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The Bottom Line:

An ethnography of for-profit elderly residential care

Joseph Greener

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Abstract

In the last 20 years the UK's elderly residential care system has become progressively more privatised with an increase in the number of for-profit organisations delivering these services.   This study is a participant observation of care work in one privatised elderly residential care home ('Meadowvale'), owned and operated by a large provider of such services ('Moonlight Care'). It provides a rich ethnographic depiction of life at Meadowvale both from the point of view of the workers and the residents. The thesis frames these ethnographic findings against pro-privatisation discourses which argue that serious raises in standards of service delivery are to be made from instilling profit motives within social care systems.

I argue that there were a series of contradictions which prevented Moonlight Care from both achieving convincing levels of profitability whilst simultaneously improving the nature of elderly residential care. The fact that the revenue received was largely determined by the local government and the distinctive nature of care work inhibited the company from transforming the service for the better.   Regulation, although crucial to ensuring that a base level of service quality was ensured, also represented a constraint on any possible restructuring. Greater gains could therefore only be increased through slashing the costs of production and enlarging the economies of scale. Both processes defined the business plan of Moonlight Care.

This thesis, therefore, argues that privatisation was incongruent with quality of elderly residential care at Meadowvale. Privatisation led to a form of 'parasitic' production where efficiency gains and innovation were absent but business objectives were met by lowering the standards of living for the people who use the service and the wages and working conditions of the people who deliver the service. Cost rationalisation took an

extreme form at Meadowvale with repercussions for both care workers and residents. Primarily the ethnographic data looks at the everyday effects of delivering care in this under-resourced labour process. The tasks of care were highly routinised within a system of bureaucratic control which emphasised the physical, "dirty" tasks of care and necessitated that all tasks were recorded. However, the numbers of workers always fell short of the workload leading to widespread falsification in the records. The high intensity of work at Meadowvale embedded various forms of mistreatment, abuse and neglect within the working routine. The system of bureaucratic control also emphasised the physical, 'dirty' tasks of care work, leaving little time for relational work. This instituted a particular form of emotional work which emphasised suppressing emotions in order to move from one task to the next as quickly as possible. This was considered problematic for many of the workers who felt that care work should be underpinned by emotional warmth and intimacy.

The organisation of care labour at Meadowvale also ran contrary to the regulatory policy discourse which constructed quality care as personalised to each recipient, supporting lifestyle choice and personal preferences. This 'personalisation agenda' was a major component of the regulatory framework, but was impossible to implement under the strict routine which permeated care home existence. The responsibility of implementing the personalisation agenda was also constructed in training courses and official documentation as located with the workers, rather than with organisational structures, regimes or motives. This suggests an individualising process in which regulatory authorities and care companies attempt pass the responsibility and risk associated with providing these poorly resourced care services on to each individual worker.

The thesis also explores the implications of the system of production in structuring the inequality experienced both by care workers and residents. The process of accumulation at Meadowvale could be described as 'parasitic' because profit arises from reducing the cost of production. Two major strategies for reducing expenditure that Moonlight Care utilised was securing a cheap, highly exploitable workforce and reducing the costs associated with care. The search for a cheap workforce has led to the employment of large numbers of migrant workers. Many of the migrant workers at Meadowvale were unable to find alternative employment because their visa's either tied them to working in the social care sector, or in some cases, specifically to Moonlight Care. I also argue that immigration status supported higher levels of exploitation by denying welfare rights to migrant workers and their families. At the same time the residents at Meadowvale were subject to a system of care which often failed to cater for their needs. Not only were there were few luxuries associated with life at Meadowvale even basic care rights were frequently denied to the residents. During my time at Meadowvale the conditions for both staff and workers seemed to be deteriorating reflecting the endemic problems in the industry. The demand for cheap highly exploitable forms of labour *and* the denial of basic care rights for the residents can be theorised as interrelated processes connecting to the current system of residential care provision. At Meadowvale, the search for profit did not, as the proponents of privatisation suggest, lead to a system defined by choice, efficiency or quality.

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Contents

Abbreviations

SSD – Social Service Department

ASI – Adam Smith Institute

CQC – Care Quality Commission

CSCI – Commission for Social Care Inspectorate

DH – Department of Health

ECCA – English Community Care Association

FT – Financial Times

GMB – General, Municipal, Boilermakers and Allied Trade Union *(this longer original name is no longer in use and the union simply refers to themselves as the GMB)*

GSCC – General Social Care Council

HREC – (Australian) Human Research Ethics Committee

NHS – National Health Service

NHS CKS – NHS Clinical Knowledge Summaries

NMC – Nursing and Midwifery Council

NMDS-SC – National Minimum Data Set for Social Care

NVQ – National Vocational Qualification

OFT – Office of Fair Trading

ONS – Office for National Statistics

POVA – Protection of Vulnerable Adults

RCN – Royal College of Nurses

UKHCA – UK Home Care Association

WHO – World Health Organisation

CHAPTER 1: Introduction

This thesis is an ethnographic study based primarily on observations made during an eight month ethnography where I worked in a residential care home for elderly people. I will call this home 'Meadowvale'. The home was a for-profit business, owned by a large private sector provider of elderly residential services in the UK. I will refer to this company as 'Moonlight Care'.

For the staff at Meadowvale there was little time to complete the tasks set out for them. The care assistants were employed to attend to the many day-to-day needs and desires of the elderly people dwelling within Meadowvale's walls. The receivers of this work were the residents whose lives were defined by complex physical, emotional and cognitive problems including dementia, psychosis, depression, schizophrenia, severe confusion, incontinence and the full range of physical disability. Often the residents at Meadowvale received substandard care and many of their needs or desires were not catered for. This thesis provides a social, political and economic account of elderly residential care. Of particular importance is the effect of profit orientated motives and the failure of regulation in determining the experiences of residents and care workers. In the case of Meadowvale, not only did the home symbolise poverty, institutionalisation and constraint for workers and residents, it was a source of great gain for some other people, most of who were far removed from the daily graft and grime of institutional care. The following story about one of the residents, 'Angela'[1], exemplifies how Meadowvale care home was failing its users, but it also highlights how frontline care workers are often left powerless to improve the standard of care.

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[1] All names used in this thesis are faked in order to protect the identity of those living and working at Meadowvale.

Angela entered institutional care because her husband, who was her main guardian and carer, had been admitted to hospital. She was in her mid-eighties when she came to Meadowvale. In the first days of living in the care home Angela was a lively woman. She would call you over and say "when can I go home?" In the beginning the care assistants simply replied "don't worry you'll be going home as soon as your husband gets better, no more than a week or two". This usually appeased her and she would and the she would ask "can you sit with me, I just want someone to talk to". She would recount stories of wild parties with the rich and famous, of family that lived in South Africa and escapades of debauchery during the war with American soldiers. These stories were fascinating, often spattered with comments like "I know more about life than you think". But Angela was also a dementia sufferer and it was impossible to explain to her the reasons why she had been admitted to the care home. She often said "just take me home". When the care workers had a spare moment they would explain to her that there was no way she could go home, because her husband was ill in hospital and she would have no one to look after her. She was quick to retort: "but I can look after myself."

Angela's zest and joviality did not last long and after a week she deteriorated rapidly. She would ask the same question over and over again: "when can I go home". If one of us found the time to sit with Angela and comfort her, she usually calmed down after five or ten minutes. Unfortunately, providing this level of emotional support on a regular basis was simply not an option for the care workers.

A day in the care home was highly organised and there was very little spare time to address Angela's emotional needs. The long list of tasks set out for the care workers in every 12 hour shift were never completed. The bureaucratic instruments which specified the working day focused on the physical tasks of care, such as feeding, changing incontinence pads and bathing, but even these core tasks, crucial for ensuring the survival

and dignity of the residents were impossible to finish within the given time. Residents were regularly left un-bathed for weeks. Residents were left to sit in their soiled incontinence pads for four hours and longer. Residents requiring assistance with their eating, but took time to chew and swallow their food, often only received half a meal or even less. The list of jobs left undone was always extensive. Angela's needs had to be assimilated into a whole host of other tasks, responsibilities and chores which were part of the slog and drudgery of care work.

After one week or so residing at Meadowvale Angela began just sitting in her chair and shouting "help". She no longer told stories from the past or declared her life philosophies. She was now deeply confused; her mind unable to concentrate on anything for longer than a matter of moments. She had also started to undress herself in the lounge area – whether this was because she thought she was in her private room, or because it was a way of gaining the attention of the care workers, is hard to say.

After another two weeks of continuing mental and emotional deterioration Angela died. Angela had managed to live, in total, for three and a half weeks at Meadowvale. I felt, and continue to feel, deeply saddened by what had happened to Angela. Initially I thought I should have done more, or that the other care workers should have done more. If we had sat with her and consoled her more often than we did, would she have settled in, would she have felt valued and, ultimately, would she have died? It is hard to prove or provide convincing evidence that her death was the result of moving into the care home. The coroner's report did not define her death as the result of negligent working practices. To me, however, her death appeared to be the result of a rupture in her social life. She was no longer being cared for by her husband and ultimately she was placed in a setting where she received little emotional warmth and had lost all her social connections.

Some of us felt that we had personally failed Angela but the level of care that she required simply could not be provided. If someone had sat by her day-in-day-out from the very first moment that she arrived at the care home, events might have taken a different turn for Angela. As it transpired Angela's husband was not going to get out of hospital and it was likely that Angela was going to have to get used to institutional care, something which she seemed unable to do. It seems to me that the only way Angela's predicament could have been resolved would have been to ensure a greater number of staff were on duty. To design a structure of tasks and an organisation of labour which ensured that the work was achievable, that no tasks were left undone and that that time for relational work was also built into the day could, perhaps, have extended Angela's life, or at the very least made Angela's death far more dignified.

In contrast to Angela's rapid decline, Moonlight Care, a large provider of elderly residential care services in the UK, was a company that had expanded rapidly in the 15 years prior to when the research took place. Despite some scandals surrounding their practices, which have been cited as the source of a dramatically falling share price (Financial Times 2008), the last years have seen Moonlight Care grow considerably. Shareholders received dividends, profits had been extracted from their operations and the board of directors received extremely large salaries.   During a period of restructuring some four years ago two of the top chair people received over £35 million through various financial dealings.

The dreadful events of Angela's short-lived experience at Meadowvale when compared with the benefits accrued by various top managers, directors and shareholders at Moonlight Care would undoubtedly invoke a feeling of injustice amongst most of us. The rift between Angela's story of care at Meadowvale and the shocking revelations of top managers' salaries underpins the political motivation for this research. It felt

fundamentally wrong that so many of the residents (and workers) lives were defined by such a severe lack of access to resources and basic dignity whilst some other groups seemed to be acquiring vast amounts of wealth.

This thesis presents many stories such Angela's but also attempts to place these stories in relation to the policy changes which have shaped elderly residential care services in recent years – namely, the increasingly role of private sector companies and the rise of market values. The thesis explores care in one care home owned by one provider of elderly social care services, but it nevertheless identifies a series of processes which, I will contend, are specifically linked to the search for profit in elderly care, at least under the current funding and regulatory system. This encapsulates the main purpose of the project. The following discussions have at their heart a desire to represent an intricate ethnographic portrayal of care work but more specifically with reference to how these observations are made meaningful through an analysis of the labour process. At Meadowvale the organisation was geared, at least partly, to the generation of wealth for shareholders and directors and this thesis is concerned with the effect of these organisational motives on the daily practices, routines and relations of care.

The Marketisation and Privatisation of Elderly Care: Harnessing the Power of Capitalism

Stories such as Angela's are by no means confined to the world of private sector care, but Angela's situation does raise some questions regarding the privatisation of elderly care services. Firstly, why did this home fail to secure the basic level of care that most of us would consider decent and right for Angela? Secondly, can privatisation be blamed for Angela's situation, or has it nothing to do with the search for profit? The following thesis addresses these issues even if it does not provide concrete answers to them. As I will show

in this section, the lack of support provided to Angela departs hugely from the visions of for-profit public services presented by the supporters of privatisation.

In the last 30 years or so the elderly social care system in the UK has undergone significant metamorphosis. The *Community Care* report by Griffith (1988), and the articulation of this into a solid policy base in the *NHS and Community Care Act* (1990), set the scene for the ensuing transformations in the delivery of social care services and remains the defining point in the development of today's system. Griffith (1988) proposed a split between health and social care. Health boards remained responsible for acute and primary health care, but local authorities took responsibility for long term care. Local authorities were to be responsible for assessing and responding to the needs of individuals in their regional areas but their role as direct providers of care services was diminished. This was the beginning of what is now called the 'mixed economy' of social care services (Wistow *et al* 1994). The independent sector, including voluntary, charitable and private sector organisations, it was envisaged by Griffith, would take over the majority of social care provision. The cherished National Health Service (NHS) would remain state run and funded, but a new policy terrain of 'social care' was instigated (Glasby and Littlechild 2004; Lewis 2001).

This research takes place more than 20 years after Griffith's original policy proposals for social care. Formal care services are now provided by a mixture of state, private and voluntary organisations. In one area of social care provision, elderly residential care, private sector involvement as been extremely high. In 2005 76% of the available places in care homes were in private sector homes (Laing and Buisson 2005).

It is clear that the separation of health and social care sanctioned private sector involvement in previously state led services, but it can be seen as a part of a more holistic ideological transformation. Support for market and profit driven welfare systems has been

promoted through innumerable policies in the last three decades (Beresford 2005). This policy agenda is guided by the idea that 'privatisation' and 'marketisation' can transform the nature of social protection and welfare provision. Both require definition before embarking on a longer discussion of the possible advantages of privatisation and marketisation. Firstly, privatisation, which has no single definition, but relates to a number of trends including 'the sale of public assets, deregulation, opening up state monopolies to greater competition, contracting out, the private provision of public service, joint capital project using public and private finance' and 'reducing subsidies and increasing or introducing user charges' (Jackson and Price 1994: 5). Essentially however, privatisation usually refers to the process by which previously state owned and operated services become owned or operated, either wholly or partly, by private profit making organisations. Secondly, marketisation refers to the opening up of public services to the principles of the market. Usually associated with privatisation but not necessarily, it is the idea that social relations should be organised around competition and exchange. Market principles assume that different organisations, and even individuals, will compete with each other to achieve economic success or failure.

The two policy agendas of privatisation and marketisation often go hand in hand. In the UK today the ideal of both the market and profit defines the policy objectives and political discourses endorsed by many factions across the whole political landscape. Traditionally, these principles are associated with right and centre-right wing organisations but are increasingly present across the whole political landscape. Those in support of the privatisation and marketisation refer to a number of supposed benefits. The benefits rest on three interrelated arguments: 1) benefits of privatisation and marketisation are marked against the deficiencies of state led services; 2) increased efficiency is thought to be gained through the processes of competition; and 3) the market leads to increased individual freedom for all citizens. Inevitably not all proponents of privatisation and/or marketisation

allude to the same discursive constructions of the benefits, but together, these narratives nevertheless represent a remarkably coherent set of philosophies which have driven many policy changes, both in elderly social care and beyond (Abromeit 1988).

Firstly, then the pro-privatisation/marketisation discourse rests on certain assumptions regarding the welfare state of the post-War period. It has been argued that the prevalence of state operated welfare state services led to a number of barriers which affected the ability of individuals to achieve self-fulfilment, created monopolistic forms of public services and threatened the overall ability of society to achieve its full economic productive capacity (see Beresford (2005), Jackson and Price (1994) and Cowden and Singh (2007) for a recount of these arguments). The following quote encapsulates this view: 'This country's "public" systems...have become too institutionalised, too bureaucratised, too professionalised, too protective of their own interests' (Kolderie quoted in Savas 1987: 10). When governments get too large or too powerful, it is argued, professional and bureaucratic agendas take over and the users of public services lose out. Professionals, such as social workers, teachers and health care workers, as well as bureaucrats had obtained too much power over services which obscured the ability of such organisations to meet public demands. Devoid of the profit motive these organisations were also conceptualised as devoid of an appropriate logic which could guide their operation. This, it is commonly argued, meant that there was no pressure to sharpen and rationalise such services. Public services were conceived as a black hole where the funds put in remained largely unaccountable, not finely tuned to any purpose and often geared towards the desires of certain professional groups who manage and operate the service, rather than addressing the needs of the service users.

The perceived inefficiency and monopolistic tendencies of state-led public services leads to the second argument for privatisation of public services– that the process of

competition and the logic of profit create greater value for money (Megginson and Netter 2001; Savas 1987; Sheilfer 1998; Sheshinski and López-Calva 1998). Efficiency is perhaps the most consistent and important theme for those who support privatisation and it often takes on an almost sacred meaning:

> *In a world of finite resources, efficiency is also an important societal goal. We should extract the maximum from each ton of raw material and from each hour of work. Efficiency is good because it produces a higher standard of living...Freedom, justice, and efficiency are all essential, and each is alloyed with the other* (Savas 1987)

Megginson and Netter, in a review of the economic literature of privatisation, state that '[R]research now supports the proposition that privately owned firms are more efficient and more profitable than otherwise-comparable state owned firms' (2001: 380). For economists, the notion of efficiency often revolves around 'x-efficiency' which refers to the ability of firms to maximise productivity with the resources available (Leibenstein 1966). X-efficiency, it is argued, can only be achieved under market conditions. Free competition operates to weed out all the weaker producers therefore those organisations with the greatest x-efficiency will prevail over the long term. For this reason, state led public services will never operate to their most efficient capacity because they are not navigated by competition. When companies are situated within a market the need to achieve maximum competitiveness guides the actions of each individual organisation. This leads to organisations continually attempting to innovate and transform their production processes to achieve a greater efficiency.

Internally within each organisation in the market place, the need to maximise profits, it is suggested, leads to forms of management and operation which are in-line with achieving best value for money. The notion of 'managerialism' within UK welfare services

was first put forward in the Griffith report. Griffith (1988) believed that the UK's public
services were failing due to a lack of direction, planning and effective leadership. Following
Frederick Winslow Taylor (2007), Griffith was committed to the notion that the conception
and execution of work should be separated. Taylor begins his treatise on *Scientific
Management* by arguing that the increased efficiency of firms leads to increasing share of
the wealth by employees. This argument is reflected by certain supporters of privatisation
who maintain that the benefits of privatisation are transferred to employees through
higher wages (Earle *et al* 2008; Jones *et al* 2008).

The third and final argument often employed by advocators of privatisation is that
marketisation and profit driven organisations create greater choice for consumers and
services which are client-focused. Again this relates to the principle of competition. It is
claimed that through competition the aims of organisations are aligned with those of
consumers. When organisations are not in competition their agendas can be defined by
those delivering the service, rather than those consuming the service. As Beesley and
Littlechild argue:

> *Privatisation will generate benefits for consumers because privately owned
> companies have a greater incentive to produce goods and services in the quantity
> and variety that consumers prefer. Companies which succeed in discovering and
> meeting consumer needs make profits and grow; the less successful wither and
> die...Resources tend to be used as consumers dictate, rather than as according to
> the wishes of the government* (Beesley and Littlechild 2003: 17)

The arguments about increased choice being a principle advantage of privatisation also
allude to a deeper ideology.   Those in support of privatisation are not only concerned with
encouraging individual freedom they are also often in favour of limiting dependency.

Certain privatisation discourses in this respect are *anti*-welfare, not just concerned with transforming the *nature* of welfare provision (Clarke 2004).

In the UK many industries, sectors and services have undergone various forms of privatisation and marketisation. Examples include the sale of the trains, water, gas and electric companies to private interests; the implementation of payment for prescriptions and dental care; the introduction of quasi-markets into the tertiary services for the NHS; and most recently, and perhaps a prophecy of things to come, the sale of the first NHS hospital to a private firm (Lister 2010). There are many more examples not mentioned. Notions that efficient, productive public services with benefits to all members of society are best secured by capitalist, business-style organisations is a belief which has contextualised public policy change in the last thirty years.

The increased private sector involvement in elderly residential care is part and parcel of wider changes which have occurred in social care and welfare services in the UK. The changes in social care have comprised of both marketisation and privatisation. Evidently missing in these privatisation discourses are the effects of these policy changes on the lives of the individuals at the forefront of these policies. This is especially relevant when discussing care work. Debates about privatisation and marketisation usually focus on macro-economic processes and fiscal benefits. Yet privatisation is likely to have a profound impact on the employees in these organisations and for the people who rely on such organisations for their welfare. Whilst much of the literature on privatisation argues that competitive market forces produce systems of welfare which are more closely aligned with the needs of users and increases choice, little evidence is ever provided for this.

Implementing profit motives into care work raises a range of questions in relation to how the work is organised. If the primary motive of these institutions is the creation of capital does this sit in opposition to the notion of caring. The concept of 'care' in itself is

positive; it denotes feelings of one person cherishing, nurturing and concerning themselves with another. The question is then whether the pursuit of profit compromises the cherished ideal of 'care' as a value is understood in society.

'Care' values versus profit values

Exploring the ways in which care is defined helps to clarify why some authors have argued that it is at loggerheads with the ideologies surrounding market competition. Judith Phillips defines care as a multifaceted concept which invokes feelings of 'affection, love, duty, well-being, responsibility and reciprocity' but which can be exhibited through 'touch, action, emotion, and body expression' (2007: 1). As Phillips describes care 'is a nebulous and ambiguous concept and a part of everyday life which is taken for granted' (2007: 1). Tronto (1989) splits 'caring for' and 'caring about'. 'Caring for' denotes a high level of commitment to the purpose of care, a commitment to meet the social and physical needs and desires of that person. *Caring about* refers to more generalised form of commitment.   Tronto (1989) suggests that masculinity equates to 'caring about' while femininity denotes 'caring for'. *Caring for*, which is the direct provision of care activities aimed at meeting the daily and basic needs and desires of people is defined by the provision of direct physical labour although this labour is often underpinned by feelings of devotion or love. Finch and Groves (1983) describe how care is both 'affection and service' (1983: 28). In other words, care is a form of purposeful activity which is engaged in the attempt to attend to the needs and desires of others but we might also contend that the best form of caring is usually underpinned by emotional commitment.

The kind of care this thesis is concerned with orientates strongly around the physical acts of caring or as Tronto (1989) calls it 'caring for'. Paid care work almost always centres on providing the physical assistance required by vulnerable individuals. This thesis explores the implications of specific way of doing care. Namely this thesis is concerned

with care done within organisations where those people providing the work are receiving a wage and those who own the organisation are seeking to generate wealth out of their operations. Because care is inherently relational it means that there may be a range of implications for both workers and residents. Because the emotions and activities of care are inseparable from the context in which they occur; care is also intrinsically organisational (Lopez 2006).

Many authors, however, have suggested that because the concept of care invokes notions of warmth, intimacy and emotional devotion, it is unavoidably at odds with the cold world profit motives and paid employment. Paid work is oppositional because it is constructed as characterised by rationalism, bureaucracy, professionalism and a lack of emotions. Lynch (2006), for example, argues that care work, both paid and unpaid, splits along the lines of 'love labour' and 'secondary care giving'. Love labour is defined by true affective and intimate relations, built over time but which, in essence, are voluntary. Love labour cannot be forced. Secondary care giving is those aspects of care work which relate to the physical tasks of attending to another's needs and desires. Paid care work becomes problematic for workers when it is expected that they should provide love labour because it is essentially voluntary in nature. Virginia Held (2002) similarly suggested that care is ultimately relational, affective work that cannot be marketised because market values are at distinct odds with nurturing ones. If the goal of profit-maximisation comes before the goal of nurturance or compassion there is degradation in the capability of that service to provide true care. Held (2002) maintains that in capitalistically driven organisations, the bottom line will always be profit, not the goal of providing true nurturance or care.

Nevertheless some, such as Zelizer (2005), suggest that there is no inherent incompatibility between the exchange of money and true affective emotional commitment and warmth. For her, the exchange of money and intimacy intermingle frequently within

the private sphere of familial relations and are not fundamentally at odds with caring

principles. However, Zelizer's (2005) arguments as well as those such as Held's (2002) and

Lynch's (2006) are of limited applicability for this study. These debates are rooted to the

arena of philosophy and social theory organising arguments around how various values are

constructed within social life, rather than being empirically orientated.

This thesis takes the view that the relationships between caring, emotional warmth

and the drive for profit must begin at the level of empirical observation. Lee-Treweek's

(1994, 1996, 1997) work on the relationship between care workers' hard-hearted and

ostensibly remorseless disposition towards the elderly care residents, and the

organisational factors which underpin their emotional disposition is criticised in the

following pages. Lee-Treweek (1997) argues that care workers engage in various forms of

objectification of the residents they attend to (effectively treating them as a material in a

labour process). While I take issue with Lee-Treweek's explanation of this as a form of

resistance to the work I would commend her approach. Rather than highlighting

differences between the philosophies of the market and the philosophies of care, such as

Held (2002) or Zelizer (2005), she focuses specifically on how organisational factors lead to

specific forms of labour process within which certain practices and emotions are

embedded. Lopez (2006) takes a similar approach and shows though a comparative

ethnography that different organisational approaches to care work can lead to distinct

caring cultures in different residential homes.

Though mindful of the contribution of authors such as Tronto (1993), Held (2002)

and Lynch (2007), particularly in respect of the implications of their ideas for understanding

the concept of care, this thesis follows a labour process approach to care work (Lee-

Treweek 1994, 1996, 1997; Lopez 2006). It examines how caring relations and practices are

embedded within elderly residential care, how these emerge from various economic and

political processes and what the implications are for giving and receiving this type of labour. Accordingly, this introduction now examines certain sections of the labour process literature which can inform an understanding of privatised care work.

Care Work and Labour Processes

Rather than emphasising how the differing values of markets and profit-orientated competition conflict with notions of care, this study highlights the process of doing care and links this with the aim of sustaining and increasing profitability. This means that rather than exploring the understandings of care the thesis explores how the practices and relations of care work emerge from specific context in which it occurs. The following discussion explores debates around body work and emotional labour, two concepts which were born out of the labour process tradition.

Labour process theory has long been concerned with how work is shaped by the imperative of capitalism to increase productivity or how capitalism functions to turn the potential for labour into actual productive activity (Braverman 1998). The pressures faced by care workers can be understood as similar to the pressures workers feel in any sector, but this is particularly true for an analysis of care workers within an organisation which follows capitalistic principles of profit generation. Following this broadly defined labour process approach prompts an line of inquiry which explores the relations of employment, the aims and motives of the organisation, the systems of management control, the form of product or service being created and the general market conditions.

While many of the findings presented in this thesis have repercussions for more general discussion about the organisation of labour care remains relatively distinctive. Many authors have described care work as a form of 'body work' (Twigg 2000; Wolkowitz 2006). Body work is used to describe forms of labour which involve working with or in

close proximity to other human bodies[2]. Examples of body workers include nurses, prostitutes, hairdressers and, of course, care workers. As Twigg describes, body work 'verges on areas of taboo in connection with sexuality or human waste' (2000: 391).

The area of the body work literature most important for thesis is the difficulties and limitations associated with labour processes which have bodies at their core. As suggested above a chief area of interest for sociologists concerning themselves with work has been to explain the consequence of competition for the restructuring of employment conditions. Body work occupies a distinctive position within this debate. It has been suggested by Cohen (2011) that working with bodies is associated with a number of constraints in how labour processes can be organised and reorganised. The irrational and unpredictable nature of bodies means that standardisation of labour processes is limited. Bodies, due to their size and immutable existence in the world, demand a high ratio of workers. For Cohen (2011), productivity is limited in labour processes where bodies are the object of work. In care work many of the tasks involve hands-on, intimate and bodies-touching-bodies tasks. The lowest ratio of worker-to-recipient in body work is one-to-one, and in care work it is often two workers to one recipient. The fundamentally labour intensive character of care work represents a major constraint on capitalist labour processes because decreasing the ratio of workers is severely limited (given that the same tasks will still be completed). The embodied nature of the work also restricts opportunities to transform labour processes through technology. Not only because bodies are large and difficult to manage spatially, but also because they have a special social significance. Bodies contain a sanctity which other objects of labour do not. People's lives are dependent on embodied existence, and compromising the safety of the body is often a matter of life and death.

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[2] The concept body work has also been used to describe work that is done on oneself, rather than on others, although this has little relevance for arguments around care work. See Gimlin (2007) for an overview of the literature on body work including self-orientated body work.

However, residential care work is also often labour intensive in a way that other forms of body-focused labour processes are not. Care work done in institutions is usually directed towards people with complex, difficult and demanding needs (Hancock *et al* 2006). Those in institutional settings often have needs which are difficult to define or require a level of assistance which extends over the whole day. Those that require assistance that is easily specifiable are more likely to receive care in their own homes. Institutional care work is therefore characterised by an even higher level of unpredictability in the overall temporal organisation of the labour than other forms of body work. For instance, in hairdressing or sex work the execution of services occurs in a relatively short and defined period of time, while in institutional care work this is not the case. The worker is physically present for a long period of time and is expected to attend to many, often concurrent, tasks. For this reason institutional care is particularly labour intensive, but also difficult to breakdown into controllable, reoccurring, fixed and temporally predictable tasks.

Many of the following arguments focus on the labour intensity of work at Meadowvale. According to 'core' labour process theory the logic of competition creates a drive within capitalist organisations to reorganise production processes in order to achieve maximum prosperity (Thompson 1989). In body work the opportunity for this kind of revolution in production processes is severely limited, at least without putting the recipient of care in danger. This labour intensive feature of care work will underpin many of the later discussions exploring how the work was managed and how to understand the pressures experienced by workers at Meadowvale. Due to these properties of body work increasing the intensity of the work and maintaining low wages may become more important as a management strategy than they might do in the production of other goods and services.

The routines laid out for workers, the time given to each tasks and the numbers of tasks laid for the workers are all significant factors in understanding the nature of care and the method and quality by which a task is executed as well as the kinds of relations which are likely to exist between workers and residents. This relates to the second key labour process concept for the research project: emotional labour.

Care work is widely recognised as 'emotionful' (Bolton 2000). The sources of emotional labour in care are diverse. Part of its emotional characteristics emerge from the fact that it is dirty work, revolving around touch, nakedness and involves the ordering of polluting substances such as faeces, vomit, blood and urine. Much of the work orders various polluting substances spatially into predetermined classifications (Douglas 1966). Miller notes that disgust is in the realm of emotion because it 'is a feeling *about* something and in response to something, not just raw unattached feeling' (1997: 8, emphasis in original). Care workers must regulate and control their emotions in dealing with bodily fluids every day.

At the same time care work aligns with accounts of service work in certain aspects. Hochschild's (1983) account of emotional labour has framed much of the debate in the role of emotions at work. She argued that certain emotional displays are appropriated by capitalist modes of production and organisational agendas. This forces workers into either faking emotional displays or into actually transforming their deep emotional state so that it is in-line with organisational goals. Indeed, because care alludes to moral and emotional issues, as well as simply issues of service, it is sometimes expected care should be underpinned by a form of emotional commitment. This is sometimes construed as problematic for the workers (Lynch 2007; Waerness 1984).

This research explores the nature of care work, the practices it involves and the forms of relations which emerge from the specific organisational context that it exists

within. This project recognises that because care is essentially relational, the emotional aspects of the work and the physical aspects of the work are important to a fruitful understanding. Crucial to the following argument, however, is how the aims and objectives of the organisation are implicated in determining these practices. In recounting Angela's story I suggested, rather subjectively, that her experiences could have distinctly different if routines had allowed for better emotional relations to be built between staff and workers. This pre-empts later discussions on how the emotional aspects of care emerge from the work environment and not necessarily from individual beliefs or actions of workers.

The discussion of emotions I care work shows that there is undeniably something more at stake when it comes to care work when compared to many other forms of minimum wage employment. The object of the workers labour is not an inanimate object; it is people. This thesis, therefore, explores how the various practices and routines determine the care received by residents. It gives attention not only to the relations between workers and management, as would be stereotypical of a labour process study, but also to the relations between workers and residents. Systems of management control which set out the form, content and structure of the work are an important area of investigation in this thesis. The thesis explores how the work was structured through routines, systems of bureaucracy and supervisory techniques. As I have stated already staffing usually fell short of the workload reflecting the general lack of resources across the system. Important for the following insights are how care work is managed at Meadowvale, how this is turned into a series of pressures on the individual workers and then what kind of working practices emerge from these pressures. In a labour process defined by minimal resources and low staff ratios it is likely that workers may be forced into various labour saving strategies. Yet because care work deals with vulnerable adults it might also be the case that these labour saving strategies have serious implications for the safety and dignity of the residents. In this sense some of data presented in the following

thesis can be described as similar to a traditional labour process approach and explores the role of organisational motives and management strategies in the formations of specific forms of working life, but departs from this more conventional schema by also considering the repercussions of this for the object of the work: the residents.

The challenge for this research is to explore how care work is ordered and arranged. So firstly, a primary question of the following research is to explore how care work is organised. How do managers control the work, which tasks are at its heart and what kinds of labour does the work involve? What combination of physical, mental and emotional labour does the work require from the workers? How do managers supervise the workers and what instruments are used to monitor the tasks? Perhaps most importantly, however, is what the implications of the organisation of the work are for the relations between care workers and residents?

The second set of research questions which also centre on labour process issues attempt to explain and explore what factors are driving the composition of the work and what factors are driving how the work is laid out. What is the relationship between Moonlight Care's search for profit and the structure of care labour at Meadowvale? For instance, how do the pressures faced to the overall profitability of Moonlight Care effect the organisation of care work? How do management strategies reflect the context of the home within a wider market?

The role of the state

The giving and receiving of care is recognised as occupying a complex position within society. Daly and Lewis (2000) argue that the term 'social care' encompasses the range of relations and activities which lie at the juncture between the state, the family and the market. In elderly residential the influence of the state is crucially important for understanding two aspects of the overall system. Firstly, local and national authorities

have an important role as funders of care effectively setting the rates, determining the overall budget and deciding where funds are distributed. Secondly, the state plays an important function in regulating the industry. In this role various authorities inspect and determine the practices of care homes and attempt to shape the nature of care giving and receiving.

So, firstly, the state controls levels of spending within the industry. In elderly residential care around three billion pounds is spent by local authorities (Hirsch 2005) with most of this going to profit making providers (OFT 2005). The total cost to the government in 2007/8 on all elderly social care was 20.7 billion (Information Centre for Health and Social Care 2009) although it is thought that the funding received by care providers from individual private sources is in the same region (CSCI 2009). Securing quality care for the elderly remains a popular objective amongst the public and consumes a massive proportion of tax (Dean and Rogers 2004; Drakeford 2006). Yet the current system of funding for long term elderly residential care is complex, comprising of both needs- and means-tested elements (Cangiano *et al* 2009). Local authorities will pay for the full rates of care for some individuals while only paying top up fees for others and paying nothing at all for some.

Nevertheless, the price that most care homes can charge is determined by the state. For example, part and complete subsidised individuals the local authority can determine the rate it will pay, effectively controlling the amount care homes are enabled to charge. Even for individuals who are self funding and for who cost is no barrier, the local authorities are obliged to provide information regarding which services are available and make an assessment regarding which kind of service they need (Age UK 2010). Even privately funded people can expect to pay a similar rate to what the local council pays for individuals who are completely or partly funded. This is often significantly lower than what an individual would expect to pay if they organised their own care package with no advice

from the local council. The effect of this funding system is that the fees paid to homes do not emerge from market competition.

It is true that all business operations and labour processes are subject to some form of regulation by government and cannot be conceived as completely untouched by state involvement (Chang 2010; Burawoy 1983). However, some industries, sectors and organisations are more heavily regulated by the state than others. Social care remains an area in which regulation remains, for the moment at least, comparatively heavy. Even if this regulation often fails to secure the wellbeing of many of the people who require these services, the state spends considerable funds and exerts substantial effort in an attempt to shape the way the service is designed and delivered. This can be situated more broadly, as a defining feature of the 'regulatory state' (Chapman, Miller and Skidmore 2003; Moran 2001). Whereas older Labour governments were concerned with the ownership of public services, New Labour policies reflected a belief that ownership is irrelevant and the public is only interested in end results (Drakeford 2006). Since New Labour the political focus has shifted to issues of regulation and control, rather than issues of ownership.

In the last ten years there have been a number of different agencies charged with the inspection and regulation of care industries. Part of the *NHS and Community Care Act* (1990) was the setting up of a number of Inspection Units which were to be situated within local authority Social Services Departments (SSD). Since then two more regulatory agencies have been and gone; firstly the Care Standards Commission and then the Commission for Social Care Inspectorate (CSCI) (which was still in place during the period this observational research took place). However, in 2009 CSCI was placed within the Care Quality Commission's (CQC) remit. Drakeford (2006) argues that this regulation has largely failed to secure the public interest in improving the standards of care because even the regulation itself has been watered down.

In spite of such claims the private sector care services are expected to follow many rules, codes and regulations. The state regulates, or at least attempts to regulate, the skills of employees, staffing levels, the fees charged, safeguarding, nutrition, the spatial organisation of the premises in which care occurs and much more. In particular, a range of social policy discourses have attempted to promote the idea of 'personalisation' in recent years. The personalisation agenda argues that receivers of social care services should be able to individually shape the nature of services (DH 2005, 2006). Inevitably the policy influence on the actual delivery and provision of care represents a major constraint for care companies affecting their ability to restructure their operations. So firstly, these regulations inhibit potential reductions in production costs that care companies could make in staffing levels, training, food costs, central heating, laundry and a whole host of other costs associated with running the service. Secondly, the care companies are pressured to try and implement certain 'styles' of care. For instance, the care providers are expected to achieve standards which implement choice, dignity, privacy and personalisation, whilst avoiding any practices which can be construed as 'abuse' (GSCC 2002).

Some authors have suggested that the movement of the state's role from provider to regulator rests on a politics of responsibility. This has been linked to a transformation in governance and the structure of the welfare state where *responsibility* for services has been transferred away from central government towards local government and non-governmental organisations although *not* necessarily power (Land and Lewis 1998). Central government retains control over taxation and distributing funding to local authorities (Humphrey 2003). Indeed, when services are deficient the central government can lay blame onto local authorities, and in the case of privatised services, the blame is partly shifted from any form of government.

There is significant evidence that regulation fails to guarantee even a minimum level service, even if it is simultaneously crucial in preventing a complete and utter 'race to the bottom'. A recent report by consumer watchdog Which? (2011) revealed that many care homes for the elderly are failing to provide sufficient feeding to residents despite regulatory influence. BBC Radio 4 (2011) reported that there was considerable resistance to closing homes, even when serious misconduct had occurred. In some cases licenses to providers are reinstated shortly after closures. The rationale of the regulatory state, therefore, might have as much to do with shifting responsibility, rather than any attempt to actually improve the nature of welfare services.

Many authors have argued that social care sits at the juncture between state, family and market (Daly and Lewis 2000; Glucksmann and Lyon 2006; Land and Lewis 1998; Lister 2003; Lyon and Glucksmann 2008). Who takes responsibility for care and under what conditions it is provided rests on the exact relationships and boundaries which are drawn between different potential providers and interest groups. In the case of elderly social care in the UK today the relationship between different 'stakeholders' (funders, providers and recipients) is complex. Scourfield explains how this system of funding is not easily understood as a simple seller-consumer relationship:

> *The privatized residential care sector largely operates within a quasimarket in which there are different groups of stakeholders: the owners, the directors, proxy customers (local authority commissioners), self-funding individuals and care home residents who are being subsidized by the state. It is difficult to envisage how the different stakeholders' best interests can be reconciled* (Scourfield 2007a: 170)*.

This complex relationship within which social care is entrenched not only poses problems for how we might understand the 'market' for social care it also questions some of the principles relating to the alleged benefits put forward by the adherents of privatisation.

The inevitable question which arises is whether these policy discourses are successful or ineffectual in the face of structural and organisational constraints. Care workers can be conceived as 'street-level bureaucrats' (Lipsky 1980) who are charged with implementing various top-down policies designed and developed by others. Lipsky (1980) argues that street-level bureaucrats, who include teachers, doctors, welfare workers and any other employee of the state, are forced to implement these political agendas in their everyday work. The result of this, according to Lipsky, is incongruence between the intentions of the policies and their actual articulation. The pressures and constraints faced by state-workers, primarily because of a lack of resources, means policies rarely have their intended consequences. Similarly, Townsend (1998) noted how the implementation of discursive constructions of 'empowerment' in mental health services in Canada were unfeasible given the resources that mental health workers had at their disposal. Townsend (1998) goes on to argue that the concept of user empowerment rests on an ideology of individualism and silences social, political and economic accounts which could explain and provide solutions for the difficulties experienced by the service users.

The state's role as both regulator and as funder of elderly residential care services means that any analysis of the labour process in a private sector care home must place the state central. The thesis is accordingly concerned with the role of the various local and central governmental organisations which finance and mould elderly residential care work. Secondly, the thesis explores how care regulation operates on a day-to-day basis. How the state authorities influence caring practices through various forms of regulation, but perhaps more importantly, whether this succeeds or not features prominently. As I discussed previously, profit motives are likely to be crucial to understanding how the work is organised and the emergent strategies of management control. However, the state might be equally or even more important for understanding the nature of care work. There might also be a tension between profit motives and regulatory influences.

This leads to a further set of research questions. Firstly, there are series of questions which relate to funding and regulation on the strategies available to profit-making providers to achieve profitability. Are funding levels sufficient for care companies to easily extract profit from operations? Are the effects of difficult funding conditions leading to cost cutting in elderly social care and if so, what are the implications of this?

Secondly, there are series of questions which relate to the effect of the state on the daily practice of care. These orientate generally around the involvement of the regulatory authorities in determining the nature of care work at Meadowvale. Firstly, in what ways does the state attempt to shape the nature of elderly residential care work through regulation, inspection and policy? Are these visions of care, such as personalisation, successfully realised in day to day care work? What attempts, if any, are made by individual care workers to implement policy visions of care? If not, what kinds of factors are significant in preventing the state's regulation of care work from being effective? In addition, if the state's influence of care does not occur in the intended manner, what are the effects of the state's involvement for the care workers and residents?

The rights of residents and workers

I have already discussed a number of key areas of enquiry for this thesis. Through an examination of the organisation of care work and the forms of relations embedded within this organisation it essentially offers a critique of privatised elderly residential care. If nothing else, Angela's story presented at the start of this thesis shows just how serious the stakes are in care work. This reveals the last and perhaps most important theme of this research: what the implications of the pursuit of profit are for the lives of residents and care workers. By and large this thesis takes a rights approach to care and care work. Benton (2006) argues that rights are enacted within everyday life. His impression of rights

stresses an understanding which underlines how rights are established through people

access to various sorts of resources (political, economic, educational and so on).

This thesis recounts and explains the inequalities associated with elderly residential

care work. Elderly residential care sees two sets of separate structures of inequality

entwine within the same social context. In the first instance, residential care homes attend

to elderly people who require care, and secondly, this care labour required by residents is

devalued and accordingly provided by low-status groups of workers. Both the workers and

the residents enter the context of residential care from positions of vulnerability defined by

complex, interlocking sets of inequalities including gender, ethnicity, class, age,

immigration status and (physical and mental) disability.

i. The Rights of Elderly People

In this thesis old age is conceptualised from a critical realist standpoint. It is understood as

a complex process of lived-reality, embodied experience and physical transformations

which are socially mediated through a range of structures and institutions (Williams 1999).

The biological process of ageing undeniably results in various forms of physical and

cognitive decline although these processes in themselves tell us little regarding the how

ageing is mediated through various institutions, discourses and social structures.

Priestley (2003) highlights the importance of both *generation* and *life course* to the

study of disability. *Generation* conceptualises broad age cohorts as culturally bound

together through shared experiences and common values which then set in opposition one

generation against another. Resources and rights are fought over and distributed

according to generational groups. *Life course* is used by Priestley (2003) to explain how

people can claim different rights and responsibilities according to their position along the

trajectory of their life. This captures how age is institutionalised in society and different

actions are expected or required of us at different points. In particular the welfare state is

highly structured around the position of each person along the life course. The state

expects children to go to school, adults to go to work and the elderly to retire. Different

types of welfare claims and responsibilities are based on the age-status of each individual.

A child can claim free education while a working adult is expected to pay national

insurance.

From Priestley's point of view, the policy decisions and social practices which

underpin the experiences of older people are inherently ageist (see also Turner 1989).

Townsend (1962, 1981, 2006) classically explored the relationship between policy and the

'structured dependency' of elderly people. Elderly people are denied a number of key

rights through policy structures. For instance through systems of benefits and obligatory

retirement, elderly people experience enforced poverty while through care institutions

they are often denied the right to self-determination. Indeed, Becker (1997) even argues

that welfare policies can engender and support poverty by preventing the wider

distribution of wealth. Turner (1989), basing his discussion on status theory, argues that

the marginalisation of elderly people rests on conflict between different powerful groups in

society. Plainly put much of the sociological literature on ageism reveals that the

exclusions experienced by the elderly are underpinned by generational conflict based on

cultural ideas but with political and economic effects.

The social status of ageing often blurs and combines with how the aged body is

treated by society. This process of sequestering those aspects of human behaviours which

have become 'uncivilised' (Elias 2000) seems to underpin the existence of secret and

hidden care facilities for older people (Elias 2001). The history of Western culture is

defined by a general civilising process in which bodily functions were increasingly tied to

the private spheres and culturally imbued with uncivilised and barbaric meanings. The

physical and mental deterioration sometimes associated with old age is seen as

problematic (and incompatible[3]) for notions of civilised public life. Elderly residential care homes are then seen as a concrete expression of a wider 'civilising process' (Elias 2001). Lawton (1998, 2000) has identified this process within palliative care contexts where it is not the process of dying itself which is catered for in hospice contexts, but actually a particular form of 'dirty dying' which determines a person's placement within such institutions. Within elderly residential care homes, Froggatt (2001) explored the relationship between sequestration and death. For her residential homes for the elderly are 'imputed with the task of containing the visible manifestations of ageing by society' (2001: 323) but not in a straight forward fashion. Within the homes in her study there was a further sequestration process in which certain residents, especially those close to death, were clearly separated from the other residents.

