therefore seen as inappropriate or impractical at best or dangerous at worst, since residents need to be under staff surveillance if their safety is to be safeguarded. This highlights a gap between the rhetoric of policy and practice documents, which place great emphasis on resident privacy and choice, and the reality of care in practice where they may be subordinate to the preoccupation with avoiding risk.

Independence and the management of risk

Acknowledging residents' independence or autonomy involved staff in homes giving up some of their power and control, thereby incurring an element of calculated risk (DoH/SSI 1989, Adams 1996). This was not something staff in local authority homes

found easy to do because they saw their primary function as to give physical care, which might be incompatible with allowing residents to take risks and possibly come to some harm by doing so.

In the case study home, the residents' right to their independence seemed to be taken for granted by the owners. Residents were, after all, free agents and could theoretically leave at any time and move elsewhere if they became dissatisfied. This right to be independent extended to residents engaging in some potentially risky activities if they chose. For instance, the home had no rules about smoking. Residents were free to smoke when and where they wished, including in their bedrooms. As I have already discussed in Chapter Six, this attitude to smoking was completely contrary to that shown in most residential homes, where staff might try to enforce a ban on smoking altogether or severely restrict it. The owners appeared to respect what Wood calls 'the bourgeois notion of the sovereignty of the self' (Wood 1994 p.74). The owners knew which of their residents smoked. They included one very heavy smoker who had epilepsy, which constituted an even greater potential risk. The owners described how they had assessed the risk this person's smoking habits involved and taken a number of precautions to minimise it with the help of the local fire officer. Safety was promoted through fire doors and by installing smoke alarms in every room and by dividing the house into a number of zones and assembly points. Waste paper bins in smokers' bedrooms were not lined, as an additional precaution. The owners calculated the potential risks involved in giving residents that degree of autonomy and because they were in the home most of the time, they were able to manage, monitor and carry that risk themselves.

Hotels cannot prevent guests smoking in the privacy of their bedrooms and must manage the risk of fire, relying on technical means to minimise it. The private home

owners adopted a similar approach, whereas local authority homes sought to minimise the risk by restricting smoking to one area of the home or by keeping residents' smoking materials for them, dispensing cigarettes or matches on request. Smoking in bedrooms was and is usually forbidden. However, as my interviews with residents and managers demonstrated, such an authoritarian approach is not necessarily less risky because some residents secretly continued to break the rules. The social care approach was more controlling and paternalistic, tending to focus on the health and safety of the resident group as a whole rather than on the independence of the individual (Parker et al. 2004, de Waele and van Hove 2005).

The private home used technical means to manage another potentially risky activity, namely that of bathing. All bedrooms had en-suite facilities, reinforcing the possibility of the initiative and control over bathing or showering remaining with the resident. Residents decided when they wished to take a bath and help from staff was available for those who wished it, but it was not routinely imposed. Residents who bathed or showered without assistance were therefore able to safeguard their dignity and their privacy when performing these intimate personal care activities. Hotels are preoccupied with maintaining a state of normality and with respecting guests' right to their privacy. For the private home residents who chose to bathe without help, technical means were again used to enable privacy and minimise the risks involved. Each bathroom was equipped with grab rails, seats and pull cords so that the resident could summon help if needed.

Although most local authority homes usually had mobility aids and alarm mechanisms in bathrooms, these did not appear to minimise risk sufficiently for staff to feel able to let residents be the judge of whether they could bathe safely without help. Moreover, staff had made a 'professional' assessment of the individual's need

for assistance with which the resident may have felt unable to disagree. A tendency towards risk avoidance rather than risk management by routinely assisting all residents to some degree can undermine their independence, privacy and dignity. Such attitudes reflected staff and a wider societal belief that, by being 'in care' a senior citizen was a 'less-than-whole-person' (Dartington et al. 1981:126.). They are seen as no longer able to cope and incapable of making realistic judgements about their competence to manage personal care activities unsupervised (Residential Forum 1996, Coleman et al, 1999, Clough 1998).

Miller and Gwynne (1972) found aids and equipment that might reduce disability were 'few and far between' (Dartington et al. 1981:128) in homes in their study governed by the less-than-whole-person construct. Homes where there was greater emphasis on trained staff providing physical care used less equipment in the caring process and staff held negative attitudes towards it.

Hockey and James (1993) discussed how the societal 'problem' of attempting to reconcile the perceived contradictions of adulthood and 'dependency' is managed. In residential homes, the process of infantilization is used in the care of senior citizens. Hockey and James (1993:3) used the concept of 'personhood' as embodying autonomy, self-determination, choice and full adult rights of citizenship in Western society. They stated that adults who are physically unable to care for themselves, are liable to be treated as children, and be denied or have their status as persons removed by those who have some degree of power or control over them. Such denial of 'personhood' by care staff was how 'very elderly people may find their freedom to choose for themselves progressively whittled away by the care they receive and experience a deepening sense of lost status as persons' as a result (Hockey and James 1993:49). Laing (1960) suggested that in ordinary circumstances 'an individual

experiences his (sic) own being as differentiated from the rest of the world so clearly that his identity and autonomy are never in question' (Laing 1960:41). Senior citizens who move into a home may lose that 'firm core of ontological security' (Laing 1960:42) because their social world no longer appears familiar to them. Their social redefinition by others as 'incompetent' may undermine their basic existential parameters of self and social identity (Giddens 1984).

The 'personal service' approach in the case study home offered residents choices about their everyday lives within a range set by the home that largely matched their expectations. Thus market segmentation and a diversity of approaches to care can enable a closer fit between the kind of care residents (and their relatives) are seeking and that which homes are able or willing to provide (Eales et al. 2001). In the 'personal service' approach the 'expert' about needs and wants is ostensibly the resident, so long as they and the owner/manager have shared expectations about what the home can offer. Homes which operate the social care approach may put less emphasis on the importance of residents' wants or expectations, since it is staff expertise that defines what constitutes residents' welfare and influences the overall approach to care.

The statutory model of 'good practice' expects homes in all sectors to enable residents to enjoy privacy, dignity, independence, choice and fulfilment in residential care and for their rights as adult citizens to be safeguarded. The approach to caring is supposed to derive from these values. However, as Dixon showed, in the social care approach the values themselves may be variously interpreted by staff (Dixon 1991). The central concern of the 'personal service' approach is to manage the hospitality it is providing for residents successfully. This is very similar to the role given to the home manager in the Methodist model of care studied by Kellaher (2000), where the

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emphasis is on 'maintaining an atmosphere of concern for the individual and mutual respect between residents and staff' (p.31). In the private home, hospitality is managed by ensuring that guests' privacy, independence, dignity and freedom of choice are maintained within mutually acceptable boundaries. These are normal, taken-for-granted elements of hospitality in hotels. The core values of 'good practice' associated with the statutory model of care are more akin to the philosophical concept of hospitality by which hotels operate than with hospital, domestic or familial models of care.