There is, however, a close relationship between the policies themselves and the cultural status of ageing and the ageing body. Within social care, elderly services have experienced much higher rates of privatisation than services for younger people. It seems that privatisation has been easier to implement in services for the elderly than say in services for children. Appadurai (1986) and Kopytoff (1986), exploring the process of commoditisation, argue that aspects of social life are culturally imbued as either open for commoditisation or not. As Kopytoff (1986) argues; political and social processes mark off which areas of life are available for commoditisation. Unsurprisingly, the state has a significant role in the creation of policies which affect the lives of elderly people but the commoditisation of elderly care services rests, to a degree, on ageist principles. There would most likely be a large scale public outcry if governments in the UK were to suggest a comprehensive profit-orientated system for primary schooling. The NHS has also proved,

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[3] Elias (2000) tends to give a cultural account of notion the 'civilised' arose in Western societies. However, in part his account is also functionalist, and he describes how the increasing complexity and interdependency of society meant that changes in conduct became a necessity for living in day-to-day contemporary modern life. He gives a memorable example of this in relation to road traffic in pre-modern and modern times (Elias 2000: 368)

as yet, to be remarkably resilient to privatisation of its core services. It seems that elderly

care has been constructed as less problematic for increased marketisation operating

originally through a policy which separated health from social care.

However, debates regarding the social and cultural status of people and services do

not necessarily address issues of rights head-on. The rights of elderly people are directly

related to the provision of services (e.g. whether it is state-led or private sector-led) but

also to the quality of these services. This means that the access to resources which

underpin people's ability to claim various rights is played out through the actual nature of

the services they receive. Part of the New Labour discourse on privatisation was that the

public was no longer concerned with ownership and all that mattered was end results

(Scourfield 2007b). This is rather an obvious point but worth emphasising. Extremely

wealthy individuals, who do not rely on any welfare support and who can afford to

dispense with thousands every week for private-sector care, are likely to have a very

different experience than the residents in this study. They are likely to be able to choose

when and what to eat, to expect that they will not have to lay in their faeces or urine for

any length of time, to smoke whenever they fancy, and to receive the appropriate level of

health care whenever it is required.

One of the important aims of this thesis is to explore the practices, relations and

associations embedded within residential care and arising from organisational motives and

agendas. Particularly important, however, is how the rights of residents arise from these

routines and procedures of care work. I emphasised earlier in this introduction how

Angela's sharp decline at Meadowvale was not due to the malpractice of individual staffing

levels, and rather resulted from the minimal staffing levels and the pervasive routine which

coordinated working patterns. Angela's story revealed how emotional neglect was

ingrained in working practices. Put differently, the rights of residents emerge not from

policy constructions or abstract theory but their success or failure depends on institutional factors. The aim is to explain how the rights of residents emerge directly from the routines, rituals and practices followed in the care home. This lends itself to an ethnographic approach which explores how rights exist within everyday situations and are not confined to abstract political debates.

This leads to a further set of research questions which are concerned with how the rights of elderly residents were either limited or enabled through the delivery of care at Meadowvale. So firstly, did the organisation of the labour at Meadowvale secure the appropriate level of care and rights for its residents? How did different working routines meet or fail to meet the needs and desires of the residents? What were the effects of management objectives and organisational aims in any failure to secure rights for elderly residents? How can we understand any failures to deliver appropriate care to residents: as the malpractice of individual workers or as emerging from organisational agendas, motives and practices?

ii. The Rights of Care Workers

As already suggested, elderly residential care work sees the bringing together of two quite distinct sets of inequalities. While social and cultural formations of ageism shed light on to discussions of the ability of elderly residential services to provide a certain level of care, the citizenship status of care workers emerges from a set of different processes related to the labour market and various societal inequalities.

The elderly residential care sector is defined by low wages for the frontline staff (Cangiano *et al* 2009; Hartmann 1979). The usual explanations provided for the low pay of the care industry revolve around theories of labour market segmentation alluding either to notions of skill or to hierarchical class structures such as ethnic and gendered inequalities. Yet, and as Grint (1998) argues, it is difficult to establish concretely that labour markets are

based on the inherent competences required within each occupational category, whilst it is also difficult to defend any holistic theory attempting to explain the inequality of rewards in relation to sector or occupation. The low pay associated with care work, however, is usually linked to gendered inequalities. Within the labour market those forms of employment which are culturally stereotyped as appropriate for female workers often have less monetary remuneration attached to them (Bubeck 2002; England 2005; Hartmann 1979). The social processes which revolve around the cultural devaluation women and the work that they do is closely related to the dichotomous societal notions of public/private. Women are viewed as maternal, familial and as the main providers of care labour and accordingly their roles have largely been tied to the private sphere or to sectors of employment which symbolically reflect those private sphere roles.

In this thesis, the gendered inequalities which underpin care work are recognised although gender does not feature as prominently through the ethnographic representations. It is nevertheless important to recognise that the difficult employment conditions described in the subsequent pages are partially articulations of gendered inequalities. Interestingly, at Meadowvale most the workers were female including those in management positions and as such patriarchal control, domination and authority, such as those discussed in some other workplace studies (Glucksmann 1982; Witz 1986) were absent within the labour process. Nevertheless, inequalities based on immigration status were far more obvious and much of the later discussion about the rights of care workers focuses on this.

Aside from longer standing deep-set structured inequalities such as ethnicity and gender, however, this thesis takes the view that the ongoing prevalence of low pay in the care industry cannot be removed from its more contemporary economic and political context. Gendered stereotypes and racialised categories undoubtedly shape the current

low wages, but the care industry has made little advancement in securing better conditions for its workers. The unrelenting persistence of poor labour conditions in this industry, despite many calls amongst charitable, academic and policy circles for better training and rewards to be instigated within the sector (Cangiano *et al* 2009), suggests that welfare state policy and privatisation are also implicated in keeping wages at rock bottom. The recognised difficulty in achieving profitability in the care industry as well as the labour intensive nature of care work suggests that the need to uphold extremely low labour costs is also significant.

The aim then is to explore the labour rights by detailing the entitlements of the work and the conditions of employment. As will be discussed in the thesis, migrant workers formed the backbone of the labour at Meadowvale and also tended to work much longer hours than their British counterparts. Private sector care homes continue to rely on cheap, highly exploitable forms of labour and Meadowvale clearly represents a wider trend in this respect. Cangiano *et al* (2009) showed that the private elderly care sector is less desirable for British workers and migrant workers also have significantly higher participation in private sector owned, as opposed to public sector owned, care homes. It seems that within the overall social care sector migrant care workers tend to be more populated in the less desirable sections which are also often in the private sector.

Whilst this study emphasises how rights arose from the activity of work and therefore focuses on the organisation of the work, the role of government policy cannot be ignored. For instance, the state plays a significant role in shaping the rights that migrants are enabled to claim. Essentially, these rights or capabilities fall into two different categories. Firstly, the state polices and determines entry through various 'doors'. These categories allow people to enter the UK for a number of reasons although they generally orientate around the categories of economic migrant and some form of refugee claim

(Meyers 2000; Maher 2002). The citizenship status associated with each of these categories influences the ability of migrants to claim different rights. These may and may not include the right to work, the right to claim benefits and the right to claim health care. The subtext of much of immigration policy is that social citizenship is not for everyone and that exclusionary notions of national belonging deny many the capability to claim rights (Faist 1995).

In sectors which are dependent on migrants there is often a dependency between the policies which enable immigration, on the one hand, and the employment terms and conditions on the other. Sectors which have high turnover rates, high vacancy rates and low pay are more likely to employ workers who are from vulnerable positions in the labour market. As Anderson *et al* (2006) found UK employers had specific reasons for employing Eastern European migrant workers. The workers to live near the place of work; the work was hazardous; the work was physically demanding; it was low wage; or the job required long or unreliable working hours. All these things seem to point towards systems of production which might be described as informal and/or flexible. Cangiano *et al* (2009) also found that social care employers preferred to employ migrants because they were perceived to be more likely to work unsocial and long hours, learn new skills and have a strong work ethic. However they also concluded that:

> *Although migrants may actually be more motivated, keen to work and culturally inclined to caring for older people, it may be the case that their attitude and preferences are shaped more by constraining factors than by motivation and inclination. What employers perceive as 'willingness' to work long hours or accept demanding working conditions is often the result of a lack of opportunities* (2009: 104).

Temporary work visas obviously restrict migrants to sectors of employment which are traditionally low status (such as agriculture, care or manufacturing). However, immigration categories also restrict migrants and their families' access to welfare services, meaning that they have no choice but to accept longer hours and poor pay.

The last set of research questions tackled orientates around the workers experiences of care work. It links the general conditions of the employment with labour process factors, such as the need to restructure and reorganise operations in line with the goal of achieving greater efficiency and competitiveness. It also examines the states involvement in determining employment rights especially through immigration rules and regulations. So firstly, what are the conditions of the employment are for the frontline workers including pay, holidays, work intensity and general rewards? Did the employment conditions at Meadowvale fail or succeed in providing the appropriate level of recompense to its frontline workers? Secondly then, it also explores the role of the state in shaping employment conditions for the migrant workers. Did restrictions operating through immigration policy compel migrants to work longer hours and to accept worse conditions of employment and work longer hours? In what ways did the migrants' experiences of care work differ from their British colleagues? How did immigration policy operate to sustain international inequalities for migrant workers at Meadowvale?

Research Questions

The primary objective of this thesis is to provide an ethnographic description of elderly residential care including the practices, relations and rights which are embedded in everyday care. It focuses on how the organisation of the labour, such as the routines, tasks and rituals, determined the relations between staff and workers. It explores the implications of care for the rights of residents and care workers paying special attention to how these rights are embedded within the daily act of giving and receiving care.

Methodologically and theoretically, this research sits between labour process analysis, on the one hand, and cultural, economic and political anthropology on the other. For that reason the wider political and economic context of elderly care is brought to the fore through an analysis which explores profit motives, state policies and welfare politics in its description of day-to-day life at Meadowvale. It links the organisational pressures of state regulation and market competition to the daily relations, practices, beliefs and rights embedded in Meadowvale care home. In this sense the thesis also offers a critical discussion of privatisation, marketisation and funding of current care services. In order to reach these wider aims it deals with more specific research questions which correspond to a number of themes:

1. The initial collection of questions is important for addressing the more ethnographic data in the thesis. These questions are aimed at capturing the market pressures and constraints facing Moonlight Care in order to understand employment and living conditions at Meadowvale. What is the market position of Moonlight Care and what factors are implicated in its current position? What is the relationship between Moonlight Care and local and central authorities? From what sources did Moonlight Care and Meadowvale receive their income – from privately paying individuals or from local government? What are the effects of the funding arrangements? What are the opportunities for restructuring operations but also what limits are there to any reformulation of frontline service delivery? How do these constraining and enabling factors determine the nature of accumulation at Meadowvale care home?

2. The second assembly of questions is concerned with how the labour process was organised, managed, controlled and planned at Meadowvale. How do the systems of management control operate? What kinds of routines were set out for the workers and what was the intensity of the work? How were differing organisational goals embedded

within these labour processes, for instance were these routines aimed at meeting the needs of residents, the goal of profit maximisation or the regulatory codes? Are labour-saving strategies used by the workers, and what are the effects of these strategies? Following on from the last set of questions the thesis explores how the structure of the work surfaced from the market position of Moonlight Care and the regulatory constraints placed upon them.

3. The third group of research questions consider what the repercussions for the organisation of the work were for interactions between workers and residents. What was the nature of affective, physical and emotional relations between workers and residents at Meadowvale? How did profit orientated goals affect the relations between staff and workers at Meadowvale care home? What forms of emotional labour were present and which forms can be closely aligned with organisational goals? What are the emotional costs of delivering this service for the workers?

4. Despite Moonlight Care's status as a privately owned and operated company the ethnographic data shows that policy attempted to influence the practice of care work. The fourth set of questions assesses whether the state's influence over care work was successful or not. How did the state's regulation affect the practices and relations of care at Meadowvale? How does the government attempt to regulate the care industry? Are the policy visions of quality care actualised at Meadowvale and how does regulation affect day-to-day practices? What organisational factors inhibit the implementation of policy agendas? Is there a divergence between the policy governing quality care and the motives of the service providing company? Does regulation succeed or fail in protecting the rights of workers and residents?

5. The final major interest of the thesis is how the conditions of care and care work relate to issues of rights for residents and workers. Thus, in what ways did the rights of residents

and care workers emerge from the conditions within Meadowvale care home? How were

basic rights embedded in the care practices at Meadowvale? Does this system of care

manage to deliver appropriate rights to residents or does this system fail to guarantee

decent care? In what ways were residents denied basic rights and how can this be

explained? Did working conditions at Meadowvale fail or succeed in providing the

appropriate level of recompense, financially and emotionally, to its frontline care workers?

How did immigration controls affect the migrant workers employment at Meadowvale and

were they compelled to work longer hours and accept, more readily, poorer entitlements

and conditions? Can the failure of Meadowvale to secure better employment contracts for

workers and better care for residents be linked to profit maximising aims with current

social care markets?

Thesis Overview

The next chapter, *chapter two*, begins by describing the research setting. This will give the

reader a general sense of where the research took place and sets the scene for later

arguments. I then recount how I gained access to Meadowvale care home and my initial

reactions to the research setting. The method I used for data collection was covert

participant observation and the rest of chapter two details the use of these methods, the

challenges associated with them and highlights the ethical dimensions of the research. I

will highlight the political importance of research which accesses areas gated by the

interests of powerful groups. I will also suggest that recent developments which are

standardising a particular 'tick box' approach to ethics across many universities represent a

serious barrier to the future of quality, politically-charged research. *Chapter three* moves

on to provide some important background arguments which contextualise later findings.

Firstly, some information regarding the current ageing population in the UK, the demand

for residential care services and the current status of the social care workforce are

described. Secondly, the chapter provides important background information regarding

the status of Moonlight Care care company generally, and then elaborates the description

of Meadowvale care home. The overall aim of *chapter 3* is to describe how the paucity of

resources in welfare services contextualises the business strategy of Moonlight Care. This

leads to two important processes which attempt to increase profitability. Firstly, through

increasing the economies of scale, and secondly, through reducing the costs of production.

In the next four chapters are significantly more data driven than the first three.

Chapter four looks at the organisation of labour at Meadowvale care home. It describes

the labour process with reference to the routines, the machinery used in care work and the

system of management control over the work. It links the organisation of the labour

process with the need to reduce the cost of production as far as possible. *Chapter five*

explores the role of emotions in care work at Meadowvale. I explore the different forms of

emotional labour/work at Meadowvale and suggest that the workers emotional display

align and deviate with organisational motives at different times. However, I also discuss

the emotional cost to the workers of providing care in a under-resourced system. In

chapter six I move to discuss the role of regulation in the nature of caring at Meadowvale.

In this chapter I suggest that despite attempts of certain agencies to ensure that certain

'style' of care was delivered, this largely failed due to financial constraints. The

penultimate chapter, *chapter seven*, explores the rights of the residents and care workers

at Meadowvale. The argument is that there is a confluence of inequality between elderly

people and care workers which can both be linked to contemporary welfare systems and

privatisation. Providing cheap, 'discount' care is the interests of the state and is key to the

profit accumulation of Moonlight Care. This has led to substandard forms of care and a

workforce defined by high levels of exploitation and labour market vulnerability.

In *chapter eight* I conclude with the main argument of the thesis – that there are a

series of constraints and contradictions which prevent gains in the efficiency and quality of

elderly care which, it is argued, are supposed to spring forth from marketised and profit-

driven residential care. These constraints are implicated in structuring the rightlessness of

care workers and elderly people who rely on residential care services.

CHAPTER 2: Research Setting and Methodology

The aims of this chapter are twofold. Firstly, it provides a detailed description of the research setting – 'Meadowvale' care home. The second aim is to describe the methods used in this study with a view to exploring some of the methodological issues emerging from the research. As well as specifying and clarifying some of the practical issues, such as data collection, the chapter accounts for my position in the field with particular concern over my covert status. A study that is covert in nature inevitably requires an elaboration of its ethical and political approach.

Research Setting: Meadowvale Elderly Residential Care Home

Meadowvale care home was built around the early nineties as a purpose-built elderly nursing home. Originally it was intended to accept older people with physical disabilities, nursing requirements and a smaller number of people with dementia. The home was situated in a fenced-off complex with another home; 'Meadowvalley' care home. The two homes shared some facilities. The laundry and food preparation for both homes was done in Meadowvale, but the payroll office was in Meadowvalley. The two homes were not connected although only a small garden separated the two. The two homes and the garden together were a secured area and access was monitored in and out of the entire complex.

At a glance, Meadowvale actually seemed like a home that was in good condition – it appeared clean, well maintained and the building was relatively new. The building was L-shaped with rooms to the right of the main entryway as you entered. To the left there was a small staff room and staff toilets. Next to this, the door entered into a large, rectangular lounge area with roughly 20 armchairs arranged in two, long imperfect lines. Each row of

chairs faced the other. Dotted between the armchairs was the occasional coffee table and

at the other end of the main lounge double doors opened up into a dining area. The

kitchen was located off the side of the dining room. The rest of the home was ordered into

four wings which were mainly comprised of bedrooms. The largest wing of the home was

situated above the lounge, dining room and kitchen and contained ten bedrooms. Another

two wings contained nine rooms and the fourth contained eight.   These were all situated

in the smaller L-section of the home on each of the three floors. Each of the four wings

contained a smaller living room/kitchen area with a microwave, fridge, kettle, TV and some

armchairs. When the home was built it had been intended that care would be delivered

separately in each wing of the home. The home was designed so that day-to-day living

would mainly occur within each of these smaller lounge/kitchen areas and the larger

lounge area was reserved for activities and events. As it was, nobody ever sat in the smaller

lounge areas situated in each wing and they were generally used as storage rooms for

moving and handling equipment. Many of the residents congregated in the main lounge

area through the day. All the residents had their own bedroom and all but five of the

bedrooms had en-suite facilities. There were also sluices scattered around the home with

roughly one for every wing. The sluices were where all human waste, such as soiled

incontinence pads, was deposited into large bins.

Meadowvale had 36 places and its formal status was as a care home that could

take elderly people with dementia, nursing needs and physical health problems. The home

had anything between 25 and 35 residents in it during the time the research was

conducted. The home accepted older people who had a range of mental and physical

problems. Some residents had no cognitive impairment but had mobility issues while

others were mobile but suffered from dementia. Some of the residents had more

complete care needs and required full care including feeding, dressing and washing. A few

of these residents were completely confined to their bedroom and they depended on others for all aspects of their survival.

The care home was a profit making organisation part of one of the major UK care providing companies. The fees for the home were a little under Moonlight Care's overall national average of around £540 per week (Moonlight Care 2009[4]), with the fees coming in at roughly between £370 and £550. As I will explain in the subsequent chapter, the fees for elderly care are variable due to the requirements of the person entering care and the source of their funding. The home was in a poor inner city area of England (outside of London). When I came to the home CSCI had rated Meadowvale as a '1 star = adequate' in their three star rating within which zero represents 'poor' and three represents 'excellent'. Another inspection was carried out during the time I was there by the CQC which came to the same '1 star =adequate' conclusion.

Going through the dining room led to an exit into a small garden courtyard which followed through to Meadowvalley care home. I worked the whole time in the Meadowvale home although on occasion I went to Meadowvalley for staff training or to visit the payroll office. Meadowvale was owned by Moonlight Care but had a different registration and was therefore effectively a separate institution. The two homes were inspected and assessed by the regulatory authority as distinct organisations. Medowvalley's formal registration was that it could accept up to 40 people with mental health problems (excluding learning difficulties) or dementia. The two buildings were only spaced 10 metres apart but were not connected; residents on either side never saw the other. Nevertheless, the management in each home often made decisions regarding whether a resident was better placed in Meadowvale or Meadowvalley. As I will show, Meadowvalley tended to accept more challenging residents. There was a considerable

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[4] Throughout the thesis I will be referring to some documents which were published by Moonlight Care. I will continue to use the pseudonym in all referencing.

amount of exchange of staff between the two homes. If a member of staff desired a change they would ask to move to the other home, while on other occasions management would move staff between the homes against their will.

In the introduction I suggested that elderly residential care work is a labour intensive form of employment. This was reflected in the number of staff at Meadowvale, although it is difficult to give an exact number of employees because of the high staff turnover and the usage of agency nurses. At any point during my time at Meadowvale there was between 26 and 42 formal staff and there were a surprising amount of different roles within the home (see *table 1* and *appendix 2*). This does not account for agency nurses. The home was heavily reliant on temporary nursing staff recruited from a local agency. It was a requirement of the Meadowvale's 'nursing home' status that a nurse be on duty 24 hours a day, seven days a week.

The core workers were the care assistants and senior care assistants. These two groups essentially did the same work, but the senior care assistants held slightly more responsibility. Together I will refer to them as the 'care staff', 'care workers' or the 'carers' for the remainder of the thesis. The conditions of employment were particularly low for the care staff who earned either minimum wage (care assistants) or slightly above (senior care assistants). They typically worked twelve hour shifts, with a total of three unpaid breaks: two 15 minute coffee breaks and one 30 minute lunch break.

Table 1: Permanent staff composition			
Care assistant	10-15	Chef	1-3
Senior Care Assistant	5-10	Head chef	1
Nurse	2-3	Kitchen assistant	1-3
Domestic staff	2	Home manager	1
Launderer	1-2	Handyman	1
Housekeeper	1	Total	26-42

At Meadowvale every single resident had their own complex mix of cognitive and/or physical difficulties mediated through their personality and their ability to adapt (or not) to institutional living. By far the commonest diagnosed health condition of the residents at Meadowvale was some form of dementia.

The NHS Clinical Knowledge Summaries (CKS 2011) defines dementia as a syndrome, rather a specific disease, meaning that it refers to a set of symptoms which include interpretive, memory and behavioural problems. Dementia therefore defined in a relatively unspecific fashion, and those labelled as suffering from dementia have diverse experiences. There are many forms of known dementia such as Alzheimer's disease, vascular dementia and frontotemporal dementia. Yet, many people labelled as having dementia have no specific diagnosis and many of the known forms of dementia still have contested etiologies. Palfrey and Harding (1997) argue that the social construction of dementia is a form of medicalisation which has its roots in cultural anxieties about old age and death. The cultural status of old age is significant because the diverse sets of symptoms are lumped together under the holistic term of 'dementia' and are often not clearly defined. While there is growing diagnoses for early onset dementia (under the age of 65), an elderly person is far more likely to receive a diagnosis of dementia than somebody younger (Mendez 2006). Indeed, the entrance of dementia sufferers into nursing homes has been linked to a decline in their condition as well as a higher risk of mortality (Aneshensel 2000). Those suffering from moderate dementia can deteriorate drastically on entering an institutional environment, usually explained by the rupture in their social life and the confusion that this can cause.

The decision making processes which governed which residents Meadowvale admitted (or who they would keep for longer than a few weeks) seemed to be based on the

principle of whether the home could cope with a particular resident, rather than the particular physical or mental condition of a potential resident. The home formally admitted people with dementia and physical nursing needs, but in reality it took in people who had other mental health problems, such as schizophrenia and lifelong mental disability. Short and long term depression were also reasonably common diagnoses for the residents at Meadowvale. In terms of day-to-day care support, some residents needed only the most minimal of assistance such as meals made for them, assistance using the toilet or help getting in and out of bed. Others were completely bed ridden and required assistance with virtually all their basic needs. In fact, the word 'assistance' fails to capture the level of support required by some of the residents. Certain residents seemed to be completely unaware that tasks were being carried out upon or around their bodies.

Meadowvalley normally received the more 'challenging' patients. Many of the residents in both homes had been diagnosed with some form of dementia but Meadowvalley's residents were inclined to more extreme forms of socially inappropriate behaviour and some had a recent or longer history of committing sexual or physical acts of violence. On occasion, if a particularly challenging resident was admitted to Meadowvale, they would sometimes be moved onto Meadowvalley. This happened on three separate occasions while I was working at Meadowvale. In all three cases the residents had first been placed in Meadowvale but it had quickly become apparent that they were prone to forms of behaviour which were institutionally problematic. Mabel, a resident prone to wandering around the home at all hours of day and night in spite of a bad hip, was one such resident. Another resident, Nancy, was moved from Meadowvale after a week because she had made a number of sexual advances towards staff and residents. Surprisingly, the staffing levels at Meadowvalley were similar to Meadowvale, so it was not that Meadowvalley offered greater support, better trained staff or higher staffing levels. They operated strict gender segregation amongst staff and residents, with the ground floor

being all women, and the first floor being all men. The security system at Meadowvalley

was stricter with keypad locks separating all the different sections of the home and,

perhaps most importantly, there were locks on every bedroom door. This meant that

residents, such as Mabel who was moved to Meadowvalley, were unable to wander and

cause a disturbance during the nighttimes when staffing levels were lower.

Most of the residents who had been previously employed had worked in factories.

Many of the residents had little or no family. These, perhaps circumstantial, facts coalesce

to mean that Meadowvale was something of a last resort rather than 'last refuge'

(Townsend 1962) for many people. It was not a place where many middle-class elderly

people, or even elderly people who had family with a high degree of social capital, ended

up staying. It was an institution where people came to when they had no choice, no

resources and nobody else to oversee their general welfare.

Research Design and Accessing the Field

This thesis is based on an eight month period of participant observation. Prior to starting in

the care home I had done a small number of pilot interviews with care home managers

(four in total) whilst concurrently trying to find work in an elderly care home. The original

intention of the research was to explore the role of immigration status, ethnicity and

gender in determining the experiences of migrant workers employed in the elderly care

industry. The original design for this PhD research was that a shorter period of participant

observation would be done prior to a series of planned interviews with care home

managers, migrant care workers and migrant nurses working in the elderly care sector. The

original intention had been to link how the citizenship status of migrant workers affected

their labour market mobility and general experiences of care work. However, the

participant observation became the focus; mainly because once I had entered Meadowvale

it quickly became clear that it was an extremely rich research setting. Emotionally, I also

became interested in the consequences of this poor system of care for the elderly people at Meadowvale. I felt that focussing on ethnographic data allowed for a detailed case study approach which could provide an economic and political account of everyday life. I also became more concerned with issues at the point of production which, it has been argued, are best served by participant, ethnographic and case study approaches (Edwards 2010).

In the early autumn of 2008 I began searching for an appropriate care home in order to conduct this research. I had three main selection criteria: that the home should be a private sector care home, that it should employ significant numbers of migrant workers and that it should be some form of elderly care institution. I began by searching for a job in a care home in the usual ways. I was checking the local advertisements and contacting the appropriate homes to see if they had any vacancies. My research on the care industry had led me to believe that acquiring a job in the sector would be simple – it was widely recognised as having serious labour shortages. Nevertheless, I was unsuccessful in acquiring a job using these normal strategies. Perhaps my lack of experience and my status as a young male prevented the homes I contacted from taking my application seriously. Furthermore, while labour shortages were recognised across the industry, Cangiano *et al* (2009) have argued that employers seek highly experienced workers despite the low pay, which also partly explains the need to recruit from overseas.

I was also attempting to remain as flexible as possible, as I realised that if I was unable to find work as a care assistant the project would have to change significantly. So at the same time as applying for positions in care homes I also conducted interviews with managers in the care home sector. My intention was that this could form a small pilot study for the main ethnographic investigation, but I realised it could also help me to build contacts in the local care industry, perhaps leading to a job. The interviews generally

focused on the use of migrant labour within the care industry, including issues around retention, recruitment and racism. I conducted three interviews during this time: one with the manager of a privately owned care home for adults with learning difficulties; one with a person who both owned and managed a home for dementia sufferers; and I finally interviewed the manager of Meadowvale, Robert.

At the end of the pilot interview I asked Robert if he had any jobs available. He replied that he did, and at that time he was looking to employ more male care workers, explaining that he believed this led to a better working environment. He thought there was less conflict in mixed-gender teams. Although I had secured Robert's informed consent for the interview, explaining in broad terms the nature of my doctoral research, I did not, however, inform him that the job I was seeking was in any way related to my PhD project. He therefore knew I was a PhD student researching the care industry, but he did not know I intended to take on the role as participant observer while working at Meadowvale. A week later I was given a short interview in which Robert asked me no questions relating to my study, mainly enquiring about previous work experience and any caring experience I had in my private life. He was happy with my answers and offered me a job straight away.

After waiting two months for my criminal records check to be processed I was able to start and I began in January 2009. Brewer (2000) argues that ethnographers need to develop certain types of personality attributes in order to negotiate the 'insider'/'outsider' balance. It is also true that *all* methods sit on a continuum between participant and observer. For example, research done from behind a one way mirror where the respondents are unaware of the research taking place would be the most extreme example of a situation where the researcher is a pure observer. In contrast, this research takes the form of the extreme participant. In many respects, I worked as a care assistant in the same way that anybody starting the job would have to do. I had to get to know the work and I

had to prioritise my commitments to performing care work above my role as a researcher. Care work inevitably entails dealing with vulnerable people with high physical and emotional needs and my role as a care assistant needed to come before my role as a researcher when in the field.

In the months after having been offered the job and waiting for the necessary checks to be completed I felt an intense sense of dread about entering the setting. Many of the sociological accounts of care work focus on the difficult nature of the job. For instance, Lee-Treweek (1997) accounts for the cold emotional disposition of care workers and Twigg (2000) explores the "dirty", taboo and intimate aspects of care work. If I am honest, it was this dirty aspect of the work which I felt most trepidation about. I wondered whether I actually would be able to change incontinence pads, assist with bathing and generally deal with the bodily fluids, nakedness and the hands-on intimacy that the job was inevitably going to entail.

As I have said, Meadowvale home appeared from the outset to be clean and comfortable place. This image was quickly dispelled when I started working there. Indeed, even now when I think back to Meadowvale home in my mind it is cemented as a filthy place with sickly-yellow walls. I remember it as an excruciating dismal and grim space. In reality the walls were clean white (regularly painted) and the carpets were a deep maroon. On walking into the home for the first time your senses are hit with a lightly repellent cloying odour shrouded by strong disinfectants. After working there I realised that the main smell of the home was urine mingled with industrial cleaning products; but it was chiefly the odour of festering infected urine. As I later discovered, healthy, well-hydrated and freshly expelled urine is moderately odourless. Once I began moving around the different sections of the home and carrying out tasks I soon realised that within the walls of

Meadowvale there was a cocktail of offensive odours, ranging from the mildly off-putting to the severely stomach-wrenching.

The distinct aromas associated with institutional elderly care are oft commented on by people who carry out the work. When they are first encountered they tend to invoke such strong feelings of disgust that and even panic. A number of the care assistants at Meadowvale described how they had left the job on their first day before their shift was finished. I myself felt extremely unnerved by it for the first month. As you moved around the home at different times of the day there were distinctly different odours. For example, in the morning, all around the bedroom areas of the home, there was a strong smell of faeces and urine because there would be many soiled incontinence pads and sheets. Inevitably, the sluices and the toilets, both of which usually had soiled incontinence pads left in them to ferment, were often the most reeking places in the home. Certain residents' bedrooms also continually emanated strong smells, especially if they were regularly incontinent and difficult to clean. This olfactory account of Meadowvale may appear gratuitously detailed but I think it is important in conveying the nature of the research setting.

Orwell's (2001) account of the working class in *The Road to Wigan Pier* suggests that smell, and the emotions that it stirs, are not only an unavoidable reaction to certain environments, but offer insights into the social worlds of others. Throughout the book Orwell's description of the smells that surround working class existence paint a vivid image in the readers mind. In the opening chapter he discusses a lodging house owned by the Brookers populated by unemployed and old aged residents. Much of his account focuses on the terrible smells permeating existence at the Brookers' lodgings:

But it is no use saying that people like the Brookers are just disgusting and trying to

put them out of mind. For they exist in tens and hundreds of thousands; they are

one of the characteristic by-products of the modern world. You cannot disregard

them if you accept the civilization that produced them...It is a kind of duty to see

and smell such places now and again, especially smell them, lest you should forget

that they exist; though perhaps it is better not to stay there too long (Orwell 2001:

9-10)

In the final chapter, Orwell develops this politics of smell even further, suggesting that

smell can even underpin and sustain class inequalities.

It has also been suggested that the notion of smell is an important part of an

ethnographer's faculties. Classen's (1997) accounts for the role of senses in anthropology

and describes how certain odours can communicate cultural values and invoke socially

imbued reactions. Our own reactions to smell can become part of the research process.

For me, the smells of Meadowvale revealed just how disconnected elderly residential care

is from the rest of everyday life. Most of us have visited one of these institutions at some

point, but to work in one reveals the truly dirty nature of the work. It also reveals some

broader, Eliasian truth about our contemporary culture too – how we shun the body's

natural odours and simply just how unused to these sides of life most of us actually are

(especially younger males like myself).

However, the shock that I experienced at the odours which permeated the care

home on my first shift was not the only revelation – I was also amazed at the dexterity of

the care workers. For the first half of the morning I shadowed Karen, a senior care

assistant, watching how she changed incontinence pads, manipulated the residents in to

getting up, gave bed baths and changed dirty bed clothes. I was struck by how difficult

carrying out the seemingly simple jobs of care actually was. The skilled labour that goes

into manoeuvring a resident who has been faecally incontinent around their bed so that

you can clean their bodies, change their clothes and bed-sheets, and then lift them on to a

wheelchair is staggering. I watched Karen perform these tasks on successive residents, and once the residents were on their wheelchair they were always clean and well presented. Karen always managed to do it in such a way that there was no faecal matter left anywhere in the room. For the second half of the morning Karen placed me with Eleanor, a care worker who seemed to lack the embodied skill that Karen had. Karen asked us to get Olive out of bed – probably the most challenging resident at Meadowvale. Karen had obviously set this up as some sort of test or rite of initiation for me. We failed miserably, and after we had put Olive back in bed there were substantial smears on the sheets. Eleanor was not nearly as adept as Karen at changing incontinence pads and giving bed baths. I had been of virtually no help. Karen, as the senior care assistant, gave Eleanor a considerable telling off later that morning.

As time went on the initial shock of care work subsided and it was replaced with feelings of anger. Unfortunately, for the people who do care work, it is dirty work. The socialisation which constructs other people's bodily fluids as disgusting rests on powerful cultural values which are not easily subverted. However, it was not the disgusting elements of the job which I struggled to overcome. I got used to the dirt, grime and drudgery but the injustice, neglect and abuse ingrained in the daily routines and the organisation of care work I was unable to accept. About a month after I started at Meadowvale I began to understand that this system of care was failing the residents in serious ways. As the months went by I also began forming closer relationships with some of the staff. I began to understand their plight, their future hopes and the daily pressures that many of them experienced. The continuation of any sort of care delivery at Meadowvale was dependent on a workforce with essentially unacceptable levels of exploitation and who found themselves in life situations with little scope for improvement.

The moment that sticks out in my mind as a crucial turning point in my emotional outlook towards the research project occurred about six weeks after I started working there. The morning shift on this particular day had been especially demanding. At the time Meadowvale had 28 residents staying in the home. There were five care workers on duty that morning and the night staff had failed to get the usual number of residents out of bed at the end of their shift. On the same morning many of the managers from other Moonlight Care home in the area had congregated in Meadowvale to examine our working practices and come to some decision regarding the future of Meadowvale. Robert, the manager who hired me, was sacked the week after I started and there had been a temporary manager, Shona, filling in. The managers were meeting to discuss who should take over at Meadowvale and what the priorities were for the home. Myself and Gita, a care assistant from Poland, had been taking one of the residents down from their bedroom when we passed the group of four loitering managers. One of the visiting managers, Ruth, had stopped us and said "come on guys you're seriously behind schedule here, what have you been doing upstairs?" I replied with "well we're short staffed aren't we". Gita agreed and said "plus the night staff haven't got as many people ready as they should have". The manager retorted "you're not short staffed, there's five of you on and there are 28 residents, easily enough to get the work done, and that's what the policy says". All the other managers nodded in agreement with Ruth.

At the time I simply felt resentment towards the managers who appeared not to understand the amount of work that we needed to complete in the morning. The management at Meadowvale rarely observed the tasks that were performed in the bedroom areas during the morning time when residents were being prepared for the day. Round the bedroom areas of the home on that morning residents were shouting that they wanted to get up. Gita and I were working as quickly as we could, cutting corners in order to try and get everyone up by noon. Ruth had implied that we were simply lazy or

incompetent. It was on this morning that I realised that the rules of the game were just not fair. While I was angry at Ruth for her unsympathetic attitude and insinuations that we were not working hard enough, she was relaying government policy on the appropriate level of care workers to residents. The 'one worker to five residents' rule that she was alluding to, did not take account of the fact that we had three extra residents over the 25. In addition, this rule was unsatisfactory. Delivering high quality care, which we were constantly reminded that we should be doing, was not usually possible when there was one worker to five residents.

As the weeks and months went by my exasperation with the system of care work at Meadowvale increased. It became more and more clear that what was being expected of the care workers was unachievable. The motivations of the state and the company seemed to be in opposition to caring values. What the state wanted (high quality care at the lowest possible cost), and what Moonlight Care wanted (to alleviate the concerns of the state whilst concurrently accruing as much profit as possible) ran contradictory to ensuring a good quality of life for residents or workers. Care work is not like some other forms of low-wage work either. The object of that labour is people: when workers are exploited and demoralised it follows that those they care for will also usually suffer.

My research agenda changed quite drastically and rapidly from the original intention of focusing on migrant workers. I was originally interested in how the politics of the welfare state entwined with the politics of immigration in response to demographic change. I was not fully prepared for the emotional reaction I had to working as a care assistant. Initially, I was concerned with labour issues in care work, such as the poor wages, poor conditions and exploitative forms of recruitment, but after entering the setting, not only was it impossible to ignore the abuse and neglect of elderly residents, I also realised that many of the same economic, political and social processes which are implicated in

theorising the exploitation of migrant care workers crossed over to theorising the position

of elderly people in society. The way the project developed rather unsystematically can be

construed as both a strength and a challenge. On the one hand, ethnographic research

lends itself to shifting research questions and changing agendas. It allows the researcher to

access the field with an open approach deciding later on which themes are emphasised and

which are of less importance. On the other hand, however, this can lead to a rather chaotic

approach to research and it can be difficult to plan appropriately. For instance, the

researcher may access the field and realise that they lack some key theoretical knowledge.

This can hamper the process of developing analyses or even the ability to identify certain

observations as pertinent.

Data Collection

Participant observation also throws up a series of issues relating to data collection and

recording. It has been suggested that explicit use of notepads and tape recorders can

jeopardise researchers' credibility as a participant (Brewer 2000). For this study note

taking and recording was completely out of the question for a number of reasons. Firstly,

the covert nature of the research – taking notes overtly would have seriously affected my

participant role. Secondly, my role within Meadowvale was dualistic: on the one hand, I

was a researcher and I had placed myself in a setting in order to collect data, on the other, I

was a care assistant. Other workplace studies utilising similar methods may not demand

such a high level of commitment to the actual job from the researcher. Nevertheless, if a

researcher places themselves in a factory, even if they adopt a covert role, they may have

split allegiances between performing the research and doing the job. For instance, they

may desire to be a productive worker so as not to let down their colleagues (Glucksmann

1982). In this study, however, I felt that commitment to the job was even more crucial

because it entailed attending to very vulnerable people rather than objects or empowered

customers. I had no previous experience of paid employment in care and very little life-

experience of unpaid care duties. My primary aim had to be performing the job to the best of my capabilities.

My covert role and the need to remain committed to the research participants necessitated note taking *after* periods in the field. There was no way that I could find the time during shifts to write notes. As I will explain in later chapters, the tasks allotted to the care assistants in this home were extensive, virtually impossible to complete and shifts were often short-staffed. Taking time out to write notes during the shifts would have seriously impacted on my ability to carry out my duties as a care assistant. This meant that notes were written up once I arrived home after shifts, however, because the shifts were 12 hours long, I usually only managed to write very brief notes. On the next free day I would spend hours transforming the smaller notes into much longer detailed notes.

Schatzman and Strauss (1973) recommend a framework of different types of notes: 'observational notes', 'theoretical notes' and 'methodological notes'. Observational notes are descriptive accounts of events that happen in the field; theoretical notes are reflections on these events and the associated attempts by the researcher discover the meanings of these events; and methodological notes are operational in nature presenting the researchers strategy and potential future actions within the field. What Schatzman and Strauss propose is that notes are assigned to one of these three groups as they are written. This means that analysis and reflection during and after the field research is convenient and conforms to theory building and consistent contemplation. The method of recording data in this project followed the approach set out by Schatzman and Strauss.

These notes formed the basis of my whole analysis. However, it is worth commenting on the imperfection of these notes, because they were written some time after any event had occurred. Sometimes I felt a frustration at not remembering events, or not remembering events in enough clarity. Again, the demanding nature of the job and the

long hours effectively meant that my ethnographic faculties were often not as sharp as

desired during certain shifts or for periods of a shift. Even now I feel a sense of regret over

my failure to record certain events that I felt were significant but which I simply did not

remember in enough detail to record them in the thesis. This method of data collection

also means that all quotes are representations of conversations that I had during my time

working as a care assistant rather than verbatim quotations.

The fluid approach set out by ethnographic research design, and followed here,

also lends itself to materials other than observations as a source of data. Okely (1983), in

her study of Gypsy-travellers, found that extra depth is created when other forms of data

were included. She used newspaper articles, political writings and policy to foster a link

between the fieldwork and the wider economic and political context. Throughout this

project a range of documents were collected and appear as supporting evidence for

empirical and theoretical insights throughout the thesis. A range of documents produced

by Moonlight Care were collected throughout the research period and after. These

documents included information produced for advertising purposes, leaflets concerning

care funding and their annual reports which described their financial status. A further

important source of data collection was information given out during training sessions. As

a care assistant I received these documents to help me perform my job more effectively

however they were also cultural texts. The codes of practice and the appropriate ways that

a care assistant was expected to behave were written into formal documentation but they

contained deeper philosophies regarding the values of contemporary society. Policy

documents written on care and migration were also useful texts for describing and

theorising the social context which embedded activities and relations existent in the care

home. In chapter six the policy documents are used to emphasise the contradictions of

contemporary political agendas around care. In chapter seven I analyse the experiences of

migrant workers at Meadowvale with reference to the policy which guides citizenship

statuses for foreign nationals. Utilising documentary evidence – in the form of employment, regulatory, political and policy documents – allows a picture of connections and associations to be built, tracing the everyday ethnographic reality to the wider social context.

However, in customary labour process analysis, a tradition that this project is at least partly rooted within, the need to gather detailed data regarding the financial goings-on of the companies being investigated is often emphasised as crucial to the methodological approach of the tradition (Edwards 2010). Many labour process studies place day-to-day financial data regarding the pressures facing managers within *individual* workplaces as crucial aspect of analysis (see Glucksmann (1982) for example). In this research that would be data referring to Meadowvale care home itself as well as the more general data that is presented but which is concerned with the overall company. This could have been extremely revealing, helping to give an exact account of the kinds of pressures experienced by management at Meadowvale. Data on heating costs, staff costs, money gained from the council and from private sources would have offered scope for a deeper analysis linking practices within Meadowvale to the specific organisational processes. Nevertheless, as I argued earlier in this chapter, achieving overt access to a Moonlight Care home is likely to have been impossible. Also, my position as covert researcher meant I was able to acquire the experience of performing care work. The fact I developed an embodied experience helped in the development of many of the themes in this research and essentially meant I had a much greater understanding of the pressures experienced by care workers. Finally, in defence of this lack of 'mid-level' data concerning the business operation of Meadowvale, I think I was able to establish through an examination of the overall trajectory of Moonlight Care, as well as providing extensive evidence for the importance of cost-cutting as an important management strategy in Meadowvale specifically.

The Ethics of Covert Research

Investigations in the social sciences which can be considered as potentially dangerous either to those under investigation or those carrying out the investigation have consistently contributed to the social scientific endeavour. There is a long history of significant sociological and anthropological research based on research techniques which could, in today's climate, easily been discounted as unethical. Standing on street corners of inner city Chicago might have been considered too risky for Whyte. When Goffman accessed asylums it would probably have been treated as a breach of privacy of the inmates, the staff and the organisation. There would no doubt be some serious questions asked of Claude Levi-Strauss when he embarked on his mission to find a tribal community which had never been contacted by any Western person. There are many more examples but it is enough to recognise that various forms of covert research, research involving deception or research which could be considered as involving serious risk to participants and investigators has been crucial in the development of the disciplines of sociology and anthropology.

Increasingly ethics committees are involved in granting permission for research projects at all levels. The decision to grant permission to research projects tends to focus on a number of key concepts which include informed consent, privacy and harm (primarily harm to research participants, but also harm to the researcher). Covert observation is often considered the most ethically sensitive method used in sociological research. Martin Bulmer (1982) contends that covert participant research is fraught with such serious ethical demerits that it can only be justified in the most extreme example. In the first instance, the notion of informed consent and the inherent lack of it in covert methods are seen as a challenge to the use of covert observation. The informed consent of participants is seen as a highly desirable gateway into exploring people's lives. However, the nature of the research setting and the role of the researcher are also significant in decisions about

acquiring informed consent. If the research setting is a public place, such as a city centre or

a night club, the ensuing issues around consent are different to those where the research

setting might be described as private in some sense. Or as Bulmer says, there 'is clearly a

distinction, however, between observation studies (perhaps in some cases not involving

participation at all) carried out in public places, and participant observation studies where

the researcher penetrates into a milieu by presenting himself in a particular role' (1982:

219).

Related problems put forward by Bulmer include 'invasion of privacy' and

'deception'. By failing to gain informed consent and delving into the lives, actions and

practices of individuals the socially sanctioned notion of privacy can be seen as breached by

the sociologist. In some situations the sociologist is a deceiver; somebody who fakes a role

and tricks participants into providing information that they otherwise would not divulge.

The ethically challenging nature of covert participation has also been framed in the

contexts of risk, danger and harm to the participants. Practitioners of covert methods

often argue that protecting the anonymity of their participants limits any damage that

might occur out of publication. Even so, while the endeavours of researchers to protect

the anonymity of individual participants may protect those individuals, the group that is the

focus of the study might receive negative reaction as a result of being revealed to the

'public gaze' (Bulmer 1982: 226).

In essence, most ethics committees in universities today base their decisions on the

principles of informed consent. However, informed consent has been criticised. Homan

argues that the notion of consent is an ethical principle guided by 'proceeding with as little

fuss as possible' (1980: 323-324), and is used in substitution for dealing with ethical and

moral issues in depth. Consent can then be seen as a kind of 'licence' which can 'displace

or substitute' morals (Homan 1980: 331). This leads to a kind of 'tick-box' instrumental

approach to ethics which fails to promote researcher flexibility in relation to ethical issues.

Once the necessary forms have been signed off by university and respondent, the

researcher can go ahead with very little commitment to ethical or moral issues. Homan's

argument is an astute critique of the functioning of codes, forms and documents currently

dominating ethical practice in many universities. Increasingly, researchers are visualising

their ethical commitments as simply a case of obtaining clearance from an ethical

committee. At the same time ethical review committees are often dominated by medical

researchers and others outside of the disciplines of sociology or anthropology.

Such committees also often consider the notion of informed consent as the

primary guiding principle of ethical soundness but the concept is easily criticised. Research

participants may not be fully aware of what they are consenting to, even when researchers

have endeavoured to obtain the gold-standard of informed consent. O'Connell Davidson

(2008) argues that when research participants approve their participation in a research

project they often have little control over how they will be represented and their consent

to having participated in the research may change over time. Czymoniewicz-Klippel *et al*

(2010) showed how in Australia the Human Research Ethics Committees (HRECs) have

defined informed consent in a rigid fashion which restricts researchers in how they can

acquire consent, therefore restricting research design generally.

The dualistic notion of public and private which also guides many of the debates

around ethics in social research can also be questioned. Bulmer (1982) construes the social

world in a simplistic manner when he discusses the notion of privacy in research. Anderson

(2000) argues that the divide between public/private is in itself a construct of Western

liberal thought. In her study she visualises migrant domestic workers as caught between

the public domain and the private sphere. In reality the rights which individuals have

access to cross public and private boundaries. Care homes provide a good example. On

the one hand, care homes can be understood as an individual's home where their right to privacy should be protected. Yet, care homes are public institutions in the sense that they cater to wider society. It might be in the public interest to reveal what is happening within the walls of these institutions, even if it involves breaching certain ideals regarding the privacy of each individual. Workplaces, hospitals, schools, prisons and military facilities can all be conceptualised as arenas of social life which are not easily defined as public or private.

This raises questions about the appropriate method that researchers should employ to gain access to these places for research purposes. For an individual researcher who aims to carry participant observation in such an institution, it is unlikely they will able to obtain informed consent from every individual member of that community. The default response of most researchers is to seek consent from 'gatekeepers' who have power over whether research within organisations is permitted. Indeed, the regulation of access to such places is sometimes geared towards protecting the institution, rather than the participants of the study or the researcher. While I would not suggest that the notion of informed consent should be ditched altogether, Bulmer's position goes too far in suggesting that covert research should only be employed in the most extreme examples. If it is in the interests of ethical research to always respect the individual's right to protect their private lives from the scrutiny of social sciences then does this include forms of exploitation, abuse or violence which occur within their own home or workplace?

In the following discussion I argue that conducting quality, politically charged research is critical to realising a vibrant research culture in sociology. However, I also suggest that current trends in ethical practices, underpinned by institutional constraints, may be severely limiting the opportunity for this sort of research to take place. Notions of informed consent, risk management and public/private distinctions fall short of dealing

with the true complexity of ethics in social research. Furthermore I will argue that if social

researchers are to simply accept that other groups, often outside of their discipline, can

regulate their research practice and agendas, this is likely to reduce the scope for future

projects to provide analyses of the social world which place power relations and conflict

centre stage.

I believe that many of these issues are exemplified by recent incidents which have

occurred in journalism which investigated various health and social care organisations. In

2005, the BBC show *Panorama* broadcast a film entitled 'Undercover Nurses' reporting on

standards of care at the Royal Sussex Hospital in Brighton (The Times 2009). Margaret

Heywood, a registered nurse, agreed to work shifts at the Royal Sussex hospital and

secretly filmed the activities of staff on some of the wards. The film uncovered consistent

failure by the organisation to deliver basic care. The documentary also discovered that the

hospital had already done some of its own investigations into certain wards and had

concluded that staffing levels were deficient. Many of the correct procedures were not

being implemented, but the hospital had taken no action. In 2009, Margaret Heywood was

struck of the nursing registration by the Royal College of Nurses (RCN) as a result of her

involvement in this filming. The RCN argued that Haywood had failed to protect patient

confidentiality and accordingly took the most severe action possible. The decision has

since changed with a campaign being led by the Nursing and Midwifery Council (NMC) and

the striking off order was changed to a 12 month caution (NMC 2009).

Nevertheless, the actions of the RCN over this case sent out a strong message to

NHS staff. While whistle blowing is encouraged, and impunity is in practice protected, it

seems that this only applies when individuals follow organisational guidelines (NHS 2010).

This effectively means that any concerns brought forward by the staff are dealt with by the

organisation and the organisation potentially has the power to keep any issues which arise

from whistle blowing hidden from wider scrutiny. In chapter six I will discuss how responsibility over care services was often constructed by regulatory agencies and Moonlight Care as laying with the workers rather than the wider organisational context. In retaining power over the procedures relating to whistle blowing these organisations are protecting themselves from wider criticism. When things go wrong in hospitals and care homes it is often individual staff members who are blamed rather than the contexts within which these employees work. Margaret Haywood's predicament is not the only example of an NHS organisation protecting their practices from scrutiny. In another case, in 2010, a student nurse at Staffordshire University was permanently excluded from her course for whistle blowing about the dementia ward at Stafford Hospital. Both the University and the NHS trust had been involved in the decision to exclude her from the course (Daily Mail 2010).

Bourgois (1990) attacks the ethics of anthropological research as they are practiced through institutional arrangements. The conceptual frameworks of informed consent, privacy and anonymity continue to define the institutional practice of ethics in social research. Bourgois argues that research should remain morally and politically motivated:

The problem with contemporary anthropological ethics is not merely that the boundaries of what is defined as ethical are too narrowly drawn, but more importantly, that ethics can be subject to rigid, righteous interpretations which place them at loggerheads with overarching human rights concerns. How does one investigate power relations and fulfil the researcher's obligation to obtain informed consent from the powerful? (Bourgois 1990: 45)

It is argued that research projects which comprise of certain elements of covertness can generate analyses of the social world that other forms of research are unable to achieve. In certain cases there is a need for research techniques which are able

to infiltrate social arenas which are gated by powerful interests. There might also be political implications for this kind of research: by showing the injustices that the powerful enforce on the less powerful can create new political agendas. Bulmer (1982) argues that covert methods are not often justified on this basis. He argues that social research often fails to have the wider implications that we hope. In some senses he might be correct, but Bulmer seems to be suggesting that researchers give up their political motivations for carrying out research altogether.

To take one example to the contrary, Goffman's (1961) study of asylums continues to shape the self-critique of psychiatry. In a recent issue of the *British Journal of Psychiatry* a range of discussion articles were published which assessed the contribution of Goffman's *Asylums* 50 years after its publication. In this issue, Mac Suibhne argues for the continuing importance of reading Goffman and its relevance for all working in mental health services: 'It remains a text that all involved in the management of mental illness, whatever point of some imagined biological–social continuum they are on, can read with interest and profit' (2011: 2). To simply discount Goffman's covert study as of little importance to the development of mental health services would be ungrounded. It is also likely that studies like Goffman's will only surface from a research community where a degree of risk and covert research is acceptable, even if not all studies have such a huge impact. Secondly, his account of the moral career of mental patients and his detailed description of 'total institutions' would not have been possible without his use of covert methods. The theories developed by Goffman would not have been possible without clandestine infiltration of this secret social setting. In this way, the insights of Goffman's studies are inextricably linked to the research methods used.

The Statement of Ethical Practice for the British Sociological Association (BSA 2002) gives a considerable amount of attention to the notion of informed consent and deception in research. In point 17 states that:

Research participants should be made aware of their right to refuse participation whenever and for whatever reason they wish (BSA 2002: 3).

This first point gives little room for the use of covert methods, but the BSA ethical statement goes on to say in point 31 that:

There are serious ethical and legal issues in the use of covert research but the use of covert methods may be justified in certain circumstances. For example, difficulties arise when research participants change their behaviour because they know they are being studied. Researchers may also face problems when access to spheres of social life is closed to social scientists by powerful or secretive interests (BSA 2002: 4).

While the BSA recognises that covert research projects are ethically problematic, it suggests that they are justified in certain instances. Yet institutional and legal factors continue to limit the opportunities for covert research to take place.

I want to argue that the use of covert methods and the regulation of social research more generally, is not only a practical issue revolving around protecting the rights of individuals and managing risk in research settings. The use of covert methods cuts to the heart of questions about the role of political agendas in determining the nature of research. Methodological freedom is crucial for the continuation of sociology and anthropology as interpretative sciences with the capacity of providing deeply critical accounts of the societies we live in. For example, NHS ethics committees, which have become a normal part of the research process for many of today's British social scientists,

should be viewed with scepticism. Can we always assume that such organisations are only

in existence to protect the interests of the people whose needs they are attending to?

These organisations have their own agendas and may not want all aspects of their

operations to be scrutinised. NHS committees often play an important role in protecting

people, such as when drugs or treatment trials are being proposed, yet their function as

gatekeepers of a potentially politically significant arena of social life should not be

forgotten. In addition, the fact that there is yet to be a consensus emerge from any branch

of the social sciences regarding the appropriate use of covert methods or general moral

standpoint from which to approach research suggests that ethics will, and should, continue

to be a contested and difficult process for researchers (Murphy and Dingwall 2007). At the

same time, sociology and anthropology must promote the political aspects of the

disciplines and the potential social impact of their work, as well as arguing for greater

control over the regulation of their own research agendas and practices. Most importantly,

researchers should not be expected to have to gain the informed consent of powerful

actors who have specific reasons for not allowing them access. This is especially true in

areas of social life defined by abuse, neglect, exploitation or mistreatment.

Elderly care is an area of social life where abuse, neglect and exploitation are

known to occur. Moonlight Care is one of the largest providers of residential care for the

elderly in the UK. Their business practices have also come under extensive scrutiny. Their

share price fell dramatically in 2008 due a higher death rate than expected (The Times

2008). They have been at the centre of a number of scandals due to mistreatment in

particular homes. They employ over 40'000 workers with almost all of them receiving

minimum wage or just over. They are heavily reliant on migrant workers who are known to

enter the labour market from a vulnerable position (McGregor 2007; Moriarty 2010).

Despite their struggling share price a number of their top-end managers have received

large salaries and attractive bonuses. Most of their revenue comes from local council

budgets so it is the tax payer that is funding them. Inevitably, conducting politically motivated research within Moonlight Care is in the public interest.

The horse does not need to be flogged to death – why would Moonlight Care open themselves up to the examination of social researchers? Simultaneously, why should Moonlight Care be given control over what sorts of scrutiny they are to be subject to? When researching powerful groups, especially those whose activities have direct consequences for the general public, it is reasonable to suggest that the gatekeepers of these social arenas should not necessarily have say over who has access to investigating them. For instance, in the case I recounted above, where nurse Margaret Heywood was struck off the nursing register for uncovering malpractice in a dementia ward, one of the family members whose mother appeared in the documentary stated that 'I was absolutely disgusted with the verdict – it shouldn't have been Margy on trial – it's should have been the supervisors at the hospital – they were the ones that were wrong because they were the ones that weren't doing their jobs properly' (Stuart Burnham on *Panorama* 2009). So while the RCN and Sussex Hospital had an interest in constructing Haywood's investigations as a breach of the privacy of the patients; the family members of the people on the wards seemed completely unconcerned about this aspect of the programme's investigation.

Substantiating the Use of Covert Research at Meadowvale Care Home

Despite my critique of Bulmer's (1982) instrumental approach to ethics in research, where methods simply have merits and demerits rather than real political consequences, his view that covert methodology should only be embarked on when other research designs do not have clout needs to be addressed. In other words, was it absolutely necessary that I should disguise my role as a researcher? Some would certainly argue that I could have acquired access into an elderly residential care home without any deception. However, prior to the participant observation I carried out a small number of interviews with managers of care

homes across the area. Recruiting for these interviews had been extremely difficult. I had

sent letters to 41 homes in the area, which laid out the purpose of the interview and

requested the help of the managers. I followed up every letter with phone calls and still

only managed to secure three interviews (in total I carried out four interviews but the first

interviewee had been contacted through an acquaintance). I had been met with a

considerable amount of suspicion and even hostility when I followed up the letters with

phone calls. The elderly residential care sector has been subject to significant negative

reporting in both national and local media outlets. I also found out later, that during the

time I was looking for interviews the local newspaper had recently published an article

claiming that they were going to put undercover reporters in elderly care home settings. It

seems likely to assume that this affected my ability to acquire more interviews. The

general climate seemed to be of wariness and suspicion in the local industry at that time. It

quickly became clear that accessing the setting through overt means was extremely

unlikely.

However, there are other reasons for engaging in covert research at Meadowvale.

Okely (2007) has highlighted the importance of the embodied fieldwork as a source of

insight into different societies, groups and cultures. In her interviews with anthropologists

she highlights the ways these scholars have used various forms of embodied experiences in

the field to inform their research. As Okely describes, the fieldwork of participatory

research involves 'bodily interaction and sensory learning' (2007: 65):

> *This is not merely verbal, nor merely cerebral, but a kinetic and sensual process*
>
> *both conscious and unconscious which occurs in unpredictable, uncontrollable*
>
> *ways...The anthropologist learns anew to sit, talk, stand, walk, dress, dance and*
>
> *labour at hitherto untried tasks. Field work contrasts with the sedentary practices of*
>
> *the academic* (Okely 2007: 77)

Care work is highly embodied labour – a theme which will crop up repeatedly in this thesis. Care is physical, requiring a considerable amount of brute strength but the object of this work is people. A mixture of force and dexterity is required to get the work done. Insights such as these would not have revealed themselves to me had I not been a participant. Doing the work, rather than asking about the work, or merely observing the work, gave an embodied experience which would have otherwise been inconceivable.

In Lee-Treweek's (1997) study of elderly residential care workers she links anti-caring values to a form of resistance against the harsh conditions of the work. As I will argue later, my feeling is that because Lee-Treweek did not actually participate in the labour but rather she only observed it, she failed to completely grasp the complexity of care work. The data I gathered during my time at Meadowvale was distinct because I was able to assume the role of care worker. Engaging in the work revealed the complex pressures that the workers were under. For instance, in a Which? (2011) undercover investigation of elderly care homes they reported that one of their actors:

> *...saw one carer shovelling food into a woman's mouth. When she raised her hand to stop so she could swallow, the carer took the food away and ended the meal. It doesn't have to be this way – the next day our actor saw another carer gently singing and feeding the same woman with dignity* (Which? 2011).

Often policy accounts of care such as these blame individual staff for poor practice. In the course of engaging in care work I realised that the intensity of work often leads individuals to behave in uncaring or callous ways. I was also able to link the behaviours and attitudes of the care workers to the organisational factors. It shed light on the relationship between the routine, the system of management and the aims of the company with the daily practices of care workers and residents.

It is worth highlighting that whilst there were certain strengths with this approach there were also various weaknesses. In particular, my covert status as well as my emphasis generally on participation means that I was unable to formally conduct interviews with staff members or residents. Interviews could have been particularly valuable in enabling me to link observations more coherently and explicitly with the beliefs and opinions of the various actors at Meadowvale.

Ethics in the Field

Having given the reader an account of the covert methods used and defending the covert nature of the research, I do not mean to imply that the project was not wrought ethical quandaries, predicaments and dilemmas. In this section I will recount some of the major challenges I faced during my time working at Meadowvale. Throughout my time at the care home I tried my very best to deceive people as little as possible. For instance, I had informed the manager that my PhD research was looking at the elderly care sector although I did omit the fact that I would use my time in the job as an opportunity for data collection. Once I started in the care home I also was never untruthful regarding my status as a student or as a researcher looking at the elderly care sector. In fact, nobody I worked with really questioned me about my studies. I did, over the months, develop close relationships with some of my colleagues and did inform some about why I was working at the care home. In covert research methods it is possible to draw a distinction between 'soft' and 'hard' covert roles. Hard covert roles would entail the researcher to design and communicate a false persona or intention while a soft covert role would be a situation where very little actual deception is involved.

I think it is reasonable to say that where covert research is used, and justified as relevant, then the researcher should endeavour to deceive other people as little as possible. In this project, I tried to resist being intentionally insincere. I often volunteered

information about my life, my opinions regarding care work and my studies, and I never hid the fact that I was a PhD student investigating care. Yet, I only told a few of the co-workers the full extent of my aims in taking employment at Meadowvale. Nevertheless, there was an element of deception throughout the project. For instance, I doubt some of the research participants would have been as friendly towards me had they known that I was noting many of the things that they did or said. Care work takes place in the tightly confined space of the home. Care work is also intense work requiring speed, skill and competence. For these reasons, a strong feeling of camaraderie was built between some of the workers and in carrying out covert research I did feel a sense of betrayal. I was also aware that I was dealing with residents on a day-to-day basis and inevitably I built relations with many of those that were at the centre of the work.

Later in this thesis I will endeavour to provide a thick description of how regulatory discourses shaped the nature of caring at Meadowvale. These discourses attempted to dictate to care workers how to deliver care and attempted to form a basis for what quality care might be. Communicated to the workers through various documents and training courses and marketed by Moonlight Care as the defining features of their service, these discourses highlight the need to provide 'personalised' services to each user but they also define any sort of deviation from these principles as a form of 'abuse'. As I will discuss later, this led to a situation where, due to staffing levels and the organisation of the work, the workers were consistently unable to deliver the sort of care that was set out for them. Shouldered with the burden of delivering a service which was impossible with the resources available meant that 'abuse', under the official definition of abuse, was rife in the practices of the workers. The official definition of abuse asserted that in every instance that 'choice' was not delivered to a resident the practice was abusive.

This essentially means that the policy version of abuse, neglect and mistreatment is not a sufficient yardstick by which to measure the ethical values of this research. The policy version of abuse was embedded in the daily routines at Meadowvale. In a later chapter I will also describe the difficulties with delivering continence to the residents at Meadowvale. The configuration of care work at Meadowvale necessitated that the care assistants leave certain residents in soiled incontinence pads for long periods of time. This could easily be construed as neglect, but the low staffing levels and high workload resulted in incontinence pads being utilised as a labour saving strategy. Leaving certain residents in soiled pads allowed the workers to manage the overall workload because residents could be left for longer. So rather than taking a resident to the toilet every hour they would simply change the incontinence pad every four hours (or longer if shifts were short staffed).

Ethical standards of the research could not be justified on the basis of policy understandings. It would not have been acceptable for me to simply assume that malpractice had occurred if care was delivered in a way that was contrary to the principles of care that were laid out by the regulatory authorities. These guidelines were breached consistently, not only by many of the workers at Meadowvale, but also by me. Staffing levels were too low to deliver the style of care set out in policy documents. The repercussions of this were that my ethical location had to be consistently evaluated and re-evaluated. I had to assess each situation as it arose.

I had decided prior to entering the field that I needed to be extremely sensitive in my approach to abuse. I could not predetermine to the letter exactly the course of action I would take if some serious abuse or misconduct was observed during the research. As Lugosi argues, conducting participant ethnographic should be an 'ethical enterprise' (2006: 555) in which 'the nature of the study, the character of the fieldwork context, and the relationships between informants and ethnographer determine overtness or covertness in

the field' (2006: 542). This means that it is difficult to predetermine the response to an

ethical quandary prior to the researcher's presence within the field. In fact, it was my first

shift which presented me with the thorniest ethical conundrum of my time at Meadowvale.

On my first shift in the care home, the manager left the building at about 6pm and

all the care assistants had another two hours to work. I noticed a real change in the

atmosphere and quickly realised that three of the care assistants, but two especially,

started to intimidate and harass some of the residents. They started by constantly asking

one resident about her weight: "Elisabeth, what are you going to do about your weight

problem", "are you going on a diet Elisabeth" and "yeah, Elisabeth you really need to lose

some weight". The real horror in this situation was that Elisabeth, despite her dementia,

was totally aware that she was being tormented. After some minutes of this Elisabeth

began to get upset and retorted with "you lot are just nasty, leave me alone". Elisabeth

was clearly upset with these unkind remarks, and it was also clear to me that this was a

regular occurrence. This is probably a small event if it is considered comparatively to other

kinds of abuse that go on within caring contexts, but this was Elisabeth's home. This was

where she was supposed to be able to relax – a place that is supposed to be warm, secure

and comfortable. I felt that this was a form of abuse, and a distinct form of abuse different

to the organisational abuse that the care assistants were forced to practice due to the low

staffing levels. This was a deliberate attempt to upset Elisabeth, and hence did seem like a

minor form of psychological abuse.

Later that evening the same care assistants also started to attack someone else.

The buzzer had been going off for some time. This meant that one of other residents

required assistance. We were sitting around the table filling in the records for the day and

one of the residents, Doris, was sitting with us. Doris was one of the most popular

residents amongst the staff, and she was sitting with care workers and joining in the

conversation. She was also sharing some of the jokes and telling some of her own. One of the care assistants then said:

Jake: go and get the buzzer Doris

Doris: what this

Karen: Yes that button press that button

Doris (confused): and do what?

Karen: Tell them to fuck off

Doris (answers the buzzer): Fuck off

Doris was laughing during this incident and I do not think it caused her much distress, mainly because she felt she was joining in with the fun and games. She was part of the team. Yet this was a case of mistreatment both towards Doris and to which ever resident had been ringing the buzzer.

The events of this first evening upset me greatly. I felt that if this was the culture at Meadowvale then it would be hard to continue with my research, but I also strongly believed that if I continued to witness incidents like this I would need to take some sort of action. One of the dangers associated with participatory research is that the researcher can become assimilated into the culture they are studying in ways which might compromise the research. On the one hand, those who practice ethnography wish to be assimilated into the milieus that they study, but at the same time wish to maintain some form of objectivity because this maintains the interpretive powers of the methodological approach. In this sense the ethnographic approach walks a tightrope between two competing desires. Firstly, to achieve subjective insider knowledge the researcher wishes to be a member of the community in question, and in opposition, the researcher wants to

maintain objective separation from those being studied to ensure some basis for scientific inquiry. In ethical terms, there is an imaginary line where the researcher feels he or she must take action on what has been witnessed or what they have been participant to. As Calvey discusses, ethics can be viewed as 'contingent, dynamic, temporal, occasioned and situated affairs' (2008: 912) where the researcher's ethical stance emerges from the specific research surroundings as well as through a process of reflection and prior anticipation. The researcher, however, should situate their ethical thinking and practices within the norms and regulations of the discipline they work within rather than it purely being an individual academic intellectual process.

I was forced to consider taking some form of formal action after the first shift, either by informing the manager or going through appropriate official channels for safeguarding. As it transpired Karen was demoted from senior care assistant to only being allowed to work in the laundry room a week after I started at Meadowvale. Robert, the manager who had employed me was fired and I never witnessed Jake, or any of the other care assistants, engage in this sort of bullying again. It was never fully clear why Karen had been demoted and Robert fired, but I had heard that a number of staff had submitted formal complaints regarding Karen's behaviour towards other staff and residents. Some of the gossip circulating round Meadowvale suggested that Robert had also been fired over these claims. Fortunately for the residents (and for the research project) the general atmosphere in the home did appear to improve after those first couple of weeks that I worked there and my ethical concerns subsided somewhat.

Nevertheless, I remained shocked and disgusted about the system of care work which prevailed at Meadowvale. Benton (2006) argues that one of the shortfalls of Western liberal notions of rights is its individualistic nature. When instances of harm have been identified at an organisational level, legal systems often do not have measures to

bring about appropriate forms of justice. Similarly, at Meadowvale the abuse and neglect

of residents and the exploitation of workers was grounded in Moonlight Care's practices

and the wider political and economic terrain. Many of those instances which I witnessed,

or was even privy to, that I did feel were unjust, neglectful and abusive, were embedded in

day-to-day living and working at Meadowvale.

Reflexivity

Before tying up the chapter, I want to briefly highlight some issues relating to reflexivity

and how my identity might have been transposed into the research context. A defining

point in the social sciences has been described as the 'reflexive turn' (Bourdieu and

Wacquant 1992). The growth of philosophical postmodernism in sociology has led to forms

of academic scepticism regarding the possibilities of knowledge and a widespread

acceptance of the infallibility of scientific claims. From a methodological point of view,

reflexivity has become the major concept by which to realise the role of the researcher in

the production of research. Reflexivity refers to the processes by which those performing

research can reflect on their own role in the production of knowledge. Macbeth (2001)

notes a number of different sides to the process of reflexivity. The researcher's position is

particularly important in observational participatory research. Macbeth describes

reflections on the researchers 'position' in the research as the means by which the

researcher analytically compares their position in the wider social world with their role in

the field. In participatory methodologies the researcher often enters a world that he or she

would otherwise not come into contact with.

In the case of this research there are a number of issues to reflect on in relation to

my position inside and outside the research context. Care work is both heavily gendered

and increasingly racialised segment of the labour market. Care work is constructed as

feminine labour requiring 'mother's wit' (Diamond 1992) rather than formal meritocratic

skills. Increasingly in the UK, care labour, and especially elderly care labour, is provided by

migrant workers (Morarity 2008, 2010). At Meadowvale the vast majority of the workforce were female and had not been born in the UK. Many had only arrived in the UK in the last five years. However, many of the staff did comment on that there was an abnormally high number of male care assistants in the home even though males still only made up a small minority (at the most there were only five). Still, I could be constructed as something of an outsider at Meadowvale. I was the only student studying at a university (as opposed to a college), I was the only "white" male for a period and I also lived in a much richer area of the locality than most of my colleagues. Despite all this, I never felt any obvious hostility or resentment from my colleagues and I never felt that people questioned whether I 'fitted in'. A number of the older female care assistants and nurses, both 'migrants' and 'non-migrants', did on occasion make comments such as "this is not a job for a young man like you". It was always said in a motherly tone rather than in a resentful way. One care assistant, Anesu, a qualified nurse from Zimbabwe, often told me that she felt sorry that I needed to do this kind of work.

Nevertheless, in a number of important ways I did not experience care work in the same way that many of the other workers did. While I can comment to a degree on the organisation of care labour at Meadowvale and the nature of many of the tasks and relations, my understanding of the true toughness of doing fulltime care work permanently is incomplete. I worked between 24 and 36 hours a week, or two to three shifts a week. Many of the care workers, especially the ones who had recently migrated to the UK, worked five 12 hour shifts a week (60 hours) and with a sizable minority working as many as six 12 hour shifts a week (72 hours). Some of the British workers would infrequently work 60 or more hours a week, but most worked less. For the workers who did work five or six shifts a week, the rota often required working as many as ten shifts in a row. Also, if there was training course being run at the home, and you were not on duty, it was expected that you would come into work on your day off to complete the course. These

shift patterns were utterly exhausting for the workers. For instance, on one occasion the care assistant Rosin, who worked Monday to Saturday every week, fainted while on duty.

The experiences of care work for many of the staff departed from mine in a number of important ways. The extreme quantity of hours worked were necessary for many of the workers. Often these workers were supporting family members living abroad and had no alternative opportunities. I never worked more than three shifts in a row and I always felt utterly drained after one. Just about all of the care assistants, myself included, complained of intermittent back ache due to the heavy lifting. For those care assistants working more regularly than me, especially if they were older, they often complained of severe back pain. The following pages I will give some account of care work, much of which is based on my experience of performing the work, but it is important to mention that my familiarity with care work departs significantly from the slog and struggle that the job means for many.

I never managed to work nightshift either, despite requesting to do so. Two employees tended to work all the night shifts from Monday to Friday and then a separate two did the weekend shifts. So this was a further aspect of the work at Meadowvale that I never experienced. In fact working the night shift was desirable for many of the workers because there were no managers on duty and the workload was thought to be much easier. It was assumed that you would get some sleep through the night and that there was generally less to do.

Relations in the home were often racialised in various ways. Many of the migrants, but especially those from African countries, felt that the managers gave promotions and organised the work favourably for the British workers. They felt that if there was some new responsibility, such as delivering training or a new type of form filling, it was always the British workers who were given preference. Agu, a Nigerian care assistant who I

became particularly friendly with, had been promised by the manager to be put on a 'train the trainer' course, on which he would learn how to deliver various sorts of training to the rest of the team. Some of the other British workers, he argued, had made sure that his name was removed.

My position as a white, middle class and educated male undoubtedly determined the experiences I had at Meadowvale although in sometimes unpredicted ways. Prior to going into the field I felt that it might be difficult to get migrant workers to talk freely to me. I felt that they might make certain judgements regarding my beliefs or opinions and I thought I would need to work harder at gaining their trust. In reality I found it far easier to form good relationships with the migrant workers and the black British workers than I did with the white British workers.   Some of the British workers were well known 'racists' by the rest of the staff and many made openly racist comments in front of me. Many of the migrant workers had middle class backgrounds and had been well educated. Also, because I have a Scottish accent, many of the workers from the local area saw me as something of an outsider anyway. I found it difficult to form friendships with people I felt had racist opinions, while simultaneously I often had more common ground with those workers who had come from other countries.

Conclusion

In this chapter I accounted for the research setting, the methods used in this study, the ethical standpoint, the ethical dilemmas emerging from the period of research and issues surrounding my position in the field. I have argued that covert research was a necessary part of the project and was imperative to the analysis given in the following pages. I have argued that understanding the true nature of the work was easier because I engaged in the work itself. However, in order to build a picture of the sorts of pressures and constraints which defined the labour process at Meadowvale it is important to clarify a number of

issues surrounding Meadowvale. It is towards this that I turn my attention in the subsequent chapter.

In the next chapter I provide some background information on the state of the elderly social care sector in the UK in recent years; the history of Moonlight Care care company; and I emphasise the processes of cost rationalisation at Meadowvale. In order to provide an analysis of working practices and resident experiences at Meadowvale, the next chapter emphasises the current funding constraints of elderly care systems in the UK.

CHAPTER 3: Background

Before entering more fully into ethnographic data it is important to set the scene for later arguments. This chapter provides a range of supporting arguments which provide a context to the ethnographic data which follows. Firstly, this chapter outlines the current elderly residential care market, demographic issues currently facing the UK and the link between these and the demand for social care. It then recounts the major policy context surrounding the privatisation of social care. This includes a discussion of how care is financed and draws attention to the relationship between the local councils and service providers. After this, the chapter investigates the status of the social care workforce which highlights the low labour rights and the significant numbers of migrant workers employed in privatised elderly social care. The chapter then describes more specific information in relation to Moonlight Care. Finally, this chapter introduces some of the ethnographic data from Meadowvale and draws the reader's attention to the extreme cost cutting in labour and in other costs. The overall argument of this chapter is to show how the current system of funding has led Moonlight Care to follow a number of strategies within this funding context which seriously constrains the ability for increasing fees.

Elderly Social Care in the UK

Jeremy Laurence, health editor for the Independent, wrote of 'all the threats to human society, including war, disease and natural disaster, one outranks all others. It is the ageing of the human population'. Laurence depicts a currently common viewpoint: that changing demographic structures will lead to a number of crises revolving around taxes, dependency ratios and stretched heath and social care services. With large numbers of the population retiring, it is contended, an economic crisis looms where those not working outnumber

those working. Elderly populations, it is reasoned, have high levels of dependency on the

working population because they consume high levels of public services.

In spite of these obvious trends towards ageing, Mullan (2002) has questioned the

reality of a social or economic catastrophe. He has argued that many of the statistics

relating to age do not capture the social relevance of demographic transformation. The

current fear, according to Mullan, around rising levels of old age is as much to do with the

government attempts to reduce its involvement in the economy and justify further welfare

cuts. However, statistics do currently point to serious marginalisation of elderly people in

the UK. Declining physical and mental health in the 'fourth age' coupled with social and

economic processes continue to exclude elderly people from claiming many of the

citizenship rights of other people in society (Townsend 1981; Walker 1983). Elderly people

in the UK continue to face poverty, social exclusion and ill health.

While many elderly people are reliant on social services, long term care of the

elderly remains a responsibility that is often carried out by family members. Census data

from 2001 shows that 6 million unpaid family and friends provided informal care in the UK

(ONS 2003) and Carers UK (2005) estimated that 70% of those cared for at home are done

so by people aged over 65. Older people themselves make up a large number of carers

with 2.8 million people in 2001 aged over 50 and 5% of people over 85 providing unpaid

care (ONS 2004). In terms of care needs it was estimated by Wanless (2006) that in

2006/2007 an estimated 2.5 million older people in England had some need for care and

support, and CSCI (2008) showed that 850'000 of these have high levels of needs (which is

10% of the population aged over 65).

There is a large formal care sector in the UK. This is comprised of two main

services: care provided within care homes, or residential care, and, home care which are

services provided within people's homes. In 2003/4, 43% of all NHS spending on hospital

and community health services was allocated to people aged over 65 (Howse 2008).

Talking of social care services (rather than health care services), 1.1 million people aged

over 65 used these services in 2006/7 out of a possible 2.4 million older people with

estimated care needs (CSCI 2008). CSCI (2008) also believed there to be 6'000 older people

with high care needs and 275'000 with lower needs who receive no services or informal

care at all. There is also a possible 450'000 older people have some sort of shortfall in their

care provision (CSCI 2008).

The population of elderly people living in residential care homes has in fact

declined despite the demographic trend in ageing. In April 2007 there were roughly

420'000 people in UK care homes which is a decline of 49'000 since 2000 and of 84'000

since 1992 (Laing and Buisson 2007). In England in 2007, 347'000 received local authority

home care services, which, perhaps surprisingly, this was also a decline from 414'700 since

2000 (The Information Centre for Health and Social Care 2009). Home care also used 66%

of all local authority elderly social care funding in 2007/2008 (CSCI 2009). There has been a

general trend towards home care rather than residential care (CSCI 2009).

Even so 317'000 elderly people received residential care services in care homes or

other long stay care facilities in 2007/2008 (which is 4 percent of the elderly population)

(CSCI 2008). Netten *et al* (2002) indicated that many smaller residential care services were

closing due to increased home care services. While residential care services are declining in

their role in overall provision of care services a range of authors have suggested that they

offer the best style of care for those with high care needs (Jack 1998; Kellaher 1998). In

total spending on care and support for the elderly, including residential and home care,

was 8.8 billion (The Information Centre for Health and Social Care 2009). However, the

proportion of private funding in residential care (57%) is much higher than in home care

services (38%) (CSCI 2008).

Two and a half million pensioners (1 in 5) in the UK live below the poverty line of £151 for single pensioner and £226 for a couple per week (Age UK 2011a). In 2011 the state pension is £97.65 for a single pensioner and £156.15 for a couple and 1.3 million pensioners have no other source of income other than this (Age UK 2011a). Age Concern (2008) have shown that those aged over 85 are most at risk of living in poverty as are many ethnic minority groups. When someone enters residential care they are only legally entitled to keep £22.60 of their pension, the rest can be acquired by the local authority to go towards care home fees (Age UK 2011b).

Elderly people are, inevitably, at risk of having poor health status. The ONS (2010) showed that in 2006 63% of people aged 65 to 74 said they had a longstanding illness and 38% said this illness affected their capability to carry out daily activities. Of those 75 and over, 70% reported having a longstanding illness and 50% said it influenced their ability to carry out daily tasks. Mental health status is also of concern. Around 25% of people over 65 living in the community in 2005 have symptoms of depression with around half meeting the clinical criteria for diagnosis (Craig and Mindell 2007). The Alzheimer's Society (2007) estimated that in 2007 there were over 600'000 people in the UK with late onset dementia (onset after the age of 65) and 20% of people aged between 80 and 89 have dementia.

Reviewing these statistics on ageing and care services it remains clear that there will continue to be a strong need for dementia services in the UK. The rise in dementia sufferers, and the highly complex care needs that dementia usually entails, indicates that the need for residential care services is likely to continue despite government attempts to shift care to the household. This might not necessarily lead to more residential services. The declining residential services might merely lead to more home care services, but in instances where people's needs are complex and extend over the whole day it is likely that residential care still offers the best option.

Financing Care

The changes proposed by the Griffith (1988) report set the tone for policy changes which happened rapidly in the early 90s but have continued to sculpt the landscape on social care provision since. Griffith's proposal was for community care to be organised around a system which resembled a market in certain ways. Responsibility for community care was transferred to local authorities' social services departments. These new powers, however, only gave local authorities remit to purchase and plan services, and Griffith proposed that social services departments would cease to be involved in the direct delivery of most frontline services. Resources would be allocated by central government to the local authorities who were responsible for ensuring that this money was successfully distributed across services which would provide the support for those in need of community care (including the elderly). The local authorities were also expected to develop the size of the voluntary and private sectors, which Griffith conjectured would help implement a system where competition (therefore efficiency) and choice would be fostered. Griffith was also keen to highlight that informal care should remain the backbone of social care provision. He asserted that the role of friends, neighbours and relatives in the provision of care should increase.

The Thatcher government took most of these changes on board and it was the beginning of what is now called the 'mixed economy' of social care. Formal care services are now provided by a mixture of state, private and voluntary organisations. The mixed economy of care also departs from previous welfare systems because buyers and sellers are split. Those funding and those providing services were separated. The mixed economy of care heralded widespread privatisation in certain areas of service provision which were previously state led non-profit organisations.

However, to conceptualise this market for social care as relatively free or unregulated would be incorrect. Social care markets do not operate the same as a typical consumer market. In England, Wales and Northern Ireland social care services are now means-tested as well as needs-tested. It is local authorities, rather than central government that budget for social care services and it is them who decide on the eligibility of individuals to access different publically funded services. The Low Pay Commission (2009) has argued that fees paid by the state to private social care providers do not represent the actual cost of providing these services.

The current system of funding for elderly residential care is complex, comprising of both needs- and means-tested elements (Cangiano *et al* 2009). Local authorities will pay for the full rates of care for some individuals and top up fees for others. The NHS will cover costs in certain instances (Age UK 2010). The total cost to the government in 2007/8 on all elderly social care was 20.7 billion (Information Centre for health and Social Care 2009) and it is thought that the funding received from private households is in the same region (CSCI 2008). This suggests that while state funding remains the backbone in providing elderly care services, contributions by private individuals remain critical in funding the overall system.

However, in spite of the large contributions of private household funding, local authorities retain a high degree of control over the rates that care homes are able to charge. For part and complete subsidised individuals the local authority determines the rate it will pay, effectively controlling care home fees. Even for individuals who are self funding, or for which cost is no barrier, the local authorities are obliged to provide information regarding which services are available and make an assessment regarding which kind of service they need (Age UK 2010). The effect of this is that even privately funded people can expect to pay a similar rate to what the local council pays for individuals

who are completely or partly funded. This is significantly lower than what an individual would expect to pay if they organised their own care package with no advice from the local council.

The social care sector has, however, experienced more intense rates of privatisation than the health care sector or social care for the disabled or children. Laing and Buisson (2007) have found that in England, 78% of places in residential and nursing homes which have older people as their main clients were in the private sector. On the last 20 years elderly-focused care services have experienced extensive privatisation. Also the UK Home Care Association (UKHCA 2009) found that 84% of home care providers were in the private or voluntary sectors. However, it is still the local councils who are responsible for paying for these services. For instance, 60% of home care providers rely on local authority funding (UKHCA 2009). Direct payments are also becoming more and more common. Direct payments are when individuals receive money directly from the government and can then choose which services to buy.

Most important point for this thesis is that payment rates to care homes are decided by local authorities, rather than by providers or a process of free competition. The social services department at each local authority assesses each individual's care needs while a legal framework decides whether individuals are able to pay for their own care or not. Some will be expected to pay for their own care but may receive benefits to assist them. The local authorities have a considerable amount of power to set rates for services. This continues to be a major factor preventing care companies from increasing the profitability on their operations.

Whether changes can be identified specifically as a form of welfare state retrenchment is difficult to determine. For instance Pavolini and Ranci (2008) argue that while long term care systems across Europe are being transformed and restructured they

are not being eroded. The percentage of GDP spent on these services has risen even when

demographic changes are factored in. The retrenchment debate is itself a specifically

historical investigation because it is attempting to resolve issues around whether what

exists now is inferior to what existed before (Starke 2006). There are a whole host of

complications to determining whether retrenchment has occurred or not. The 'welfare

state' as a concept has been described as an 'indefinable abstraction' (Titmuss 1968: 124),

and accordingly, issues around how to measure and theorise change as retrenchment is

complex.

Regulation of the Care Industry

Coupled with the increasing privatisation and marketisation of care provision has been the

rise in the importance of regulation. Pierson (1994, 1996) argued that, despite widespread

believe in the rolling back of the welfare state, welfare regimes in Western countries

remained considerably resilient to retrenchment. The persisting popularity of welfare

benefits and institutions amongst electorates was a major factor sustaining the

continuation of large welfare states in Western countries. Others are less positive about

the resistance of welfare states to neoliberal agendas. Bob Jessop's discussion of the

decline of welfare states, argues that the state has 'major roles in securing the expanded

reproduction and regulation of capitalism' including 'helping to secure the conditions for

the valorisation of capital; and, second, helping to secure the conditions for the

reproduction of labour-power' (1993: 7). Accordingly, the regulation of economies and the

facilitation of markets is an important role of nation states. The privatisation and

regulation of welfare brings these two functions of the state together. The state then acts

as a regulator of the market, ensuring that companies can continue to operate, while

simultaneously determining the actual nature of these services. A number of authors have

commented that New Labour's approach to welfare was indicative of a 'regulatory state'

(Chapman, Miller and Skidmore 2003; Moran 2001). Whereas Old Labour was concerned

with the ownership of public services, New Labour policies reflected a belief that

ownership was irrelevant and that the public is only interested in end results (Drakeford

2006).

Humphrey (2003) details the regulatory system which pervaded social care systems

under New Labour. Her interpretation of the system of regulation is highly critical of the

relationship between local councils, regulatory bodies and central government. Central

government allocates the funding to each local council and determines the appropriate

level of care. Humphrey argues that the funding is not realistically aligned with the goals

set out for care agencies and regulatory organisations. Furthermore, the goals themselves

are often conflicting especially in the sense that they require, on the one hand, resources

to be rationed, but on the other hand, dictate a high level of service quality. Humphrey

depicts the regulatory authorities as a 'buffer' (2004: 12) between central and local

government. Central government is able to subvert responsibility over operating and

policing care services. The local councils are charged with providing and organising care

services in their area but then have no direct access to discussion with central government.

If some sort of catastrophe arises within a local area, central government agencies are able

to argue that they fulfilled their responsibilities by funding local councils and regulatory

authorities. The locus of blame can then easily be shifted to the devolved responsibilities

of local councils and/or the regulatory authorities.

The recent history of regulation in the care industry, however, has been extremely

volatile. In 2000 the National Care Standards Commission was set up to regulate the

industry. Shortly after its inception, however, it was replaced with the Commission for

Social Care Inspectorate (CSCI) in 2004. CSCI remained the regulator throughout the period

that this ethnography took place. CSCI carried out inspections in all care homes at

intermittent intervals, yet this has since been replaced with the Care Quality Commission

(CQC). The CQC, however, does not carry out inspections in all homes, instead, it randomly takes a selection of all homes which has caused concern that standards of inspection are falling (BBC Radio 4 2010).

Regulation, nevertheless, remains a major barrier to the profitability for private sector care homes. As Humphrey's (2003) study shows, there is a gap between policy goals outlined by central government as to what represents appropriate care and the actual resources given over to local councils and regulation authorities to ensure these standards are met. A range of policy documents including *Modernising Social Services* (DH 1997); *Independence, Well Being and Choice* (DH 2005); and *Our Health, Our Care, Our Say* (DH 2006) set out the nature of quality care. While regulation remains of utmost importance to securing a base level of care services the resources given over are insufficient to realise the goals set out in these various policy documents. In a traditional model of the capitalist production process, the value of goods is thought to arise from a process of market functioning and production costs. The money spent on raw materials, technology and labour determines the price of the product and the surplus value accrued from production (Thompson 1989). The market also determines the prices of goods by determining what people are prepared to pay producers. This underlines competition, it is typically thought, because it is this process which also eliminates wasteful and inefficient producers (Beesley and Littlechild 2003; Savas 1987). Of course, most markets do not behave in this way. Partly this is due to the regulation of production by the state but also processes of monopolisation leads to larger players dominating markets therefore eradicating competition. Finally, the role of branding creates a different basis for value and competitiveness lying outside the processes of production (Baran and Sweezey 1968). Nevertheless, markets for many goods, such as say manufactured items, do follow some of these rules, at least some of the time.

The processes involved in the competition and production of elderly care services in the UK mixed economy of care depart from these typical understandings of capitalist production and competition. In the current care system the notion of 'consumer' and 'market' is obscured greatly by the number of different stakeholders in the system. Exactly who is buying what is not easy to decipher. When an elderly person enters residential care, is it the consumer who is buying the service? Or is it the public, since all or some of the funding comes from public money? Or, again, is it the council who are buying the service as they have control over budgets? The state is also involved, because it is central government which distributes the budgets to local authorities and imbues the powers of regulation to certain bodies. The state also defines the nature of regulation. Finally, often it is family members that play a key role in choosing care homes for their relatives. The fact that the 'consumer' of elderly care is hard to identify questions some of the supposed benefits of marketisation and privatisation. Beesley and Littlechild (2003) state that '[P]privatisation will generate benefits for consumers...' because '[C]companies which succeed in discovering and meeting consumer needs make profits and grow; the less successful wither and die' (2003: 17). The supporters of the privatisation constantly assert that competition improves choice and leads to a consumer led service (Kirkpatrick 2006; Van Mierlo 2007). In elderly care, however, it is not clear who the 'consumer' is, which raises the issue of exactly whose preferences, needs and desires are driving services. When it is not easy to visualise who is the user, or if it is possible to conceive that other groups are the major consumer rather than the people utilizing the services, the whole notion that market choice and competition benefits citizens is brought into question.