Conclusion

In this chapter I have compared two approaches to 'good practice' in residential care, principally in terms of their success in enabling residents to retain their independence and how they manage any associated risk. I have argued that the 'personal service' approach to 'good practice' adopted in the private home derived from the owners' previous experience of providing a personal residential service based on the concept of hospitality used in hotels and the way in which he defined the objectives of residential care. This approach appeared to be more successful in realising the core 'good practice' values of independence, choice, privacy, and dignity for residents than the social care approach adopted in the local authority homes I studied.

I argue that four main factors account for this. Firstly, the right of residents to their autonomy and independence was not contested by the owners or by care staff. Risks were calculated and managed using technical means rather than by controlling residents through the imposition of unrealistic rules and sanctions. Secondly, residents were able to maintain control over their lives because they and the staff had a shared understanding of and respect for the normal social conventions of privacy between strangers which applied to both residents' rooms and staff quarters. The

provision of television and tea-making facilities in bedrooms encouraged residents to use them during the day as bed-sitting rooms rather than solely for sleeping at night. Residents could therefore choose to spend time in the company of other residents or enjoy the privacy and solitude of their room and had somewhere to entertain visitors in private. Thirdly, residents were primarily responded to by the home owners as socially competent adult guests or customers who were purchasing (or contributing to the charges for) a service, rather than as frail, vulnerable people, identified as needing to be cared for and protected like children. The home responded to its residents who had dementia with the same respect for the adult 'self' shown to other residents, rather than treating them as children. Fourthly, because the home owners had a background as hoteliers rather than in the caring professions, there was no threat to their professional image or their 'caring' role in allowing residents rather than themselves to be the 'experts' about their needs and wishes, exercising greater control over their lives. The owners' expertise was as hosts providing a model of hospitality that included assistance with care as part of the overall personal service rather than being the central function of the enterprise, as it is in public sector homes. As I have already discussed in the previous chapter, staff in public sector residential care have low morale and self-esteem and most are untrained. Their sense of self-worth and value as workers is tied to their function as 'carers' for people who are 'dependent' on them. Encouraging residents to remain autonomous and allowing them to exercise choice about their daily lives undermines the status and power of staff and the stated function and rationale of the home, which is to provide physical care.

The 'good practice' emphasis on independence, choice and privacy as core values in homes conflicted with the staff's definition of their role, which was to give physical care to 'dependent' people and their overriding need to minimise or avoid risks by

keeping residents under surveillance. The social care approach in public sector homes denies these rights to residents if they do not control their own money, have to share bedrooms, cannot lock their rooms or have to submit to assistance with bathing. Such arrangements resemble a hospital or custodial model of care rather than the normal cultural expectations surrounding the right to privacy among strangers that apply in hotels and applied in the home operating the 'personal service' approach. The uncertainty and ambivalence surrounding the objectives of residential care homes and the confused and disputed definitions of 'good practice', led to a lack of shared expectations and understandings between staff and residents about what conventions of social behaviour should apply.

I argue that there is some evidence from this case study to suggest that the residential service model of 'hospitality' adopted by hotels can be successfully applied to other residential care settings. Hospitality respects the right of guests to their privacy and autonomy, and uses technical means for managing risk with positive outcomes for the quality of residents' lives. Major studies of care in local authority homes concluded that it did not yet provide senior citizens with an environment in which they could 'maintain a level of control supported by the right to privacy, continuity and security' (Willcocks et al. 1987:138, Peace et al. 1997). Concepts such as privacy, respect and choice have previously tended to be regarded as privileges rather than rights (Booth 1985). These ageist attitudes have not been changed by codes of practice, quality of care guidelines or service standards (Oldman and Quilgars 1999). I argue that this is because they were drawn up by 'acknowledged professional experts' and judgements about their outcomes for residents made by another set of experts (see also Peace et al. 1997:106) rather than by senior citizens themselves. Rather, I would argue, it is the ideology of 'care' itself as the focus for residential care that impedes change (see

Sutherland 1999:81). A focus on the hospitality model of hotels rather than care may

be a way to enable senior citizens to maintain their adult status while receiving the

support they need to enjoy quality of life.

Chapter Nine - Conclusion

In this thesis I have examined the concept of 'good practice' in residential care homes for senior citizens. In the study on which this thesis is built, I considered how 'good practice' has been defined in policy and practice literature, how it is implemented in care homes and experienced by residents in terms of their quality of life. My reason for using these three dimensions of 'good practice' in my study was because I wanted to understand the policy rationale: how it had developed and changed over time, how the ideas and ideals enunciated in policy are understood and implemented in care homes and particularly how 'good practice' is experienced by senior citizens as residents. It seemed to me that one could claim aspects of residential care as demonstrably 'good practice' only if their effect was perceived to be good by residents, a test that had not previously been applied. I used the concepts of independence, choice and privacy to investigate the meanings of 'good practice' since, as I showed in Chapter Six, these are aspects of life that senior citizens place great store by. They have also been given prominence in policy and practice literature as principles by which services and professional conduct in providing services to senior citizens should be judged.

In my analysis of the meanings of 'good practice', I argued that exploration of ideas about 'good practice' in residential care has to be understood within the wider social context of ideas, attitudes and policies towards ageing. I argued that these attitudes are discriminatory and ageist. Ageism is expressed in social policy in terms of ambivalence and minimalism. In Chapter Two, I argued, following Townsend (1981), that much of the 'dependency' that is typically associated with ageing and the 'need' for residential care is socially constructed. However, Townsend failed to

include in his argument the key part played by ageist attitudes, policies and practices within the Health Service, particularly in hospitals, in marginalizing and structuring the 'dependency' of senior citizens. I have argued, in Chapter Two, that there are structural influences in terms of ideas around 'good practice' in residential care. These are policies concerning the level of the state pension and income maintenance, the neglect of disability in later life and the attitudes and policies of the NHS and social services towards senior citizens who treat them as 'dependent' and in need of 'care'.

Senior citizens have been equally consistent in their attitudes to residential care, which is largely to resist it by maintaining their independent status in their own homes, often with help from their families. A minority of people who find themselves becoming markedly less able and who wish to avoid putting undue physical strain on their relatives and emotional strain on the quality of their family relationships, apply for residential care as the means of getting the assistance they need. For these people, residential care could be said to be a 'positive choice', as I discuss in Chapter Six. This is a group of senior citizens that research has often tended to ignore or overlook.