The heavy regulation of the care industry reveals some of the contradictions of the modern state. Regulation remains strong and intense in the elderly residential care market perhaps because there is a realisation that simply leaving the market to run its course fails to ensure a quality service. The politics of neoliberalism structure the actions of the

contemporary UK state in certain aspects (Clarke 2004); in particular, the state seems to want to wash its hands of responsibility over delivering care and simultaneously employs pro-privatisation and pro-marketisation discourses in order to implement different modes of service provision. But as Pierson (1994, 1996) rightly suggests, the state's legitimacy still emerges from its capability to provide welfare for its citizens, which in the case of elderly care services leads to systems defined by intense regulation. So as Clarke (2004) argues it is easy to identify the influence of neo-liberal agendas and discourses on many policy changes in the UK since the 1980s but there are counteractive forces which prevent the ideology of the market from taking over completely. State-funded elderly residential care remains in place but funding has remained severely limited even if it does remain large. This is evident in the continuing low wages associated with care work, which is what I turn my attention to next.

Social Care Workforce

The care workforce in the UK comprises of two main groups (Cangiano *et al* 2009). The first group provide 'direct care' including care assistants, home carers and support workers and the second group comprises of professional staff including social workers, nurses and occupational therapists. In total this group comprises 5 percent of the total UK workforce comprising of approximately a million workers (Moriarty 2008).

The composition of this workforce suggests segmentation on a number of variables: immigration status, gender and ethnicity. In total migrant workers make up 18% of the total social care workforce and more than half the social care workforce in the city of London (Beesley 2006; Moriarty 2008). Some enter on work permits specially geared towards working in the care industry while others come in as irregular migrants, asylum seekers or EU citizens and end up finding work in this sector. The composition of this workforce is also heavily gendered with 85% of the workforce being female. Also non-

white ethnic minority groups are over represented making up 17% of the care workforce and 44% of registered nursing staff (Cangiano *et al* 2009).

In the elderly care sector in 2007/8, Cangiano *et al* (2009) found that 19% of all care workers and 35% of all nurses were migrants. Of those care workers recruited in the last year of their dataset the proportion was higher with 28% of care workers and 45% of nurses that were migrants. They have also shown that in 2007/08 the largest proportions of recent immigrants recruited into the social care sector came from Africa, Asia and Eastern Europe. Migrants entering the UK to work in the care sector have a range of immigration statuses.

Recent migrant workers to the UK elderly social care sector tend to be overrepresented in private care services, rather than state owned or voluntary services (see *figure 1*). Recent migrants are hugely over represented in private care services with UK born care workers being more likely to work in local authority services.

Figure 1: Distribution of care workers by sector, UK born and foreign born by period of entry 2007/2008 (Cangiano *et al* 2009: 75)
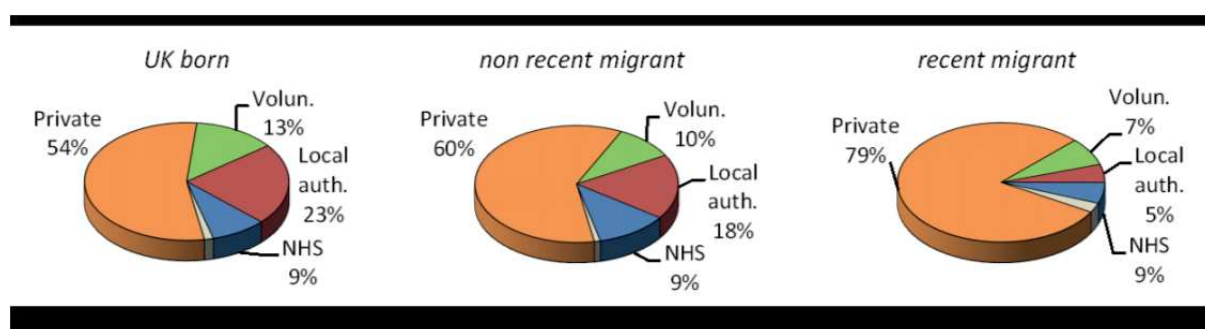
The social care sector has been identified as one where minimum wage is common (Low Pay Commission 2005). Wanless (2006) found that workers' wages accounted for two thirds of the running costs of residential care homes making pay levels extremely

sensitive. In North East England, North West England and the West Midlands, average pay was barely above minimum wage at £6.00 an hour (the minimum wage was £5.73 in 2008 when the). However, many workers reported receiving wages below the national minimum in Cangiano *et al*'s (2009) study. Workers aged between 17-21 are not entitled to the full minimum wage in the UK and can be paid a development rate of £4.60 an hour. However, Labour Force Survey statistics suggest that 1 in 10 workers received below £4.95 and 1 in 5 reported receiving below £5.56 suggesting that some workers are receiving wages below the national minimum, including some above the age of 21 (for a full account of the debate on care wages see Cangiano *et al* 2009: 21-26).

The vacancy rates in social care are thought to be double that of almost all industrial, commercial and public employment (Eborall and Griffiths 2008). CSCI recognised labour shortages in this industry as a massive problem (2006). Yet, Moriarity (2008) describes this problem as relating to skills shortages rather than the numbers of candidates. This suggests a possible mismatch between wages and the appropriate skills required to do care work. Interestingly, the turnover rates were significantly divergent between state (9.6%), voluntary (15.8%) and private (23.6%) sectors (CSCI 2009).

Nevertheless, picking apart wages and working conditions for care workers rests on the relationship between business and the state. This was exemplified by a pay dispute which has lasted for a number of years. The Border Agency issued a declaration in 2007 which argued that in order for migrant care assistants to be considered skilled labour, which would then justify their immigration status, they needed to earn at least £7.02 (Unison 2007). At the time the average senior care assistant was only on £6.24. The care industry argued that the labour was irreplaceable with UK citizens and that these migrant workers supplied critical labour for the industry. This led to a strange situation where some unions and migrant rights groups were effectively campaigning for lower wages in order to

protect the right to remain in the UK for migrants from developing countries. The catch 22 was that if migrant workers wages were increased to £7.02 many care organisations would have been unable to pay this amount and would therefore be forced to redefine the work of senior care assistants as care assistants. This would have meant that these positions would no longer be skilled enough to grant immigration status. The minimum £7.02 has now been enforced in policy but as yet there is little evidence to suggest whether it has been enforced in practice. However, migrant rights group Kanlungan (2010) has predicted an 'impending crisis' over this dispute.

The low labour rights, the high turnover rates and the difficulty in recruiting workers from domestic labour markets suggests that employment in the private social care sector is generally perceived as undesirable. Feminist scholars have argued that care work is valued as necessary yet devalued as feminised, unskilled and naturally occurring labour. What some authors have described as the 'circle of care' is an 'exploitative mechanism' (Bubeck 2002: 173) of interrelated processes and ideologies which binds women to caring roles and simultaneously devalues these roles. The socialised gendered identity of women and the self-fulfilment and approval that they receive from care-giving, encourages them to engage in caring practices in public and private realms. The devalued status of caring roles also prevents women from accessing the same material benefits as men. Private caring obligations often prevent women from participating in the most economically rewarding sections of the labour market (Daly 2000), while within the labour market those forms of employment which value the culturally stereotyped feminised labour have little monetary remuneration attached to them (Hartmann 1979). Bound up with feminine stereotypes, care work is also women's work because it is dirty. For instance, Twigg (2000) explores the relationship between dirt and care work suggesting that it is also devalued because it involves a high intensity of intimate touch, nakedness and the control of bodily fluids.

These interrelated social, cultural and political currents which determine the status of care work have also made it a segment of the labour market which is populated by a significant quantity of migrant workers (Moriarty 2008, 2010). The processes of globalisation and international inequality have clashed with structures of patriarchy to transform the care sector from a purely a feminised, to a feminised and racialised, segment of the labour market (McGregor 2007).

Moonlight Care Care Company and Meadowvale Care Home

Moonlight Care

The residential elderly care market is relatively mature now and a smaller number of large scale care monopolies are beginning to rise from this diverse and fragmented market (Drakeford 2006; Scourfield 2007a). The company under scrutiny in this thesis, Moonlight Care, is one of the largest providers of elderly residential care in the UK, and its swift growth, I will contend, is closely linked to various constraints inherent in making the provision of care a profitable operation. The following paragraphs reports the short history of Moonlight Care and highlights the various strategies used by the company in recent years in the attempt to achieve business success.

At the end of financial year 2009[5], Moonlight Care Group were one of the leading providers of elderly residential care in the UK with over 740 care homes and 37'000 beds nationwide. However, the large number of small providers in the residential care industry means that they still only have 10.2% (rising from 8% in 2008) share of the sector. Inevitably, they are a very large employer with over 42'000 employees. However, Moonlight Care Group is divided into three separate divisions: Moonlight Care,

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[5] Moonlight Care's financial year runs from September to September.

Rowangrove Senior Living and Dynamic Care Partnerships[6]. Moonlight Care provides care homes and nursing homes to the elderly and the ethnography took place in one of these homes. This wing of the company makes up the largest part of Moonlight Care Group by far with over 600 homes and 31'000 beds. The second largest brand is the Rowangrove Senior Living division which offers residential care services to the more 'discerning' client with over 70 homes across the country. Dynamic Care Partnerships offer specialist care services, both live-in and community, to people with a range of needs including, but not limited to, learning difficulties, autism spectrum disorders, enduring mental health problems and dementia. The quantity of the services supplied Dynamic Care Partnerships was not available.

Moonlight Care has undergone very rapid growth in the last 10 to 15 years. The company acquired 39 homes in April 2001, 26 homes in February 2002, 190 homes in November 2005, and 193 homes from Rowangrove group (from which the Rowangrove Senior Living brand was developed). In the year from 2007 to 2008 Moonlight Care reported that they have increased the number of beds they offer by a further 3'121 through the attainment of a further 62 homes. In that year alone this represents a growth of 9.1% in terms of the beds offered across the whole company. Twenty of these homes were acquisitioned through outright purchasing, 39 of the homes were leased; therefore remaining owned by other parties but operated by Moonlight Care. The final three homes were purpose built by the company. In 2007-8 there was also a further six homes under construction, and in year ending September 2009, accounting for the new homes opened, acquisitioned and leased, as well discounting the small number of homes closed, they added a further 1'000 beds. Moonlight Care has undergone rapid expansion in terms of the size of its operation.

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[6] The divisional names of the company are also pseudonyms.

However, in terms of profitability the picture is not so rosy. Moonlight Care Group is a PLC (Public Limited Company) meaning that they sell shares of their business to the general public. Moonlight Care Annual Report and Accounts (2008) gives an overview of company performance for the period beginning September 2007 and ending September 2008. The chairman's statement from 2008 reveals the company's crisis:

> *This has been a very difficult year for Moonlight Care after promising debut in 2006 as a listed company. Our share price has fallen from an average of 564p in the first quarter to an average of 119p in the last quarter*

In this statement the chairman goes onto suggest the major components of their strategy in order to improve future business prospects as well as laying out the reason for the struggling share price. He lays out the company's plans for 'improving quality of service', 'lowering costs' and 'maximizing cash flow'. He also lays out the desire to continue growing the firm by leasing homes directly from landlords and developers. Without specifying which 'events' he is referring to, he calls for better risk assessment and risk management:

> *The events which took place during the course of the year have caused us to re-examine our internal control systems and management of risk. We are making some fundamental changes to the way in which management report and interact between themselves and the Board. We are continually assessing areas of risk in the business in order to embed risk awareness within the organization from the Board to the most junior of care home staff. With over 42'000 employees and an industry where staff turnover is typically high, we know we have to be more diligent (2008: 4)*

The Times (2008b) reported the fall of Moonlight Care share prices which crashed by 75% and cited a 'higher-than-expected death rate' as partly to blame. Other incidents of abuse and neglect that have been reported in the media have put Moonlight Care in glum light. The chairman was responding to the increasingly poor reputation of the business, which seems to have had a major impact on the share prices, if not expansion.

The chairman mentions a number of other opportunities and obstacles to future profitability and expansion of Moonlight Care. A key obstacle is the low levels of fees currently paid by local authorities and the chairman indicates that Moonlight Care has been in contact with a number of care associations in England, Scotland and Wales in order to campaign for increased fees. The chairman discloses that cost pressures currently stem from three main sources: 'legislation, regulation and the minimum wage'.

Later on in the 2008 Annual Review costs to Moonlight Care operations are expanded on in greater depth. The major difficulties seem to be fee rates, staff costs, occupancy difficulties and rent. The total revenue for the company in 2007-8 was £889.4 million (a £157.5 million increase from the year before cited as being due to the expansion in the number of homes). Payroll costs alone for the year 2007-2008 were £500.2 million representing a 4.4% increase from the year before, and also highlighting the labour intensive nature of the business. They recognise that there has been pressure from both the national minimum wage and the working time directive. The occupancy rate (number of beds filled) was 89.5% which was 0.6% lower than the previous year. Fee rates increased slightly from the year before from £499 per resident per week in 2007 to £522 in 2008, although they argue elsewhere that rates remain too low to drastically improve the service or increase profit. Rent charges were £221.6 million and central running costs were £26.5 million. Despite the struggling share price, however, the 11 board of directors at Moonlight Care cleared £2.2 million in benefits and pay in the year 2007-8, and the just over £2 million

in 2008/9. In total, £16.5 million was paid out in share dividends[7] in 2007-8 but none were

paid in the 2008/9.

Furthermore, it has recently come to light that when Moonlight Care became a PLC

in 2006, floating themselves on the stock market, significant bodies of wealth were

generated for both the equity company that backed them and some of the board

members. By 2007 the equity company had made £1 billion through various deals to do

with Moonlight Care. Four of the board directors between them had cleared in the region

of £35 million through selling their shares (The Sunday Times 2011)

In their review for 2008/9, however, Moonlight Care managed to make some

advancements in the overall business functioning. Revenue increased to £937 million by

increasing the overall occupancy of their homes (from 87% to 89%), 68% of which they

received from the local councils, 10% from the health authorities and therefore only 22%

from privately funded care recipients. They managed to secure an increase in the rates

charged from an average of £522 per resident per week in 2007/8 to £546 in 2008/9 (a

sizable increase of 4.6%). Even so, they failed to prevent a fall in their share price by a

further 11 pence. Overall profitability also remained questionable. A pre-tax loss of £19

million was stated. The company spent over £530 million on pay, over £110 million on

running costs and just over £290 million on rent. However, in the year 2008-9 they

managed to reverse the trend of rising debt and reduce overall debt from £64 million to

£33 million.

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[7] Understanding Moonlight Care's accounts is difficult. They publish their review of accounts from September to September rather than for the tax year (April to April). This leads to what appears to be some inconsistencies or discrepancies. For instance, they reported losses, not profits, in both their reviews of accounts 2008 and 2009 but also report paying out dividends in 2008. It is illegal to pay out dividends if profit has not been made therefore it seems that they were able to file profits for the financial year even though they declare losses in their annual reviews. The reasons for why they do this are difficult to conjecture.

In 2006, the equity company behind Moonlight Care also split the company into two different arms: an operating company and a property company (a strategy sometimes called 'opco propco'). This meant that rent was paid by the operating arm to the property arm. Recent investigation by the GMB (2011) trade union suggests that it is possible that much of rent was in fact paid to tax free off-shore havens indicating figures on profits by the operating arm do not indicate the true profitability of the company. It seems that this process is important for profitability because while Moonlight Care has little ability to increase the fees it raises it can charge itself higher rent. For instance, rent rose by more than £120 million between years 2008/9. The benefit of this seems to be that rather than paying taxes on any profit, the profit itself can be redefined as a rental charge.

So in spite of Moonlight Care's rise as a major player in elderly residential care they are now in a state of serious crisis. A damaged reputation, a struggling share price and a negative profit margin led to a change in leadership at the beginning of 2011. More recently, since the data collection took place, the plight of Moonlight Care has deteriorated greatly. Most recent data suggests that occupancy rates have fallen to 82% in 2011 (Guardian 2011). The chairman resigned in the spring of 2011 and many analysts believe the company is close to failing. It is expected to close over 50 homes in the coming months. What is not clear, and probably never will be, is whether the equity group which backed Moonlight Care ever saw their involvement in the company as a long term business opportunity. It seems from recent developments that the events of the last five years may have emerged from a short term attempt to make profits through various sorts of financial trickery and it was never a resolute attempt to make elderly residential care profitable.

This analysis of Moonlight Care brings two important points to light. Firstly, that the accumulation of profit from the provision of care services, under the current system of care, is a difficult process to achieve. The pro-privatisation arguments suggest that social

care systems can be revolutionised through the transformative powers of capitalism and markets seems to have little grip when the locus of profitability in this industry is explored. In particular, while Moonlight Care clears substantial earnings of almost a billion pounds they have huge running costs and in particular labour costs.

In the case of Moonlight Care, there are a number of specific strategies which emerge as crucial to accumulation of profit. These include: 1) expanding operations (for economies of scale reasons); 2) Campaigning for higher fees from local authorities; 3) tax avoidance; and 4) decreasing the costs of production.

The first strategy easily identifiable is the expansion in order to make gains through increases in the economies of scale. The company has gone from being a minor company, 20 years ago, to being a colossal provider of care. However, it seems that their longer term strategy hinges on increasing the overall size of the company. It is also worth reiterating that Moonlight Care's true profitability might not actually be known. The GMB (2011) believes that Moonlight Care is currently hiding profits in order to resist calls for higher staff wages and better living conditions for the residents. Furthermore, a company which makes a large degree of its money from public funds is likely to come under a certain amount criticism if it consistently publishes large profits every year. Through increasing the economies of scale, by buying extra homes, and increasing operations it also means that reducing expenditures in labour processes and in the costs of production has greater significance on the money accumulated. So once operations have a reached a large enough scale, even the smallest reductions in production costs will significantly increase profits. This explains that while their success as a business remains questionable they have been unrelenting in their expansion strategy. In many other sectors attempts to increase profitability would lead to changes in the style of operation including changes in the labour process, novel advertising campaigns or transformations in service delivery. Due to

regulation of the care sector by governmental organisations and the fact that Moonlight

Care receives most of its payment from local councils means that expansion is one of the

few strategies available for them.

The second strategy used by Moonlight Care is their attempts to campaign for

higher fees from local councils. Statements in both 2008 and 2009 by the chairman in the

annual accounts set out their intention to continue lobbying local councils to increase the

rates that they are able to charge the local authorities for care. The very fact that this

intention was communicated in the annual review of accounts highlights that much of their

profitability rests on obtaining public funds – business success rests essentially on state

funding. However, because Moonlight Care is so dependent on this source of funding it

seems hard to picture how increased funding would necessarily lead to a better service for

the residents. Any increases in funding from local authorities are likely to go into the hands

of the shareholders and directors, especially because the company is currently struggling.

Thirdly, although perhaps partly based on conjecture rather than solid fact, it

seems that a major strategy for securing profits is tax avoidance. The opco propco style of

business means that the rent paid by Moonlight Care (to themselves) is not open to as

much taxation as other profits would be.

Finally, Care work is associated with high levels of expenditure for little return and

the wage levels are a massive proportion (>50%) of the overall revenue, highlighting the

labour intensive nature of care work (Cohen 2011). While not necessarily explicit in the

annual accounts, reducing the costs of production is the third major profit maximisation

strategy. When their overall revenue is divided by their total number of employees for the

year 2008-9 a staggeringly low figure of £21'300 comes out. If the amount of profit

generated by an enterprise is essentially the money made minus the money spent on

operating (raw materials, wages, running costs and so on) then we can understand just

how much is spent on labour by Moonlight Care. This highlights the generally low profit margins but also the low wages across the company. The strategy of reducing the costs of production is the most significant for arguments made in the rest of thesis. The processes of reducing the costs of production permeated all aspects of living and working at Meadowvale and for the remainder of this chapter I want to account for this process. In other words the search for profit across the company at large seemed to have a direct consequence on the nature of working and living at Meadowvale care home.

The Division of Labour at Meadowvale

I have already given broad breakdown of the numbers of staff employed at Meadowvale (see *table 1* in the previous chapter) however, I now want to clarify how the labour was divided at Meadowvale, which begins to reveal the low staffing levels at Meadowvale.

The working shift patterns for each of the staff is as follows: between two and seven care assistants (8am until 8pm), one nurse (8am until 8.30pm), two or three kitchen staff (7am until 6pm), one home manager (8am or 9am until 5pm or 6pm), the handyman (8am until 5pm or 6 pm), and two or three domestics (8am until 2pm). For the night shift, which started at 8pm and finished at 8am, there would be one nurse and two or three care assistants. For weekend day shifts there was no handyman and no home manager but kitchen staff, care assistants, domestics and a nurse would all be present although often in reduced numbers.

Shifts for care workers (care assistants and senior care assistants) were mostly 12 hours long, although some shifts were six hours in length but were only provided for a small number of staff and were not available to most. The work of the care assistants is difficult to summarise because it encompassed all aspects of personal care (see also *appendix 1* and *appendix 3*); including feeding, washing, changing clothes, some healthcare orientated tasks (such as changing catheter bags), toileting, incontinence management,

ensuring personal hygiene and presentation, serving food/drinks, moving residents around the home and updating care records. But it also included a significant amount of cleaning. The care assistants needed to ensure that bedrooms were always clean and tidy, that dirty laundry was always taken to the wash room immediately, that the bin bags in the sluice which held incontinence pads and other such dangerous waste were intermittently emptied; and that lounge and dining areas were cleared after meals and snacks. All care tasks completed by the care workers, such as changing incontinence pads, feeding and washing, were noted in records and each worker had to ensure that their name was signed next to specific tasks. Actually this process of writing up records consumed quite a considerable amount of time during every shift.

The care assistants and senior care assistants essentially had similar roles although some administrative tasks were the sole responsibility of senior care assistants. Such as when a new resident was admitted to Meadowvale it was usually the role of one of the senior care assistants to put together a care plan which indicated the preferences of that resident and to ensure that these care plans were updated. Accountability over the care charts which recorded all care tasks was also largely with the senior care assistants. This reflects the basic difference in role between senior and basic care assistants. While the day-to-day work for both groups was basically the same, the senior care assistants assumed more responsibility to the managers.

The nurses almost always worked 12 and half hour shifts because they needed to be there for half an hour extra to give "handover" at the end of each shift. The long working hours meant that 24 hours could be covered by two shifts of workers making coordination simpler. The number of nurses formally employed by the home at any time was much harder to determine. There would have only been a couple of nurses employed by Meadowvale at any given time with a large percentage of the shifts covered by agency

nurses. Nursing staff generally took charge of handing out pharmaceuticals to residents, dealt with paperwork and carried out the more clinical care procedures such as changing peg-feeds or dressing wounds (see *appendix 1*). Their role was also to deal with the hospital and the local GPs on behalf of the residents. Generally, however, nursing labour was used minimally. There was only ever one nurse on duty at a time, which was a legal requirement for the home. The nurses only rarely provided direct physical care which might be traditionally considered as nursing work. Nurses had two major roles: firstly, completing the extensive paper work such as assessments when residents came to the home and dealing with NHS services; and secondly, distributing and organising medication. As the drugs dispenser, the nurses were to ensure that all residents received the appropriate medication, at the appropriate time and were to monitor all the residents in consuming the pharmaceuticals. Inevitably, this was a time consuming and organisationally challenging task with serious ramifications if not done correctly. Many of the nurses complained that it was difficult to complete within the time allocated and that the system used by Meadowvale to keep track of the drugs was awkward. The nurse's tasks for the day very rarely overlapped with that of the care assistants. The tasks completed by nurses at Meadowvale departed significantly from what many might consider to be stereotypical hands-on nursing work.

Meadowvale employed a considerable number of tertiary workers who were crucial to the running of the home but not directly associated with providing care (see *appendix 1* for a more detailed description of each of the roles of the tertiary workers). There were 2 or 3 "domestics" who were employed to clean the home and do the laundry. Some of the care assistants would do the domestic work if they were sick of care work, or wanted extra shifts. They worked from 8am until 2pm. The home also employed a handyman who doubled up as a painter and decorator. His role was to ensure that all the correct maintenance was carried out across the home, the work being completed either by

him or by arranging for contractors to do the work. However, his job was more important than it might first seem. His job entailed making sure that all the mobility equipment (wheelchairs, airbeds, stand-aids etc) were assessed at the appropriate intervals. If equipment was being used after the date it was supposed to have been checked, and if there was an accident, the culpability lay with care assistant that had used the machinery. On top of this the home employed three to five kitchen staff whose responsibility was to cook all meals, plan the weeks menu, manage food deliveries and generally attend to the running of the kitchen. Within the kitchen staff there was a hierarchy of one head chef, one or two chefs and one or two kitchen assistants.

The home manager was responsible for the general running of the home: hiring, firing, organising training, dealing with families if they had serious concerns and dealing with the regulatory authorities. It is likely that there many other tasks, but these were not observable. However, the manager responsibilities were generally bureaucratic in nature, and they did not exercise consistent or regular supervision over the other workers. They spent most the time in the office, and rarely strayed further than the lounge or kitchen.

Labour Rights at Meadowvale

At Meadowvale the wages were low. Care assistants and senior care assistants, who made up the majority of the workforce, received extremely poor wages. Care assistants received minimum wage (£5.73 per hour[8]) and senior care assistants only received 37 pence more (£6.10 per hour). Many of the care assistants complained that the increase in wages was not sufficient to justify the increase in responsibility when moving up to a senior care assistant position. As mentioned before, average shifts were 12 hours in length and the low wages encouraged the workers to take more shifts and work longer hours.

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[8] In fact when I began working at the care home they were paying me below the minimum wage at £5.64 an hour. Whether this was deliberate or an accounting error (as they argued) I will never know. I did receive the back pay in the end, but not without a fight and it was months before they increased my wages to the legal minimum.

Furthermore, some of the staff worked up to six shifts a week (72 hours) and most worked five shifts (60 hours). Also, because shift patterns did not always give staff the same day off every week some workers were often on duty for eight or even as much as ten shifts in a row. Many of the workers were migrant workers and sent remittances to their family abroad. Others commented that working this long was necessary if they were to go on holiday or pay the bills. Arguments between workers broke out from time to time when an individual wanted more shifts but was unable to acquire them. The nurses received £8.50 an hour but most of the other staff received minimum wage, apart from the head chef, the housekeeper and the activities coordinator who received the slightly higher rate of £6.10.

The workers received no pay for breaks. In a twelve hour shift the care assistants and senior care assistants were entitled to a total of one hour of breaks – 15 minutes in the morning and the afternoon and half an hour at lunch time – all of which were completely unpaid. Holidays were also scant. All workers received the legal minimum of 28 paid days a year and they were unable to accrue more by working overtime.

There was a Union presence at Meadowvale. The head chef was the union representative for the GMB. The GMB was the only union formally recognised by Moonlight Care. However, membership to the union was generally low and many workers claimed they could not afford to join. The cost was a little over £6 a month.

Cost-cutting care at Meadowvale

Labour was not the only expenditure which was kept to minimum at Meadowvale. I was struck during my time at Meadowvale about the variety and extent of production costs. The operation of a residential care home requires a high number of employees with a diverse set of skills: cooks, cleaners, maintenance workers, nurses, managers, trainers, laundry workers, gardeners, entertainment/activity workers and care workers. Then there were the food costs, heating costs (and the home was always stifling hot), maintenance

costs and laundry costs. Considering laundry costs and it becomes apparent that tertiary operational costs were substantial. Bed sheets at Meadowvale were changed every single day at least. Due to the high levels of incontinence and the difficulties that many residents had feeding themselves, almost all clothes (and nightclothes) needed to be washed every day. If someone had an accident (which usually happened three or four times through the day) then their clothes would need to be changed a further time. For residents who were bed ridden and suffered from regular incontinence bed sheets would be changed as many as four times through the day and then more times through the night shift.

During my time at Meadowvale the management seemed to be in a continuous process of rationalising the expenditure involved in providing care. Most significantly this was done through rationalising staffing levels. There was a minimum level at which staff should work and this was one care assistant to every five residents. This is a minimum legal requirement for care homes. The number of residents in the home consistently fluctuated due to illness, death and also because many of the residents were only there on respite. The home's capacity was for 36 residents but there was usually between 25 and 30 and hence there were usually five care assistants on duty at any time. Anything over 25 but below 30 residents was seen as only part of the extra five and therefore not worthy of an extra care assistant. Occasionally there would be more than the minimum requirement of staff, so for instance, there was a period of a few weeks after the new manager, Margaret (who replaced Robert and remained for six weeks), had started and there was regularly seven staff on duty. However, Margaret had quickly been informed by head office that this was not acceptable. Margaret had commented that she wanted to "get the place in order" by putting more staff on each shift, but a few weeks later said "the company has told me that it is not acceptable to have this many staff on". If there was a member of staff off sick, as was often the case, this number would drop below five and it was normal to work shifts with only four care assistants on duty. Sporadically, however, I had worked shifts where in

total only two or three care assistants were attempting to work the entire home. The number of staff did not reflect the needs of the residents either. For a period we had two very demanding residents who both needed one-on-one attention with care assistants. Extra workers were never supplied to account for this. On almost every week day shift one of the residents would need to visit the doctor or the hospital attended by a care worker so this would mean that the shift would effectively be a "man down" (as the care workers liked to say) for a few hours.

The intensity of the work was a constant concern, especially for care assistants and nurses and complaints were regularly muttered between workers about how bad certain shifts had been[9]. Inevitably the long shifts and the intensity of the work left some people exhausted, stressed and often it seemed that fatigue led to workers losing control with residents. On one shift, Rosin, a Kenyan senior care assistant fainted. As one care assistant, Katerina, said "sometimes you just feel so tired that you don't even care anymore, you know, you have to work hard at controlling your emotions when you feel like that". As subsequent chapters reveal in much greater detail, the work laid out for the care assistants was essentially unachievable – staffing levels were simply too low.

Cost-cutting was evident in other aspects of the running of the home. While I worked in the home the company was in dispute with the GMB trade union over staff lunches. One hot meal had been provided to all staff working a 12 hour shift but the company had taken this away[10]. After this happened staff were only entitled to toast and margarine and hot drinks.

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[9] In fact Aiken *et al* (2002) link nurse burnout and job satisfaction to the number of patients that they are required to look after.

[10] While the quality of the food was poor at Meadowvale many of the workers did consider their free staff meal as a significant bonus, even if they complained about the food. One of the care assistants, Gita, explained to me how, because she worked six 12 hour shifts a week, she had little time to shop or prepare decent meals. She, and many of the other employees who worked long weeks, valued

The prevalence of cutting production costs had more grave repercussions for the residents. The company were aiming to reduce the cost of meals for every resident. The chefs were currently getting £2.75 per day per resident for food costs but it was proposed that this should be reduced by as much as a further 30p a day. This price was to provide all the food and drink for residents for the whole day and as it stood the chefs could only afford to buy the cheapest of ingredients. The activities coordinator, Chrissie, also complained of a reduced budget. Her role was to provide entertainment, activities and events for the residents. She worked a 30 hour week and was the only member of staff with this role. When I was there the company had taken away most of the funds that she used to put on events (such as Christmas parties), pay for new entertainment resources (such as games and books) and pay for entertainment (sometimes singers and musicians would visit the home). I asked Chrissie what she was supposed to do. She said that the company argued that she was supposed to organise fundraising activities in order to finance her events. Chrissie explained to me that within the 30 hours a week that she was paid for she was unable to finish her paperwork, which she usually completed in her own time, never mind organise fund raising events. Soon after I had started at the home Chrissie signed me and a number of other staff up to a 'dealing with dementia' course which was supposed to teach us about how to communicate with dementia sufferers. When I left eight months later she was still trying to get the company to pay for it.

Many of the staff recognised these reductions in expenditures and some commented that the company were "in trouble" yet others just said "they're greedy". When I started at Meadowvale the expenditure on wages and running costs were already extremely low. However in the eight months I worked there it was obvious that Moonlight Care were attempting to reduce the costs associated with delivering care at Meadowvale

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the free meal although often because it saved them time, rather than because they enjoyed the food.

even further. It seemed upper management were eroding further the entitlements of working at Meadowvale through eliminating staff meals and reducing the quality of care through slashing various running costs such as food and entertainment. On one occasion the senior care assistant, Jake, had described to me how the homes decline had started some years ago when Meadowvale had changed hands. This 'race to the bottom' seemed to show no signs of slowing. Jake had worked at Meadowvale on and off for 11 years and when he began the home was owned by a different, smaller care company:

> Jake: This company [Moonlight Care] bought it five or six years ago and it all went downhill. Well there were 200 people on the waiting list and people would wait for years for a place. On a shift they would have eight care assistants and three nurses. The training was good too, when I started I was basically observing for four months before you were allowed to do anything. They would have at least seven care assistants on at a time and they would have at least two nurses. The nurses would even help with feeding and things like that.

> Me: Was it a lot more expensive than now, I mean for the residents?

> Jake: No, it was quite a bit cheaper. But this company have bought them all now. I think they are buying another five or six in this area. They are so stingy too you know like the food and machinery and everything they don't want to spend any money on anything.

Conclusion: Constraining profitability

In this chapter I have set out much of the background for the arguments that follow in this thesis. Due to the relationship between the state and Moonlight Care there are a number of serious constraints placed on the company which curb its ability to restructure operations or increase charges. This rests on a number of peculiarities of the privatised

care sector. Those discussed here show that: 1) the company is unable to make serious gains in how much they charge for their services because rates remain controlled by local councils; and 2) many state apparatuses have an interest in regulating care to ensure that a base level of care is achieved which restrains the company from transforming the service further. The form of privatisation which structures the elderly residential care sector reveals a contradiction in the contemporary welfare state. While modernising agendas of successive Conservative and New Labour Governments have consistently argued that benefits are to be had from instilling market- and profit-orientated goals into social care systems, regulation has remained important in the overall system. This implies that central and local authorities remain sceptical about whether the principles underlying privatisation are really able to ensure quality care.

Despite the limitations faced by care companies, Moonlight Care was engaged in attempts to achieve greater efficiency (although analysis of recent annual reports suggests that these strategies are not wholly successful). The strategies to overcome the constraints discussed in this chapter are: 1) Moonlight Care have embarked on an unrelenting project to increase their size in the elderly residential care market; 2) they have attempted to campaign for better rates to be paid by local councils (with some success); 3) they have engaged in tax avoidance; and 4) they have attempted to reduce the costs of production. I went on to illustrate that this third point is particularly relevant to understanding life at Meadowvale. I revealed how this process of reducing the costs of production seemed to be prevalent in various ways at Meadowvale home. The remainder of this thesis explores the implications of this system of 'discount' care for two commonly disempowered groups: the elderly and the care workers who attend to them. In the following chapter I explore how the need to reduce the costs of service delivery through low staffing levels led to a particular form of management control and forced workers in to various dirty and unsafe practices.

CHAPTER 4: The Care Labour Process at Meadowvale

The overall aim of this chapter is to account for the organisation of the labour process at Meadowvale care home. In this chapter I explore three dimensions of care work at Meadowvale. Each dimension reveals how malpractice or mistreatment was embedded in the labour process at Meadowvale. The first section discusses the system of management control over the work through a strict regimen controlling each aspect of the routine and a form of bureaucratic record keeping. This meant that direct supervision was largely unnecessary. However, because the system of record keeping set out an unachievable workload, workers had no choice but to engage in widespread falsification of the records. The second dimension of care work which comes under scrutiny in this chapter reveals that the organisational structure of the work accentuates the taboo aspects of care work. I will also expand on a concept I name as 'organisational incontinence', which links profit accumulation, cultural values associated with bodily decline and the process of reducing the costs of delivering care with the existence and acceptance of high levels of incontinence. Thirdly, the chapter also explores the use of machinery at Meadowvale and highlights how the high intensity of the workload led to various forms of dangerous working practices.

Management Control and the Labour Process

Before discussing the nature of management control at Meadowvale I will briefly provide some general theoretical context for the notion of management control in labour process theory. Debates on the nature and importance of management control have lost some momentum since Braverman's (1998) classic study on the labour process. Attacks have come from a range of sources.

Halford and Strangleman (2009) argue that two major critiques are at the heart of the loss of momentum in the sociology of work. From a feminist perspective, sociological interpretations of work were classically gender-biased in that they focused on male paid employment and they failed to draw attention to the unpaid labour largely supplied by women. Secondly, and especially relevant to the decline of labour process analysis, is the lack of a coherent political economy of capitalism within the sociology of work. While Braverman revamped Marxist analysis for a brief period of time, it also opened the flood gates for a critique, of what has been come to be known, as an oversimplified view of labour-capital relations. Storey (1985) reflects more specifically on the issue of management control, but in a similar vein, argues that scholars working in the period after Braverman focused on the need to create 'definitive and comprehensive' theories of management. Managers tended to be viewed as pure embodiments of capital and therefore the academic gaze could design and develop models of management control which could be applied to any situation where there was accumulation or even just employment. Storey suggests this project was doomed to failure because, firstly, it did not convey the true range and multiplicity of forms of management control, and secondly, it assumed that managers (and their techniques, strategies and practices) were the pure embodiment of capitalist motives. Storey argues for a dialectical approach to management control with reference to three interrelated conceptual tools: 'totality', 'contradictions' and 'social construction'. He argues that management practices must be situated within the social, cultural and economic *totality* recognising the significance of capital, transcending the individual organisation, but also placing competitive production at its heart. Scholarly accounts of control at work should also recognise the myriad of *contradictions* which are exemplified within workplaces. For example, changes in management systems can empower certain workers while disempowering others. Finally, the continual *social construction* and reconstruction of management control should be recognised. Means of

control are socially produced requiring, therefore, a degree of consent amongst the workers. Systems of control within organisation have social histories and pertain to the norms of that sector.

Crucial to Story's impression of management control is theorising the 'totality' of wider economic structures, linking factors such as market pressures, political economy and state intervention to the daily working lives of people. Pahl (1988) argued that a fruitful sociology of work requires a wider understanding of the social processes important in determining paid and unpaid labour. This should include emotional and subjective meanings as well as cultural, social, political and economic structures. Indeed, Halford and Strangleman (2009) conclude that the future of industrial sociology lay in locating wider social structures in the position of labour in society. A successful sociology of work has the potential to 'shape and contribute to wider sociological discussions in areas such as gender, class, race, religion, community, family, globalisation and identity' (Halford and Strangleman 2009: 824).

Storey (1985) maintains that because labour processes are complex it is impossible to apply many of the concepts which emerged from the labour process debate in a straightforward manner. For instance, Edwards' (1979) typology of 'technical' and 'bureaucratic' control are concepts which can be applied to build a picture management control strategies, although it is unlikely that a particular workplace will be defined by one system of control or the other. Edwards describes technical control as those aspects of organisational command which employ technology and novel management strategies in order to monitor the activities of employees. Bureaucratic control, on the other hand, are those elements of record keeping which are sources of management power, such as monitoring sick days. Another important set of concepts which can be employed as conceptual tools for understanding labour processes are 'direct control' and 'responsible

autonomy' (Friedman 1977). Direct control is used to theorise those labour processes defined by intense supervision, a strong division of labour and a complete separation between conception and execution of tasks. In contrast, responsible autonomy describes those labour processes where workers are expected to exercise discretion and judgement over the work, and crucially, management attempt to align workers' motives with that of the organisation. Labour relations defined by responsible autonomy are where workers and managers share common goals. In the following section I will discuss the forms of management control at Meadowvale and the effect of this on the working practices of the carers.

The System of Management Control at Meadowvale

I. Caring routine

Care work at Meadowvale, which is the work completed by care assistants and senior care assistants, largely consisted of performing or assisting various forms of personal tasks on or with residents such as washing, clothing, feeding and toileting. The cognitive and physical abilities of the resident being worked on/with determined whether the task is completed in cooperation, manipulation or force. Lee-Treweek (1998) sees elderly residential care work as 'transformative' because the processes are concerned with changing residents' physical state from dirty to clean, from unfed to fed, from resident who needs the toilet to resident who does not. As well as the direct personal care many of the tasks completed by care workers at Meadowvale could be defined as more general domestic labour; it was concerned with cleaning the environment around the residents, serving food and serving drinks.

With such a large amount of diverse tasks requiring inclusion in the schedule at Meadowvale, the routine was critical for getting through the work. Routinisation and standardisation of work have long been key ideas in the sociology of work and labour

process analysis (Braverman 1998; Fox 1974; Leidner 1993). Employers standardise work practices to ensure a predictable and desirable production process which is less determinate on the abilities and motives of the employee. However, cultural ideologies relating to biomedicine are also manifested in the routines of institutions such as care homes (Goffman 1957; Holland 1993). In other words the routines which characterise living and working in Meadowvale, and in most residential care homes, relate to cultural tendencies not purely arising from privatisation. The history of institutionalisation defined by strict routines goes back to the Poor Law and emerges from state led policies which predated the privatisation of these services (Townsend 1962).

In this section I will argue that the routinisation of production was a key system of management control over the labour process, the logic of which was twofold but contradictory. Firstly, it allowed control over caring tasks so that the indeterminacy of labour was largely exempt from the work processes and the system of production was more fully automated. Secondly, the system of bureaucracy which underpinned this routine placed considerable accountability over the labour process into the hands of the workers. This system meant that control over the labour process remained firmly in the hands of management but it simultaneously transferred responsibility to the care staff when the full workload was not completed. As will become apparent later, this led workers to engage in labour saving practices which could be described as negligent and unsafe.

Time	Activity
Table 2: The daily routine	
Time	**Activity**
08:00 - 08:30	Handover (nurses who had worked the night shift relay information regarding the residents' health status to the next shift of workers)
08:30 - 11:00	Getting residents out of bed (changing incontinence pads, bed baths and dressing)
11:00 - 11:30	Tea time for residents/staff breaks
11:30 - 12:00	Toileting
12:00 - 13:30	Lunch time, feeding and handing out medication
13:30 - 15:00	Resting and toileting
15: 00 - 15:30	Tea time for residents
15:30 – 16:30	Resting, games and toileting
13:30 – 16:30	This period was also for baths: three to six of the residents were supposed to be bathed at this time
16:30 – 18:00	Dinner time, feeding and handing out medication
18:00 – 20:00	Putting residents to bed, so changing incontinence pads and putting on nightclothes

The routine was structured around a bureaucratic system of record keeping and rigid time constraints. The entire day followed this process of moving from one set of tasks to the next: from entertainment, to dinnertime, to bedtime and so on. If any care assistants felt that they were having a "bad day" it was often because the routine had been displaced either through short staffing or some uncontrollable event. Tasks were completed at certain times and there was little opportunity to transform this routine either by the workers or the residents. *Table 2* provides a crude breakdown of the daily routine that all activities in the home were organised around.

The task of getting everyone in the home out of bed, cleaned, dressed and made presentable was the most labour intensive part of the day for the care assistants. Even with a full team of 5 people, doing this often took from 8:15am until 11:30am, and when the team was short staffed, or we were not feeling quick-witted, it could go on until 12:00pm. Once this was completed it was time to "toilet" the residents ("toileting" was

when all residents who required assistance were taken to the toilet). By 12:15pm it was lunch time which meant moving residents from the lounge into the dining room. The task was then to serve food and drinks to all residents and to assist certain residents with eating. Some residents required you to sit and feed them all of their food while others would need minimal assistance in cutting tough meat and so on. After lunch it was time for toileting again, and between 1:30pm and 3:30pm all staff needed to take breaks. This was also bathing time and staff were supposed to bathe three to six residents every day. In addition, those who were bed ridden needed to have their incontinence pads changed again. By 4:15pm it was time to repeat what occurred at lunch for dinner time. Once this was finished (usually around 5:30pm) many of the residents were taken to bed. And again, before staff went home, all residents needed toileting, and bed ridden residents needed their pads changed. However, this workload was never completed by the care workers. Residents often went without baths or sat for long periods of time without having their incontinence pads changed. The number of tasks set out was too large for the number of staff.

While the account given is an impression of the working day it fails to grasps the complexity of care work at Meadowvale. Toileting, for example, was in reality completed throughout the day and not just at the specified times. In addition to the routine described in the previous paragraphs, there were a number of residents who were bed-bound and their incontinence pads were changed throughout the day. Bed-bound residents were also supposed to be repositioned on the bed at regular intervals with pillows, placed either on the right or left side of the bed, to reduce the risk of bed sores. A small number (usually between two or three) of the residents also went to bed in the afternoon. This in itself was time consuming because each resident needed to be hoisted from their lounge chair to a wheelchair, taken upstairs, undressed, incontinence pad checked and changed if it was dirty, clothed in nightclothes and then the resident was put into bed. These residents were

then taken back down to the lounge for dinner time and then were put straight back to bed after dinner. In fact, one of the reasons that the tasks were so time consuming was because of the need to move around the home – 'travelling' from one from task to the next, finding the appropriate equipment and materials, moving the residents, acquiring clothes from the laundry and disposing of various dirty objects such as sheets, clothes and incontinence pads took a considerable amount of working time out of the day.

While there was a strict routine it is difficult to summarise simply because of the sheer magnitude of the tasks. In addition, because there were many different routines for different residents, and there were different types of tasks running next to each other, the true nature of the routine is difficult to convey. Anderson (2000) conceptualises domestic labour as a series of processes that run in tandem. For instance, domestic work might require the worker to put the dinner on, then the laundry and then do some cleaning while these other two processes are ongoing. Care is similar. It was often the case that a care assistant might put one resident on the toilet, continue making tea for ten minutes, and then return to the resident on the toilet.

In spite of the complex nature of the routine and the fact that all tasks were never completed, the structured day *was* crucial for the running the home because without defined work processes chaos would have ensued. The response to the residents' needs, wants and desires lay not only with the individual care workers but also with the organisation. When caring practices are transformed into a labour process the implications rest partly on what kind of labour process it has been transformed into. Crucial to this are the motives of the organisation as well as the actions and goals of those individuals living and working in the organisation. At Meadowvale, higher expenditure on staffing by the company would probably have resulted in a lessening of the tendency for care to be a strict

standardised labour process. A higher ratio of staff to residents would have meant that both groups would not have constantly been slaves to the routine.

The routine I have described so far takes account of how work was formally organised however the residents also had distinct needs and desires which were both part of an informal routine *and* competed with the routine. An issue I will return to in greater depth later is how care relations were dependent on the various mental and physical states of the residents. Residents who were immobile and could not communicate were more likely to be left in bed 24 hours a day. Residents with good mental faculties were better placed to demand caring tasks and shape their daily routine. Caring tasks were also sometimes given as 'gifts' by the care assistants (Bolton 2000). Residents who were liked by the care assistants or had the faculties to demand assistance could shape the routine to a certain extent.

Despite the complexity of the routine, management control played a crucial role in determining the organisation of care work at Meadowvale. The mechanisms of management control seemed to be an attempt to standardise the work. It was an attempt to reduce the unpredictable and inherently uncontrollable aspects of care work.

II. Management Control at Meadowvale

The routine was one of the principle measures used to organise the work, but the second function was the system of record keeping. There was a record sheet for each resident in the home which laid out all the tasks the care staff were expected to complete and at what time, roughly, each task was to be completed. Each individual task on each individual resident needed to be signed off by a care worker. Completing all the tasks that were listed was always unachievable and the full workload was not completed on any of the shifts that I worked. Writing the records involved recording all the incidents of the day. This should have truthfully recorded exactly what every resident had consumed and excreted, and

noted every single caring task that had been completed (washing, bathing, weighing, clipping nails etc).

For the managers, it was unacceptable if not every task had been documented as complete in the administrative system. This pressure from management led to widespread and habitual falsification of records. A crucial component of the record keeping and the overall logic of the system of management control was that each task had to be assigned to an individual worker. Occasionally, the managers would caution workers either for signing off tasks they had not done or signing on behalf of their colleagues. So it was not only a record of caring tasks in themselves, it was also a record of who had completed each task. This was an important dimension of the bureaucratic instruments of management control because it meant accountability for each task was linked to a specific worker. If a task was found out to have been forged there would be a culprit at hand. Despite the fact that there were insufficient workers on any shift to complete all the tasks, the system of record keeping ensured that if any inspection from a regulatory authority took place, it would appear all tasks had been completed. Management therefore checked whether records were correctly filled in, not whether the tasks themselves had been completed.

Despite the widespread falsification of records the workers did engage in a process of negotiation over which tasks should be completed. For instance, during a shift we might fail to feed a certain resident, who took a long time to eat all of her dinner, but we would have given her some of it. Or, we might not have given a certain resident a bath, but we would have given him a body wash. Despite the forgery of the care charts, many of the workers had a strong sense of commitment to the job and would endeavour to complete as many tasks as possible. Moreover, even if there had been sufficient staff to complete all the tasks there would have been an element of forgery. The level of detail which the charts demanded was too thorough. For example, it was impossible to remember exactly how

many times a certain resident had been to the toilet, and what she had done on the toilet, during a twelve hour shift where five different people might be attending to her. Yet this data was expected to be noted.

Even so, there was always a long list of uncompleted tasks at the end of a shift. During most day shifts no baths were done, if any were done it was usually only one or two, despite it being written into the routine that between three and six were to be completed. The weekly bathing rota only accounted for each resident to have a bath once a week so some residents would have gone months without a proper bath. This was plainly evident by the black and brown scum left at the base of a drained bath tub after a lucky resident had received a proper wash.

The system of recording all the data about caring tasks, however, served a different function than it would in many typical capitalist enterprises. In a typical capitalist enterprise, bureaucratic systems of control and measurement allow management to scientifically come to decisions which are aimed to increase efficiency through transforming production processes. At Meadowvale the systems of bureaucracy were in place largely to prove to social services and other regulatory authorities that the work had been carried out. This system of record keeping was primarily concerned with risk management and culpability. With a deft shift in responsibility, the home was able to prove that all tasks were completed, whilst laying the duty of forging any records in the hands of the workers. The workload set by Meadowvale's management was impossible but much of the responsibility for this lay with the workers. The care workers were presented with the unrealistic decision to either work at a superhuman rate in order to complete all the tasks laid out in the bureaucratic system, or simply to counterfeit the books.

Intriguingly, this system of control seemed so effective that managers were rarely seen on the floor and tended to stay in the office, perhaps also so that if any malpractice

did occur they would not be witness to it. It could be argued that if they did not witness any form of malpractice, then they might feel that their accountability is reduced if there was a resulting accident. Nor did I ever see managers check that what was written in the records matched with what had been done. Occasionally managers would walk through the lounge or dining room requesting that certain tasks were done, or suggest that a certain task was not being done correctly, but direct supervisory techniques were neither thorough nor rigorous.

In this sense, control at Meadowvale can be considered as essentially 'bureaucratic' (Edwards 1979). The difficulty in conceptualising the labour process, however, is that the routine and the record keeping, which were the two major influences over the organisation of the work, were contradictory. While the managers wanted workers to complete all tasks, if possible, they also seemed to recognise that this was largely infeasible. The upshot of this was that managers gave the workers a considerable amount of autonomy over the work as long as the necessary forms were completed. The following section explores how the care workers were forced into in various labour saving strategies.

'Body Work' at Meadowvale

I. Controlling bodies at Meadowvale and dirty work

The routine that was laid out for the care workers did however have a guiding principle – the work focused on the physical/bodily needs of the residents. Social interaction was not built into the routine. Of course relational work was necessary in order to carry out many of the care tasks; but time was not clearly put aside for interacting with residents. Managers would sometimes state that any time spare should be spent interacting with residents but it was not clearly or consistently enforced. Neither was it the case that care workers did not interact with residents, as this happened regularly, but this was not noted

in the record keeping system. Essentially, the organisation of the labour process at Meadowvale emphasised the physical servicing of residents and the environment around them. Care work is a form of 'body work' (Twigg 2000; Wolkowitz 2006) which is sociological occupational category describing work which involves close contact or touching of other bodies and/or the substances which leak from bodies. Kang (2003) suggests that body work and body labour may be split so that work which involves commodification or wages is clearly demarcated from that which is unpaid work.

Body work describes much of the labour that care assistants provided at Meadowvale. With reference to *table 2*, it is evident just how much of the daily routine focused on ordering bodies through cleaning, handling and servicing. However, further explanation is required. Getting people out of bed and ready for the day, for instance, required the care assistant to ensure that the resident was clean and presentable. For most residents this required changing an incontinence pad, disposing of the soiled pad in a sluice, changing their clothes, putting their nightclothes in the laundry, changing their bed-sheets, putting the dirty ones in the laundry, washing the residents body to ensure that there was no sweat, urine or faeces on it and finally ensuring the resident's bedroom was left in a clean and tidy state. The act of getting someone out of bed revolved around ordering the things on and around the resident. Placing certain things on the resident such as clean clothes, ointment or make-up, and removing other dirty things, such as dirty clothes and excrement, defined much of the work done by care assistants. Ordering the environment around the residents was also part of this process. Much of the day was spent running to and from the laundry and the sluice for instance. Disposing of dirty clothes and acquiring new ones needed to be done throughout the day. Getting new incontinence pads from the store room and disposing of dirty ones in the sluice was consistently done by all care workers. Within the care home there was a system of classification in which polluting and non-polluting things each had their appropriate place

within the home environment. Even some tasks which are not, at a first glance, clearly body work or dirty, are in fact both physically intimate and involve managing polluting substances. For instance, feeding someone does not appear to be a dirty task, but when faced with the thick gummy green-brown soft dinners and attempting to force these into the mouth of a barely conscious bed-ridden resident, it is easy to see that it is dirty work.

These kinds of tasks, which are completed in care work day-in-day-out, are often concerned with ordering the environment – placing different substances in their appropriate place and removing them from their inappropriate place. From an anthropological perspective this pertains to classificatory socio-psychological schemas which order the world into polluting and non-polluting substances. As Mary Douglas describes:

> *We can recognise in our own notions of dirt that we are using a kind of omnibus compendium which includes all the rejected elements of ordered systems. It is a relative idea. Shoes are not dirty in themselves, but it is dirty to place them on the dining-table; food is not dirty itself, but it is dirty to leave cooking utensils in the bedroom, or food bespattered on clothing; similarly, bathroom equipment in the drawing room; clothing lying on chairs; outdoor things indoors; upstairs things downstairs; under-clothing appearing where over-clothing should be, and so on. In short, our pollution behaviour condemns any object or idea likely to confuse or contradict cherished classifications* (1966: 44-45).

However, the act of working on bodies has a specific relationship to the organisation of the labour processes. Cohen (2011) argues that labouring on bodies results in three distinct constraints for the organisation of capitalist labour processes. Firstly, the ratio of labour to bodies restricts the organisation of labour processes which deal with multiple bodies at the same time. Bodies 'are simply too large, complex and contrary'

(2011: 5) to allow for one worker to work on many bodies simultaneously. Bodies are also unpredictable. The effect of this is that many body work occupations are defined by time periods where there are insufficient bodies to work on the number of bodies requiring attention. Thus body work is also often defined by situations where those being worked on are not receiving services for periods of time.

Secondly, the pursuit of surplus value in labour processes defined by body work is linked to constraints arising from the limited 'temporal and spatial malleability' of work on bodies (2010: 9). For instance, localised demand for body work rarely falters in Western economies because body labour is inextricably linked to the site where it takes place. The co-presence of worker and recipient is essential for body work to occur. Bodies, unlike capital or many other commodities, are spatially constrained. They are temporally unpredictable as due to their inherently impulsive nature; they are ruled in part by biological processes. Bodies, as a material in a production remain erratic and capricious. It is intrinsically difficult to rationalise and subsume bodies into systems of scientific management. The first two constraints effectively make up the final constraint of bodies in labour processes – that is the ways in which they can be reorganised or standardised is limited and constrained.

II. 'Organisational Incontinence'

At Meadowvale where there was a constant negotiation between dirt, on the one hand, and the work intensity on the other. The routine of care work often necessitated that certain care tasks were left undone for periods in order to complete other tasks. The inherent impulsiveness of bodies means that when they are the focus of a labour process one of the challenges for systems of management is to recapture control over bodies – to limit their unpredictability. I now want to focus on issues around continence and incontinence as it was managed at Meadowvale. This not only illustrates some of the

difficulties with attempting to organise bodies into a labour process, but also reveals the inherently organisational dimensions of care work. I will argue that while care work is inherently dirty and physically intimate; the structure of the work including staffing levels, routines, the resources at hand, the length of shifts and so on; determines how dirty the work is.

Not long after I had started in the care home I received a training course aimed at instilling the care workers with the appropriate skills in "continence management". The continence training in itself took up half a day and the district continence advisor from the Primary Care Trust, Helen, came to carry out the training. Aside from the practical issues of using incontinence pads (such as sizing, length of time they could be left on and so on) the course seemed to have two main aims. The first being to demystify the dirtiness of dealing with incontinence in an attempt to mitigate against the pure emotional reactions that human waste incurs. Helen endeavoured to take out the social meaning that is attached to the substances that we were dealing with everyday – to dampen our emotional response to the disgusting elements of care work. To begin the training the nurse put out a questionnaire to all the attendees. The questions were "what are the worst aspects of being incontinent?", "how would you feel?", "what feelings do you have caring for clients who are incontinent?" and "is continence a realistic goal for older people?" This provoked a discussion about what people felt about dealing with issues of incontinence. Helen asked "do people find it disgusting having to deal with it?" One woman said "It's like dealing with babies, that's the way I see it, once you've had babies it no longer bothers you". One of the younger care assistants commented, "I looked after my dad for years, so it doesn't bother me". However, one of the care assistants admitted, "it's disgusting, of course it is, you can't deny it". In fact I appreciated what the regional continence nurse was trying to achieve. She wanted to unhinge the disgust we had at dealing with these substances in the hope that we could deliver better care without stigmatising or objectifying the residents.

The second aim of the training course was to discuss the reasons for incontinence, or the failure of continence. Firstly, the biological, physiological and psychological reasons for incontinence were discussed. These included confusion (being unable to find the toilet, or being unable to understand one's own body's signals) and lack of bowel or bladder control. However, the discourse on continence and incontinence propagated by Helen focused mainly on highlighting our role in either achieving continence or facilitating incontinence. In this training course Helen described forms of incontinence which related to the care home work processes naming this form as "institutional incontinence".

Incontinence can be viewed as a health problem largely associated with old age. Elderly people themselves are often constructed as dirty (Nuessel 1982). The ways in which old age is imagined as a form of decline and isolation helps to reinforce understandings that incontinence is inevitable. Similar to Lawton's (1998, 2000) study on hospices, where 'dirty' dying forms the insitituional function of hospices, incontinence explains some of the functions of elderly care homes. Some studies indicate incontinence as a factor in the insititutionalisation of elderly people (Brittain *et al* 1998; Tilvis *et al* 1995). Common sense understandings of incontinence see biological factors such as weakening bladder and bowel control as the major cause and conceptualise the erosion of one's control over these functions as an inevitable aspect of ageing. However, the institutional factors often go unexplained or underemphasised. If a particular resident is unable to rememeber to go to the toilet, is too confused to find the toilet or is unable to use the toilet because of physical disability, then the act of incontinence is largely related to a failure of care rather than an unavoidable biological process. As Williams' (1999) critical realist understanding of health and illness emphasises, the body has a tangible, biological existence but it is mediated through the institutions and practices of society. Mitteness and Barker (1995) describe how incontinence is socially constructed as part of the ageing process despite the widespread belief in the health care literature that incontinence can be

greatly reduced through better management. As one of the elderly respondents in their study said, when asked to provide a reason for their incontinence: '[I]it's just that the body's wearing out, that's all. I just consider that it's my age and it's to be expected' (Mitteness and Barker 1995: 194). Thompson (1980) highlights that when incontinence arises in younger people much greater effort is exerted by health professionals to ensure that it is either treated or managed in order to ensure the individual can re-enter normal, everyday life.

Here I want to capture the relationship between the labour process and organisational resources in predicting the level of experienced incontinence through the concept of *organisational incontinence*. I define organisational incontinence as those forms of faecal and urinary expulsion which do not occur in the socially appropriate physical space of the toilet, but which arise through a failure of organisations to assist the individual to achieve continence. There is a fragile distinction between what can be deemed as organisational incontinence and that which can be understood as emerging from the body's biological decline. The following discussion will highlight that many of the instances of incontinence at Meadowvale were both preventable and directly connected to the organisation of the labour process. In fact, incontinence was structured into the labour process as an important labour saving device which was crucial to the overall delivery of care.

Firstly, I want to highlight the principle of organisational incontinence through a discussion of one resident for who continence *was* achieved. Margery had good mobility and only suffered from brief periods of confusion. She was generally one of the most independent residents. She was able to go to the toilet herself and she washed and dressed herself in the mornings. However, during my time at the home she began having episodes of faecal incontinence in the evening, shortly before her bed time. It quickly

became apparent to the care assistants that if Margery was reminded to use the toilet at about 6.00pm any incontinence later in the evening was prevented. When Margery was incontinent, however, a lot of extra work was created for the care assistants. Cleaning the person without spreading faeces all round the room is extremely difficult (see also Anne-Mei The (2008) for an example of this task). Ensuring Margery's continence in the evening saved the workers a considerable amount of effort later. In Margery's case, prompting her to use the toilet required much less work and the workers, therefore, endeavoured to facilitate her continence.

For other residents incontinence was an ordinary part of everyday life and incontinence pads were consistently used as a labour saving device. For those residents confined to their beds toileting was never done. Many of these residents were in a state of extreme confusion and had little or no mobility. Taking them to the toilet was also highly labour intensive. The resident would be required to be lifted from the bed, placed on a wheelchair, taken to the toilet, then hoisted off the wheelchair and on to the toilet. Inevitably, there might be many occasions where, if this was done, the resident would not actually use the toilet. This meant that bed ridden residents were fitted with incontinence pads and these were simply checked, and if dirty, changed periodically. The frequency of how often residents were checked for soiled incontinence pads was dependant on the staffing levels and the workload of that particular shift. Also, residents who were taken to the lounge through the day, but who were prone to incontinence were also often fitted with incontinence pads. Sometimes there would be an attempt to toilet these residents, but at other times the workers would simply wait until they were soiled and put on a new incontinence pad. Diamond (1992) observed very similar work practices in his ethnography of elderly institutional care work:

Nursing assistants had to snatch time when they could to take people to the toilet, and the time did not always coincide with residents' bodily needs. Often an accident happened, and a nursing assistant arrived after the fact. Yet this was not considered an organsational disruption, nor did it mean that messes would be on the floor, for most people were secured with a diaper first thing in the morning (1992: 87-88).

Incontinence at Meadowvale had a distinct relationship to the work practices and the organisational routine. The impulsive nature of bodies seems to suggest that incontinence is an inescapable experience of bodily decline but it *is* possible to imagine a system of care which eliminates or greatly reduces the frequency of incontinence for many residents. If each resident were able to buy 24 hour care from a single care worker it would only be on a rare occasion that they would experience incontinence. The organisational factors which determine the nature of care work seem to suggest that the work of the care assistants and the dirty lives of the residents at Meadowvale are not necessarily inevitable. Organisational factors emerging from the strict routine and the lack of staff make the dirty work of care dirtier.

Technologies of care and dangerous working practices

The pressures of providing care in the poorly resourced labour process at Meadowvale can be extended out to analyse the usage of the equipment involved in care work. Firstly, it is important to highlight the social character of technology. Theories of 'technological determinism' view technology as an external, objective force driven by science and innovation. Social and cultural change is thought to ensue as a result of technological advancements (Marx and Smith 1994). Pure forms of technological determinism tend to take the social nature of machinery out of the picture. However, more Marxian approaches to technology emphasise the human and political nature of technology (Gallie (1978) for

example). The agendas which drive technology are cultural forces rather than purely scientific or engineering discoveries. Furthermore, technological advances in workplaces can have obtuse and shrouded effects. Technologies may appear to be simply rational ways of improving the efficiency of production but they may also deskill, re-skill or up-skill different groups. For instance, the increasing use of computers in employment has led to processes of up-skilling amongst certain groups but it has been coupled with deskilling in other occupational categories (Attewell 1987).

Technologies, in certain instances, are implemented into labour processes to improve management control over labour or to unhinge the skill set of a particular group of workers. However, technology in the workplace may have different objectives than simply efficiency of productivity. For instance much of the machinery used at work is concerned with health and safety and not with production and accumulation specifically. Other social and cultural ideologies find their articulation in technologies of the work place. In care work technology seems to have a number of uses. Most ethnographic accounts of paid care work emphasise emotional aspects of paid care work and the machinery involved in the delivery of these services are often not emphasised. Nevertheless, Sandelowski (2000) describes nursing has having a long and complex history in relation to technology. In reality the work is defined by the persistent use of various sorts of equipment and tools (see *table 3* and *appendix 2* for a list of the major equipment used by care assistants at Meadowvale). The purpose of most of the technology in care, however, is for risk management purposes rather than to increase the intensity of the work. Devices used in care work usually revolve around protecting the bodies of those providing and receiving the labour, and they are not concerned with labour saving. Many of the devices in care work add time to the routine. They cannot be seen as geared towards labour saving or efficiency improvements. The intention of the tools is to ensure safe working practices.

Faced with a workload which was never really achievable, working practices at Meadowvale were often contrary to the appropriate usage of machinery. Pressures to complete tasks quickly resulted in care workers either: not using some of the equipment in stances when it was supposed to be used; use the equipment in a dangerous fashion; or use machinery for a purpose that it was not intended for (which was also usually dangerous). As mentioned earlier, direct supervision from management was rare and this gave care workers a degree of control over how machinery was used. It would be wrong to suggest that this was a form of empowered control because there was always a feeling amongst the care workers that what was being done was potentially dangerous.

After three weeks of working in the care home I was placed on the moving and handling training course. The course was delivered by Judy, one of the company's ex-managers now employed to deliver training. The training included both theory and practical training. The theory section covered the importance of communicating to residents while moving them, some anatomy related to moving and handling and the legality surrounding moving and handling. The final section took the majority of the time. At this point Judy highlighted our responsibility to ensure that the machinery was correctly maintained, that we used the right equipment in the correct manner, and that we reported any incidents and bruises or marks if we found them on residents. She repeatedly stated that the company were unable to support us if the documentation was not correctly filled in.

Table 3: Tools of care used by care workers at Meadowvale Care Home (elaborated in greater depth in appendix 2)	
Equipment name	**Description**
Incontinence pad	White nappy-like pads which come in a range of sizes and strengths of absorbency.
Hoist	The hoist is a crane-like piece of equipment. It has a large arm with hooks on which either a sling or a toileting sling is attached (see below). The whole structure sits on a base which is on wheels. It has an electric motor which operates off a rechargeable battery which slots into the back of it. The hoist in operable without a sling. The person is manoeuvred into the sling and then the sling is attached to the hoist. There is a button on the back of the machine which controls the arm of the hoist and allows the operators to raise or lower the arm.
Slide-sheet	The slide sheet is for moving care recipients when they are on the bed. The slide sheet is made of two pieces of non-resistant plastic sheeting.
Sling	The sling is a piece of equipment that is used in conjunction with the hoist. It is a piece of material which completely encompasses the care recipient while they are being lifted in the hoist. Slings come in different sizes for different sizes of care recipients.
Toileting sling	The toileting sling is the same as the sling, talked about above, but it has a large space around the crotch area so that residents can be placed directly onto the toilet. They can then use the toilet and be lifted off without needing to remove or replace the sling.
Stand-aid	The stand aid is a frame placed on wheels and serves a similar function to the hoist. It has a padded board which the care recipient rests their knees on. There is also a strap which is attached to the frame of the stand-aid and goes behind the recipients back. It has two handle which jut out from the frame and the recipient needs to hold on to these with their hands. The machine, like the hoist, relies on a chargeable battery and has an electric motor.
Strap	The strap was a canvas padded belt with handles on it. It had a plastic buckle to link it together. The strap was wrapped around the recipient's upper body, just under their arms and around their chest, which then allowed the care assistants to grip the handles and move the resident.

Before receiving this training I was formally forbidden to do any work in the home which entailed moving or handling which meant I was basically relegated to the position of observer. In the practical session I hoped I would receive guidance on how to move, clothe, undress and handle people. Having observed many times in the three weeks prior to attending the training session many of the hands-on care tasks, my feeling was that performing these care tasks required a complex set of embodied and communicative abilities. I was looking forward to the training which I anticipated would aim at teaching some of the skills required to perform care work. I quickly realised that most of the practices that I had witnessed during the previous three weeks contradicted what Judy was

teaching. For instance, we often used "straps" to manoeuvre people in and out of chairs and so on. The strap fits round person's upper body (see *table 2*) and handles are attached to it for the care workers to hold. When one of the care assistants asked Judy about the correct manner in which to use these straps she replied "you shouldn't be using them at all". Unfortunately they were an integral part of our working day. The strap offered the quickest method of moving many of the residents. Many of the residents actually preferred the strap as it was fast and not as humiliating as being placed in a sling and then hoisted in the air. Yet strangely, Judy did not insist on having the strap removed from the home, despite having the power to do this and repeatedly commenting that she should order the strap to be removed from the home.

Some of the practical training delivered in the moving and handling course focused on using slide sheets to move people around the bed when they were in a reclined position. The function was to prevent bed sores by providing a non-resistant surface which would not tear delicate skin. In my first three weeks of working there I had never even seen one never mind witnessed being used. Subsequently, I only observed these being used very occasionally. Normally, we just picked the resident up and moved them up the bed. In fact, the company supplied only two slide sheets for the entire home. If they had been placed in every room it is likely they would have been used much more frequently. I left the training course feeling cheated. Many of the difficult tasks which we were expected to carry out were not covered by Judy. No training was given on how to remove and replace incontinence pads or clothes, despite this being one of the major tasks in every shift for all care workers. Many of the working practices she described were not part of our routine and simply could not be accommodated into daily practice because of the heavy workload.

Malpractice in the use of equipment was regular. If shifts were severely understaffed then the workers would be forced to use the strap on many more residents who were usually hoisted (see *table 3* for a description of hoists). Short staffing also led to the incorrect use of hoists. The appropriate and safe use of hoists and stand-aids depended on two care workers being present. The hoist could be very dangerous if only used by one worker. Once the resident is raised from their bed or chair they are suspended in mid air for a short period supported by the sling (see *table 3*). Any slight movement made by the resident or a slight knock for the care worker could cause the sling to start swaying like a pendulum. For this reason it was important to have two care workers: one to operate and manoeuvre the hoist, and another to hold the resident in place once they were hoisted. Often, if the shift was short staffed, care workers would begin using the hoist on their own.   Pushing the heavy hoist with one hand and holding the resident still with the other. The slings which were used to hoist residents came in a range of sizes for different body shapes and weights of care recipients, however, often care workers would grab the one closest to hand. Indeed, the inappropriate usage of much of the equipment emerged from the lack of it. For instance, in order to move a certain resident who required hoisting from their chair in the lounge to the toilet required a specific size of sling. But because the numbers of slings in the home was limited we would end up searching around the entire building for the correctly fitting sling. If the shift was short staffed, or the routine had been compromised for some reason, the workers grabbed whatever was at hand. In fact, an incredibly time consuming part of the job was simply locating the right equipment.

The malpractice of using equipment by the care assistants emerged from the persistently low staffing levels and the high intensity of the work. Also, there was a lack of machinery provided, another element of cost reduction in the labour process. Care workers used machinery differently than how it was formally stated in training courses.

Training courses themselves were distinctly insufficient and failed to educate how we should handle bodies and dirt. The company did not provide an organisational environment in which many of the principles and procedures it stated were essential for good and safe care could actually be put into practice.

Conclusion

Many of the routines, rituals and practices followed by the workers at Meadowvale clearly emerged from the desire of the company to limit spending. I argued that the system of management control at Meadowvale revolved around two important concepts: a strong and fixed routine and a system of record keeping. Both emphasised meeting residents' physical (not emotional) needs. In addition, the minimal staffing levels resulted in a range of labour saving practices. There was an evident contradiction between the need to do care correctly – completing and recording all the tasks, enabling continence and using the machinery in the safe manner – and the pressures faced by the workers. The consistently low staffing levels forced workers to engage in various labour saving strategies such as faking documents, the use of incontinence pads rather than regular toileting and the operation of machinery in ways contrary to their approved use. It seems that management were aware that staffing levels were insufficient to complete the number of tasks that were identified in the system of record keeping because managers rarely provided direct supervision and never assessed whether what had been recorded in the records had been completed.

The system of management at Meadowvale might be described as a form of 'responsible control' which is defined by diverging elements of 'responsible autonomy' and 'direct control' (Friedman 1977). Workers at Meadowvale were tightly supervised through the system of bureaucracy (Edwards 1979). At the same time, they can be seen as 'responsible' because the liability of completing the tasks is left up to them and they are

forced to invent strategies which enable them to complete the work. The tension here,

however, is that management never formally endorsed many of the labour saving

strategies that workers utilised in order to get through the heavy workload. A further

dimension of control was that workers were forced into forging the records and in this way

were constructed as responsible when the workload was not achieved. This chapter has

discussed the relationship between various features of the labour process and linked this to

a range of dirty, unsafe and even dangerous working practices. However, the following

chapter keeps within this theme to a degree but investigates how the overall configuration

of the work influences the interactions between workers and residents. The next chapter

explores how the relationships, emotions and interpersonal ties between carers and cared-

for were rooted to organisational aims.

CHAPTER 5: Emotional Labour at Meadowvale

In this chapter I explore the nature of care labour at Meadowvale. In the last chapter I argued that the organisation of care labour was defined by a strict routine, a system of bureaucratic management control, low staffing levels and an emphasis on the physical tasks of care. These low staffing levels led to dangerous and dirty working practices. This chapter clarifies what the labour process at Meadowvale demanded from the workers, painting a picture of the emotional costs of this form of care labour. My point of departure is a description of the specific tasks of care which describes how emotionally challenging and complex the work can be.

Caring Tasks Revealed: Physical, Emotional and Dirty

In order to fully explore the issues of emotion management at Meadowvale it is important to elaborate on the problematic nature of the tasks. The overall routine of care, expanded on in chapter four, gives a sense of management control and the intensity of the work but does not recognise the intricacies of performing individual caring tasks. The detailed description of the caring tasks which follows depicts care work as dirty, emotional and physical labour. I will describe, in detail, four tasks as they were done every day on four different residents.

Caring Tasks Revealed 1: Getting Mary Out of Bed

I always found Mary was one of the most emotionally challenging residents to perform care tasks on at Meadowvale. Some of the residents were known as "fighters" by the staff. Fighters were residents who physically resisted the caring tasks that the workers were attempting to complete. Mary was not a "fighter" so she did not try to resist any of the tasks such as washing, toileting or bathing. Her figure was slight and emaciated so moving

and handling Mary was not problematic either. The difficulty with dealing with Mary was that it invoked a deep emotional reaction to her state from the care worker.

Mary was in her early eighties when I worked with her. Recorded in her care files was evidence of a difficult life. She had experienced sexual abuse in her childhood and subsequently a host of mental health issues were noted in her files. She had also lived much of her life in poverty and on benefits, and her daughter seemed to experience similar difficulties now. Her daughter would on occasion request food from Meadowvale's kitchen staff because she had run out of money.

Mary's mental situation during the time I worked at the home was complex and partly unknowable. She appeared to be close to death and seriously ill. Often in the morning when I entered her room I momentarily wondered whether she had died in the night. Even when Mary was awake she rarely appeared to be conscious and when she was more alert she seemed profoundly confused. Her arms were twisted out of shape, her skin was sallow and her expression was almost always lifeless. Her daily routine consisted of either lying in bed or lying on a specially adapted reclining chair in the lounge area. The most disturbing part of Mary's demeanour, however, was her wailing. She would regularly have bouts of loud screaming which could be heard throughout the home. Sometimes it seemed random and unprovoked although whenever the workers needed to touch her to complete a care task she would begin wailing. Her howling would increase in volume the longer we took to complete our tasks. Mary's vocal outbursts were also completely incomprehensible. Sometimes she would babble like a baby but the noises never appeared to be an attempt at communication – they appeared to be utterly meaningless. Mostly, it was simply screams that came out of Mary's mouth. One of the senior care assistants, Leanne, described Mary as "damaged" and many of the workers commented that Mary was reliving older troubling memories. It is impossible to know what Mary really felt like;

whether she was in physical pain or mental anguish or if she was simply unaware of the world and her own existence in it. Her behaviour distressed many of the staff and the workers often made compassionate remarks regarding her condition.

On many shifts I worked at Meadowvale the first task of the day was to get Mary out of bed and dressed. To prepare her for the day required you to remove her nightclothes, change her incontinence pad, wash her and then dress her. We would begin by washing her and changing her incontinence pad. As soon as you touched Mary she would howl, once you rolled her onto her side to clean the faeces away, this howl turned into a full blown scream. The distress that you were causing her was inescapable. Simultaneously you were hit with the smell of her excrement which I found inescapably disgusting despite my desire to resist such feelings. A degree of force was often required, not because Mary was putting up a fight, but because her body was permanently rigid and twisted, assumedly because of years of immobility. To remove her nightwear and replace it with an outfit for the day meant manipulating her misshapen arms out of what she was wearing and into something clean. Once she was dressed and clean, she was rolled over and then a sling was pushed underneath her. We were then able hoist her from her bed and on to her specially designed chair which she spent the rest of the day in. Usually, however, she would be returned to her room by 2.00pm or 3.00pm.

The task of getting of getting Mary up in the morning was difficult for a number of reasons. Obviously, it was dirty, but then many of the caring tasks were dirty. Cleaning Mary was no more disgusting than many other tasks that we completed throughout the day at Meadowvale. Manoeuvring Mary's body into various different positions in order to dress her and undress her was testing work, but then precise and delicate moving and handling was performed on many of the residents. What was characteristically difficult about completing the process of getting Mary up in the morning was that it conjured a

strong emotional reaction. Her predicament, and the obvious distress you caused when completing caring tasks, were emotionally challenging. Her cries increased in volume the longer you worked on her. Touching and handling Mary seemed to cause her pain, discomfort and distress but yet there was no way to reason with Mary or to calm her. Executing care tasks on Mary contradicted many of the ideological principles of care as it is imagined by most of us. It is hard to describe it has an intimate, reciprocal and affective relation built on any shared understanding of these notions. Working with Mary was more like working *on* Mary and it felt that there was always something wrong with this. Mary was voiceless and inert, and although Mary was so feeble that the level of coercion required to complete the task was minimal, there was, nevertheless, a feeling that we were exercising force over Mary. This was not the case with some of the other residents whose size and temperament made tasks physically as well as emotionally challenging.

Caring Tasks Revealed 2: Toileting Maggie

Maggie was one of the more difficult residents to deal with. There were two reasons for this. Firstly, she was a large woman with very poor mobility. She was unable to walk but also unable to stand. Secondly, she had a quick temper and became easily annoyed. Yet there was also no reasoning with Maggie – it was impossible to explain to her why you were trying to get her into a sling, forcing her to stand up or attempting to wrap a strap round her. She quickly became ill tempered when you tried to perform any sort of task which involved handling or touching her.

One of the most difficult tasks to complete through the day shift at Meadowvale was taking Maggie to the toilet. In the morning Maggie would be got out of bed and placed on a chair in the lounge. After this she was never moved until bed time unless she wanted to go to the toilet. When the other residents went to the dining room to receive meals, Maggie would stay in the lounge and have her dinner on a table positioned over her lap. It

was too much effort for the care assistants and too much distress for Maggie to move her to the dining room and back. Maggie was only moved when absolutely necessary. The main difficulty in toileting Maggie was getting her on and off her armchair, the wheelchair and the toilet. On a couple of occasions, when I had used the strap with another colleague to move Maggie, we had almost dropped her. She was so weighty that even two of the strongest care workers would struggle to lift her. Maggie had no use at all in her legs and was a dead weight when you tried to move her. If we tried to use the stand-aid on Maggie she usually complained about pain in her knees, and, once again, this was also dangerous because the stand-aid requires the recipient to have some strength and mobility in their legs to be used correctly. Both the strap and the sling required a degree of cooperation which Maggie was unable to give. However, if we wanted to use the hoist then it was difficult to get the sling underneath her because of her weight. She also detested the hoist; it seemed to frighten and confuse her. Also if the workers decided to use the hoist then it was not possible to manoeuvre into one of the smaller toilets in the lounge area so we would then need to take her upstairs. In reality we used a range of these methods but the best way to move Maggie was a problem that was never solved during my time at Meadowvale. Whatever strategy was employed, moving her always required substantial effort and caused Maggie a great deal of anguish.

For these reasons toileting Maggie was a task that was often avoided by the care assistants or was left during busier periods of the day. Regardless of the technique we used (stand-aid, hoist or strap) we had to try and move Maggie enough to get a strap or sling round her body which usually took 3 people. It required two care workers to lift her and then one to slide the strap/sling underneath her. Once on the wheelchair you would have to move her to the bathroom and repeat the whole exercise in order to get her on to the toilet. Once you had removed her trousers, incontinence pad and pants, she occasionally started defecating prior to being placed on the toilet. If this did happen, chaos

usually ensued. We would attempt to minimise the mess because if it got onto Maggie's clothes or body we would then need to change her whole outfit and give her a bath or body wash. Effectively turning a 15 or 20 minute task into 45 minute task. At this point we usually started shouting at each to cover Maggie with tissues to protect her clothes and body from the faeces and urged each other to catch as much of it as possible. Often we failed and faeces would go all over her clothes and legs and all over the bathroom floor.

Without fail toileting Maggie was always an ordeal and required a mammoth effort, both physical and mental. Emotional control here was of utmost importance. Many of the care workers thought that Maggie was deliberately resisting the task, that she was deliberately making it more difficult for them. This was exacerbated by the fact that Maggie never showed any appreciation for the tasks completed on her. Often she said at the end of a toileting session "well, I hope you're happy now!" A few of the care assistants believed that Maggie was just lazy and could walk but could not be bothered. She was never appreciative of the assistance that she received and she was often irate with the workers when they were performing caring tasks. However, it is also worth reiterating that this task was placed within a routine and was therefore competing with the hundreds of other jobs that needed to be done. Toileting Maggie took three care assistants something between 15 minutes and 1 hour. Remaining calm, getting the job done speedily and resisting any negative emotional reaction was crucial to keeping on top of the wider routine. Yet even Maggie's resistance to be taken to the toilet was not as severe as that shown by certain residents.

Caring Tasks Revealed 3: Changing Olive's Incontinence Pad

Olive was a bed ridden resident who was on a PEG feed which directed her food straight into her stomach. Olive was known as a "fighter" and she would often lash out violently at the care assistants as they tried to attend to her. Cleaning Olive was incredibly difficult

because she was strong, uncooperative and heavy. Her PEG feed also meant that she defecated in her incontinence pads in large fluid quantities which almost always soaked through onto the sheets and the bed underneath. To change her incontinence pad required us to change her clothes, wash her and ensure that her sheets and bed were clean.

On my first shift at the home I assisted Lynn in changing Olive's incontinence pad. I restrained her, while Lynn undressed her and then changed her incontinence pad. All the time she was shouting "why you always come in here?" We then needed to shift her on to her side so that we could remove and change the sheet and ensure the bed was spotless. Witnessing this act amazed me. I could not fathom how Lynn had managed to undress, clean her, clean the bed, change the sheets and re-clothe this woman without even lifting her off the bed. Additionally, extra care needed to be taken not to damage the wound where the PEG feed entered Olive's stomach. Perhaps the most astonishing thing about watching this process that Lynn performed on Olive was that when she had finished there was not a single piece of dirt on the sheets, on Olive or her clothes or anywhere else in the room. It is difficult to describe how this is done but it requires the care assistants to roll the resident from side to side. When the resident is on one side of the bed the other is cleaned and then towels are placed over the clean area. Then the resident is rolled on to the towels and the other side of the bed is cleaned. Crucial to minimising the stress caused to the resident is to reduce the amount of times you need to roll them. There is a specific order in which things need to be done for this technique to work. For instance, when removing nightclothes, especially if they are soiled, you must remember to take the residents arm out one side prior to rolling them over. If this process is done efficiently, then a worker can clean the bed, wash the side of the resident, remove their soiled clothes and replace clean ones simply by rolling the resident to the left once and to the right once. The speed and precision by which Lynn carried out this task on Olive was particularly

amazing. Not only was Olive attempting to resist our actions, and she was a heavy-set strong woman, but she had also defecated in large gooey amounts that had over spilled from her incontinence pad on to the bed sheets and on to her. Yet Lynn's skill in systematically cleaning this mess using towels, wipes and a soapy flannel, whilst ensuring that none of the faeces tainted any of the parts just cleaned, was truly remarkable.

In the time I was there I never became as adept at completing this sort of care task as Lynn was. However, I did become better and I was able to complete a similar process on other residents who were not as large or as uncooperative as Olive. Dealing with bodies in care requires a considerable amount of skill and dexterity. The pure physicality and hard labour involved in care is often underplayed in accounts of care and in popular imaginings of what caring involves. However, Olive was a fighter. Carrying out the tasks demanded the workers to exercise physical force to restrain Olive otherwise it would have been impossible to complete the necessary tasks.

Caring Tasks Revealed 4: Dealing with Shelley

These first three examples of care work I have given attention to the dirty, emotional and physical aspects of working at Meadowvale. They also stress the complex nature of care. In some respects the first three examples of caring tasks with Mary, Maggie and Olive highlight the backbone of the work. These kinds of physical caring tasks are so time consuming that they consumed most of the care workers time. As is evident from the examples above, the tasks themselves demand emotion management because they involve carrying out dirty work with distressed individuals.

Sometimes care work at Meadowvale was emotionally difficult for different reasons emerging from the relationships that care workers formed with residents. Shelley had lived her whole life either caring for others or residing within care institutions. For much of her life she had cared for her brother, who had had learning difficulties, and then

later in life she had cared for her sick mother. However, this caring role, I believe, was

probably ascribed to her because she had spent her whole life in and out of psychiatric

services suffering from schizophrenia. It was common for Shelley to be attracted to new

care assistants and it was obvious that this attraction was not only platonic. On one

occasion Shelley told me she "loved me". In fact, one of the other care assistants had

warned me that Shelley had "inappropriate" feelings towards me and had been warned to

steer clear and ensure that I was never alone with her (in case she made some sort of

accusation). It was the view of most care workers that Shelley should be avoided. It

became quickly clear to me that there was some benefit in steering clear of Shelley,

although this might say more about the current fear of being accused of abuse which

pervades in the care sector. Shelley's behaviour did often border on the socially

inappropriate. She regularly reflected on her previous sex life. She would say "you know

I've never been with a man". She would start to inform me of how she still wants the

chance to be with a man, how she fancies this person or that person.

Shelley's eccentricities made her one of the least popular residents amongst the

workers. None of the workers wanted to put her to bed or to get her up in the morning.

Partly this was because she demanded a lot of time as she liked to chat for a long while.

Nevertheless, I think that her sexualising the relations with care workers contributed to

people's unease of dealing with Shelley. Over the months that followed I did steer clear of

Shelley and only carried out caring tasks when it was totally necessary. I decided that,

because I was a man, I should take the advice of the other care workers and I only

completed care tasks on Shelley when absolutely necessary.

After a few months I was working the morning on the bottom floor on my own.

This meant that I was required to get everybody on the bottom floor up by myself. We

were short staffed and I thought that I would just get Shelley up on my own. I had steered

clear of her for a considerable amount of time prior to this and I thought that maybe things had cooled off. I must admit that when I got her up I was considerably stressed. Doing the ground floor in the morning meant getting three or four of the residents up, feeding all the residents who needed assistance and serving breakfast to most of the residents. Maybe it was this, or maybe it was that I still felt I should not 'encourage' Shelley, but I was quite abrupt with Shelley that morning and I evaded getting into any conversation which was over and above the necessary issues like what clothes she was going to wear. Out of nowhere Shelley said "fuck off". It was strange and she had not said it in the context of any conversation. I left the room immediately and informed the manager of what had happened. Shelley probably said this because I had kept my distance over the previous months and I had rushed her that morning.

Shelley was perhaps one of the most difficult residents to deal with emotionally. Many of the workers had had experiences like this in their relations with Shelley. It was a different sort of emotional management required by the workers than when they were attempting to carry out the physical care tasks. Shelley's behaviour was difficult to manage, and was made even more so by the fear of being accused of abuse.

Care: Complex Labour

The four previous examples of care work as it is performed with individual residents reveals the complex nature of care work at Meadowvale. Care work sees the collusion of various types of different labour which are various forms of interrelated physical and mental labour which often coalesce within the same task. Sometimes the work is more physical, especially when those receiving the care are passive, although even in these instances it can provoke an emotional response in those delivering the care. My findings here back up those of Lynch (2006):

*What is clear from the work of care researchers is that care work generally involves not only **emotional work** and **moral commitment**, but also **mental work** (including a considerable amount of planning), **physical work** (doing practical tasks including body work such as cleaning, lifting, touching and massaging) and **cognitive work** (using the skills of knowing how to care)* (emphasis in original, Lynch 2006: 557)

The tasks described sat within a routine which, as described previously, was highly structured. From this routine we can see that not only is care work at Meadowvale difficult when individual tasks are considered, but placed within the routine of the day the tasks are even more demanding. Each task needed to be completed as swiftly as possible despite the complex and often highly emotional nature of the work.

In the following section I will begin by examining the general debate on emotional labour and emotion work. I will argue that it is important to keep an understanding of emotion work which recognises that there are a range of distinct forms of emotional control employed by workers in care settings (Bolton 2005; Bolton and Boyd 2003), but that it is still important to retain an analysis of those forms which are more strongly implicated with organisational rationales, in other words emotional *labour* (Brook 2009; Hochschild 1983). I will then move to explore how different forms of emotional labour and emotion work which were present out at Meadowvale. Part of the following argument is to emphasise the relationship between the physical aspects of the labour and the emotional reactions it imposes.

Emotional Labour

In Hochschild's (1983) classic book *The Managed Heart* she argues that emotional displays, and even the feelings themselves, can be appropriated by capitalist organisations in the interests of accumulation. Hochschild's account of the role of emotions within paid employment has become a modern classic in the sociology of work. She links the demands

of the market and the commercial motives of organisations directly to pressures on workers to enact or suppress certain emotions. She distinguishes between 'emotion work' and 'emotional labour'. Emotion work, which is the management of feelings and displays of emotion, occurs in the everyday private life of individuals. Emotional labour occurs in organisational contexts when employees are pressurised into expressing or suppressing certain feelings so that their emotional behaviour accords to organisational goals.

Hochschild was also concerned with the implications that this process of turning emotional labour power into emotional labour signified for workers. Whatever the emotional response that is required from the worker, whether warm and fuzzy or cold and harsh, the need to force emotional displays, according to Hochschild, has a psychological impact on the worker. The worker is forced into either 'deep acting' or 'surface acting'. Firstly, 'surface acting' is where workers are aware that their affective display is disingenuous. Secondly, 'deep acting' within which the 'transmutation' of the emotions of the workers occurs, and workers emotional states align with organisational motives. Both the conscious form of emotional labour, where workers are awake to their emotion management, and the less conscious process, where workers true feelings and emotions are subsumed by organisational motives, have negative psychological effects for the worker.

Hochschild's account has inevitably been criticised. Bolton and Boyd (2003) argue that Hochschild's conception of emotional labour falls down in two important respects. Firstly, Hochschild is criticised for conceiving the distinction between public and private emotional work as clear-cut. This means that all forms of emotional labour that occur within the workplace are the same. All individuals engaged in interactional service work are engaged in providing emotional labour which is essentially alienating and forced downwardly upon them by the interests of the organisation they work for. Bolton and

Boyd (2003) describe a number of different types of emotional work performed during paid employment which blur the line between public and private. For instance, normal interaction with colleagues or professionally normative ways of behaving both represent dimensions of emotional work not necessarily directly related to accumulation or organisational intentions.

The second criticism put forward by Bolton and Boyd is that Hochschild equates the physical labour process with the emotional one. Essentially the argument presented here revolves around the indeterminacy of labour. Bolton and Boyd argue that emotional labour processes are defined by a greater unpredictability between normative systems of management control and the actual outcome. As they explain, '[U]nlike the factory worker, they own the means of production and, therefore, the capacity to present a 'sincere' or 'cynical' performance lies within the emotional labourer' (2003: 293-294).