Other senior citizens place great value on retaining their independence in later life and strive to do so in a number of ways, not least, in some cases, by refraining from making demands for assistance, whether financial or in terms of services, from the State. I gave evidence of this in Chapter Two. Income and services which senior citizens cannot obtain as of right, rather than by proving their lack of resources via the hated process of means-testing, tend to be avoided. Since nearly half of all senior citizens are reliant on the state pension for their income, this expression of 'independence' by not claiming additional, means-tested benefits results in very considerable sums of money going unclaimed and an impoverished existence for a not

inconsiderable minority of senior citizens. Poverty, I have argued in Chapter Two, is still a major factor, as well as disability, in determining whether senior citizens can maintain their independence or find themselves being assessed as needing residential care.

Definitions of 'good practice'

Policymakers

My exploration of how 'good practice' has been and is defined in policy terms in relation to residential care for senior citizens turned out to be more complicated than I had expected. I concluded that, going back even to the nineteenth century, the underlying basis of 'good practice' in social policies towards senior citizens and residential care has remained remarkably consistent, despite challenges and modifications over time. These policies have been to encourage independence from the State, to expect families to provide care and support, with the statutory provision of residential care as the 'last resort' for the small minority of senior citizens unable to maintain their physical independence and lacking family support. I argued in Chapter Four that despite changes and modifications, these policies continue to have a very strong underlying influence on senior citizens' attitudes and on policy towards senior citizens and the provision of residential care.

My review of social policies towards senior citizens showed that definitions of 'good practice' in policy are often contradictory, advocating the promotion of senior citizens' independence within a model of ageing that characterizes it as a state of physical 'dependency'. Thus 'good practice' in policy terms, I argued in Chapter Three, is to provide residential care only for people whose lack of resources and assessed level of 'need' for 'care' is such that this is the most cost-effective solution to meeting those needs as far as the State is concerned.

Policymakers define 'good practice' in legislative terms to establish what services residential care homes should provide and for whom. Over time, I argued in Chapter Four, the legal definitions of the services to be provided by residential care have expanded. These have moved from an initial emphasis on people needing 'care and attention' that they were unable to get elsewhere, to providing 'board and personal care' to people who needed 'personal care' and, most recently, to include people needing 'nursing care' also, reflecting more recent changes in health service policy.

Ageist attitudes and policies towards senior citizens within the health service have, even since the development of hospital-based medicine pre-welfare state, had a marked influence on policies and practice in residential care. As I argued in Chapter Four, residential care homes, together with nursing homes, have increasingly been expected to provide care previously available from the health service. What was formerly designated as 'health care' has been re-designated as 'social care' and subject to a means test rather than being free to all at the point of use. For senior citizens unable to fund their care, the cost has to be borne by local authorities rather than central government.

In the early days of the NHS, as I pointed out in Chapter Three, policymakers emphasised the much lower cost of local authority residential care for senior citizens compared with the high cost of hospital beds and advocated greatly increased expansion of residential care homes. Within the NHS, the policy response to increases in the elderly population, has been to close beds rather than expand their availability. As I discussed in Chapter Two, acute beds as well as specialist geriatric long-stay beds have been withdrawn, causing downward pressure on the remaining provision. Convalescence is no longer available in the NHS and rehabilitation is restricted. The withdrawal of these services has particularly affected senior citizens

with chronic conditions or recovering from major trauma, whose recovery may take longer. As I pointed out in Chapter Two, 'good practice' in NHS policymaking as far as senior citizens are concerned is to shorten their length of stay in hospital and to prevent 'unnecessary' hospitalisation in the first place. Pressure to avoid so-called 'delayed discharges' of senior citizens from hospital care may result in an admission to residential care that is unwanted and in the longer term, may prove to have been unnecessary. Such health policies towards senior citizens impede rather than promote opportunities for them to exercise choice or influence decisions about their long term care and support.

Residential care is regarded as a scarce and expensive resource to be used sparingly. It is therefore important to be as precise as possible, without cramping policymakers' options, in defining the group, or groups, of people for whom such a service is to be provided. Residential care is for people who have 'needs'. 'Need', variously defined, as I showed in Chapter Three, has remained the overarching criterion for establishing eligibility for residential care. The causal factors behind the 'need' for personal care or nursing care might be age, disability, mental illness, learning disability or drug or alcohol misuse. The role of poverty has been implicit rather than explicit as a causal factor for 'needing' residential care.

Policies towards senior citizens have varied in their emphasis on whether senior citizens should be given the 'care' they are assessed as needing in a residential or 'community' setting, depending on whichever was thought to represent the lowest cost to the 'public pound' at the time. However, not infrequently, central government policies have provided, intentionally or otherwise, what have been termed 'perverse incentives' to local authorities to offer residential rather than community care, as I discussed in Chapter Two. Local authorities could access additional sources of

finance for residential care, whether from central government or from senior citizens themselves, that were not available for services provided to people living in the 'community'. The tendency has been to promote 'care in the community', where policy expectations of the family as the prime source of support and care can be realised and costs to the State minimized. In policy terms, 'good practice' in the provision of 'care' for senior citizens has more and more emphasised that they should be supported to remain at home, 'in the community' for as 'long as possible', a policy that generally accords with public sentiment and the wish of most senior citizens.

Despite this renewed policy emphasis on supporting senior citizens to remain at home, admissions to residential and nursing homes have, until the last few years, continued to increase. 'Good practice' in policy has been redefined to mean that there should be reductions in admissions to residential care. These reductions have been achieved but have not, the Social Services Inspectorate found, been substituted for by corresponding increases in domiciliary care services (Bainbridge and Ricketts 2003:32). The conclusion to be drawn from this, is either that some senior citizens were being admitted unnecessarily to residential care or that they are once again being forced to rely on their families for support and care at home. Thus 'good practice' in policy towards senior citizens, whose numbers, policy documents constantly remind us, are continuing to increase, appears to be to reduce both residential and domiciliary services to senior citizens by raising the criteria of eligibility.

Over the last decade or so, with the 'marketisation' of social services, policymakers have stressed as 'good practice' the importance of treating people who use social services as 'consumers' or 'customers'. People should be involved in the assessment of their needs and in decisions about how they should receive the care or support they require. However, decisions about whether the 'need' is for residential care rest

ultimately on the professional assessment of social workers and the availability of resources rather than the choice of the senior citizen. The element of choice for senior citizens being funded wholly or partly by the State is confined to the particular residential or nursing homes whose fees are within the financial limits that the local authority is willing to fund. Only those with the additional financial resources or friends or relatives willing to pay the difference can choose a home that is above local authority limits. Choices about whether to have their assessed need for care and support met 'at home' or 'in a home' are now available to senior citizens through the introduction of Direct Payments. Direct Payments enables some senior citizens to remain at home using payments from the local authority to enable them to purchase their own care and support independently.

As I have documented in Chapter Four, England and Scotland have adopted different policies in response to the Royal Commission on Long Term Care of senior citizens. The Royal Commission deliberately set out in its recommendations to make support and care for senior citizens a non-means-tested, universal service, based on 'need for support or care' rather than dependent on the means-tested financial resources of individuals. In Scotland, senior citizens over the age of 65, who qualify by virtue of their assessed physical needs, receive a financial contribution towards their nursing care if they are in a residential or nursing home. They also receive a larger financial contribution towards their personal care, irrespective of whether this is provided to them at home or in a home. Those people in residential or nursing home care who have the financial resources, must contribute proportionately to the 'hotel' costs of their care, which are not included in the free personal or nursing care allowance. The implication of this policy is that it should enable more senior citizens with limited or modest means and who wish to do so, to remain in their own homes, paying others for

the personal care and support they need to enable them to retain their independence. This policy, then, provided it is regarded as 'affordable', which may be in doubt, makes individual choice about where care and support are provided more of a possibility for senior citizens than hitherto.

Professionals and practitioners

Ideas about what constitutes 'good practice' in social work and social care professional and practice terms are characterized in terms of ideals. These are expressed as a number of principles or values, including the right of senior citizens to independence, choice and privacy in residential care, as I have discussed in Chapter Four and Chapter Six. However, such principles conflict with the application of policies that use physical and social 'dependency' to establish eligibility for assistance from the State and professional judgements about the extent to which a person is deemed to be 'vulnerable' or 'at risk'.

Social workers are principally required to act as assessors of 'need' and gatekeepers to limited local authority resources rather than act as advocates on behalf of individual senior citizens. The choice they are able to extend to senior citizens about their long term care and support is limited: by the resources of the individual – whether they are able to fund their own care costs – the domiciliary services and the levels of funding available, which vary greatly. There are other limits on social workers being able to implement 'good practice' in terms of choice. These may be the urgency of the need for residential care or the geographical preferences of the senior citizen. In the independent sector, choice may be limited by the ability and willingness of the provider to meet the person's assessed needs or to accept the local authority fee rate, as I discussed in Chapter Three and Chapter Four.

The legal right to a choice of residential home, within funding limits, may even be foregone in circumstances where the local authority's budget for purchasing independent sector care is exhausted or where it operates an 'in-house first' policy (Argyle et al. 2000). This obliges the social worker to use vacancies in the authority's own homes before purchasing a place in the independent sector. Privacy in terms of having a single room in residential care may be denied to those senior citizens who are entirely reliant on state funding where the accommodation available within the local authority's funding limit may only be in shared rooms.

The principles of 'good practice' also conflict with the wider public expectations of 'care' towards senior citizens, which characterize 'good practice' in residential care as providing physical care while ensuring safety and protection from harm for what are seen as 'frail', 'vulnerable' and 'dependent' people. In these circumstances, some social work professionals may 'play safe' and assess senior citizens as in need of residential care as a defence against possible risk and attribution of blame if the potentially more risky care and support is provided to the person in their own home (Audit Commission 1997).

There is continuing evidence that social workers do not always implement the 'good practice' principle of choice in terms of giving senior citizens adequate information to enable them to make an informed choice of care home. Most senior citizens do not receive adequate information about the care homes available in their area, the fees and services they offer or what happens if their health or financial circumstances change, before taking up residence, as I discussed in Chapter 6. Now that more than half of moves into residential care take place direct from hospital (OFT 2005:24), it is increasingly unlikely that people will be able to make preliminary visits, let alone

have the opportunity to visit several homes or have a 'trial stay' before committing themselves.

While professionals may broadly agree around a number of key principles or values in relation to 'good practice', they may vary markedly in their interpretation of the meaning of concepts such as independence, choice and privacy when applied to senior citizens in residential care. Within social work and social care there are ongoing debates about the meaning of 'independence' as far as 'good practice' with senior citizens in residential care is concerned, as I discussed in Chapter Four. Those professionals adhering to a biomedical model of care, see independence in terms of functional ability and the objective of residential care as to provide a therapeutic regime of care. This is designed to bring about change by encouraging residents to remain or become physically active within the narrow field of activities of daily living. Other professionals see independence as a moral concept, in terms of autonomy rather than physical ability, emphasising the rights of senior citizens, as adults, to exercise their independence about how they live their lives in residential care, which may involve an element of risk-taking.

A different definition of what 'good practice' means is used by government social work professionals exercising their inspectorial role *vis à vis* local authorities and the provision of social services, as I discussed in Chapter Four. Reports on inspections cite examples of 'good practice' which consist of administrative arrangements, procedures or processes which are in sympathy with or which reflect current government policies and preoccupations. These may include arrangements to facilitate better joint working between health and social services, such as unified procedures or documentation to streamline assessments of senior citizens' needs or initiatives to facilitate their speedier discharge from or avoid admission to, hospital,

for example. Used in this way, the meaning of 'good practice' is about achieving greater administrative efficiency, which may produce good or better outcomes for senior citizens but not necessarily so, as I have already suggested in Chapter Four.

Thus definitions of 'good practice' by professionals and practitioners may or may not be focused on the service user – in this case, the senior citizen – and the meanings and understandings of those definitions may vary markedly. What none of the definitions of 'good practice' that I have discussed reflect are the priorities and aspirations of senior citizens about the manner and substance of services they wish to be provided, at home or in residential care, to assist them in maintaining their independence and quality of life.

The implementation of 'good practice' in residential homes

My research findings showed, in Chapter Four, evidence of confusing and contradictory messages in policy documents about the nature of what constituted 'good practice' in residential care and varied interpretations of 'good practice' principles by professionals and practitioners. It is, therefore, not at all surprising that the implementation of 'good practice' at the level of residential care homes has been similarly confused and contradictory. Principles of 'good practice' such as independence, choice and privacy are seen as ideals that conflict with the taken-for-granted 'reality' that senior citizens who move into residential care do so because they have been assessed as being incapable of remaining independent and managing their lives themselves. This perceived incapacity may be reinforced by moral judgements about the reasons for 'needing' care, whether due to misfortune, illness or disability or 'improvidence' in failing to make adequate financial provision for later life.

My research showed that assessments emphasise the physical 'dependencies' of senior citizens rather than their abilities (Hudson et al 2004). Part of the assessment entails an estimate of the level of 'risk' the person is deemed to be exposed to. Assessments therefore put greatest emphasis on the incapacities rather than capacities of people who therefore 'need' to be 'looked after' by staff. A move into residential care is widely seen as confirmation of 'an inability to cope' or live independently and therefore as a loss of competence, as I discussed in Chapter Six. Being 'dependent' or 'in need of care' is incompatible with the cultural definitions of adult status as independence and competence. Loss of their adult status means senior citizens no longer have power and control over their lives. Power and control can only be exercised by people who are seen as competent adults, and in residential care, that is the staff. Staff assume responsibility for residents' wellbeing in terms of their physical care and safety rather than promoting independence and quality of life. Quality of life becomes secondary to the core tasks of providing physical care for residents and maintaining their safety. Physical care and safety become the focus around which the principles of 'good practice' are implemented to the neglect of quality of life.