In an attempt to overcome what they consider as a one-dimensional approach to emotions at within paid employment, Bolton (2005) and Bolton and Boyd (2003) develop four forms of emotional management in organisations: 'pecuniary', 'presentational', 'prescriptive' and 'philanthropic'. *Pecuniary* emotion management refers to those forms of emotional control and display which are top down forms of influence, relating to commercial objectives and formal systems of management control. This is akin to Hochschild's notion of emotional labour and represents a commercialisation of feelings. *Prescriptive* emotion management refers to those instances when a worker may follow company guidelines, but when the feeling rules do not necessarily relate to profit motives or cost effectiveness. This form of emotion display could refer to when workers are engaged in emotional displays which relate to professional rather than organisational norms for instance. A doctor in a private health clinic may have a certain professional demeanour even when they are not directly involved with an activity integral to the labour

process. *Presentational* emotion management refers to those types of emotional labour which are in harmony with commercial goals but relate to aspects of the self which actors take to the production process regardless of organisational hierarchy. In other words, those aspects of the social being which are developed over the life course and are comprised of interactional skills, understandings and preconceptions divorced from the economic life of that person. The final aspect of emotion management is *philanthropic*. This form of emotion management refers to those occasions when workers actions are in-line with prescribed organisational motives, but where the worker gives over more than what is required.

Nevertheless, in a dialogue between Paul Brook (2009) and Sharon Bolton (2009) in *Work, Employment and Society*, Brook suggests that Bolton's critique of emotional labour is flawed because she fails to integrate her mapping of emotional management with labour process theory. According to Brook her understanding of emotional labour fails to understand the critical distinction between Marx's theory of labour power and actual labour, or in other words, the difference between the capacity for human productivity and the actual activity of work. While Brook recognises that Bolton's typology of emotion management successfully conceives the role of emotions within organisations, he condemns its overall application because it 'implies a much more benign and de-politicized workplace than in Hochschild's portrayal' (2009: 545). Bolton's actors become too multifaceted, too indeterminate and essentially too vague. It seems from Bolton (2005) and Bolton and Boyd's (2003) description that only a small part of what anybody does in an 'emotionful' job relates to organisational goals, accumulation or hierarchical structures of power. Brook wants to retain Hochschild's central tenet of emotional labour in the analysis of the labour process. The processes by which the feelings and emotional displays are transformed into 'customer contentment' (Hochschild 1983: 8) or any other emotional response from the people who come into contact with a service remains a source for the

creation of surplus value, a site for capital-labour conflict and should remain an important point of departure for the sociological theorisations of work.

Before moving on, I want to highlight a further aspect of emotion management often left under-theorized. Often the focus in studies of emotional labour is on the pressures experienced by workers to enact certain emotional displays, such as service workers who must conjure friendliness and amicability. Yet the following account of emotions in care underlines the suppression of emotions as critical and there are other studies which highlight the need for workers to suppress emotions (Grandey 2000; Lewis 2005). This is even true for the most manual of jobs. Working in a high pressure environment, such as a restaurant, a factory or a hotel, even if the work is essentially manual and does not entail any sort of interaction with consumers, often requires a certain level of emotional control. Knights and Thanem (2005), for instance, argue that understanding emotions at work requires an analysis of physical factors and the relationship between bodies and emotions. Many of us who have had such jobs will have witnessed an employee 'losing their cool' or walking out, or done so ourselves, because the physical intensity of the work expected from us was too great. Glucksmann, for example, describes how she 'exploded' (1982: 110) after the factory line she worked on was reorganised making her task almost impossible. It seems that workers may not actually have ownership of the 'means of production' to the extent that Bolton and Boyd (2003) seem to suggest. The pressures of working environments can cause emotional responses which are uncontrollable, and more to the point, the very control of emotions in the face of working pressures is an important aspect of emotional labour. It *is* emotional labour, rather than emotion work, because processes of accumulation often depend on workers being able to remain calm, whether it be in a kitchen, on a factory line or in a care home.

Emotional Labour at Meadowvale

Following the debate laid out above I want to explore how each of the different forms of emotion management and emotional labour help explain the subjective understanding of care work at Meadowvale. I will explore how each of the four dimensions of emotional displays were observable at Meadowvale, but I want to highlight the distinction between those which directly emerge from the commercial agenda of the company and those which were divorced from issues of accumulation.

i. Philanthropic and Presentational Emotion Management

Presentational emotion management represents that basic social self which all actors take to work. In fact care work suffers because it is conceived as a form of labour which emerges from the basic (feminine) self. For instance, in Diamond's study on becoming a care worker he described the unsatisfactory nature of care training and the assumption that care work involved 'mother's wit' (1992: 34). Care remains a difficult and skilled job, and one which is learnt despite its connotations with either naturally occurring or gendered socialised skill sets (Hartmann 1979; MacDonald and Merrill 2002). Nevertheless, a range of aspects of the basic self, inevitably, did come to Meadowvale with the workers.

For many of the workers doing care work entailed a strong sense of emotional commitment. Care work was about "helping people" and many noted that the work did give a sense of satisfaction. Many of the workers had strong opinions on doing the work correctly and it should be underpinned by a strong sense of commitment to those being cared for. This was not true for all the workers, and many *did* describe some sense of dedication to caring values even if simultaneously they also wanted to find alternative work. Leanne, a senior care assistant who had worked at the home for three years, often talked about the reasons for why she worked as a carer. Her account had a strong moral dimension. On one particular morning shift I was working with Leanne and we went into

one of the resident's room, Lucy. Lucy had been incontinent during the night. The night

staff were supposed to make sure everyone was clean before the day shift began, but on

this occasion had failed to clean Lucy or change her clothes and bed-sheets. After the

incident Leanne started discussing her reasons for doing care work:

> *For me, I'm not in it for the money. Some people have lost their way they've*
>
> *forgotten what's important. Everyone is in it for the money now, nobody is caring*
>
> *anymore, I mean really caring. Look at how these night staff have left Lucy, it really*
>
> *pisses me off.*

She went to discuss her view that care was not a job that should be done for

money. She thought that to be a successful, conscientious carer necessitated a deeper

level of commitment. Nevertheless, she seemed to think that the majority of the workers

at Meadowvale were doing the work simply for the money and that this undermined their

ability to provide quality care. Leanne also described, how for her, the tension between

caring ethics and money ran much deeper than her beliefs about care work. She described

later in the same conversation how she had recently split up with her boyfriend and that

they had differences of opinion over the importance of money:

> *I recently split up with my boyfriend...He's just totally obsessed with money, he*
>
> *couldn't believe that I did this job, you know when I told him about having to clean*
>
> *up shit and everything, he couldn't believe it. But this is the job, these people need*
>
> *looking after and somebody has to do it. I think we've lost our way now, I mean*
>
> *society has, we're totally obsessed with money and we need to be more caring. My*
>
> *boyfriend was like that, he was always just worried about money.*

Rosin, a worker from Kenya who had moved to the UK eight years previously,

discussed similar motivations for doing care work. She had worked in care homes in

another city before moving to Meadowvale but previous to that she had worked in a better paying position as a manager in a warehouse. She said she wanted to do a job "helping people" and also described religious motivations for doing care work. Rosin had even left a better paying job with higher status to work in care. Spiritual motivations have been linked to people's entry into the care sector and have been shown to have a powerful effect on the personal morality of some workers in the caring professions (Stewart and Nash 2002).

These ideas which highlight the value of care are aspects of the basic socialised self. For Rosin, the desire to engage in care work was also a spiritual motivation. These aspects of a caring ethic reflect wider social notions of the status of 'care' and 'caring' in society. While care is devalued in some senses, it is also cherished in others. It is tied to the private sphere and hence is not constructed as appropriate for high levels of reward or remuneration, but it seen as valuable to the overall good of society (England 2005). These stories told by Rosin and Leanne show that the emotional side of care work is often underpinned by presentational forms of emotion management. Some of the workers took their motivation to care and their desire to provide support and assistance to those more vulnerable to the job. This motivation to care and provide good care can be construed as part of the basic socialised self which workers bring with them to labour process and can therefore be described as presentational.

Simultaneously, however, care workers often engaged in practices comparable with those aspects of philanthropic emotion work. However, the workers often thought of residents in terms of "favourites" and did not distribute their affections equally amongst all residents. One day, myself, a number of other care assistants (Alua, Agu and Trinny) and one nurse (Jacoline) were in the staff room and we had the following conversation:

Agu: But Jane is the problem one, she's twisted that woman, there is no helping her.

Alua: I know she's always buzzing at 4 am and wanting to get up.

Jacoline: Who's your favourite?

Alua: I like Edwina, she's just so sweet, and Elisabeth, I love Elisabeth.

Trinny: I like Jane, that's my favourite (sarcastically).

(everyone laughs)

Jacoline: You know you shouldn't get close to them anyway. When I was training in South Africa I cried when one the patients died and the charge nurse took me through and gave me into trouble. You don't need to get close to them to care for them.

Agu: Yeah, this is care not love, care not love.

Alua: Seriously though, Joan is a big problem, and she is beyond help, whatever happened to her before she came in her has made her into a bad person.

This conversation reflects an important aspect of life at Meadowvale. The care assistants continually gave certain care acts as 'gifts'. Philanthropic emotional labour also has a close relation to caring contexts (Bolton 2000).

At Meadowvale, all residents received these care giving gifts at particular times. However, those who were constructed as deserving of care received more substantial gifts at more regular intervals. For instance, Jane, the woman being talked about in the conversation above, consistently contravened the routine by making demands for one-on-one conversations with the care workers, but she nevertheless received some of these 'gifts' on occasion. The care workers would sometimes sit with her and engage her in conversation although she did not receive these emotional gifts as often as certain well-liked residents received them. Shelley, discussed earlier in this chapter, rarely received acts

of emotional warmth due to her difficult temperament. Those residents which received these gifts the least were often those who disrupted the routine in some respect or made the work more difficult which emphasises the importance of maintaining the routine (Goffman 1961; Lee-Treweek 1996, 1997). Freddie, a wheelchair bound resident who was also the only resident who regularly smoked, consistently disrupted the routine by asking to go outside for a cigarette. Nevertheless, many of the care workers would take Freddie outside often smoking a sneaky cigarette themselves. However, even those which did not smoke often took Freddie outside if he asked. He was a well liked resident. Residents who had been through a traumatic experience such as a stressful visit to hospital, a period of unexpected and severe incontinence (such as Margery discussed in the last chapter) or if they were feeling ill were often given extra attention by the staff.

ii. Pecuniary and Prescriptive Emotional Work

Not all the work done by the workers was in the realm of presentational or philanthropic emotional management. Perhaps more importantly to the description of care work at Meadowvale is those aspects of the emotional work which emerge from the organisational agendas rather than those which relate to more general societal understandings of the nature of care. This necessitates emphasising aspects of emotional management which are crucial in commercial agendas and goals, and what the costs of these specific pressures are for the individual workers.

The routine of care, as discussed in the previous chapter, is extremely demanding but also the major source of emotional labour for the workers. The workload was immense. The sheer capacity of tasks that needed to be completed within a 12 hour shift was impossible to complete. Most of the workers did attempt to complete as much of the workload as they could but there was a constant process of negotiation that went on. The four examples of care tasks I gave at the beginning of this chapter highlight the difficult

nature of the work. It was not a simple case of moving from one task to the next because

often the tasks were emotionally and physically draining. By the end of a 12 hour shift it

was difficult to muster much compassion for anybody. This required a different sort of

emotional control to be exercised. The care workers needed to remain calm and in control

of their emotions in order to move from one task to the next. Changing Olive's

incontinence pad, taking Maggie to the toilet and a whole range of other tasks in the home

invoked strong feelings. These tasks involved dealing with people with complex emotional,

physical and mental problems. It was not always easy to complete one task and then move

on to another.

The primary focus of the work was completing the physical caring tasks on the

works. This often necessitated emotional control rather than emotional displays of

affection or intimacy. Dampening gut emotional reactions was crucial to completing each

task speedily and moving to the next. As I have set out at the beginning of this chapter, the

tasks themselves are demanding and often emotionally charged for various reasons.

Furthermore, the emotional management that occurred can be related to the dirtiness of

the work. Miller (1997) describes disgust as a socialised emotional reaction. Disgust is in

the realm of emotion because it is uncontrollable reaction to an external object. In elderly

residential care work emotional control is important to get through the day. Emotional

discipline was also required in order to deal with the disgusting elements of care work. A

number of the workers described the initial panic of having to carry out the intimate and

dirty aspects of the work when they had started. Agu and Pamela had in fact both been so

shocked when they started care work that they left the first shift early, believing that they

were unable to do the work. They had both been convinced to give it a second shot and

had overcome this initial fright.

Furthermore, during a shift there would be the feeling that many of the residents' needs or desires were being neglected. Chloe, for example, was a very elderly resident in her nineties. She was in a permanent state of confusion and suffered from a very severe form of dementia. She had some movement in her upper arms but was otherwise immobile. She was completely reliant on all forms of personal care including feeding. Chloe only weighed around seven stones and the charts showed that she was continuing to lose weight. Chloe was an extremely slow eater and often kept food in her cheeks in a hamster-like fashion. When feeding we had to regularly force the food out of cheek and down her gullet. Chloe also had problems with her oesophageal peristalsis and vomited easily after eating, especially if she had been fed quickly. In order to give Chloe a proper meal it would take a care assistant roughly an hour to feed her, so ensuring she got three square meals a day took three man hours. This was simply not possible under the conditions at Meadowvale. Often we fed Chloe for twenty minutes or half an hour, and however much she consumed in that period was all she got. Spending an hour feeding Chloe would have led to the neglect of another resident's needs. Feeding Chloe could easily become a very frustrating endeavour. Unless you fed her incredibly slowly she would throw up or simply keep all the food in her cheeks. Many of the staff thought that the amount of food that Chloe received was considerably lower than what she should be eating. While we recognised that there was insufficient time to ensure that Chloe received enough sustenance many of the workers noted that they felt a sense of guilt over Chloe's consistent undernourishment.

These aspects of the work were often recognised as undermining caring and professional values. Leanne, in a separate conversation, stated her frustration at the insurmountable workload:

> *The thing is though, sometimes you just feel they've turned it into a factory. It's just*
>
> *like bang, bang, bang and on to the next one. No time to talk to anybody, no time*
>
> *to look after anybody if they're not alright.*

Workers often made statements like this believing that caring values had been undermined by the routine and intense workload. The staffing levels on one particular shift reached crisis point. An abnormally high number of staff had called in sick and no cover had been supplied. This was definitively the most difficult shift I ever worked at Meadowvale. Myself, and a care assistant, Gita, worked the entire shift between the two of us. There were 29 residents in the home at that time, so legally there should have been at least five care workers on duty, which, as I have already said, was still insufficient to achieve the supposed workload. This was a superhuman effort but we failed to do most of the work. The following day both Gita and I were back on duty and we discussed the previous day's shift. She imparted her more experienced outlook on working severely understaffed shifts:

> *On days like that you just have to get your head down and do what you can. You*
>
> *know that you're not going to be able to complete all the work but you just have to*
>
> *do what you can and try not to stress about it.*

Moving from one task to the next, as brusquely as possible and without becoming distressed or even hysterical was the critical emotional control exercised by the care workers. This also helps explain the cold-hearted and icy disposition that many care assistants develop after years in the job. It also questions Bolton and Boyd's (2003) assertion that physical labour and emotional labour are distinctly different. They argue that physical labour is more easily expropriated by management than emotional labour. Emotional labour, according to Bolton and Boyd (2003), is inherently owned by the person giving it. However, the worker has limited control over their reaction to the conditions of work. As Lopez states in a defence of Brook (2010) 'if Hochschild goes too far in saying that

the feelings and selves of emotional labourers no longer belong to them but to their employers, Bolton goes too far in asserting that the feelings and selves of emotional labourers belong exclusively to them' (2010: 254). The emotional labour of care is undeniably difficult and deals with challenging aspects of living (and dying). There is a close relationship between the physical and material aspects of the labour and the emotional control required to be exercised by the workers. Lopez in a comparative ethnographic research of three nursing homes, argues that care facilities can be conceptualised on a scale between 'emotional labour' and 'organised emotional care' (2006: 134). Emotional labour represents those pressures which emerge from organisational power and which force workers into coerced emotional displays or emotional suppression. Organised emotional care is utilised by Lopez (2006) to signify those nursing homes which attempt to create an atmosphere where intimate and quality relationships are free to grow, but where workers are freer from forced emotional reactions and displays.

The context in which care is delivered, the intensity of the work, the routines involved in care and the different work practices instituted within particular care homes are inseparable from the forms of emotional labour which will arise. At Meadowvale, the heavy workload inevitably led to a certain form of emotional control being critical to completing the work. The four examples given at the beginning of this chapter highlight the problematic nature of the work which is emotionally difficult, hands-on and dirty work, dealing with individuals who have complex mental and physical disabilities. When considered within the overall routine, each individual task is even more difficult because workers need to remain calm and in control of their emotions. For instance, changing Olive's incontinence pad can invoke a strong emotional reaction – not only was Olive's case extremely sad but she was also partial to violent outbursts. There were many instances where I witnessed care assistants losing their temper with residents whilst carrying out caring tasks. On rare occasions, workers lost their cool and became aggressive, forceful or

disrespectful towards residents. This often occurred when workers were attempting to toilet Maggie who, as I described before, was usually non-compliant with any care task. Karen, a care assistant who was demoted soon after I started reflected one of the other care assistants, Lynn. She said 'Lynn, just can't handle it, she can't do care work. She gets flustered and loses control'. This was a common view amongst the staff that Lynn was not cut out for care work because she was, as Jake described her, 'too close to the job'.

A professional distance from the work was seen as a valuable skill by many. A proficient care assistant at Meadowvale was one who could get tasks done quickly and with little fuss. Whether the task was delivered with warmth and intimacy was usually of little importance. Furthermore, and tying back to arguments made in chapter four, the intensity of the workload was specifically related to requirement for this form of emotional control. For instance, the 'organisational incontinence' which meant that rather than providing the more dignified and less disgusting (for workers and residents) version of continence management through regular toileting; workers were instead expected to constantly change incontinence pads and give bed-baths. This essentially makes the work more emotionally testing.

Due to the pressures associated with care work, there was often a strong sense of guilt and unease experienced by many of the care workers. Just as some workers did not locate moral and ethical motivations for doing care, the same workers did not tend to mention feelings of remorse over the system of care at Meadowvale. However, for some of the workers, and I include myself in this group, there was a common feeling of personal failure at the inability to provide decent care to all the residents at Meadowvale. One day Leanne was asked by the manager to show the daughter of a potential short term resident to Meadowvale around the home. Leanne had described this situation as intensely difficult because she felt she could not tell the daughter of this prospective resident the truth about

the nature of care at Meadowvale. According to Leanne the woman had been in considerable distress about moving her father into residential care but could no longer cope with the responsibility of caring. Leanne described her as "close to breaking point". Leanne said she had no choice but to suggest to the woman that the home provided reasonable care but she said that she had felt incredibly guilty about the situation.

This emphasises how the various types of emotional labour which can be seen as pecuniary and presentational are not necessarily clear cut. Different types of emotionality can be aligned with organisational rationales at particular times. This was underlined when family and friends visited their relatives living at Meadowvale. The form of emotional labour required in these instances was less concerned with the emotion work which orientates around doing the tasks of care into cooperating in care tasks, to a form of emotion work akin to service work. Those suffering from dementia are ambiguously set up as consumers, but as Scourfield (2007b) argues, they struggle to exercise any of the powers normally associated with customer status. In many cases they cannot leave the service to find an alternative ('exit'[11]) and the scope for them to complain or transform the service ('voice') is also limited. The friends and family are often charged with making decisions over the recipients care and more likely to have the social capital to take action if care is failing. Hence, when there were family members present within Meadowvale home the staff would be on "best behaviour". Managers would generally have a greater presence in the lounge and dining room area when family members were present.

One of the residents, Laura, had been losing weight extremely quickly. Her daughter, Ailsa, came in regularly to visit and often got upset. She consistently raised her concerns to the manager and had made some formal complaints to the local authorities. There was widespread resentment towards Ailsa amongst the care workers. When she

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[11] Based on Hirschman's (1970) theory of behavioural responses to organisational failure ('exit', 'voice' and 'loyalty').

came into the home she would comment on the conduct of the care assistants, including criticising the tasks that were completed on other residents aside from Ailsa. All the workers were on edge when Ailsa came into the home and Ailsa also had an open dislike for the African care workers. During one shift she had complained to one of the Polish workers, Olenka, about the two African workers who usually worked the night shift:

> *Olenka: Laura's daughter is such a bitch.*

> *Me: What was she saying to you?*

> *Olenka: She was just going on about how night staff are not looking after Sheila properly, I mean she's slagging off the staff to me, does she expect me to agree with her or what, I mean I'm not going to agree with what she is saying am I.*

> *Me: Why does she expect you to agree?*

> *Olenka: I think she just doesn't like black people, and she thinks I am going to agree with everything she says.*

> *Me: What at did you say to her?*

> *Olenka: I just smiled, said nothing and walked off.*

Despite Olenka's dislike of Ailsa she resisted an argument and instead simply ignored her comments regarding the night staff. Had a resident made a similar comment I doubt Olenka would have ignored it. When visitors came to the home emotional management required for interaction became akin to typical service work. We attempted to give an image of the home as a warm and comfortable place and we consistently tried to do everything, such as moving and handling, in the correct manner.

This was a further example of prescriptive or pecuniary emotional labour. Regulating our behaviour when visitors were present was important in order to protect the

image of the home in the local area. It also prevented any of the family members from moving their residents to a different home. In this sense it emerged specifically from certain aims of the care home although not necessarily directly related with the production process, rather protecting their image in the local area was likely to bring more business. Not only was it stipulated in the job description that workers must '[M]make visitors feel welcome' and '[P]provide refreshments/assistance as and when required' (see *appendix 3*) but managers were more likely to have presence in the public areas of the home when there were visitors.

The examples given here reveal the disparate nature of emotional work at Meadowvale. It shows that different forms emotion work, suppression and expression, come into play at different at times. It is also the case that different forms of emotion work are important for organisational goals at different times. In other words, it is not easy to identify which processes are particularly important for accumulation and therefore it is not theoretically possible to identify a clear relationship between emotional displays and management practices. For instance, emotional warmth can be of advantage to Moonlight Care when a relative is present but is largely irrelevant when workers are completing the physical tasks of care. Furthermore, what was often embedded in the processes of care at Meadowvale was a form of emotional control or suppression required by the workers if they were to complete dirty and emotional tasks at speed.

Emotion work at Meadowvale: Subjective Understandings, Objective Conditions

In this section I want to highlight that while the different forms of emotional labour are inherently complex, a pressure to enact certain emotional displays can be identified as a crucial aspect of the labour process. In particular, this section deals with the pressures facing workers to enact emotionally disengaged displays which are in opposition to the way 'care' is usually understood in society (Finch and Groves 1983; Phillips 2007).

Lee-Treweek's (1994, 1996, 1997) ethnographies of care work are essentially concerned with explaining why care assistants working in residential care homes often act in emotionally detached and sometimes even malicious or cruel ways towards the residents. She describes the emotion work of care work as having an important role in maintaining order in care homes. The behaviour of the residents was responded to by the care assistants according to predictable patterns. This was, again, often punitive in nature and involved categorising residents into the 'lovelies', 'the disliked' and 'the confused'. Importantly, Lee-Treweek (1996) sees the emotion work as critical for maintaining order in the home, so different residents were conceived by the workers as either a problematic to the routine or not. She concludes that 'emotional skills are not necessarily commodities used by management against the best interests of the workers' (1996: 131). She argues that both managers and workers have an interest in an ordered home.

In a later publication Lee-Treweek (1997) attempts to link the harshness of the care workers to a form of working class subculture which is essentially a form of resistance to the heavy, hard work of caring. She points towards the cyclical, repetitive and strenuous nature of care work as underpinning the callous subculture of the care assistants:

> *Like their counterparts in other forms of labour, the auxiliaries based their resistance upon the materials they worked with and could therefore control. The material was the patients' bodies, and the processes involved in working on them...Resistance by non-compliance or selective compliance to patient needs was observed on a daily basis and had become part of the routines of auxiliary labour, a ritualised response to the sheer amount of work* (Lee-Treweek 1997: 56)

The care assistants in her study conceptualised the work in contradictory ways. On the one hand they alluded to caring values but they also saw that '[R]real nursing was hands-on, physical, dirty and strictly routinised work' (1997: 56). Resistance took place through a

number of practices including non-compliance to patient needs, reinterpreting the sick

roles of the patients into pretence and routine depersonalisation of patients. The workers

often acted towards residents as if they were objects in a labour process – the materials of

the work rather than individual people. Lee-Treweek explains the icy indifference of the

care assistants as directly related to the organisational regime and the low status of care

work.

However, the description put forward here shows that a whole range of different

emotional dispositions and displays are necessary for care work. In a sort of fluid process

these will either align or run contrary with the organisational goals at various points in

time. This emerges from both the objective conditions of the work and the subjective

values regarding care. Lee-Treweek (1997) asserts that care workers' unpleasant responses

to residents were a form of resistance against the difficult conditions that prevail in care.

However, this fails to develop a theory of what the organisational goals *are* in residential

care. In other words, this attitude of the care workers can only be seen as resistance if it

runs contrary to the emotional responses management are seeking from their workers.

As I have argued previously, the role of emotions in labour processes should be

considered specifically in relation to what organisational goals and motives are. Two

criticisms emerge from Lee-Treweek's lack of discussion into what care homes are

attempting to achieve and what the actual interests of the management are. Firstly, at

certain points she assumes that the interests of managers are distinguishable and in

conflict with the workers' interests. She argues that the 'resistance displayed by nursing

auxiliaries was based around defying the official status and formal definitions of their work'

(1997: 47). However, and as Leidner (1993, 1999) shows, in the service sector workers and

managers interests can often align against those of the customers.   Put simply, the cold,

nasty and indifferent forms of emotional work done by the workers at Meadowvale, and in

Lee-Treweek's study, could be conceptualised as completely in-line with management interests, and therefore not a form of resistance.

Managers, as well as workers, have an interest in a clean, orderly home. Lee-Treweek recognises this but still conceives the workers disposition as one of resistance. Secondly, Lee-Treweek ignores the subtle processes by which management control can operate. As I laid out in the previous chapter, the system of management control at Meadowvale involved very little direct supervision over the work. Lee-Treweek does not recognise that outward and formal definitions of care that are often promoted by managers and care organisations do not necessarily reflect the true motives of that organisation. Managers may not actually be concerned whether intimate, affective and caring emotional displays are what define the behaviour of their employees. Within elderly residential care homes the routine itself represents the mode of supervisory control determining which work is done and when it is done. Completing the routine might be more important than *how* the routine is completed. Lee-Treweek suggests that the work practices engaged in by the care home workers which depersonalised the residents is a form of 'resistance...aimed primarily at the nature of the work and the drudgery it entailed' (1997: 60). Yet the lack of intimacy in care work can equally be envisaged as a form of objectification emerging from the pressure to treat people as tasks and get through the workload. These cold practices which also comprise of ignoring some residents can be viewed as an important part of completing care work in a poorly resourced labour process, rather than the workers resisting any of the definitions of their work, management or otherwise.

Regardless of the organisational motives, many of the workers also came to Meadowvale with preconceptions regarding care work. Leanne was one of the best examples. For her, care work had deep meanings which transcended service work. For

these individuals care work at Meadowvale was particularly problematic because the emphasis on providing physical care, and the speed at which the care workers were expected to work, undermined their subjective understandings of caring. In a conversation with Susie, a care assistant, and Jake, a senior care assistant, Susie started to criticise many of the workers at Meadowvale, stating that there were two types of people who did care work: "those who care and those who don't". Jake agreed with Susie passionately on the subject. I engaged in a whole host of other conversations with care workers during my time at Meadowvale and many expressed the same philosophy regarding care work.

So contradictory to Lee-Treweek's analysis, issues of resistance at Meadowvale were not as significant as she argues. Importantly this resistance, as she sees it, was against the 'official status and formal definitions of their work' (1997: 47). This conceptualises both the organisational motives and the management agenda rather simplistically. Care work at Meadowvale was an articulation of paradoxical and ambiguous political and economic structural conditions. It is not exactly clear where wealth is generated from the services provided at Meadowvale. On the one hand, it can be suggested that Moonlight Care has an interest in providing a quality service: one in which service users are respected and cherished, and where caring contexts are developed which promote emotional intimacy between its residents and staff. However, in contrast it is not necessarily obvious that this is where value is added. A point of interest is that in their annual accounts there is little discussion regarding improving the quality of the service, and rather, they rest their future success on greater funding from local and central government pots as well increasing their share of the market. In the previous chapter I have shown that the system of management control involves increasing the amount of physical caring tasks that are achieved within a given shift. The regulatory devices, which measures the number of tasks completed, seemed more important than the actual quality of the service. Moonlight Care is not necessarily competing over the nature of their service. It seems that

the cost of the service, rather than the quality, defines market success more strongly than it might in other sectors.

Conclusion

This chapter has argued that forms of emotion work and emotional labour at Meadowvale were complex. I have argued that it is important to keep the notion of emotional labour in analyses of organisations because it reveals the costs and pressures associated with certain types of work (Brook 2009; Hochschild 1983). Furthermore, an analysis of the aims and motives of the organisation are critical to discovering which types of emotional labour are embedded in work processes. I showed that the organisational goals associated with care are not easily identifiable. This means that care work is defined by a whole host of different forms of emotion work and emotional labour which align with organisational aims at different points. I suggested that at certain times it was in the organisation's interests for care workers to put on warm, intimate and affective emotional displays, such as when families were visiting residents. At other times the organisation is uninterested in the emotional displays of workers. I argued that in order to complete the heavy workload of physical and dirty tasks, the workers often exercised a form of emotional indifference in order to move quickly from one challenging task to the next. The pressures of working at Meadowvale were often noted by the workers. Workers often stated the difficulty in remaining calm in the face of the stressful environment. However, I also suggested that there was an emotional cost to care work which emerged from the poorly resourced labour process which promoted various forms of ill-practice.

Perhaps the most concerning element of analysing emotional labour at Meadowvale is that it appears to be the case that there is no great motivation for the companies ensure or even promote quality intimate relationships between carers and cared-for. In many respects the commercial success of providers in elderly residential does

not emerge from the quality of the caring environment despite the efforts of regulatory

authorities. In the next section I turn my attention to the role of regulatory authorities in

attempting to shape the nature of care at Meadowvale. It will become apparent in the

next chapter that the forms of emotional work and general caring practices engaged in by

care workers at Meadowvale departed significantly from how care was defined through

official policy.

CHAPTER 6: The Failure of Regulation and the Management of Risk at Meadowvale

This chapter turns its attention to the failure of regulation to transform care for the better. In chapters four and five I have presented a wealth of data suggesting that care was deficient in various ways. Yet the work at Meadowvale was subject to political and regulatory organisations attempts to monitor, control, inspect and regulate the nature of giving and receiving. The issue that is addressed here is why regulation fails to secure quality care for the residents. Towards the end of the chapter I argue that the failure to achieve the policy visions of care is part of a larger political process where providers and funders attempt to remove the risks and responsibilities of providing social care services. I explore the implications of this politics of risk transference for the workers and residents at Meadowvale.

Personalisation and Abuse at Meadowvale

The Rhetoric of Personalisation

The construction of citizens as consumers with 'choice' has become a staple in many areas of public policy in recent years (Malpass *et al* 2007). In care services the New Labour Government formally called this the personalisation agenda in community care. The idea was that individually-tailored services ensure that public services respond to the diversity of needs in society. The handbook of Moonlight Care states in the heading under 'philosophy of care' that '[W]we are committed to providing our Clients with a safe, comfortable and caring environment which addresses their needs and preserves their individuality, choice, rights, dignity, privacy and independence'. The *Codes of Practice for Social Care Workers* by the General Social Care Council (GSCC 2002) also put emphasis on protecting individuality. The first aim in this code of practice is to 'protect the rights and

promote the interests of service users and carers' and this comprises of the following sub-points:

a. *Treating each person as an individual*

b. *Respecting and, where appropriate, promoting the individual views and wishes of both service users and carers*

c. *Supporting service users' rights to control their lives and make informed choices about the they services they receive*

d. *Respecting and maintaining the dignity and privacy of service users*

e. *Promoting equal opportunities for service users and carers; and*

f. *Respecting diversity and different culture and values.* (GSCC 2002: page number not applicable)

The Department of Health defines that personalised services as those which 'help maintain the independence of the individual by giving them greater choice and control over the way in which their needs are met' (DH 2005). At a glance, it is difficult to see what is wrong with the personalisation agenda and it perhaps seems reasonable, relatively straight forward and undeniably constructive.

However many authors have linked the personalisation agenda with wider welfare state transformations viewing it as indicative of general changing relations between citizens and the state. Cowden and Singh provide a critique of 'user involvement' within welfare services, arguing that the principles of user involvement and power are 'a continuing means of promoting the commodification of welfare' (2007: 7). User involvement policies are those policies which purport to increase user power within welfare services though personal budget control and choice over services. Cowden and Singh argue that the current discourse on user involvement arose from two criticisms led by, on the one hand New Social Movements (NSM), and on the other, the New Right. NSMs included disability

rights campaigners, gay and lesbian activists and ethnic minority groups. They essentially overlapped in their criticism of the state as a source of majority power, excluding many minorities. Welfare services were conceptualised by these groups as being led by professionals rather than users (CSE 1980). The New Right, according to Cowden and Singh, were concerned with a set of interrelated problems which included the demise of the British Empire with economic implications for the UK, the need to ensure the prosperity of the UK in the future, and therefore the need to roll back certain welfare services. The changes which occurred in the late eighties to welfare policy are a repercussion of these two demands:

> *Hence the triumph of the Griffith Report and the subsequent NHS and Community Care Act of 1990 concerned the development of a model that was able to on the one hand appropriate progressive demands for democratization of services, at the same time as presenting market efficiency and the private sector as the vehicles that would deliver this* (Cowden and Singh 2007:12).

User involvement and consumer power are policy discourses which comprise of a range of policy dictates and discourses including personalised packages of care; power and choice over services; the existence of a range of services provided by a range of organisational types (public-, private- and third-sector). Many authors have suggested that 'user involvement' represents a decrease in the social protection offered by the state (Braye and Preston-Shoot 1995; Ferguson 2007; Scourfield 2007b). Cowden and Singh argue that user involvement is practiced most effectively by those with 'cultural capital' (Bourdieu 1986). They link user involvement to rise of managerialism in welfare states. Managerial control, according to them, is weakened by the separation of the execution of services and their planning. By sympathising with 'the user' the power of frontline welfare workers who deliver services is compromised. Cowden and Singh think that the changes

'elides and obscures issues of power relations' (2007: 20) and is a process where a 'language of progressive social movements has been appropriated and become a passenger in the vehicle of 'welfare retrenchment''(2007: 18).

It is clear that this discourse on personalisation and 'choice' is closely allied with the ideology that underpins privatisation. Those in favour of privatisation often argue that state delivered services fail to meet the demands of individual users (Beesley and Littlechild 2003; Savas 1987). Furthermore, the privatisation discourses also often argue that societies generally can only succeed if individuals are enabled to exercise freedom whilst simultaneously being forced to be responsible (Hirst 2007). While personalisation is not usually discussed explicitly by governmental organisations in this way, it is easy to draw parallels between some components of pro-privatisation ideology and the personalisation agenda.

The foremost issue for this thesis, however, is to explore if the ideals of personalisation did shape working practices at Meadowvale. As will become apparent, the images of customised care promoted by the care homes and the regulators seldom guided the practices of the workers. To capture why these policies were futile, and inevitably so, I will discuss Lipsky's (1980) impression of 'street-level bureaucrats'.

Care Workers as 'Street-level Bureaucrats'

Lipsky (1980) conceptualises frontline public sector workers as 'street-level bureaucrats'. He argued that to illustrate the nature of much public sector work entails not the analysis of high level policy changes but how the workers' experience policies individually and day-to-day. As he describes:

> *The decisions of street-level bureaucrats, the routines they establish, and the*
>
> *devices they invent to cope with uncertainties and work pressure, effectively*

become the public policies they carry out...that public policy is not best understood

as made by legislatures of top-floor suites of high-ranking administrators, because

in important ways it is actually made in the crowded offices and daily encounters of

street level workers (Lipsky 1980: xii)

There are a number of key facets which combine in Lipsky's description of such work:

1. Resources are chronically inadequate relative to the tasks workers are asked to

perform

2. The demand for services tends to increase to meet supply

3. Goal expectations for the agencies in which they work tend to be ambiguous,

vague, or conflicting.

4. Performance orientated towards goal achievement tends to be difficult if not

impossible to measure.

5. Clients are typically nonvoluntary; partly as a result, clients do not serve as

primary bureaucratic reference groups (Lipsky 1980: 27-28).

While Lipsky did not focus on care assistants, and pays little attention to health care workers in general, his ideas were intended to be relevant for any workers who are charged with implementing policy. It is obvious from the above quote that many of the processes which Lipsky associates with street-level bureaucracy are relevant for discussions about Care work at Meadowvale. A recurrent theme of this thesis is the inadequate resources governing working the work at Meadowvale. Furthermore, the expectations presented to elderly residential care homes, which have their genesis both in the state-led governmental apparatus and in the immediate organisational motives, often tend to be incompatible and unspecified. In spite of the complex and time-consuming paperwork expected to be completed by one of the care workers, in practice it entailed large-scale falsification of records. Indeed, despite the discourse that 'good' care is defined by choice and

individualisation, care recipients were never included in the fundamental design of care services (such as the daily routine). From the above vantage points it seems appropriate to treat care workers as street-level bureaucrats who constantly negotiate top-down political agendas within a difficult and contradictory working life which demands tricky decisions to be made spontaneously. The following discussions will focus on the discrepancies between political agendas and the practice of care work.

Another feature of Lipsky's street level-bureaucracy is that the goals policy goals set out for workers are often contradictory. The contradictions arise from three forms of discrepancy:

1. Client-centred goals conflict with social engineering goals.

2. Client-centred goals conflict with organization-centred goals.

3. Goals conflict because street-level bureaucrats' role expectations are communicated generally through multiple conflicting reference groups (Lipsky 1980: 41).

All three points can be identified in elderly residential care homes. For a start the social functions of elderly residential care homes are thought to be conflicting. It has been argued that care homes simultaneously serve to sequester death and dirty living within secret places (Froggatt 2003) *and* offer genuine care and support to vulnerable and frail people (Lopez 2006). Secondly, client goals conflict with organisational goals. There is of course a difficulty in defining the 'client' when speaking on issues to do with elderly residential care. Most notably, it is not always clear whether the families or guardians of the elderly care recipient or the elderly care recipient themselves is the client. The state, the general public and the local council can also be conceptualised as the clients of elderly care. Lipsky points out that *who* is the client of a public service is often obscure. The clients of certain services are sometimes not even the people who come into contact with

the service in question. For instance, police officers' clients are the general public rather than those identified as criminals. Yet in conducting their role with the decency and civility, which the public expects of police officers, necessitates them to consider the rights and treatment of criminals.

In elderly residential care the client goals are easily imagined as conflicting with certain organisational goals. A reduction in the cost of elderly care is easily imagined to have benefits for governments and private sector providers but those in care systems are likely to benefit from greater expenditure. Finally, the role of the care worker is communicated and conceptualised differently by different stakeholder groups in the care process. The care home has an interest in defining the work as a routine, structured and standardised process, which is easily measured and tightly controlled. The regulatory authorities, such as CSCI, have an interest in defining care work differently. Their definitions of care surface from a political process of campaign, party politics and democratic accountability. Response to these distinct policy codes, as I will show in this chapter, was difficult in light of the working conditions at Meadowvale.

The following analysis of care work describes care workers as street-level bureaucrats, transforming policy into practice in ways which often contravened and completely ignored those discourses set out by regulatory authorities. The issues of poor funding and the accumulation of profit affected both how the work was organised and the practices of the workers at Meadowvale. Policy discourses on choice, dignity, abuse and the nature of quality care generally affected caring processes in an incidental manner. The following sections analyse how policy discourses were communicated and how they played out in practice. The aim is to follow the policy from the top downwards, firstly examining their discursive features, and then highlighting there manifestation in daily working and caring practices. It follows an 'anthropology of policy' approach by tracing the actions and beliefs of daily life and their relationship to policy (Shore and Wright 1997). The following

discussion highlights two policy discourses idealising care: the desirability of 'personalisation' of services and the undesirability of 'abuse'.

Personalisation On-the-floor

Outwardly, Moonlight Care fully endorsed the idea of personalising services to each resident. In all literature produced by the company and the other stakeholders in the care home, including the local council, the NHS and CSCI, there was a strong emphasis on treating care recipients as individuals. This is in itself may well result partly because of a recognition that care, when it is rationalised and formalised, has a tendency to become defined by unequal power relations, standardised routines and institutionalisation (similar to those arguments put forward by Goffman (1961). In all documentation advertising their services Moonlight Care highlighted that they provided personally tailored services emphasising that each resident is provided with an individualised service. In the training courses I attended, even when they were developed by the company, the emphasis was often on providing choice and enabling lifestyle preferences within the institutional context. For instance, in training courses on nutrition, duty of care and dignity, the importance of choice was consistently stressed.

The care home was also judged by CSCI on its capacity to individualise services. This section provides descriptive evidence of the rift between the rhetoric on personalisation and the inability of workers to deliver such care at Meadowvale. The care workers at Meadowvale were not provided with an context within which these discourses on choice could be realised. On admittance, each resident would have a care plan opened and in this their preferences and dislikes were recorded. If the person was unable to communicate for themselves, which occurred frequently, their next of kin would be asked to provide the information. A number of the residents had been unable to communicate but had also had nobody present to voice their preferences on their behalf when they had

arrived at Meadowvale - these individuals' care plans were virtually empty. Featured in the care plan were the kinds of food each resident liked, the clothes they liked to wear, the kinds of activities they liked to engage in, as well as lifestyle characteristics such as religion and sexuality. Care plans were a legal requirement of all care homes but, nevertheless, their usage at Meadowvale provides tangible evidence of the home's desire to be visibly implementing individualised, personalised care. Unlike other forms and documentary procedures the care plans were filled in honestly and were not faked. However, the transformation of these 'likes' and 'dislikes' into a guiding principles for the staff's daily work ranged from being fragmentary and sporadic to utterly ignored. The day-to-day life of the residents rarely reflected anything written in the care plans.

The behaviour of certain residents defines the tension between choice and the requirement to maintain routinised and standardised systems of working in the care home. One resident, Jane an ex-shop owner, was known to all the staff as a difficult resident and many of the workers felt that she deliberately behaved in testing ways. Jane consistently made eccentric demands on the care workers. So through the day, when she was sitting in the lounge, she demanded that the table next to her armchair was set out in a specific fashion. A glass of orange juice, a couple of paper towels and a small bowl of liquorice allsorts all had to be arranged according to her preference. When any caring task was carried out with Jane the same considerations needed to be taken. For instance, when she was in bed she liked the bed-sheets to be arranged in particular way and she liked her clothes for the following morning to be hung up in particular place. Jane's behaviour was viewed by the staff usually as "attention seeking", often as deliberate and inexcusable spitefulness and less frequently with a feeling of compassion. Perhaps most saddening about Jane's behaviour, however, was that when care assistants spent time engaging her in conversation her obsessive tendencies quickly ceased. It seemed to me that she merely desired interaction. Nevertheless her demands were often a strain on the routine and

many of the care assistants thought negatively towards Jane. Most of the time the care

workers construed Jane's preferences as unreasonable because the demands she made

competed with the rest of the workload. Jane's idiosyncrasies prevented workers from

providing even minimal care that other residents required. So for instance, at bed time

care assistants would frequently become irate with Jane because her requirements

prevented them from getting other residents prepared for the night-time.

Towards the end of my period working at Meadowvale, Jane's condition

deteriorated rapidly – she began to constantly complain about feeling unwell and

experienced diarrhoea at regular intervals. She began refusing to eat proper meals,

preferring to live on a diet of orange squash, biscuits and liquorice allsorts. The activities

coordinator, Chrissie, thought she had "given up on life" and her refusal to eat was part of

her wish to die. Jane started to insist that she remain in her bed and that all her meals be

brought to her. To begin with, and in the name of personal choice and preference, the

senior care assistants decided that it was acceptable for Jane to stay in her bed: it was her

decision. However, when she was left in her bed she would persistently ring the buzzer.

Usually, when one of the care assistants went up to Jane's room, it was for something that

the care workers deemed trivial. Either she did not like the way her sweets had been

arranged on her table or she wanted the bed-sheets ever so slightly repositioned. During

this period her behaviour quickly escalated out of what our daily routine could respond to.

If one of the care assistants stayed with her and engaged her in conversation then she was

happy and her constant requests would stop immediately. I discussed with Leanne, a

senior care assistant about how we should deal with Jane's changing situation and she said

"Jane just wants someone to sit with her all day, but we just can't do that, we don't have

the staff, and everyone else suffers if we do that". Often Leanne would try and explain this

to Jane and say "we can't give you special attention we have everyone else to look after as

well".

The routine which allowed Jane to stay in bed only lasted a couple of days before the senior care assistants decided that the situation was untenable. They decided that Jane was no longer permitted to stay in the room and she was forced to come and sit in the lounge every day. The persistent buzzing and constant attention that Jane demanded was disrupting the fragile routine. In this instance, even though there had been some attempt to let Jane choose her lifestyle, it had been quickly overruled because it undermined the running of the home. The policies advocating choice and personalisation in Jane's case were simply disregarded at the 'street-level' of implementation. The limited resources and low margins in care homes often precluded any real commitment to individually tailored care in an institutional setting.

This negotiation between creating a context for individualisation of service provision without compromising the daily routine in the care home was often impossible. As I have argued in a previous chapter, the highly structured nature of care work at Meadowvale was critical for ensuring that a basic level of care was completed. There are many other examples at Meadowvale that illustrate the gap between the discourse on personalisation and the practice of 'care'.

Certain work practices of the care assistants did support and enable choice yet it was very superficially. For example, often choice would be whether the residents wanted cut-price orange squash or cut-price black current squash. Whether they preferred dry overcooked chicken covered in gelatinous gravy, or dry overcooked liver covered in gelatinous gravy for their main meal of the day. If a resident had said "actually I prefer a glass of wine with my meal" or "I would love a steak this evening" it would not have been not have been provided. The whole notion of choice rests on what choices are presented.