As I argued in Chapter Four, reconciling principles of 'good practice' such as 'independence' with the assessed 'dependence' of senior citizens in residential care can only be achieved within a therapeutic approach to the meaning of 'independence'. If the residential care task is to promote 'independence' within a model of care that puts greatest emphasis on physical care, the meaning of 'independence' for staff becomes promoting functional independence, irrespective of the individual resident's inclinations or wishes. Allowing or enabling residents to be autonomous is in contradiction with the social construction of senior citizens as 'dependent'. Hence, as

no longer adult people, responsibility has to be assumed for them by other adults, who in residential care homes are the staff.

I also argued in Chapter Four that staff interpretations of 'good practice' in relation to residents' rights to choice are similarly influenced by the association of physical disability or 'dependency' with assumed incompetence to make rational or sensible choices. Regimes tend to treat residents as a homogeneous group, reflecting the needs or inabilities of people who are most disabled or 'dependent'. Now that more than half of all admissions to residential care are direct from hospital, this may reinforce the regime tendency to adopt a medical model of care, as the proportion of residents with moderate or severe disabilities increases.

There are risks, which tend to remain unacknowledged, in failing to treat senior citizens in residential care as adults, as I demonstrated in Chapter Six. Having lost their adult status as 'older people', residents are judged 'unsafe' to make ordinary everyday adult choices about rising and retiring, or going out for themselves. Allowing residents to make such basic choices or decisions might result in unsafe or anarchic behaviour by residents and a loss of staff control. Other adult behaviours such as managing money, smoking and drinking are seen by staff as problematic because of their association with risk and safety. Again, the therapeutic approach to care and the emphasis on safety being the responsibility of staff, militate against residents being allowed to be self-determining in such adult pursuits. As I showed in Chapter Six of the thesis, rules that residents cannot or choose not to comply with, such as limiting or banning smoking, are liable to be broken, causing a potentially greater rather than lesser danger of fire.

The keyworker role and the compiling with residents of individual care plans are core elements of professionally defined 'good practice' that are intended to enable senior

citizens to receive care and support in a way that meets their wishes and aspirations, as I discussed in Chapter Seven. The keyworker can be the means of enabling each resident to receive individualised care within an essentially communal form of provision. The model of keyworking that is implemented in residential homes is variable. Most commonly, as I demonstrated in Chapter Seven, in public sector homes, the member of staff who draws up the care plan with, or without the resident's involvement, is not the same person who assists them with personal care, such as bathing. This splitting of the role weakens the link between the plan for care and the way in which it is executed. As I showed in the thesis, in some homes care staff do not have direct access to residents' care plans. The potential for the keyworker to enhance the quality of life of individual residents may be reduced if care is given in ignorance of residents' wishes and preferences recorded in the care plan.

Care plans may be confined to detailing aspects of daily physical care-giving such as managing medication or assistance needed with activities of daily living, as I discussed in Chapter Seven. The potential of care plans to be based on those aspects of daily life that have significance and meaning for individual residents, such as maintaining contacts with family and friends, enabling continued involvement in outings, activities and pastimes that give quality to life is often not realised.

As I demonstrated in Chapter Six, the right to privacy – another value of 'good practice' – is also subject to staff evaluations of safety and what is in the resident's 'best interests'. Bodily privacy in using the toilet or bathing or showering is subject to the physical facilities of the home, such as the existence of locks and suitably designed toilets and showers that are useable independently by people with disabilities. More importantly, bodily privacy when carrying out intimate personal care tasks is subject to staff assessment of any associated risk. Bathing or showering

is regarded as an activity that carries with it a certain risk, particularly if undertaken without help or supervision. Most people in residential care are assisted with this activity, with a consequent loss of bodily privacy and choice about the timing and frequency of baths or showers.

Privacy about their financial status may be denied to those senior citizens entirely reliant on state funding, who may have the tiny weekly personal allowance transmitted to them by home staff, as I demonstrated in Chapter Six. In some cases, staff understanding of 'good practice' may extend to assuming responsibility for the safekeeping or spending of the personal allowance on the resident's behalf, where there are doubts about the resident's ability to manage it competently themselves or about the likelihood of their losing it altogether.

The residents' experience of 'good practice'

Senior citizens who live in residential care homes are an extremely heterogeneous group who may only have 'age' in common. How senior citizens experience ageing is shaped by their previous experiences across the life course and their attitude to life in general. Consequently, how they experience 'good practice' in terms of its effect on their quality of life is equally variable. However, despite their diversity, there are common areas of life that senior citizens value and others that they see as potential threats to their quality of life, as I illustrated in Chapter Six.

It is only in the last few years that information and knowledge has been sought and gained from senior citizens themselves about how they define elements of their lives which give it its quality. What we are now learning is how varied senior citizens' views are but also how similar are the factors that are key to their quality of life to those of other people. Where they differ, is in their interpretation of the meaning of

these factors in the light of their personal circumstances, as I discussed in Chapter Two.

We now know, from a number of recent studies, including from this thesis, that senior citizens, particularly women, see social relationships as key to their quality of life, whether living in their own homes or in residential care. Men are more likely to rate having good health and an 'adequate' income above social relationships in terms of being a key influence on their quality of life. Having a positive outlook on life, a good home in a safe neighbourhood and being able to pursue hobbies and activities alone as well as elsewhere with others are also regarded as important aspects of life quality, as are being independent and in control of one's life.

Now that we know what aspects of life are key to its quality as far as senior citizens are concerned, how does this affect their experience of 'good practice' as implemented in residential care? This new knowledge gives powerful support to my contention that it is not adequate to make judgements about 'good practice' in residential care solely in terms of the *care* available to people. As Davis and Knapp have argued, quality of care and quality of life are not the same and to equate them is both invalid and dangerous. Quality of care and quality of life would only be the same if the best environments for some people were the best environments for all (1981). As researchers undertake more qualitative studies of senior citizens and elicit their views about their lives, the disparity between the beliefs of researchers about ageing and those of the people with longer experience of living with the process become clearer. There is surprise that the disabilities and poor health that may be part of the ageing process for some senior citizens do not dominate their thinking or their lives. Most get on with living as best they may in spite of the difficulties and challenges that poverty, poor health or disability may pose. I have argued that, if

'good practice' is to develop in a way that senior citizens would value and understand, it has to address the quality of their whole life in terms of the definitions and meanings *they* give to concepts such as choice, independence and privacy, not just the quality of their care.