The limited expenditure on care itself and on the few luxuries associated with living at Meadowvale limited choices severely. Those aspects relating to the overall organisation

of the work and staffing levels restricted many aspects of life. For instance, female

residents were often denied make-up in the morning. Limited resources being spent on the

care process ultimately meant that few choices could be structured into routine. The

kitchen, which was the main source of luxuries for the residents, was poorly funded and

only able to provide the most basic of foodstuffs. Many residents had virtually no say over

their own routine, including bed times, meal times, when they received a bath or a shower

or when they had their incontinence pads changed.

In an ethnographic account of occupational therapists dealing with people with

mental health problems, Elizabeth Townsend (1998) sets up a basic dichotomy between

'empowerment' and 'caregiving'. Caregiving requires a person to be treated as a patient

and as an object of care while empowerment suggests that individuals should be treated as

holistic, autonomous and equal human beings. Empowerment is defined as a 'participatory

process of learning to critique and transform individual feelings, thoughts, and actions, as

well as the organisation of society, so that power and resources can be shared equally'

(1998: 13). This definition sits in opposition to the reality of how empowerment was

exercised and manifested in the relations that occupational therapists had with their

service users in Townsend's study. In reality, the service users were unable to influence the

nature of the services being offered to them and hence unable to take to control of their

own lives. Bureaucratic systems transformed occupational therapists into caregiving

workers rather than conduits in an empowering process. For Townsend authentic

empowering care rests on humanistic ideals, a recognition of a certain degree of autonomy

and an ethic of equality. However, for her this was significantly different to common sense

understandings of individualism:

> *Unfortunately, beliefs in humanism and autonomy are often used to support the*
>
> *overpowering individualism of Western societies...The emphasis on individualism*

makes many forget about the potential of economic social, political, physical, and

organisational conditions to foster or limit autonomy (1998: 31)

In other words, social structures generally, not just organisational influences, determine the kinds of choices and resources to which individuals have access. Inevitably, for an individual entering a social care context, the practices, rituals and pressures of the organisation are likely to shape the ability of individuals to make choices and realise self-determined plans. The practices embedded within social care services affect the kinds of lifestyles people are able to live. Some authors have in fact argued that institutional care can provide truly supportive environments (Jack 1998; Kahan 1994; Kelleher 1998) although it certainly seemed to fail at Meadowvale.

However, what seems to emerge as crucial for the more general consideration of the personalisation agenda is its disregard within the overall system for the importance of the nature of services in determining whether choice and personalisation are realistic goals for most institutions. Whether it was Jane or any other number of residents trying to shape their own destinies it was clear that the routines which prevailed were an obstacle to real choice and control. Care plans were filed away and not looked at again. The cyclical routine of physical care dominated the workers tasks and the life of the residents. As I revealed in chapters three, four and five, the nature of care work at Meadowvale can be traced to wider economic and social trends and to the profit-orientated goals of the organisation. Realising personalisation across the care sector will depend on far more holistic and far reaching change than simply communicating to the workers that things should be done in a different way.

The gaping chasm between what was communicated as ideal care and what was delivered was often noted by the care workers. In some instances, the feeling that care had not been delivered correctly also formed the basis for feelings of guilt and was a

further source of emotional discomfort for some of the workers. Nevertheless, typically the workers at the forefront of delivering the personalisation agenda, were more concerned with getting the work done, than they were concerned about whether residents had been given enough choice. Lipsky's (1980) description of street-level bureaucrats captures the tensions of the work at Meadowvale. The decisions made by care staff were concerned with more serious matters than whether residents had been empowered to smoke, stay in their own room or choose what they wanted to eat or drink. The decisions often revolved around whether a certain resident was lying in their faeces or whether another seriously underweight resident had been assisted to eat all her dinner.

The tension between delivering a personalised service and the organisational agenda of cutting the costs of production speaks to the major theme of this thesis. Care, in many respects, can be conceptualised as an economic issue. Elderly residential care is deeply underfunded. A more affluent system of care could provide greater personalisation with real opportunities for residents to choose lifestyles which do not clash with or hinder the working regime. The quality of residential elderly care services is likely to rely on budgets far more than it ever will on the construction of novel codes of conduct, pioneering policy discourses or innovative systems of regulation. Humphrey (2003) describes the system of regulation in care as a 'buffer' between central and local government. Central government, which distributes funding and shapes the regulatory climate, is able to shirk accountability over services to local government. One of the respondents in her study stated that 'I'm not sure that politicians will ever own up to "What is the quality of life that the state is prepared to subsidise and for whom and for how long"' (Humphrey 2003: 210). This statement captures the contradiction between the expectations communicated to care providers and local government through various discourses and regulatory practices and the actual allocation of resources by central funding bodies.

Policy Constructions of Abuse

Choice, personalisation and individualisation set a benchmark discourse for much of the training courses in the care home. However, a separate, but related, narrative on abuse also contextualised much of the discourse on the nature of inappropriate, rather than appropriate care at Meadowvale. The Department of Health's *No Secrets* report, published in 2000, remains the main document for definitions of abuse in health and social care policy. The *No Secrets* report defines abuse as the 'violation of an individual's human and civil rights by any other person or persons' (DH 2000: 8). Significantly, abuse is defined by the deliberate actions of one toward another. In itself this construction of mistreatment is an individualising discourse geared around victim/perpetrator that is one act or a series of acts with negative consequences committed by one on another. 'Abuse' as a concept is increasingly prevalent in paid care as a governing principle for care. If abuse is avoided then good care is achieved. The CSCI (2009) fact sheet on abuse describes many types of abuse which include 'physical, emotional, sexual, neglect of physical and emotional needs, financial exploitation and racial abuse'.

The concept of abuse has also been widened to include the many organisational factors, not only intentional, individual acts. The discourse on individual rights, preferences and decisions is often interrelated with personalisation so care that to deny 'choice' is now defined as abuse in documentation produced by regulatory authorities. The CSCI (2008b) fact sheet, for instance, implicates many types of organisational practices in abuse:

> *Lack of respect for older people's privacy, dignity, choice and rights can chip away*
>
> *at their self-esteem, while still stopping short of a criminal act. The daily routine*
>
> *followed by staff in some care homes can leave people feeling and being neglected*
>
> *and ignored. Older people may suffer abuse and neglect in this way too. This can be*
>
> *just as abusive as deliberate acts of harm and needs reporting* (CSCI 2008b)

The term 'abuse' then has been elevated to a catch-all idiom which not only involves deliberate harm by an individual towards another, but also those actions which ultimately have the effect of harm. This elevates care work to a position of responsibility which most other forms of minimum wage work do not have. For instance, when a care assistant fails to carry out an act at work which they are supposed to have completed, such as changing an incontinence pad, this act is not idleness, resistance, bad practice or bad management: it is abuse. If a factory workers fails to pull their weight on the production line they may be letting down their colleagues but they could hardly be said to be committing abuse. This catch-all definition of abuse may even be said to obscure that which is more serious and deliberate abuse.

Forms of abuse which relate to organisational and institutional factors have gained recognition by various sections in the policy narrative, but few, if any, of the policy documents develop a complex discourse on how to tackle forms of abuse which arise from the context of care. The Department of Health defines institutional abuse as lack of 'poor care standards, lack of positive responses to complex needs, rigid routines, inadequate staffing and an insufficient knowledge base within the service' (2000: 12). In the same *No Secrets* document, the 'perpetrators' of abuse are considered to be 'relatives and family members, professional staff, paid care workers, volunteers, other service users, neighbours, friends and associates, people who deliberately exploit vulnerable people and strangers' (2000: 10). Organisational structures, systems of management, working routines and funding systems are not identified as perpetrators, reflecting a more general tendency to see harm and abuse as the act of one or more deviant individuals.

Benton (2006) argues for a version of rights based on sociological understandings of society. He argues that rights need to be conceptualised as inherently tied to the economic, political and social conditions which structure the entitlements available to

people. Inequality and power are emphasised as important processes for understanding the current position of rights in societies. He believes that sociologically-based rights entails the move from 'passive' rights 'protecting individuals from abuse' towards 'active' rights which focus on the pursuit of 'a self chosen life-plan' (2006: 22). Those rights put forward by Marshall, and most of the rights imbued by Western states, revolve around notions of passivity. Rights are usually concerned with providing a bare minimum of protection against poverty, ill health and destitution, rather than enabling individuals to realise goals and aspirations. This inevitably entails the dismantling of the structures which maintain inequality and obstruct access to political, cultural and economic resources.

As I will show later, those rights which relate to abuse and the need to resist practices which might be conceived of as abuse, essentially relegates personalisation to the status of a passive, rather than an active, right. Furthermore, the policy discourses on abuse obscures those forms which surface from organisational factors and the social, political and economic environment. For instance, Benton (2006) argues that liberal, passive rights are inherently problematic when it comes to revealing and responding to acts which might have caused considerable harm, but are not reducible to a single person or set of persons. Liberal rights tend to see any act which has caused suffering, pain or harm in essentially individualistic terms. Some individual (or set of individuals) is blamed for any wrong-doing and the social worlds which ultimately guide the motivations and actions of both perpetrators and victims are written out of the story.

These policy discourses on abuse fall short of being able to reveal the form, nature and extent of abuse within residential care home contexts. Largely this is because they fail to take account of the social circumstances within which abuse occurs. A more nuanced and sociological understanding of abuse is required in order to fully understand both why abuse might occur within the delivery of social care services. Gelles (1999), investigating

family violence, argues that the key aim of sociology is to describe the relationship

between social structures and people's actions. Focusing on a sociological explanation of

family violence he implicates the full range of social structural factors (such as age, gender,

ethnicity and so on) and also the modern family as the primary institutional cause. The

importance of social, economic and political processes in contextualising abuse remains

significant in explaining any situation of abuse in a care home setting.

Pincus (1994, 2000) suggests that discrimination can be understood as 'structural',

'institutional' and 'individual'. Inspired by this typology it is possible to construct abuse in a

similar vein. A *structural* basis for abuse relates to the wider social, political and economic

context. In care work this would relate to policies that determine the funding and

regulation of care as well as its overall cultural status and its position as a poorly funded

segment of the labour market. *Institutional* factors, which mediate between structural and

individual factors, relate to the practices, routines and systems of work solidified within

specific care services. *Individual* factors take recognition of the existence of human agency

within the social world. Abuse can be a direct, intentional act existing outside of any

specific organisational or structural context. Thus different levels of abuse are interrelated,

complex and therefore difficult to treat as theoretically and empirically distinct areas for

analysis. The following discussion highlights the correlation between different sources of

abuse and the contradictions inherent within the definitions of abuse contextualised in

policy and practice.

Abuse on the Floor

Under the definitions constructed through training and care practice documents abuse *was*

an unavoidable and frequent occurrence at Meadowvale. The routine of the day and

limited resources given over to service delivery essentially prevented staff from combating

the institutionalising tendencies of care work. Despite the recognition that routines and

organisational practices can be tantamount to abuse, the discourse on abuse is often individualising, or locates the blame with staff. So for instance, the quote from CSCI (2008b) above says that the 'daily routine' can lead to a 'lack of respect for older people's privacy, dignity, choice and rights'. However, it fails to mention specifically that the daily routine is structured by organisational motives and practices, and instead locates the 'staff in some care homes' as the root of the problem. It was communicated that privacy should be respected and choice should be enabled but the resources and the general organisational context was at odds with these principles. Essentially, certain forms of abuse were emphasised at the expense of others. There was little discussion in training courses around how to complain if the staff felt that staffing levels or work practices led to forms of abuse or neglect.   When examples of appropriate instances which required whistle blowing were provided in training courses and in official documentation the emphasis was always on instances of intentional physical, sexual or verbal cruelty.

In the discussion of the methodology in chapter two I recounted the story of my first shift when a number of the workers began intimidating and tormenting some of the residents. In this case a small number of the workers deliberately tormented some of the residents and one resident became obviously distressed. This was the only instance of serious intentional malice which I encountered, as suggested earlier, I doubt I could have continued with the research had this been more frequent.

The current understanding of abuse, in which almost any form of malpractice is deemed as abuse, seems to take some of the seriousness away from deliberate instances of harassment. This fissure between conceptualisation and practice did not escape the care assistants. Many of the workers highlighted this difference between their own understanding of abuse and the way it had been constructed. A conversation I had with two other care assistants after a training course on health and safety stays in my mind:

Susie: Yeah but we abuse people all the time

Jake: Yeah that's true

Susie: They've said to us that this is abuse, that's abuse, whenever somebody says they don't want to do something and we say they have to, that's abuse. Or I mean, take Viola, the way we always say to her, "do you want to go swimming?", "are you going swimming?", that would be called abuse too. Or whenever we say "right come on you it's time to do this". It's all abuse.

Jake: Exactly, but when real abuse happens here they sweep it under the carpet

Me: (surprised) Really, there has been some serious cases here

Jake: Well Joline was sweeping them under the carpet, but yeah

Me: Like what kind of things? Who?

Susie: Well, Dianne was found with bruises on her, and another time Laura was too, and Joline made sure nobody told social services, she told us directly not to tell anybody else

Certain staff, although they were not the norm, sometimes directed humorous comments towards the residents. Other workplace studies have highlighted humour as a means of 'letting off steam' (Fine 1988) and as an important aspect of workplace subculture (Holmes and Marra 2002). Humour can easily be seen to have organisational pertinence as a coping mechanism for difficult conditions and is not simply a form of direct abuse by one individual on another.

However, the most prevalent, consistent and fixed forms of abuse and neglect were undoubtedly those forms which emerged from the composition of the work and the practices rooted to the daily grind. In chapter four I highlighted those labour saving

strategies employed by workers that led to unsafe and dirty working practices. Machinery was used incorrectly, incontinence was accepted as part of the routine and tasks such as feeding were often not completed. These working practices, even when compared with policy narratives, are easily defined as abuse. In this sense abuse is directly related to the wider economic context of care because it is the inadequate staffing which imposed endemic forms of abuse and neglect. Certain residents never received enough food over the course of a week, everyday some residents were left for long periods of time in soiled incontinence pads and consistently bedridden residents were not turned enough to ensure the prevention of bed sores. Other residents were confined to their rooms with little or no social interaction all day, every day, with no choice in the matter. These practices cannot be construed as the intentional acts of individual care workers, they were either embedded within the routines at Meadowvale or they were decisions that were forced upon the care workers.

The observations from Meadowvale care home paint an intricate picture of the nature of abuse. It remains important to retain a comprehension that many of the activities in care homes can lead to forms of injustice, harm and neglect for the residents. In certain cases these can even be attributable to the deliberate acts of cruelty by particular workers and can be expected to occur even in the best care homes. Abuse can therefore be an individual act but, as Pincus (1994, 2000) indicates in relation to discrimination, it is usually interrelated with institutional and structural factors. Most acts of abuse in care homes are mediated through the working workplace environment. However Lee-Treweek's (1994, 1996, 1997) ethnographic description of the resistance amongst care workers to deliver warm and intimate care also does not quite capture the underlying pressures of care work. Lee-Treweek says the 'resistance displayed by nursing auxiliaries was based around defying the official status and formal definitions of their work' (1997: 47). My argument is that Lee-Treweek seems to locate the forms of abusive practices as a

subculture of the workers, rather than specifically ensuing from the organisation of the work. Secondly, she describes the resistance as a counteraction to the 'official status and formal definitions of their work' (1997: 47), but in so doing fails to recognise the contradictory organisational motives inherent in many care homes. For instance, on the one hand, a care home might be outwardly present a marketable image of itself which suggests that it respects individuality, autonomous living and delivers nurturing respectable care, but delivering this 'style' of service might not actually accrue greater monetary gains. Supplying personalised services, as far as management are concerned, does contribute to greater profits.

This means the practices and beliefs of the workers may appear to be contrary to management ideology of quality, personalised care. However, in actual fact the unfeeling manner by which care workers interact with residents might be more aligned to management objectives. When the care workers use various forms of control over residents they are protecting the routine which is in managerial interests. For instance, at Meadowvale the system of bureaucracy was crucial in determining the workload of the care assistants. The process of recording all tasks emphasised the physical tasks of care resulting in a system where it was also in the workers interests to maintain the routine, often at the cost of the emotional and intimate aspects of caring relations. Hence, it was not a form of resistance against what the managers set out. It was actually a form of compliance with profit orientated goals. Essentially, although Lee-Treweek recognises the relationship between emotional displays and organisational factors, I think she underestimates just how entrenched the pressure is for workers to behave in 'nasty' ways towards the object of their labour.

When Suzie, in the quote above, stated that "we abuse people all the time" she encapsulated two failures of the abuse discourse at Meadowvale. Firstly, staff felt that in

training courses abuse was constructed contrary to their understanding of care work and their own practices. While it would not be right to condone some of the practices that the workers engaged in terms of how they joked and made fun of residents, it seems too strong to define this as abuse. The abuse discourse as it was presented at Meadowvale provided little recognition of the organisational context as a major source of abuse. It also presented virtually no potential gateways for care workers to complain or voice concerns over routines or practices which were normalised at Meadowvale.

Both the policy discourses discussed here – the personalisation agenda and those discourses relating to resisting abuse – failed to have much impact on the nature of care at Meadowvale. One attempted to construct the nature of 'bad' care and the other 'good' care although both located the individual workers as responsible for realising these political images. Both the implementation of personalisation and the need to resist abuse are examples of how political constructions of care are at odds with daily practice. An analysis of both the concepts of abuse and personalisation emphasise Lipsky's (1980) notion of street-level bureaucrats. The care workers at Meadowvale were not specifically public sector workers but they were subject to a large amount of discourse which either came directly from central governmental policy or was influenced by the regulatory authorities' depiction of appropriate care. Despite the desire to transform and improve care on the behalf of the government, real commitment through resources was not supplied. As Lipsky (1980) describes, street-level bureaucrats transform and remodel policies through their actions while working. These actions in the care home were often at distinct odds with the policy agenda, not necessarily because of an unwillingness by those working at Meadowvale, but because the organisation was not able to provide an environment in which this was likely to take place. The low staffing levels and the intense work load prevented care workers from being able to implement the individualised and personalised services which were expected to be delivered by the care workers. Furthermore, the form

of care work ingrained in the routines at Meadowvale essentially led all workers to become 'abusers'.

The discussion in this chapter has highlighted how care workers at Meadowvale were rendered powerless, effectively by the burdens of their work, to implement political and regulatory imaginations of care. In the following part I suggest that the unrealistic expectations imposed on the workers by Moonlight Care and the regulatory agencies rests politics of shifting responsibility.

Managing Risk and Shifting Responsibility

In care work potential harm to the objects of the labour – the residents – represents a risk to the operations of Moonlight Care. The remainder of this chapter discusses the inherently risky nature of care work. However, in a process of risk transference Moonlight Care attempted to displace the responsibility for risks over the delivery of the service to the workers. I conceptualise this movement of responsibility as resting on a specific relationship between the privatised care industry and the contemporary welfare state. Due to the continuing poverty of elderly residential care services and the relations of responsibility between the private sector, local authorities and central government, risk is parcelled down from one organisation to the next, and eventually bears down on each individual worker.

Responsibility and Risk in Elderly Care Work

In care work, the notion of risk can be employed to explain a number of different threats potentially affecting a number of different groups. To a degree, the ability of Moonlight Care, and each of its individual care homes, to sustain viability depends on its ability to manage risk. As discussed in chapter three, the share prices fell dramatically due to a number of publicised failures to deliver even basic care to its residents. In particular this

dramatic fall was due to the death of eight residents in one care home when the heating system broke down during winter and was not fixed for eight days. In addition, a rising death rate amongst the clients across the whole company indicated an overall decrease in service quality. Moonlight Care's chairman indicated in a recent annual review that managing risk effectively was a priority for the organisation. Early in 2009, a national newspaper reported that Moonlight Care had been prosecuted five times in seven years. This came to at least £331'000 in fines and costs. Other fines have been issued since including a further £200'000 issued in 2009 after the aforementioned newspaper article.

However, these measures taken against Moonlight Care for malpractice should not be overemphasised in affecting their ability to continue to operate. Despite all these instances of severe malpractice only a handful of care homes owned by Moonlight Care have been closed. No measures have been taken to prevent the company from opening and acquisitioning new homes and they have still managed to pay significant fees to their board of directors and their shareholders (Moonlight Care 2008, 2009). In fact regulatory authorities seem to be extremely reluctant to take serious action against Moonlight Care in case it does lead to home closures, which is often argued to have negative consequences for residents (BBC Radio 4 2011). The state, having embarked on a long term strategy of shifting responsibility for care services, inevitably seems unwilling to retake failing homes under their authority. In light of this, it seems that the fines issued to Moonlight Care are nothing but an extra operating cost.

Furthermore, the risks to others with a 'stake' in elderly care are greater than those that the company experiences. Death and disease can occur when labour processes fail. The risk involved in production is therefore greater than in some other forms of capitalist labour process. Despite this, there have been growing calls from social work academics to accept risk in social care services because without it independent and empowered living is

curbed. Fyson and Kitson (2007) argue that there are competing policy agendas between enabling choice and independence versus the protection of vulnerable people. Nevertheless, it remains that the risks associated with operating care homes can be serious and far-reaching. Many of the observations of this PhD can be seen in terms of risk. Risks include death or premature death, illness and mental illness. Chloe, for example, was slowly starved because of insufficient time for feeding. Angela's mental condition, discussed at the start of the thesis, deteriorated rapidly after she entered Meadowvale and died shortly after. More generally, institutional living in care homes can be seen as a loss of freedom for many of the residents who are no longer able to make decisions about their lifestyle and their day-to-day activities.

There are also specific risks to care workers which relate to the specific nature of elderly residential care. Issues of service user protection from financial, sexual, physical and emotional abuse have led to the POVA (Protection of Vulnerable Adults) scheme. This lists all care workers who have relevant previous convictions. Once on this scheme such workers will be unlikely to find jobs in care work ever again. It is a statutory requirement that all people applying for care work must be checked against the POVA list. The risks to care workers include criminal conviction with the possibility of imprisonment or more commonly a large fine. In actual fact many of the training courses I attended during my time at Meadowvale spent significant time going over past cases where care assistants had been prosecuted for their participation in various accidents and incidents. Examples of very large fines having been issued to individual workers were consistently emphasised. There is a range of less formal of legal risks to care work. Most notably, and as argued in chapter four and five, care work is defined by intense emotional pressures and workers are forced to carry out dirty tasks with challenging residents. This is exacerbated by working structures which demand these caring tasks to be completely quickly.

We see then that the workers and the residents, in some senses, are open to greater risks than the company. Regulation, it can be posited, is partly in place as an attempt to ensure that the risks that care companies are subject to are aligned to the risks associated with residents and to a lesser degree the workers. So for example when Moonlight Care was shown to have failed to deliver appropriate care they were also fined. However, I think it is plain that the risks to individual workers and care recipients are far greater than the risks experienced by the shareholders and upper management of Moonlight Care. This politics of risk burdening and an unequal sharing of risk were visible at Meadowvale (Mythen 2005; Wolfson and Likic-Brboric 2008). The exact nature by which this unequal sharing of risk operated is explained in the following section.

Constructions of Individual Responsibility at Meadowvale Care Home

At Meadowvale care work was often constructed as the responsibility of the workers, and not the responsibility of the company or even the management of the individual home. In chapter four I discussed in depth the ways in which care is controlled and specified in a labour process. I argued that a form of bureaucratic control over the work, and one which enforced faking the charts which recorded the tasks completed, left the responsibility for the work with the care assistants. There was a constant process of individualisation where the company attempted to shift responsibility to worker occurring both in discourse and practice at Meadowvale.

Previously I focussed on how the moving and handling training was lacking in respect to how the work was actually completed on-the-floor. During this training course, the trainer – Jody, focussed on the need to document all care tasks that were completed and the need to properly assess which types of equipment should be used on residents. Jody was at pains to highlight the duty of care law. However, rather than focus on the

employer's responsibility to ensure the duty of care she focused on employee's

responsibility:

> *There are so many accidents you wouldn't believe it. Just the other month a*
>
> *woman fell out of the sling and hit her head, she died there on the spot, she had an*
>
> *instant haemorrhage. She was 90 odd too, she probably wouldn't have lived much*
>
> *longer anyway but there you go she died there and then. That poor lad who picked*
>
> *her up is now getting sued by the family and he will certainly never be able to work*
>
> *in care again. Remember that when you are moving or handling you are the line*
>
> *manager, if something happens it is you who will be sued... so guys, remember, that*
>
> *you are responsible for your actions. If you say you are a care assistant then you*
>
> *need to take all the responsibilities that come along with that...remember if it's not*
>
> *written down, as far as we're concerned it didn't happen*

Many of the principles in the moving and handling course were reiterated in other training

courses including nutrition, control of substances hazardous to health, safeguarding and

dignity in care. The discourse which highlighted individual responsibility was pervasive in

the job description too. For instance 'maintain professional knowledge and competence' is

clearly marked as one of the major responsibilities. The duties, responsibilities and roles

listed in the job description are diverse. Cleaning, performing care tasks, hosting family

members, following regulations, whistle blowing, implementing choice, protecting privacy

and being accountable to people higher up in the organisation are some of the many

responsibilities highlighted in the job description that is distributed prior to beginning the

first shift (see *appendix 3*).

On reading the job description it would appear that care work is a highly valued

occupation with a professional code of conduct, requiring continual training and a high

level of commitment. For Evetts (2003) the concept of 'professionalization' is driving

occupational change in many sectors. For her this professionalization can occur as a horizontal or vertical process from within professional categories or from above. Professionalism can be viewed as a value system which alludes how each profession is bound by normative system of values or principles which contribute to the general social order. Ideological professionalism, on the other hand, refers to the more top-down elements of professionalism whereby members are bound by powerful monopolies on knowledge and draw closed boundaries round them. While it would be difficult to describe care assistant work as a profession, there does seem to be a degree by which top down professionalization taking place. For example, all fulltime care assistants are expected to take NVQ in social care, unpaid and in their own time.

However, any professionalisation of care assistant of senior care assistant roles is currently limited. The small rises in pay which care workers obtain when moving up the career structure do not represent a typical professionalised ladder. Furthermore, once an employee has reached senior care assistant there exist few opportunities for further promotion and those that there are usually entail moving into care home management, a significantly different area of work. The 1998 white paper *Modernising Social Services* (DH 1998) recognised the lack of qualifications and training amongst social care staff. Since then there has been a drive to increase the numbers of workers with qualifications and national minimum standards have been imposed on care homes and the industry at large. The evidence that wages have increased as a result of this training is inconclusive. The evidence also suggests that many care workers are being paid less than the minimum wage and that care work overall still suffers from being a lowly paid occupational category (see Cangiano *et al* (2009) for a fuller account of the current status of pay levels amongst care assistants).

While policy decisions are brought into the care labour process from above, and these policies attempt to control and change the work done by care assistants, the low status of the employment continues to determine the nature of care work. Care work is a low discretion job defined by systems of control which give workers little opportunity to change the nature of the work that they do (Fox 1974). Management systems at Meadowvale were contradictory in the sense that they defined each care worker as individually responsible, yet controlled the work through a strict routine (as discussed in chapter four). While workers were constructed as autonomously accountable and empowered, they were simultaneously disempowered because the routine, the lack of staffing and the general organisation of the work meant they were unable to practice quality care. Despite the discourse of up-skilling, training and responsibility; discretion and control over the labour process remained firmly in the hands of the company.

At Meadowvale this left the worker in a rather odd position. On the one hand, they were imbued with increased responsibility and in some senses increased trust – for instance, I discussed in chapter four how management rarely engaged in direct supervision. Yet, inversely, there was always the feeling that the responsibility over the work was placed within the hands of the care workers but only in terms of the risks to delivering the service. Workers did not have true empowerment over the work.

This process of individualising responsibility over the work is exemplified by the story of Abeke. Abeke was a nurse at Meadowvale. She had come from Nigeria four years previously and had worked for various Moonlight Care homes around the UK. She had worked at Meadowvale for about two years. On one night shift Abeke was working when one of the residents, James, had fallen out of bed. James had severe dementia and died shortly after arriving at Meadowvale. His health problems meant he little had control over his bodily movements. He jerked violently all the time and was never at rest. Some weeks

after I started at Meadowvale Francis, another nurse, informed us during one of the morning handovers that James required a new bed. She said "James is jerking all night. That bed is not big enough for him; we need to get him a bigger bed and one which is padded". Francis went on to describe that she was worried. James had fallen out of his bed during her night shift but on this occasion he had been lucky and was unhurt.

Roughly a week later James did fall out of his bed and he injured his head. On any 12 hour (8pm-8am) night shift there was one nurse and two care assistants on duty. James had suffered a head injury and therefore needed to go to hospital. This meant that the home was forced to fill in an accident report and explain the incident. After this incident Abeke never came back to work. I was chatting with Lynn shortly after Abeke had been fired and I asked what had happened to her. Lynn said:

> *Well James had been found on the floor the other night, he had fallen out the bed,*
>
> *he had hurt his head, he's in hospital now. Apparently Abeke had found him on the*
>
> *floor but done nothing.*

I felt the injustice of it on Abeke's behalf. Despite the manager having been in the handover when Francis stated that James needed a different bed, nothing had happened. James had remained in the same bed until a serious injury had occurred.

In a chance meeting I actually bumped into Abeke after she had stopped working for Meadowvale. Her account of the events was significantly different to the version circulating round the home, such Lynn's, and, presumably, the one written into the accident report. Abeke described her resignation:

> *They were trying to stitch me up. They expect you to look after all those resident all*
>
> *night when in total there's only three of you. The care assistants are not able to do*
>
> *most the things the nurses do...They knew they should have either got him a new*

bed or made sure someone was in the room with him all night. They were trying to blame me and they were saying that I did not do anything, which is not true, I got a care assistant to sort him and I phoned for an ambulance...I had to resign, they told me that either I could leave or I would risk having my PIN[12] taken away. So I left, I am never working for them again [Moonlight Care]*, I'm going to get a job in London.*

Abeke had been forced to either leave her current position or risk having further action taken against her. It seemed that the manager at Meadowvale had taken advice from other managers in the area and the regional manager over this decision. In the days before Abeke had been fired there was a meeting at Meadowvale of all these managers. Jake had told me that they had been meeting to discuss this incident. It seems that by forcing Abeke to leave they were also able to claim that they had taken action in relation to James' accident. Rather than having the activities of the home questioned by any of the regulatory authorities the management were able to locate the incident with the malpractice of the worker. Jacoline, another nurse at Meadowvale, and a friend of Abeke's, claimed that the management submitted the accident report for the incident without allowing Abeke to comment on what had happened. It seems likely that the managers were attempting to obscure their culpability in James' accident. Evidently they were concerned about their failure to ensure that James had an appropriate bed and appropriate care during the evenings.

The company constantly engaged in practices and discursive constructions which shifted responsibility over the risks of care onto the workers and drew attention away from organisation issues such as staffing and environmental safety. In one training course on Health and Safety and Control of Substances Hazardous to Health, delivered by the regional

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[12] By PIN Abeke was referring to her Personal Registration Number given to her by the NMC. Without it she would be unable to work as a nurse in the UK.

manager, Mike, this philosophy was laid bare. Mike gave a lengthy story about a fire in an elderly care home where the care assistant deemed responsible had been given a £10'000 fine. The fire had started because towels had been stacked up until they touched a light bulb. During the course I questioned whether Mike had thought this situation was fair:

> *Me: But what happens if something in the workplace is just simply the done practice and not to do it is going to cause your colleagues to fall out with you?*
>
> *Mike: Well you just shouldn't do it, in this case the shelf was not supposed to be used.*
>
> *Me: But surely everyone had been using it? I mean surely the manager has got to take all the wrap in that sort of situation? Where else were they supposed to put the towels? Why was there even a shelf there?*
>
> *Mike: Well it was written in the policy that they were not supposed to do it, so therefore she had to take some of the blame.*

The presentation of this story, and many others like it, in training courses were employed by the company to generate a feeling amongst the workers that they were responsible for the risks of caring. Legally this was not necessarily true but Abeke's case shows this was more than discourse, and when things did go wrong the company were prepared take actions that located responsibility with workers for failures in care. When James fell out of the bed and injured his head the causes are easily located as linked to wider organisational factors such as short staffing and lack of equipment, not to the malpractice of any particular nurse. It could have just easily been Francis, rather than Abeke, that was blamed for this incident had it occurred on a different shift.

Conclusion

The responsibilities ascribed to the workers at Meadowvale were immense. Whether they were charged with implementing unrealistic policy goals or managing the risks of delivering care, Moonlight Care attempted to shift these responsibilities to each individual worker. This chapter (and previous chapters) has shown how structural and organisational factors are more significant in determining the nature of care than the policy discourses are. Abuse often emerged from the insufficient staffing just as the failure to implement personalisation did. I went on to suggest that the regulatory activities of the state represent an attempt to reduce its liability over the nature of care services. It passes the operating duties to local authorities, private and third sector operators and even onto individuals who require care (such as through individual budgets) (Humphrey 2003; Kemshell 2002).

One potential effect of the privatisation of elderly residential care services is the increasing burdening of risk lying with workers rather than more holistically with organisations. Other authors have suggested that contemporary welfare changes have resulted in the 'privatising' of risk to service users (Ferguson 2007; Scourfield 2007b) and non-state organisations (Hacker 2004). Thus far there is little recognition of how the care providing organisations redistribute this risk to individual workers. While some have suggested that the individualisation is a trend of contemporary employment in general, it seems that privatisation can lead to increasing risk burdening by workers. As I noted earlier, Moonlight Care have been forced to pay sums of money due to various instances of severe malpractice. Their share price has also suffered as a result. However, because profit margins are so low they attempt to resolve this through passing responsibility. This process is never complete partly because the legal system does not allow companies to completely absolve themselves of responsibility. However, Abeke's forced resignation

shows how they can be successful at 'passing the buck' in certain cases and protecting themselves from more rigorous inspection.

It seems that one of the contradictions of the contemporary governance is the process of passing accountability to non-governmental bodies, but simultaneously exercising a significant amount of effort in regulating and controlling these services. In essence, the regulation that has evolved around elderly residential care, and which can be linked more generally to the rise of the 'regulatory state' (Chapman, Miller and Skidmore 2003; Moran 2001), has failed to ensure quality care.

CHAPTER 7: Rights at Meadowvale

Up until this point the thesis has largely been concerned with the nature of care work and care receiving at Meadowvale. I have described the consequences of the poorly resourced system of care that prevailed at Meadowvale. This, I have argued, led to a certain form of cyclical and routinised labour process, which focused on physically orientated tasks, left little time for relational work and failed to implement many of the political images of 'good' care or resist 'bad' good. It should be evident to the reader that a range of inequalities were rooted to life in the care home.

This chapter develops the notion of rights in relation to elderly care work. Firstly, the rights of elderly people are explored through the concept of social death. I argue that entering residential care represents a denial of social life and leads to forms of institutionally enforced death. Social death is construed as a reaction to the appearance of another's mental state. I will argue that social death is a form of experience established through organisational factors relating to the specific health or social care context. Secondly, while residents were forced to live certain lifestyles and were denied even a bare minimum of care, workers suffered from a different set of exclusions and inequalities. Care remains inherently devalued form of employment, constructed as requiring intrinsic feminist abilities whilst also being dirty and requiring taboo forms of physical intimacy. Elderly care work has been fairly resilient to efforts to increase its status and rewards. The industry has become heavily reliant on migrant workers that are often constrained in their ability to act freely in the labour market, and as I will show, are coerced into care work through various processes which relate to the role of the UK state and international inequalities. This chapter argues that their day-to-day experiences of work are very much fashioned by these wider labour market conditions.

The rights of elderly residents at Meadowvale: Social death, institutionalisation and old age

The rights imbued to humans within the societies they live are both real and imagined. Rights are political constructs which denote the entitlements and obligations of citizens which can be written in law, existing in the political imagination or practiced in daily life. Rights embedded within daily life offer the most suitable sort for exploration in ethnographic research.

T.H. Marshall (2003) famously wrote *Citizenship and Social Class* in the UK in the same era as mass welfare construction occurred in the post war UK. Marshall's (2003) description of rights was both a theory but also came to represent a form of organising society which structured the policies and practices of many post war European governments (Lister 2003: 14). For Marshall there was an inherent tension within the capitalist social system. On the one hand, the economics of capitalism consistently led to large scale inequality across society, but on the other hand, the political system advocated for universalistic rights and formal equality. The role of citizenship rights was to ensure that there was a certain amount of constraint on the market which prevented widespread inequalities previously associated with capitalism. The welfare state operated to secure a base of level of wealth and economic security for all citizens regardless of each person's market performance. This mostly assisted the working class because they were the ones who historically bore the brunt of economic crises, downturns and general hardship.

Sociologists have developed theories of rights to have special implications for the elderly. Most famous in the British sociology was Peter Townsend. Townsend (1989, 2006) focused on the social structures which determined the experiences of the elderly in society. Through retirement, forced poverty, institutionalisation and the loss of participation in communities the elderly can be conceptualised as structurally dependent. Townsend

(2006) gives some examples which include fixed age for pensions, the low rates that pensions pay, the compulsory admission to care homes and the dependent forms of living which arise from institutional contexts in homes or hospitals. Social policies are strongly implicated in the creation of structured dependency of the elderly – negating ideas that the social problems of old age are simply about mental and physical corrosion and a failure of people to adjust to retirement and the transformations in social identity and role. In the later paper, Townsend (2006) highlights the use of human rights discourses to identify where structured dependency is taking place and also what kinds of abuses against the elderly might be considered as a loss or denial of human rights. These possible indicators include a range of things such as premature death, denial of privacy, denial of access to services and poverty.

Townsend's idea of structured dependency emphasises the economic dimensions of growing old as structured by policy. Similarly, Becker (1997) develops the notion of welfare as poverty in a more holistic sense arguing that welfare structures in themselves sustain poverty for many groups in society. Political commitment to wealth redistribution could, for Becker, eliminate poverty. Welfare policies sustain poverty through individualisation and a general politics which blames the poor for their condition, rather than focussing on the structural processes which lead to poverty (one of which *is* social policy). Cultural notions underpin policy decisions (Thane 2005; Turner 1989) which structure poverty but importantly it is the economic distribution which is still the crucial feature in shaping peoples experiences of welfare. So for instance, the increasing commoditisation of elderly residential care is bound with public opinions concerning which areas of the welfare state have candidacy for marketisation (Appadurai 1986; Kopytoff 1986).

However, of particular relevance to how rights are situational and dependent on everyday practices, is debates around institutionalisation which explore how rights are interrelated to residential care. Residential care facilities have diminished in terms of their importance in the overall welfare provision of the elderly. The community care bills led to an increase in people's care needs being met at home by domiciliary services yet there is also evidence to suggest that these services are often deficient in terms of securing quality care for the elderly (McKinley *et al* 2002) and are often defined by extreme exploitation when it comes to the workers (Stacey 2005). Contrary to Goffman's (1961) often cited description of total institutions there is some evidence that care homes can be successful in securing the rights and status of their residents (Kahan 1994; Kellaher 1998; Lopez 2006). Nevertheless, a number of other studies highlight the loss of status suffered by people in elderly residential care homes (Watson 2002). Elderly care homes now cater for people with high levels of care needs who are unable to be in the community, either because they do not have sufficient familial care support or their level of need is too high for other domiciliary services. Chronic debilitating illness and dementia are the most common forms of needs held by care home residents (Hancock *et al* 2006; Shah *et al* 2010).

The regulation of the care industry has attempted to implement a base level of service quality for all people receiving care in England. Whether, for instance, the GCSS (2002) codes of practice for social care workers are talking about respect for the individual's identity, privacy and dignity or the need to resist abuse, these governmental organisations are attempting to provide a base level of welfare rights in relation to care. Certain rights, more generally, are seen as universal and can be claimed by all citizens. The current system of elderly care, at its heart, has the ethos that while the state cannot be expected to pick up all the costs of elderly care, and those who can afford to pick these costs should do so, it will ensure that a basic level of care is acquired by all UK citizens. In the face of privatisation and the rationalisation of welfare expenditure there is inevitably

only limited resources which a welfare system has at hand. Nevertheless, a certain standard of elderly care rights remain in place as the provision of these services remains a source of the state's legitimacy (Pierson 1994, 1996). The transformation of the system of care in the UK from a state operated system to a mixed economy of care, where much of the delivery of services has been given over to non-state organisations (private and third sector), does not automatically entail a destruction of the welfare state.

In terms of the rights associated with institutional care it is not only the ability to obtain care that contextualises rights, it is the process of care itself which can be one of either enabling rights or a restriction of rights. The rights emerge from the process of care receiving not only the fact that the right to care exists. The notion of citizenship and the ability for actors to exercise their rights resides within the welfare institutions themselves. Residential care homes are one example of how people can either be enabled to exercise rights or constrained in their capabilities depending on the organisational context. The purpose of this following section is to argue that poverty remains critical to understanding the denial of basic human rights and the nature caring relations at Meadowvale.

The role of poverty in determining the experiences of elderly people residing within care homes is somewhat obscured by the status of these institutions as ones which respond to the needs of individuals. Care homes are thought of as institutions which protect and shelter individuals who vulnerable. They are not usually considered as organisations which sustain poverty and social exclusion even when they fail to deliver quality care. In this chapter I explore negligence of the care recipients through concept of rights and social death. The following arguments emphasise the situational aspects of rights (Benton 2006) as well as the importance of wider economic and cultural structures in forming the experiences of care (Becker 1987; Townsend 1989, 2006; Turner 1989). In

order to emphasise the tension between the biological ageing processes and the organisational determinants of care I will use the concept of social death.

The Concept of Social Death

The early developers of the concept of social death defined it as comprising of two main tenets (Glaser and Strauss 1966, 1968; Sudnow 1967). Firstly, social death relates to people who are treated as dead by others. This is mainly associated with diminishing opportunities for social interaction in general. Secondly, social death is also defined in terms of participation in the rest of social life by the sufferer of social death. In other words, social death represents a withdrawal from public life. Sweeting and Gilhooly (1997) illustrate three major groups within society who are commonly constructed and treated as socially dead. These include those suffering from lengthy fatal illness, very old people and those who have been subject to a loss of personhood. In the case of those with severe degenerative illness and the very old age social death resides partly in a general withdrawal from society and also from a process of expectant bereavement by friends and family occurring prior to the final biological death. The ability to recognise others is the main ability by which an individual suffers from a loss of personhood, such as when they are comatose. However, with patients suffering from dementia, the three attributes set out by Sweeting and Gilhooly collide:

> *Firstly, the lengthy but irreversible and relentless course of dementia might be assumed to encourage the resolution of emotional reactions in those around the sufferer. Secondly, dementia becomes increasingly likely with increasing age. Finally, people with dementia are frequently held up as examples of individuals for whom life may not be worthwhile anymore - it appears that by attaining a certain level of dementia an individual might cease to possess those characteristics which allow us to regard them as a person* (Sweeting and Gilhooly 1997: 98-99)

Davis (2004) explored the philosophical and sociological constructions of dementia. For him dementia is traditionally understood through the 'anatomo-clinical' gaze. The anatomo-clinical gaze rests on the idea that the human body has a normal state, any illness or medical condition is defined as any symptom that deviates from the normal healthy state-of-being. Any deviation is therefore understood as pathological and requiring medical attention and intervention. Alzheimer's disease and cognitive deterioration for the elderly is then often understood within this biomedical tradition. WHO (1993) have defined dementia as 'a syndrome due to disease of the brain'. Davis thinks that this construction of dementia as a disease entity is tenuous because it constructs the conditions as both normal (for the elderly) and pathological (in relation to the general population). The prevailing normative understanding of the healthy and ill state make medicalised understandings of old age difficult. Harding and Palfrey (1997) also explore the ways in which dementia has been constructed in biomedical discourses and argue that its medicalisation is a reflection of deep seated anxieties regarding the irreversible nature of death. Vittoria (1999) argues that the language surrounding Alzhiemer's emerges from wider ageisms.

The current literature on social death and dementia tends to see an automatic correlation between certain cognitive and mental states and social death. For instance, those who suffer dementia are conceptualised as socially dead due to a collusion of various forms stigma and an erosion of self awareness and communication skills (Sweeting and Gilhooly 1997). However, this tends to lose sight of the social and cultural context of social death. Social death is inherently, at minimum, a two way process. For instance, social death is not *purely* located within the person experiencing it. Social death is socially experienced therefore it is a response by others to the condition of one. For instance, if a relative or friend sits and talks to someone in a comatose state it could be argued there is a process of reinstating social life. Therefore in institutional care it is important to emphasise

how routines, practices and the general organisational context leads to forms of social death. Social death does not inevitably follow from the state of dementia suffered by the residents, it is also born in the limitations of the organisation to provide the kind of care which would limit social death and enable social life.

Froggatt (2001) in her study of life and death in English care homes found that residents were on a continuum of 'transitional states'. As Froggatt describes:

The relationship between life and death in nursing homes is problematic. An institution provides a well-bounded space to contain evidence of ageing and dying amongst older people, thereby sequestering them from wider society. Within the institution, however, the boundary is less clear. Living and dying occur in the same space, and staff members are required to care for residents, whatever their position on this continuum (2001: 331).

In the home examined by Froggatt the health conditions underpinned the spatial organisation of different residents. Those with less bounded bodies, suffering from severe incontinence or vomiting, remained in the more private areas of the home while others spent much of their days in the public lounge areas. Froggatt says that separating residents differed within a day and between days, and this depended on 'resident's condition and choices, and the different perceptions held by the staff of the, primarily physical, state of residents' (2003: 327-328). So in Froggatt's study certain residents were defined as 'poorly' for shorter periods and would then remain in bed, other's would be defined as dying and similarly placed in the more private parts of the home. Froggatt's work mirrors many of the practices at Meadowvale however her work fails to capture the work pressures which underpin many of the decisions that often account for residents being treated as socially dead. While the staff's behaviour to certain residents treated them as socially dead, these responses to the conditions of a resident (such as their unbounded body, their state of

confusion or their poor communication skills) are decisions about the intensity of care that can be provided to each resident across the organisation. At Meadowvale, the denial of care acts was often based on each individual's apparent cognitive awareness but *in relation* to the limited resources within the care home. As I will show in the following section the denial of basic care rights at Meadowvale was linked to social death, but social death was a process that emerged from the care context.