Senior Citizens' expectations of 'good practice'

What senior citizens expect when they move into residential care is a function of their attitude towards their move, their prior knowledge of residential care and the information they receive about their particular residential home.

People who have decided for themselves that the time has come to move into residential care view it positively, seeing the support and care available as a welcome relief from trying to manage on their own or relying on relatives or friends. Expectations of continuing independence throughout later life can be as oppressive as expectations of passivity and 'dependence'. Ageing well, which tends to be defined in terms of maintaining an independent existence, requires considerable courage, which often goes unrecognised (Reed et al 2003). People who continue to see themselves as independent, despite their difficulties, are resistant to the idea of residential care because they expect and fear they will lose control over their lives.

As I showed in Chapter Six, most people who move into residential care do not know what to expect of 'good practice' because the majority have never visited previously a residential home. Some people express surprise and relief that the reality is not as bad as they had expected. Others are surprised and shocked by finding themselves unexpectedly sharing a room with a stranger. Others express shock and resentment at finding themselves suddenly impoverished because they did not have information before their move about how their contribution towards the cost would be calculated.

They had not expected so much of their financial assets and income to be taken towards meeting the cost of their care. People with no additional financial assets than their pension to contribute towards the cost, do not expect to be left with so little money in residential care.

Researchers have been critical of senior citizens for having low expectations of residential care but they ignore the reality that the majority of people who move into residential care are poor, or have only modest incomes, as I demonstrated in Chapter Two. Residential care is a social response to poverty as well as disability in later life that was originally based on providing for destitute people at a subsistence level. People who have had little by way of income, resources, or power throughout their lives do not suddenly have high expectations of what the State will provide for them at the end of their lives.

Independence

How senior citizens define 'independence' varies considerably and is a function of their health status and living arrangements, as I demonstrated in Chapter Two and Chapter Six. People who are in good health and leading active lives define independence as self-reliance – an ability to look after themselves from day to day without need of any assistance from others. People who use domiciliary care services define their independence in terms of being enabled to remain in their own homes. Senior citizens living in residential homes say that independence for them is being able to exercise choice over their daily living arrangements. As residents, they value being able to 'be themselves', which they express through their personal appearance, their possessions and their ability to secure personal space. Some residents see their independence in terms of the freedom they are given by the home to continue their previous, normal pattern of life.

Choice

As I have already argued in Chapter Six, most people entering residential care do not do so from personal choice and this affects how they subsequently perceive and experience their quality of life in care. Even among those who have had information, time and the financial resources to consider their options and finally make a deliberate choice to move into a residential care home, there are those who describe how difficult they found the decision to give up their home.

Although the majority of senior citizens are resistant to residential care as a way of meeting their care and support needs, a minority do actively choose residential care for a number of reasons, as I discussed in Chapter Three and Chapter Six. These may include fears about living alone in an unsafe area, a quest for companionship or as a way of expressing their independence from an unwanted reliance on their family to provide them with support and care. For those people who choose residential care positively, it does not symbolize the 'failure to cope' or 'last resort' that it does to some of the people who find themselves there against their will or inclination. Assistance with personal care from staff may be seen by some disabled residents as a way of freeing them to be independent or autonomous in other aspects of their lives. This is in contrast to the tendency among staff to equate a 'dependency' in one area of life such as personal care, with 'dependency' in all aspects of living.

I argued that although residents generally express resigned, if resentful acceptance of the limits to the choices available to them in residential care some nevertheless exercise choice for themselves. This may take the form of ignoring or bending the rules imposed by staff or failing to co-operate in attempts to encourage conviviality. Some people choose positively to help staff with minor housekeeping tasks as a way of passing the time, while others pursue old or new private hobbies as a way of giving

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their life an individual quality. Some people make active choices to pursue new friendships among fellow residents while others choose to maintain their private selves and opt for a general, superficial friendliness to residents and staff. The Methodist Homes model of residential care is unique, perhaps, in making friendliness and sociability the defining ethos of their model.

Senior citizens speak more about the choices they can no longer make for themselves than what they choose to do because the regime of the home is often such that staff make many of the every day decisions and choices on residents' behalf, as I showed in Chapter Six. It is often in their side comments or throw-away remarks that residents reveal how they continue to exercise choice in some aspects of their lives.

Implications of findings for practice and policy

Implications for Practice

In the light of the study findings that 'good practice' is a concept that has many different and sometimes contradictory meanings, how might one consider developing models of 'good practice' that are based on aspects of life quality that are 'good' and important as far as senior citizens themselves are concerned? Two possibilities suggest themselves. One involves using the keyworker and the personal plan as the vehicle for developing a resident-led model of 'good practice', and the other encourages a consumer or customer-centred approach to 'good practice' by adopting the 'hospitality' approach in the 'hotel' model of the private residential home.

The Keyworker role in developing 'good practice'

Since senior citizens see being able to choose how they live their lives in residential care as the expression of their independence, this is one route to making the implementation of principles of independence and choice in 'good practice' more

relevant. As I have already discussed, one of the ideas behind the keyworker role and the care plan (or 'personal plan' as it is now called in Scotland), is to record, with each resident, how they wish to live their life from day to day, within a communal setting. This enables them to maintain continuity of those aspects that give their life meaning and quality. Giving this activity the importance and priority it deserves in terms of staff time and training would enable residents to feel that they still enjoyed a measure of independence. It would be one strategy for developing a common approach to residential care between staff and residents that potentially provides rewards for both. We already know that staff experience job satisfaction in situations where they explicitly make time to sit and talk to residents, getting to know them better as people. We also know from this study, that residents are very keen to have more prolonged contact with their keyworker other than for the purposes of assistance with personal care.

As I have already discussed, the people in my studies who knew they had a keyworker appreciated what they did for them. These residents also expressed unfulfilled aspirations for the keyworker's help with practical, social and emotional aspects of their lives that affected its quality and were of greater importance to them than their personal care. A model of 'good practice' that started from the basis of prioritizing aspects of life that are most important to the individual resident, would be more likely to achieve the 'good' outcomes aspired to in the currently expressed professional principles of 'good practice' on which Care Standards are based.

The 'hotel' model of 'good practice'

An alternative strategy to secure a model of 'good practice' that reflects what senior citizens want to enhance their quality of life in residential care might be to adopt the 'hotel' model of the case study private home. As I have described in the thesis, this

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home operates a model of residential care that is based on the concept of 'hospitality', offering a 'personal service' to residents as individual autonomous adults rather than as a homogenous group of 'dependent' people who are in need of 'care'. Adopting a philosophy of 'good practice' focused on 'hospitality' rather than 'care' could produce a model of 'good practice' that is more successful in meeting senior citizens' expectations of independence, choice and privacy than that in homes operating the public sector model, with its emphasis on 'care', 'dependency' and the avoidance of risk. I have argued that as senior citizens are an extremely diverse group of people we need a range of models of residential care home to cater to that diversity (see Eales et al 2001). I have also argued that ageism, with its acceptance of the biomedical model of ageing as dependency, lies at the heart of the failure of 'good practice' to promote the quality of life of senior citizens in residential care. The home operating the 'hotel' model of care showed that not all providers are ageist. It demonstrated that treating senior citizens as 'consumers' or 'customers' rather than 'residents' may be one way of successfully combating the tendency towards the pathologization of ageing and the marginalisation of people using residential care services.

Implications for Policy

The findings of this study have a number of implications for policy development of 'good practice'.

Firstly, that what may be determined as 'good practice' in one service for senior citizens may have undesirable repercussions for them in others. For instance, the development of health service policies to minimise senior citizens' delayed discharge from hospital can result in the loss of their independence by inappropriate and unnecessary admission to long term residential care. This highlights the importance of joined up and joint policymaking in addressing 'good practice' particularly across

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the health/social services interface. Strategies such as the Single Shared Assessment and joint or unified budgets are promising ways of trying to achieve greater synthesis in achieving 'good practice' with senior citizens, enabling them to get the care and support services they need and want. However, Glendinning (2003) has argued that the success of these new, horizontal arrangements excludes the voices of senior citizens, raising questions about the ability of this reorganisation to deliver the changes that senior citizens value (2003).

Secondly, policies that define 'good practice' in terms of local authorities achieving Best Value can undermine other policy guidance to social services professionals. Where the emphasis of 'good practice' with senior citizens is on involving them in decisions about how their care needs will be met and in enabling them to exercise choice, this may conflict where they are assessed as being in need of residential or nursing home care. Recent initiatives such as the availability of Direct Payments to senior citizens and the availability of Free Personal and Nursing Care in Scotland, which I discussed in Chapter Four, are ways in which senior citizens may have greater choice in how their support and care is provided and received.

Thirdly, ideas about what should constitute 'good practice' in residential care are now expressed in terms of National Standards (Scottish Executive 2001). Senior citizens are beginning to be involved in developing these standards but the overwhelming influence remains that of professionals and policymakers. Over time, as senior citizens develop greater confidence, this influence may be moderated by the voices of service users. Standards themselves continue to emphasise processes and procedures as elements of 'good practice' but as the thesis showed, the effect or outcome of these processes and procedures on promoting the wellbeing of senior citizens in care has not always been achieved. Studies, such as the one carried out for this thesis, attest to

the ignorance or perceived irrelevance of core elements of professionally defined 'good practice' such as the keyworker and the personal plan, as far as residents are concerned. Straight forward, plain language explanations of such initiatives and their intended purpose of individualizing a person's life experience in residential care could usefully be included in the brochures that care providers produce as part of the information to prospective residents about the model of care they provide.

Fourthly, my argument that there could be benefit to senior citizens from a customer or consumer focus on 'good practice' in residential care has been supported by recent action on their behalf by the consumer movement. Alleged unfair or illegal treatment of senior citizens as customers or consumers of residential care, has kindled the interest of non-governmental organisations who, in turn, have prompted other government departments to take an interest in upholding senior citizens' rights under consumer legislation. These departments have applied a different focus to definitions of 'good practice' in highlighting unfair terms or contracts between senior citizens, local authorities and residential care home providers within the context of senior citizens' legal rights as citizens and consumers.

Finally, there may be a more constructive role than previously thought for the private sector in developing new models and new approaches to 'good practice' that may help to 'normalise' residential care for all senior citizens, irrespective of their means. I have argued in the thesis that the stigma that is still associated with public sector care in some people's minds has been persistent, despite numerous policy initiatives to make it more acceptable. Models that develop ideas and definitions of 'good practice' in residential care based on housing have proved more popular with senior citizens than the traditional approach to 'good practice'. Innovative developments by the private sector in harnessing technology to enhance 'good practice' in residential care

suggest that the continuous search for new, customer-focused products that epitomise the capitalist approach to business and consumers, may be a useful stimulus to the development of new, resident-focused approaches to 'good practice'.

Ideas for future research

This thesis argued that research methodology has had a part in play in perpetuating stereotypes of ageing and the experience of residential care. The increase in qualitative approaches to research with senior citizens is revealing important insights into the diversity of ageing experiences and how senior citizens view and manage the process of growing older. One possible future avenue for research into 'good practice' might be an action research study comparing the principles of professionally defined 'good practice' with the constraints and incentives operating around enabling choice for senior citizens in decisions about their long term care and support.

An alternative approach to 'good practice' might be to base a study on implementation theory, as developed by Goggin et al. (1990) in their study of state implementation of federal policies in the United States. It might be fruitful to explore whether their conclusions, that what they term 'state ecological capacity' as a key determinant of policy implementation, hold good in the context of British social services policy implementation.

Given the different approaches to and implementation of policy between England and Wales and Scotland that, I showed, have existed for centuries, it would be valuable for further comparative research to explore the effects, for instance, of the differential implementation of the Royal Commission on Long Term Care's recommendations.

Further research is needed to explore the impact of recent policies such as Direct Payments on senior citizens' ability to exercise independence and choice about how

they are supported as they age. Studies of the implementation and outcomes for senior citizens of the Single, Shared Assessment are needed to see how far policy imperatives enable or constrain their self-determination.

It would be interesting to undertake further research into alternative models of residential care, including those developed for people from ethnic minorities and for people with dementia. There are interesting and innovative models of residential care in the voluntary sector in Scotland which merit further investigation. Research has shown the positive cultural influences of some minority ethnic groups in demonstrating positive, anti-ageist practice towards senior citizens from other cultural backgrounds.

Research might usefully explore the potential impact of anti-ageism legislation on the social inclusion of senior citizens. Securing the views of senior citizens themselves about such a proposal would be key to such a study.

Further action research with social workers and staff of residential homes could very usefully be undertaken in the context of policies to promote socially inclusive, anti-ageist practice.

Appendices

Appendix 1- Previous research studies used in Thesis

Study Title	Dates	Methods of research	Numbers of interviews
1.'Client Characteristics and Patterns of Care in local authority old people's homes' (in one Scottish Region) **The first residential care study**	**1982-1985**	Individual interviews with residents of 13 homes once, and a random half of survivors 12 months later, individual interviews with home managers twice.	Residents – Time 1…387 Residents - Time 2… 93 Staff – Time 1……… 13 Staff – Time 2……… 13 'Dependency' Measured for ……….312 Residents
2. 'Residential Homes for Elderly People: their costs and quality' **The National Study**	**1990-1992**	**Phase 1.** Individual survey interviews owner/managers of 100 private, voluntary and local authority residential homes conducted by SCPR; Interview observation questionnaires Postal questionnaires to each employee of each home Staff completed 'dependency measures' for each resident Pilotting of resident interview guide in one private residential home outwith the sample **Phase 2.** Postal questionnaires to residents of 6 case study homes Postal questionnaires for relatives Research team interviews with managers/owners of case study homes Individual interviews with 36 randomly selected residents (plus one self-referral – 37 interviews)	**Phase 1.** Owner/Managers …100 SCPR Interviewer Observation Q'aires…100 Staff Questionnaires………1734 'Dependency' measured for..2325 Residents. **Pilot.** Resident questionnaires..………12 Relatives questionnaires……..12 Resident interviews…………7 **Phase 2.** Resident questionnaires………70 Relatives questionnaires………86 Interviews with owner/ Managers…………….6 Interviews with residents…… ...37

Appendix 2 Bland and Bland 1985 – Questionnaire 1

Home: Date:

Name: Mr.,Mrs.,Miss	S,W,D	D.O.B. D.O.A.
Previous Occpn/Spouse's:	Admission to Part 4	
BRIEF DETAILS: M.I? Cong. M.H?	From: Home...0 Type of Admn. Other Dom….1 Planned…..0 Hospital……..2 No option...1 Other Instn….3 Emergency 2	Reason Physical Mental Bereaved Other circs.
PERSONAL CAPACITY: 1. Eyesight: Can see (incl. specs) 0 Partially blind 1 Totally blind 2	8. Wash Self: Pre Post (a) Yes 0 0 (b) Difficult 1 1 (c) No 2 2 (d) N/A 8 8 (e) D.K. 9 9	4. Make Tea/Coffee: (a) Yes 0 (b) Difficult 1 (c) No 2 (d) N/A 8 (e) D.K. 9
2. Hearing: (a) No diffs.(incl. aid) 0 (b) Hard to communicate 1 (c) Very deaf 2	9. Dress Self: (a) Yes 0 0 (b) Difficult 1 1 (c) No 2 2 (d) N/A 8 8 (e) D.K. 9 9	AT HOME: any help from: No. days p.w. M.O.W. D.N. Rel. Friend/Nbr.
3. Walking Aids: Pre Post (a) None	10. Put on shoes: (a) Yes 0 0	FAMILY: Spouse living? Yes 1 No 0

0 0 (b) Stick 1 1 (c) Zimmer/Tripod 2 2 (d) Wheelchair 3 3	(b) Difficult 1 1 (c) No 2 2 (d) N/A 8 8 (e) D.K. 9 9	Siblings living? Yes 1 No 0 Sons living? Yes 1 No 0 Daughters living? Yes 1 No 0
4. Up/downstairs: (a) Yes 0 0 (b) Sometimes 1 1 (c) No 2 2 (d) N/A if None 8 8 (e) D.K. 9 9	11. Cut toenails: (a) Yes 0 0 (b) Difficult 1 1 (c) No 2 2 (d) N/A 8 8 (e) D.K. 9 9	How often to children visit? Daily 0 Weekly 1 Monthly 2 Annually 3 N/A 8 D.K. 9
5. Outdoors: (a) Yes 0 0 (b) Difficult 1 1 (c) No 2 2 (d) N/A **8 8** (e) D.K. 9 9	**HOUSEHOLD CAPACITY**: Did you do? Light Housework: (a) Yes 0 (b) Difficult 1 (c) No 2 (d) N/A 8 (e) D.K. 9	**MENTAL STATUS**: 1.Communication: understands when spoken to? Yes 0, Sometimes 1, Never 2 communicates sensibly with others? Yes 0, Sometimes 1, Never 2
Get about House: (a) Yes 0 0 (b) Difficult 1 1 (c) No 2 2	Heavy Housework: (a) Yes 0 (b) Difficult 1 (c) No 2 (d) N/A 8 (e) D.K. 9	2. Memory: (a) Normal 0 (b) Some impairment 1 (c) Severe memory loss 2 (a) Aware of social status? Yes 0, Sometimes 1,

(d) N/A 8 8 (e) D.K. 9 9		Never 2.
Bathe Self: (a) Yes 0 0 (b) Difficult 1 1 (c) No 2 2 (d) N/A 8 8 (e) D.K. 9 9	Make hot meal: Yes 0 Difficult 1 No 2 N/A 8 D.K. 9	(b) Aware of location? Yes 0, Sometimes 1, Never 2. (c) Knows way round home? Yes 0, Sometimes 1, Never 2.
Loses possessions? No 0 Sometimes 1 Yes 2	Takes others' possessions? No 0 Sometimes 1 Yes 2	CONTINENCE: (a) Always continent 0 Occasionally incontinent 1 Normally incont. Urine only 2 Doubly incontinent 3
BEHAVIOURAL ABNORMALITIES Is resident aggressive to others? No 0, Sometimes 1, Yes, often 2	Is resident aimless wanderer? No 0, Sometimes 1, Yes, often 2. (c) Is resident a directed wanderer? No 0, Sometimes 1, Yes, often 2	(d) Does resident show bizarre behaviour (smearing, etc.)? No 0, Sometimes 1, Yes, often 2 Is resident repeatedly noisy? No 0, Sometimes 1, Yes, often 2
Does resident wander at night? No 0, Sometimes 1, Yes, often 2.	Source of info. On mental status? OIC, Staff (other), inferred by i/er, client.	

Appendix 3 Bland and Bland 1985 Questionnaire 2

Questions to residents on Personal Capacity and new questions on Home Life; questions on resident mental status and behavioural abnormalities to staff, as in Questionnaire 1.

HOME LIFE

Can you tell me when your day begins and how?

2. Can you tell me about meal times and snacks?

3. What about going to bed? Any time limit?

Can you choose how often and when you bathe?

Can you choose who will help you take a bath?

6. Can you go in and out of the home as you wish?

Appendix 4 National Study Bland et al. 1992 – Phase 2 – Thematic

Guide used in individual resident interviews

The circumstances of admission, including choice of that home, the information before taking up residence, any contract/letter setting out terms and conditions, and what they were invited to bring by way of furniture and possessions.

Awareness of who to approach to make a complaint about the home and any experience of doing so.

The extent of individual knowledge and understanding of care planning and the keyworker system and their views about them.

The extent of involvement of relatives in everyday life.

Observations on how staff handled potentially embarrassing and distressing events, such as a fellow resident being incontinent in public part of home.

Experience of the home at night and staff availability to provide care at that time.

Feelings about extent of activities available in the home, whether enjoyed and alternatives preferred.

Awareness of home rules and regulations and attitude to them.

Feelings about mealtimes and quality and quantity of food available; whether any opportunities to make suggestions about menus.

Views about semi-group living (asked in the one home that had recently introduced this model).

Views about the residents' committee and its usefulness (in the one home that had a committee operating).

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