Social Death and Economic Exclusion at Meadowvale Care home

Life at Meadowvale for many of the residents was a continued a history of economic exclusion. The location of the home was in a poor inner city area. Most of those who had worked during their lives had been employed in lowly paid manufacturing jobs. The residents themselves were from a marginalised section of society regardless of their disabled state. Few of the residents paid any of the fees themselves, and the vast majority were reliant on the local council to pay for their care. Those that did pay were usually only resident for short periods to give their principle carers a break. The home also consistently had empty beds reflecting the relevantly undesirable status of the home in the local market.

In 2009 the rates at Meadowvale were between £370 and £540 a week which was even below the Moonlight Care's average charge of £550. The low fees paid to the home were reflected in the luxuries which residents had access to. Alcohol was rarely permitted, the food was some of the cheapest available and entertainment was minimal. Some of the female residents were unable to afford hair cuts as often as they would have liked. However, the residents were relatively uncomplaining about the few 'extras' in their lives and some residents even thought life at Meadowvale had its benefits although only the cognitively aware residents were able to communicate this. However, it was not only the lack of access to small treats that the residents suffered it was also basic care rights that

were frequently denied. By this I mean rights such as the right to eat a full dinner; the right to clean sheets, clothes and body; and the right to proper healthcare.

At Meadowvale the residents were categorised in similar ways as described by Froggatt (2003). The staff referred to certain residents as "not here" or "already gone" suggesting that they conceptualised some residents as effectively dead in some respects even though the final biological event had not occurred. One resident, Beatrice, exemplified the tenuous and ambiguous nature of social death as an inherently communicative experience mediated both by embodied and cognitive impairment, on the hand, *but also* organisational factors, on the other.

Beatrice, a migrant from India, had been in the home for some years. While I worked at Meadowvale she had consistently high care needs and was in an enduring state of confusion. She was completely dependent on the care assistants for everything, including complete feeding, dressing, washing and the changing of incontinence pads, similar to Olive and Mary that I discussed in chapter five. She remained in bed almost 24 hours a day, 7 days a week although occasionally she would be placed in her specially designed armchair on wheels and moved to the lounge. This occurred very infrequently. While Beatrice did not resist when care tasks were carried out on her, she did not comply either. She never responded to questions or comments made by care staff yet she did sometimes sing and make seemingly random comments, usually religious in nature. Yet there was no way of knowing for sure if she had any comprehension of what was being said to her, but she seemed to having her hand held by one of the care assistants. Many of the care staff believed that Beatrice knew "more than what she lets on". Occasionally musical entertainment was supplied by volunteers in the lounge and she would sometimes be taken down for it. She seemed to enjoy music and sometimes she even hummed or sang

along. One day I discussed Beatrice's condition with one of the senior care assistants, Leanne:

> *Me: What do you think about Beatrice, I mean how come we leave her in bed all the time? She never seems to be a problem when she comes down stairs* (to the lounge) *and I think she enjoys it when some of the entertainment comes in.*
>
> *Leanne: I know what you mean, I had never really thought about it. Her daughter has apparently complained before about us just leaving her in her room all the time. If it weren't for me I doubt anybody would even give her a bath.*

On one shift her daughter had phoned in the morning and informed the nurse that she was going to be on a TV documentary that afternoon. The nurse had passed the information on to me, notifying me of the time and TV channel and asked if I could ensure that Beatrice was down from her room so that she could watch the programme. To take her down to the TV lounge would take two people 15 minutes. The care assistants would need to check if she was soiled (and change her incontinence pad if she was), hoist her into her chair and wheel her downstairs. It was already ten past four. I only just remembered and I said to the senior care assistant, Viv, "oh, we had better get Beatrice down so that she can see this programme". Viv replied "we don't have time, if we take her down we'll be behind in serving dinner, we just can't do it...anyway she won't know what's going on".

Beatrice is just one example, but many of the residents had their lives decided for them by the care assistants on the basis that they could not complain or request something different. However, often it was inexplicable why some residents were taken down to lounge area everyday while others were left in their bed. Mary, discussed at length in chapter five, was a resident who appeared to be a constant state of distress and disorientation yet every day she was placed in her specially adapted armchair on wheels

and placed in the lounge. There were another four or five residents similar to Mary who were all got out of bed and moved to the lounge area in the morning. Some of them then went back to bed at lunch time while others remained in bed until the evening meal. Two residents, Dianne and Glenda, were put to bed after lunch and then often got up again for the evening meal. To my knowledge none of the residents had requested to be subject to this routine. Other residents, such as Olive and Beatrice, were virtually never moved to the public areas of the care home. On one occasion I had a conversation with the activities coordinator, Chrissie, who had worked at the home for many years regarding the seemingly illogical routine that we followed. I wandered why some residents went to bed in the afternoon, and why some residents were never got out of bed, and when I asked Chrissie she said:

> *Sometimes the family will demand that, you know, a resident has got to sit in the lounge all the time, and then it will be what we do. But then you know there is only so much we can do so some people are left in bed.*

For Beatrice, even her daughter's complaints and requests were not even enough to ensure that she was taken to the lounge more often. The staff faced an incredibly high workload which was essentially unachievable. Care workers continually needed to prioritise their work. So when faced with decisions (on an day-by-day, hour-by-hour and even minute-by-minute basis) regarding which residents should receive care it was notions of social death and personhood which often underpinned the decision to do particular caring tasks and leave others undone. Whether to feed Chloe and leave Olive sitting in a soiled incontinence pad for longer, whether to take Freddie out for a cigarette or take Shelley to the toilet are examples of the prioritising that was constantly done. Inevitably those who could request assistance, quarrel with the care workers or make complaints to the management and nurses, were those most likely to receive attention. Accordingly

when staffing was particularly low, or there was an incident and the routine was threatened, it was those who whose personhood had eroded the most who lost out first.

In the previous chapter I have shown how care assistants might be understood as 'street-level bureaucrats' (Lipsky 1980) transforming and interpreting top down policy discourses in relation to the constraints of their work. The same is true in relation to social death. Despite the supposed universality of rights and care rights, the staff engaged in a type of categorisation of residents. This was founded largely on the residents' ability to communicate. The level to which the needs and desires of residents were met was a process of negotiation where the ability of the residents to make demands and the resources at hand during a shift resulted in different day-to-day routines for each resident. Some residents were always assisted to the lounge, others were virtually never assisted to the lounge, and some residents were only assisted to the lounge sometimes or for certain periods of the day. There was constant negotiation between the number of staff on duty and the workload completed. If there were extra staff then residents who usually remained in their room were often assisted to the lounge, and if there was less than the usual number of workers, which was more common, then residents often taken to the lounge would be left in their room.

While Froggatt (2001) and Sweeting and Gilhooly (1997) point towards cultural processes as defining the experiences of social death, I argue that these overly cultural approaches fail to recognise organisational and economic factors. There is a cultural basis to social death in which individuals make judgements regarding the intensity of existence that others have in the world due to their cognitive and physical disability or ability. This was clearly related to the behaviour of residents and in particular their ability to communicate with care assistants and other workers. Nevertheless, the organisational restrictions in staffing led to a series of denials of care rights and ultimately increased the

instances where people were treated as dead. If the workload was a bucket then it was always full. It was possible to replace certain tasks or commitments with others but ultimately the needs of the residents were too numerous for all them to be responded to. If a guardian complained that their Mother or Father was not getting the appropriate care then routines would change but a different resident would miss out. The stretched resources meant that only a certain amount of work could ever be completed and some residents would always have certain care needs left unmet.

Those arguments put forward by the likes of Townsend (1989, 2006) and Becker (1987) describing the role of social policies in configuring the poverty and dependency of elderly people continue to carry significant weight. Inevitably it is cultural ideals which underpin the economic exclusion of elderly people (Turner 1989), but an overly cultural account which describes social death as an inevitable response to biological or mental capacities of individuals would be improper. Put differently, it is the lack of resources which society is willing to commit to elderly care systems which leads a loss of rights, even basic ones, for elderly care residents. In this way social death can be viewed as a form of economic exclusion, not simply an inevitable reaction by an individual to another's mental capacity.

The Rights of Workers at Meadowvale: Labour Markets, Immigration and the Experience of Care Work

Whilst the denial of basic care rights to residents was inseparable from the issues of funding, work routines and staffing levels, the workers themselves suffered from a different form of social exclusion relating to labour markets and immigration. The following section argues that the actual employment experiences of the workers are clearly produced by immigration policies and the rights to welfare. The reliance on migrant

workers in the elderly social care sector is widely recognised (Cangiano REF; McGregor REF; Moriarty REF). Moriarty (2010) has suggested that the rise in migrant workers in the social care sector is related to the rise in demand for social care. This is related to a number of processes including demographic changes, policy transformations, increased state regulation of social care and increasing public demand for social care services. It is suggested by Moriarty (2010) that this increased demand is coupled with constraining funding arrangements. The widespread reliance on migrant labour is implicated as an effect of the demand for social care but expressly a demand for cheap social care. However, particularly important for understanding migrant labour in social care is the function of the state as an authority which permits and restricts migration but also effectively directs labour into certain sectors of the labour market.

Anderson (2010) and Anderson and Ruhs (2010) have indicated a system of 'managed migration' which shapes the kinds of labour which are enabled to enter the UK and directs them into sectors with labour shortages. However, it is important emphasise the structural element in the economic system at large. It is not a simple fact that migrant labour fulfils demands for labour shortages, the existence of migrant labour can actually open lead to new services and new production processes. Anderson *et al* (2006) argued that Eastern European workers were undertaking forms of employment in the UK which other workers were unwilling to do. Labour processes which demand live-in labour for example, such as certain forms of farm labour like fruit picking, are unlikely to attract British workers. The effects of migration are therefore not easily viewed as simply demand and supply. Some business ventures have only become possible because of the presence of immigrant workers. Other industries have been able to reconfigure the conditions and terms of employment because new pools of labour are available. The effect of immigration on the economy can in fact enable certain forms of accumulation otherwise not possible, and structurally determines modes of accumulation within particular sectors.

However, it is important to point out that there may be a cyclical relationship between the demand for cheap social care, exploitative work arrangements and the organisation of labour processes. Anderson *et al* (2006) found that many of the UK employers that employed low wage Eastern European workers did so because the jobs were ones which required the workers to live near the place of work; the work was hazardous; the work was physically demanding; it was low wage; or the job necessitated long or variable working hours. This links forms of accumulation with specific forms of labour (especially informal and/or flexible labour). Cangiano *et al* (2009) have found that in the care workforce migrants had a whole range of immigration statuses. They also found that employers preferred to employ migrants because they were perceived to be more likely to work unsocial hours, learn new skills and have a strong work ethic. However, they also concluded that migrants may appear to employers to be more motivated and committed to their work but this compliance to long hours, low pay or challenging employment circumstances may actually result from their lack of alternative employment options. For instance, Anderson (2010) highlights three ways in which immigration controls produce the status of migrants in the UK labour market. The formation and maintenance of categories restricts migrants to certain sectors or prevents them from taking employment legally. The state also influences of employment conditions through regulation such as health and safety and minimum wages. Finally the state is involved in the 'institutionalisation of uncertainty' such as limiting an individual's stay within the country. All these policies create a series of vulnerabilities for migrant workers which also give preference to UK nationals.

The close relationship between the state and the actual experience of work for migrants brings the discussion back to issues of citizenship. Maher (2000) describes how, despite the intended universalism and postnationalism of the human rights project, rights are consistently consigned to migrants on the basis of their legal status arising from their

nationality (see also Faist (1995)). Not only are migrant workers subject to strict conditions determining where they can take employment, they also have limited access to welfare rights.

The wider political and economic structural context of immigration in the UK tells us much about the high levels of migrant labour in the elderly social care sector. Discussed throughout this thesis is the policy context of privatisation which continues to keep care funding at a low level. The economic and social conditions which prerequisite the high levels of immigrant labour are directly related with welfare state funding. The current UK system ascribes the status of migrants into categories based on skills and nationality. The rest of this chapter is interested in how the poor working conditions and entitlements that Meadowvale's workers were subject to were related to various structural factors such as immigration policy and international inequalities.

Migrant Labour at Meadowvale

At the time the ethnography took place the immigration system was under review and was moving towards the 'points based system'. This had not been implemented at that time and the system under which migrants at Meadowvale were entering the UK was through a number of 'doors'. In the years leading up to 2009 there had been a period of relaxed immigration policy, at least when compared to previous periods (Flynn 2005). These gateways laid out in policy were complex and discriminated on perceived skills, nationality and the ability to claim asylum or refugee status. There were over eighty separate ways of entering the UK depending on nationality and occupation, each with specific entitlements and constraints attached (Flynn 2005).

Meyers (2000) separates immigration policy within receiving countries into two separate distinct fields. In the first instance, immigration policies relate to the different kinds of regulations and controls that determine the immigration itself, put differently, who

is able to enter and for how long. The second area relates to policies that contextualise the experience of migrants once they have entered a receiving nation, what they are entitled to in terms of benefits such as health care, education and whether they are entitled to seek employment. This area of policy is concerned with linking certain immigration and citizenship statuses to a range of entitlements. Mainly the UK system divided migrants from those that came from within the European Community (EU) and those that came from outside. In practice it was more complex because different immigration policies were applicable to individual nationalities although generally the policies orientated around whether an individual had emigrated from a developing or a developed country. Many migrants coming from developed countries outside of the EU had less stringent controls placed over their entry (such as those from Australia, New Zealand, Norway or the USA). Those coming from the EU were essentially free to enter but those coming from the A8 countries such as Poland, Slovakia or Estonia could sign on for the worker registration scheme (WRS). The WRS asked for a fee to be paid by the workers but if they did claiming entitlements from the state such as unemployment benefit and health care was easier. At the time of data collection joining the WRS was not mandatory but the scheme has since been closed.

For those entering from outside of the EU, such as Africa, Asia, non-EU Eastern European countries and Asia, their movement was much more highly constrained. For migration that is not linked to refugee or asylum status there was a number of separate gateways for entry to the UK for work. This included sponsorship from an employer resulting in the migrant being tied to that specific company; entry without sponsorship but where a specific sector is identified consequentially fastening migrant workers to particular industries; and finally through attending higher education which meant that non-EU

migrants entering fulltime education were able to work for 20 hours a week (UK Border Agency 2009[13]).

There are some special concerns which relate to care work and nursing within the UK's immigration policy. For a start the NMC (2007) has implemented a system of registration whereby nurses entering from certain countries are required to go through training prior to taking full nursing roles. Not all nurses need to go through the 'PIN registration' process as many countries nursing qualifications are recognised by the NMC (such as most EU countries, most developed countries and some extra ones including South Africa). The NMC has evolved its own system to regulate the migration of nurses and developed individual relationships with a host of other nursing authorities across the world. On entering the UK, nurses whose qualifications are not recognised by the NMC must work a period in a training role where they effectively work as a senior care assistant (normally with senior care assistant wages) but are required to gain some extra training and prove a certain amount of experience. Once they have completed a period of on-the-job paid training they would then be able take a full nursing role.

However, this is not automatic and if the appropriate training has not been acquired then promotion is not enabled. The NMC decrees that registering as a nurse requires '20 days protected learning time (which everyone must undertake) plus, where appropriate, a period of supervised practice' (2007: 15). The process therefore required to gain registration varies for each individual based on their experience and the reputation of the various countries training schemes. Nurses educated in countries considered to have poor training systems may end up working for years in care assistant roles without obtaining a nursing position. Certain nurses trained abroad will never manage to have their qualifications recognised in the UK. There is also evidence that many care providers have

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[13] The source of these immigration rules was http://www.ukba.homeoffice.gov.uk accessed in July 2009. The policy around immigration has since changed.

discrete reasons for recruiting relatively highly trained foreign nurses but keeping them in the more lowly paid care assistant positions (McGregor REF; Oxfam REF). Employers essentially gain overqualified labour that is effectively tied into the contract because the employee relies on receiving the training to realise longer term career success.

The complex rules and regulations surrounding nurse migration as well as the demand for this sort of labour has led to a proliferation of employment agencies who often actively recruit for positions in the UK abroad (Kingma REF). Agencies operate as a middleman connecting up the individual seeking to go abroad with the employer. The agencies also help both parties mediate the various paperwork requirements of the Home Office and the NMC. There have also been numerous concerns about unscrupulous agencies with inflated rates, advertising roles which are

As the following discussion reveals, the distinct policy gateways which allow migrants to enter the UK also determines the sorts of claims they are able to make from the state. The following section will argue that through these immigration controls many of the migrant workers find themselves in a position of increased exploitation. Being tied to the sector, or tied effectively tied to the company, results in increased power by the employer over the workers. Also, international inequality and migration sets a context in which migrants are forced to remittance wages to their home countries. This rests on the inability of their family which many leave in developing countries to claim many of the welfare rights which are considered normal in the UK, including the rights to education and health care.

To set the scene for the next section, however, it is worth highlighting the numbers of migrants present at the company and at Meadowvale home. In the 2008-9 annual report, Moonlight Care declared that 9% of their workforce were 'from outside the EU' and they recognised that issues of incorporating migrant workers into the businesses practices

were sometimes problematic, highlighting language and deficient skill sets in particular.

This statistic suggests that Moonlight Care is highly dependent on workers entering the UK

from abroad although this does not indicate specifically what types of legal status these

workers have. Moonlight Care provides no information about how they arrived at this

statistic and whether they count on workers who have arrived in the UK some years

previously and now have UK citizenship or the right to remain. This data does not seem to

be derived from any survey, and it seems likely that their records will only show employees

who Moonlight Care have formally mediated with Home Office about. More general data

shows that migrants are heavily employed in the elderly care sector (Moriarty 2008, 2010),

Also, in residential care, private sector providers have shown to employ higher rates of

migrant workers (Cangiano *et al* 2009).

Despite the fact that Moonlight Care does not seem offer formal definition of what

a migrant, overseas or foreign worker actually is for the purposes of analysing the

experiences of the workers at Meadowvale on is required. The term 'migrant' is recognised

as awkward because it fails to recognise differences in length of stay and citizenship status

(Anderson 2010). I will use the term to refer to anybody who has moved to the UK

regardless of when or their citizenship status although I recognise that this usage is

problematic. Nevertheless, I contend that the term 'migrant worker' used to refer to

specific individuals at Meadowvale provides insights into distinctive constraints

experienced by this definition of a group of people. The 9% of 'overseas' workers reported

by Moonlight Care probably underestimates massively the company's reliance on migrant

workers, if they were to use my definition.

Most of the migrants I met during my time at Meadowvale had moved within five

years. Due to the high turnover rates at Meadowvale it is difficult provide exact numbers

of migrant workers at Meadowvale but at any time there was roughly between 20-30. This

was a sizeable proportion of the 26-42 workers that the home employed. It seems that Meadowvale, when compared to Moonlight Care overall, did employ a greater number of migrant workers. This is perhaps related to Meadowvale's location in an inner city area with a large immigrant population. It might also be connected to Meadowvale's high staff turnover which required management to consistently replace workers. The permanent workers who were migrants came from a range of countries including South Africa, Zimbabwe, Poland, India, Pakistan, Ukraine, Ghana, Nigeria, Kenya, Mali and the Philippines. The three most prevalent countries where permanent employees came from were Poland, Nigeria and Ghana. The migrant workers at Meadowvale predominantly worked in senior care assistant and care assistant roles with a smaller number taking permanent nursing positions.   However, as discussed before, the home was heavily reliant on agency workers for nursing staff and these workers were predominantly migrants from various southern and sub-Saharan African countries.

A number of the care assistants and senior care assistants at Meadowvale were qualified nurses in their home country. This was especially true for the African workers and those coming from the Philippines. The non-EU qualified nurses with roles as senior care assistants at Meadowvale were usually working a 'period of supervised practice' (as dictated by the NMC) before being enabled to move into a nursing role. A small number of these workers had been recruited abroad and were tied to Moonlight Care, as will be revealed in the following discussion. However, there was a range of formal immigration statuses across the migrant workers including those whose partners were in fulltime education and some who had recently finished higher education courses and were enabled to work for a period after. Polish workers were coming from within the EU so they had no need to go through any formal immigration procedure, although this does not mean that informal constraints did not affect their labour market mobility.

There was evidence of undocumented migrants working both at Meadowvale and across the company. Only one worker during my time at Meadowvale reported that she was working illegally. Her asylum status did not allow her to take any form of paid employment but she hinted that there were others. It is possible that others were doing the same but they had not informed me[14]. One of the managers, Shona, also told me that she received an email reminding all homes to thoroughly check the immigration status of new employees suggesting that undocumented immigration was a problem or at least a concern.

i. EU migrants

All the migrants that came from within the EU that worked at Meadowvale were Polish. The two that worked consistently in Meadowvale (rather than Meadowvalley) and remained in employment for the whole duration that I worked at Meadowvale were Olenka and Gita. In this section I will focus on their stories because it was them that I got to know sufficiently enough to build a detailed picture of their lives, their motivations and experiences[15].

Both Olenka and Gita had emigrated from Poland to work in the UK. During my time at Meadowvale they were both aged 23. Gita had been in the UK for around four years and Olenka five. In one conversation, Gita described the reasons for why she had come to the UK and how she had found work at Meadowvale. Olenka and Gita had gone

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[14] While I was at Meadowvale I did often speak to my colleagues about their experiences of migration but I did not usually ask direct questions about immigration status. I felt that this issue was too sensitive to be broached. People often volunteered their own stories of migration but it is likely that is some of my colleagues were undocumented migrants they might not have admitted it to me.

[15] The stories of the different workers in this chapter are selected for arbitrary reasons. Inevitably, while I worked at Meadowvale I formed better relationships with certain people than others, and therefore received greater details concerning their lives. Some of the stories are presented simply because I managed to have chance conversations with particular individuals on certain shifts. However, the high turnover rate and the use of agency workers meant that often I worked with people for short periods of time and barely got chance to speak to them. Also, because I generally worked through the week, doing day shifts, I rarely got the chance to converse with those that primarily worked weekends and nightshifts.

right through primary and secondary school together and they were both close friends. Olenka had moved to the UK slightly before Gita and had found work in a coffee shop in London. Olenka had prompted Gita's move to the UK because her manager at the coffee shop was looking for an au pair. Gita decided to take this job as a live out au pair. However, this had quickly gone sour. The wages were already low, at only a £100 a week, but after a few months of working her employer steadily dropped the pay. First to £90 and then by the time she left she was only receiving £60 a week. She said at that point her English was very poor and she felt in a weak bargaining position to argue with her employer. In addition, and she also blamed this on her poor English skills, the two boys she looked after "did whatever they wanted". She reflected on the job as extremely difficult and stressful. Olenka also felt that the wages she received working in the coffee shop were insufficient to live in London. At the time Olenka's cousin, Tom, was working at Meadowvale as a care assistant. He found both Olenka and Gita jobs as care assistants in the home and both took the opportunity and moved away from London to start at Meadowvale. Tom had already moved on to a different Moonlight Care home in the area when I started in the home, but both Olenka and Gita remained at Meadowvale.

Despite Olenka and Gita explicitly stating that they were happy to have left Poland for England, and glad that they had moved on from London, both felt that care work was not for them. As Olenka explained, she had attended college in Poland studying history and various foreign languages. She described herself has having a "love of languages" and hankered to find work in this area. Olenka and Gita complained at the long hours and low pay at Meadowvale – both often worked shift patterns of 10 days in a row. One day Olenka complained to me about how tired she was; she was on her ninth shift with no day off. I was shocked and she explained why she felt she needed to take on this heavy workload:

But the thing is I'm only earning so little after tax so I've got to work like this. I mean I want to go on holiday twice this year, I want to go to Poland and I really want to go to France as well, so basically I've got to work constantly to get enough money... and after I take tax into consideration I'm only on something like £4.60 an hour.

She also complained about the training she was forced to engage in. While she said she was trying to obtain her NVQ in Health and Social Care to obtain a pay increase and to have more chance of promotion, she said it took a long time because she was trying to fit this in around the long hours she was working. However, when I spoke to Olenka during one shift which had been particularly hard going, and she had complained at length about the job, I asked why she did not work in a coffee shop like previously. She replied that, in spite of her dislike of care work, especially the dirty aspects, she still found it less stressful than working in the coffee shop in London. She said it offered longer hours and that you "can find the odd moment to sit down".

Olenka did not send any of her wages back to family in Poland: her mum and dad were only 40 and her dad had good employment. She described herself as "lucky" because her parents needed no financial assistance from her. All her wages she kept for herself. She expressed a strong desire to leave care work and said that social work offered good wages and also thought that she might like to go into management for Moonlight Care. In fact, near the end of my period working at Meadowvale Olenka did find new employment in a different Moonlight Care home as a secretarial and pay roll worker. She was happy with this new role as she said the money was better, the hours were better and it was an opportunity for future promotion.

Olenka and Gita's intertwining story of moving to the UK and then to the Midlands and finding work in care was one defined by a lack of opportunities. Both said that they

were happy to have moved to the UK because it had offered new opportunities, to see new places and to develop language skills. But neither wanted to remain in care work. Both complained of the low pay and tough conditions. Indeed, both commented on separate occasions that this job was one that British people were unwilling to do. While Olenka and Gita's immigration status did not restrict them to any occupation or sector, both still experienced significant barriers in finding better work. They perceived language and a lack of qualifications as crucial barriers to achieving success in the UK labour market. They both felt coerced into care work because they unable to find better alternative employment. They did perceive care work to have certain benefits but these benefits can only be construed alongside their greater inability to find better paying work however. Gita in particular had experienced very difficult working conditions when she arrived in the UK so while care work was a step forward for her it remained tough. Olenka stated that she wanted longer hours in order earn enough money, but it was plainly apparent that working these long hours took its toll on her. Olenka and Gita often complained about the difficult conditions at Meadowvale.

ii. Non-EU migrants

The life stories and career trajectories of non-EU migrants, as opposed to EU migrants such as Olenka and Gita, were generally defined by the formal constraints imposed by immigration controls. Bayani had moved to the UK from the Philippines about year prior to my employment at Meadowvale. Bayani was an engineer trained at a university in Manila and had worked in engineering in the Philippines. He was unable to get the appropriate visa to work in engineering in the UK. He had tried contacting many companies to see if they would sponsor him for a new visa allowing him to work in the area of mechanical engineering but he said none were prepared to do it. He said that the companies he had approached always said that they were unwilling to deal with the Home Office.

I think it is fair to say that Bayani had little vocation for care work. He often acted inappropriately with residents. On a number of occasions he would take residents to the toilet and leave the door open so that they were exposed to the whole lounge area. Generally, he struggled to develop a rapport and the correct manner with the residents and would quickly become forceful when attempting to complete care tasks. This meant that the manager would often have Bayani doing other types of work. On one occasion he had been washing dishes for most the day. I saw him later on and I asked how his day was going and he replied: 'It's all right I am washing dishes I suppose I can do that (shrugs), you know I am a trained mechanic...but this is my life now though'. Bayani had a son who was 26 living in Singapore also studying engineering. Bayani explained that he had no choice but to carry on working in the care home and stay in the UK in order to support his son in Singapore. He was also sending money back to the Philippines. Bayani's complete and utter lack of desire to do care work did not stop him from working six shifts a week when it was available.

Other non-EU migrants had also taken a serious knock to their employment status during the migration process. Tala was 29 years old and from the Philippines. She was a trained nurse and had completed her qualification in Manila. She had moved to the UK about three years prior to when I met her. Before coming to the UK, however, she was employed in an elderly nursing home in Singapore. Neither in Singapore or in the UK had Tala been able to get her nursing qualification recognised. In Singapore she had also done nursing support work. I asked why she had moved to the UK and she said Moonlight Care had been recruiting in Singapore for positions in England. The move to the UK had been sold partly on the opportunity of the company paying for the PIN registration. As I have already stated, some nurses must work as a care assistant for a period of time ranging from a few months to a few years in order to obtain a nursing position (NMC 2007). Tala, unfortunately, needed to do more training in a university to acquire a PIN, and this entailed

working part time for a year and roughly £3000 in fees. Tala was frustrated at her current

position because she felt she could not afford the time or the money to obtain the PIN and

was stuck doing care assistant work, which she felt was below her qualifications and poorly

paid. Indeed, when she had been recruited by Moonlight Care in Singapore, they had

informed the prospective workers that they often paid for care assistants to become

nurses. Tala described how she was incredibly disappointed with what had happened to

her.

It is not certain how prevalent these kinds of recruitment practices are in the

elderly care industry. There is a growing body of evidence that forms of coercive

recruitment which might even be described as trafficking are widespread within elderly

residential care sector (Cangiano *et al* 2009; Oxfam 2009). Nobody else at Meadowvale

told me a story as severe as Tala's although there were rumours that some of the workers

at Meadowvalley were in similar situations. Some might consider it too extreme to term

Tala's situation as a form of trafficking. Certain media and political discourses construct

'trafficking' as a hard and fast concept – an individual has, within a conventional

understandings of trafficking, either been forced into migration through threats, violence

and deception or they have freely chosen to migrate. In reality, migrants experience a

range of constraints and opportunities during the migration process which vary in their

degree (Anderson and O'Connell Davidson 2002; O'Connell Davidson 2006, 2010).

Simultaneously, typical explanations locate the causes of trafficking as specific acts

committed by "evil" individuals. In reality, the policy context of the receiving countries has

an important role in determining the extent and nature of trafficking in a given territory.

Furthermore, Tala's story indicates the often hidden processes by which trafficking can

operate. O'Connell Davidson (2010) argues that when trafficking is viewed as 'modern

slavery' certain liberal political ideals are upheld which dichotomise and simplify the

experiences into either 'free' or not. The effect of this is that many groups of migrants (and

non-migrants) who are subject to structured forms of unfreedom, such as being denied access to better paying forms of work, are categorised as free subjects justifying their exploitation. Many of the prevailing discourses on trafficking would exclude Tala's experience of migration as a form of trafficking. However, Tala's situation was obviously one of constraint, coercion and even serious deception. Empty promises had been used in order to gain her qualified labour at poorer rate of pay.

However, while immigration status obviously restricts, constrains and compels individual's into particular segments of the labour market, I want to also argue that policy is crucial also for structuring the employment experience. The pressure to work long hours also relates to a different aspect of immigration policy and the rights it fails to provide to care workers. Rosin's story exemplifies how it is welfare rights, not only labour market immobility which obliges workers to work much loner hours. Rosin was a migrant who had come to the UK from Kenya eight years prior to my working with her. She had originally moved to London and she had managed to find work as a manager. She described this previous job as well paying. However not long after she moved from London to the Midlands and took a job in care work for Moonlight Care. Her reasons for this were that she liked "working with people". Leaving her original employment at the warehouse had entailed a pay cut of £1 an hour. The care job that she had originally taken had been in a different Midlands town and she talked about this previous employment very positively. Although it had been for Moonlight Care she had been working with adults with learning disabilities, rather than elderly residents. The staffing levels had been much better, time had been built into the shift to sit and talk to the residents and regular trips out the home with the residents, including holidays, had all been part of Rosin's previous job.

She moved to Meadowvale after I had been working there for about three months. Moonlight Care had transferred Rosin, on her request, to Meadowvale because she wanted

to move cities to help care for her aunt. Her aunt lived in the local area and was ill with cancer. Rosin looked after her aunt every second night in turn with her cousin who also lived in the local area. However, Rosin's familial obligations outstretched those living in the UK and she sent a large proportion of her salary to Kenya. Rosin's sister had been killed in an industrial accident in Nairobi many years ago, so Rosin was supporting her deceased sister's daughter as well as her own son who had remained in Kenya. Recently her mother had also been involved in a car accident and so Rosin was paying for her health care as well. This forced Rosin into a situation where she needed to work between five and six 12 hour shifts a week to earn sufficient money to support her family in Kenya and herself. Just after I left employment at the home Rosin informed that she had fainted during a shift due, she said this had happened because she was "tired and stressed". Despite the obvious pressures coercing Rosin into care work, and to work such long hours, Rosin maintained that she would not want to work outside of the care sector. She could have found alternative work and her visa did not restrict from finding alternative work, but she felt she had a deep vocation for care work. She did, however, often complain at having to work such long hours. Due to the low pay and the burden of financially supporting her family in Kenya she had to live between her aunt's and her cousin's house. She often complained at this saying that she desired her own space. Rosin therefore spent virtually no wages on herself – she sent the vast majority of it back to Kenya.

Rosin's situation draws attention to an important aspect of immigration policy. Rosin had obtained the right to remain in the UK which brought no restrictions to her visa status and she actually described a desire to engage in care work. But another aspect Rosin's situation was similar to Bayani's – both were sending large amounts of money to support family members abroad. Rosin often talked of her strong desire to have her son, her sister's daughter and her mother with her in the UK. At that time they had all failed to get visas and so had remained in Kenya. She often commented to me that if her son and

daughter were in the UK she would be able to work far fewer hours. Because of the minimal welfare protection offered by the Kenyan government Rosin was forced into working extremely long hours in order to remittance sufficient money to pay for the care of her mother and the education of her other dependents. The state was crucial in institutionalising Rosin's insecurity by rejecting visa's for her family members (Anderson 2010). Many of the workers at Meadowvale complained, like Rosin, about the long hours they were forced to work. As I will show in the next section, the British workers seemed to find it easier to realise better working hours and find more leisure and family time.

iii. British workers

The forms of institutional precariousness that immigration policy creates for migrant workers undoubtedly structured the compulsion to do care work. This section shows that the low entitlements and poor status of care work in the labour market also meant that many of the British workers who were formally 'free' to take other employment also spoke of life constraints as compelling them to find employment in care. The British workers, however, rarely worked as many shifts as the migrant workers. Some British workers also had more flexible working patterns doing more half shifts or chose to work weekends only.

Jake's story was typical of those workers who were planning to leave the job. Jake had actually been in care work for about ten years, straight from school, and was employed as a senior care assistant by the home. I asked Jake how he came to work in care:

Well I wanted to join the army but I couldn't because I had had an inhaler prescribed. You know, I didn't even have asthma I had just had an inhaler prescribed a year or something before I wanted to join but they still wouldn't take me.

He told me on a separate occasion that both his mother and father were care workers which suggests that entry into care work had been normalised for him to an extent. Jake was currently doing is NVQ level four in Health and Social Care. His intention was to enter nursing once he had completed and thought he might eventually be able to go into a care home management role. Nevertheless, Jake never spoke of caring in light of its worthiness. Rather, he was concerned about the future career opportunities that it might offer him.

Leanne, on the other hand, another senior care assistant said she had entered care because she had a "calling" for it. She had had a daughter at a young age. When this happened her parents had forced her out of the home and she had to live in a bedsit with her newly born. Her daughter was 19 when I met Leanne and Leanne herself was 36. She had raised her daughter as a single mother and had not worked for years. However, Leanne said that she had reached a certain age and wanted to find work:

> *When my daughter had been at school for a few years I decided that I wanted to do something with my life, something for me you know, I could have stayed on benefits. And to be honest that might have been less hassle. But I wanted to show my daughter a good role model, you know what I mean, I didn't want her to think that she should just spend her life on benefits. I want her to do something with her life, not to get pregnant like I did and to study or something.*

Just before I left the home Leanne was in the process of getting on a tax credit system which would allow her to work less hours at the home and still earn roughly the same amount of money as working four or five shifts. As Jake, Leanne was working towards the NVQ level four in Health and Social Care. After I left she had completed this and managed to get onto a nursing course. Leanne always talked about the importance of care work emphasising its value and saw her job as a senior care assistant as valuable.

Steph was one the care assistants who worked more flexible hours. She would work morning shifts from 8am until 2pm during the week and full 12 hour shifts at the weekend. She explained to me that these hours fitted in nicely with looking after her children. Her husband could drop them off at school in the morning and then she would finish work in time to pick them up. Steph said she did not like the job and that she would happily do something else if the hours were right. Steph, like Leanne and Jake, also said she wanted to leave. She thought about doing care work for one of the companies which provided home care in the community.

My intent here is not to suggest that those workers who were "British" had a similar experience to migrants, especially those such as Rosin, Bayani or Tala, but it is significant to point out that informal labour market constraints, such as poor educational attainment and general social exclusion, remained important themes for the composition of the non-migrant workforce at Meadowvale. Nevertheless, Leanne's situation underlines the benefits of being a fully-fledged UK citizen. Not only was she able to drop her hours and retain her standard of living she was also able to acquire access to a funded nursing course which also paid a small stipend and would undoubtedly improve her future labour market prospects.

The experience of the British workers emphasised the role of welfare protection and various other citizenship rights in determining the actual experience of employment. There seemed to be a number of aspects to this. Firstly, the British workers through access to working tax credits in some cases were actually able to reduce the amount of hours they should work. Secondly, through access to free or partially funded higher education they were able to improve their longer term career prospects. Finally, because their family members were also British citizens and claim the various rights such as education or

healthcare, the compulsion to work is comparatively less than those whose family's remained in developing countries.

Migration, Care Work and the Welfare State

From all the stories discussed above we see that there are varying degrees of coercion which structure entry into care work and a weaker set of 'benefits' which attract workers to the job. Investigating the historical existence of slave labour throughout the development of capitalism Steinfeld (2001) questions the binary opposition between free labour and slavery. Traditional theory describes capitalism as a distinctive form of production marked out crucially by employment relations which operate around freedom. In capitalism the labourer is thought to be free to sell their labour to the highest bidder. For Steinfeld (2001), the analysis of labour relations orientates around the form of coercion or compulsion to work, not the absence of compulsion altogether, he shows that a certain amount of similarity between a wage labourer and slave exists. While specific forms of coercion used by the employer to secure labour power are different from those used by the slave owner, the underlying philosophy of coercion remains the same: both slave and wage labourer must choose the 'lesser of two evils' (2001: 15). Stereotypically, if slaves refuse to work they will receive some form of physical punishment, but if a wage labourer refuses employment they will endanger their ability to acquire subsistence for themselves or their family. In other words, slavery and wage labour are not necessarily defined by force versus freedom, rather the divergence between the two stereotypical forms of labour operate around different mechanism of compulsion. Steinfeld argues that because of this:

> *The judgement about where to draw a line to separate free from coerced labour turns out not to be a judgement about whether labour is voluntary or compelled but rather a judgement about what kinds of coercive pressures are legitimate and illegitimate in labour relations* (Steinfeld 2002: 16).

The relevance of Steinfeld's historical argument for today's Western capitalist system is it recognises that not all wage labourers experience the same kind of freedom or compulsion when it comes to choosing employment. The line between servitude and empowered choice, in a labour market context, is far more tenuous than many certain traditional liberal thinkers might suggest. Furthermore, the idealisation of the employment contract as the process by which individuals consent to their own subordination cuts to the heart of Western liberal political fictions regarding individualism and free-choice (Pateman 1988). Factory workers enduring 15 hour days in Indonesia for a pittance could hardly be described as freely choosing those condition and relations of their employment. They 'choose' that work because they have no other choice.

Specifically concerning migration, O'Connell Davidson (2010) argues that the split between free-labourer and 'slave', as it presented in many dominant constructions of trafficking fails to encapsulate the reality of diverse, complex forms of coercive mechanisms which determine labour relations. In an earlier paper, O'Connell Davidson (2006) sets out how the forms of prostitution can differ greatly despite being identifiable as forms of 'trafficked' migration. In her study the workers in three separate brothels were all paying back 'debts' for their international migration but the employment relations in each establishment differed greatly. The political effects of seeing labour as either 'free' or as simply engaged in 'bad' forms of work, not only obscures the greater social and economic context which produces certain employment relations, it tends to conceal the state's role in migration and trafficking. Rogaly (2008) criticises the ILO forced labour agenda because it fails to consider how many workers subject to forced labour are partially compliant in their exploitation. Secondly, and related, systems which include forms of forced labour are part and parcel of a wider economic system (Miles 1992). Or as Rogaly has said when criticising the ILO's position on forced labour:

States are rightly encouraged to tighten the means of persecuting unscrupulous employers, but no space is given to discussion of the potential for state regulations of the market relations through which large scale capital may be reshaping the conditions under which employment takes place (2008: 1444)

Many of the workers at Meadowvale, whether they were British, EU migrants or non-EU migrants, told stories of constraints in their life which led to employment in the elderly social care sector or coerced them into working much longer hours than they would ideally like. The divergence in experiences between the British workers and the migrant workers reveals certain political implications of the care sector as a low-wage segment of the wider labour market. The British workers seemed much more capable of using their period in the care home as a stepping stone on to further careers and were less inclined to long working hours. It is worth reiterating that migrant workers formed the backbone of the care assistant and senior care assistant labour in the care home making up over two thirds of this workforce and almost all the nurses. Additionally, the welfare rights which could be claimed by British workers and by their families meant that they often worked fewer hours than the migrant workers.

Temporary work visas obviously restrict migrants to sectors of employment many of which are often subject to informalised and highly flexible working conditions (such as agriculture, care or manufacturing). Sectors which have high turnover rates, high vacancy rates and low pay, all of which coalesce in the elderly social care sector (Cangliano *et al* 2009), are more likely to employ workers who are from vulnerable positions in the labour market. The state, through the creation of these immigration policies directs labour into certain industries, answering labour shortages and creating the conditions for the increased exploitation of workers.

However, talking to the many migrants working at Meadowvale revealed that the state plays a more indirect role. As Meyers (2000) points out, it is not just the right to work that is significant it is also the right to claim other citizen benefits. The migration process tends to create relations existing internationally between two or more locales. Rosin's story reveals how the compulsion to work longer hours and more frequently is directly related to the lack of welfare system in the country of emigration. Her children and her mother could not access good education or health resources in Kenya and Rosin was required to send back as much money as she could. Remittances were a significant motivation to work for most of the migrants, but in this home, it was especially so for those who had come from outside the EU. In contrast, the British workers, while still aware of the low pay and poor rights of care work, were able to decrease working hours and claim some entitlements from the UK welfare state reducing their need to work as many hours.

Burawoy (1983) discusses how the relationship between capitalist production, the influence of the state and structures the transformation of labour power into productive activity. He orientates his discussion around two concepts: *despotic regimes* and *hegemonic regimes*. Despotic regimes, which are more associated with early capitalism, are where workers are compelled to engage in employment because there is no other option to ensure survival or reproduction. These forms of state/capitalist relationship entail forms of employment where capitalists retain a high degree of control over the workers. Hegemonic regimes, on the other hand, are more complex and revolve around the notion of compulsion, rather than coercion. In these systems the state intervenes in production through two processes. Firstly, the state guarantees reproduction and basic survival through the welfare state and, secondly, curbs managerial power through regulating the terms of employment through policies which ensure collective bargaining, minimum wages, maximum hours and so on. It is possible to take Burawoy's discussion to enlighten the role of migrant labour in care work. Citizenship status often denies migrant

workers welfare rights in receiving countries while the sending countries they leave often have little or no welfare protection. This renders the migrant workers more dependent on the market for their and their family's survival and economic success.

It seems that there are a number of structural reasons for why care labour is often sought from foreign workers rather than from domestic labour pools. Management may both expect migrant workers to both to remain in the same position longer and also to work longer hours due to their immigration status. Workers from developing countries often have limited access to welfare and they are also often forced to provide financial support for family members abroad that have little to no access to a welfare state or income creation. This leads to a situation where migrant workers are more willing to work longer hours in order to provide themselves with a degree of financial security as well as secure wealth for their families through wage remittances. Other areas of precariousness which contextualise migrant workers discrimination in the labour market is poor language skills, qualifications which are not recognised and the fact that many potentially alternative employers are simply unwilling to deal with the immigration authorities.

Care of the elderly in a residential setting raises interesting questions regards whose rights and freedoms are being eroded, lost or compromised. In relation to migrant domestic workers, Anderson points out that:

> *A potential conflict between the rights of two groups of citizens (men and middle-class women) to participate in the public sphere is resolved without requiring restructuring of the public and private, by using the labour of non-citizens* (2000: 195)

Can elderly residential care work, with its high levels of immigrant labour and the fact that it remains a ghettoised, low paid sector of the economy, be seen in the same light? The

care of the elderly, which if not done by the state, still largely remains the responsibility of unpaid feminine labour, suggests that there is a wider structural need for migrant domestic workers. Indeed, from the point of view that the total social organisation of labour provides, in its entirety, includes the services that are directed towards the elderly maintain hierarchical arrangements of employment structure, enabling freedom for some. In understanding care work, it is perhaps the nature of the work as dirty, taboo and therefore feminised and essentially undesirable for cultural reasons, not only economic ones. The employment of migrant care workers represents a form of service work, as a service class to the British public is somewhat obscured by the role of the state and migration policy. The policy context which has enabled this large immigration of cheaper and highly exploitable workers maintains the care rights of many British citizens while also protecting the British working class from engaging in the poorly remunerated and culturally stigmatised form of labour.

Conclusion: Associations of Rightlessness

This chapter has argued that both the residents and the carers at Meadowvale can be conceived as groups who are deprived of various rights. On the one hand, elderly people suffered indignities and a rebuttal of even the most basic of care rights. The routines forced onto the workers instituted an experience of social death for many of residents who were subject to these, often extreme, forms of neglect. On the other hand, the experiences of care work for the workers were determined by various welfare and immigration policies. The doors of entry into the UK often formally tie workers to the care sector whilst the inability of migrant workers and their families to claim welfare rights compelled them to accept and even choose to work longer hours. The limited access to rights of both the care workers and residents is therefore interrelated with state processes of welfare spending thrift and private sector objectives of attaining an inexpensive profit accumulation. The chapter has shown how the rights of care recipients and workers are

entrenched in everyday lives but arise from wider political and economic backdrop (Benton

REF).

CHAPTER 8: Conclusion

As was stated at the beginning of the thesis that the aim is not only to construct an intricately detailed of life at Meadowvale care home, it is also to move towards a political and economic clarification of why working and living at Meadowvale was the way it was. The descriptions of neglect, difficult working conditions and general hardship provoke more wide-ranging sociological analysis. Also, it should be self-explanatory by this point that care at Meadowvale contrasted wildly from the depictions of privatisation put forward by the adherents of marketised and profit driven public services. This conclusion attempts to construct a sociological narrative elucidating the social forces which guided the experience of Meadowvale for workers and residents.

Proponents of the privatisation of public services hold that profit motives and competition lead to increases in efficiency and quality of previously state-owned and delivered services (Butler and Pirie 2001; Savas 1987). These narrative constructions and policy objectives usually suggest that older forms of welfare provision were deficient in two respects. First, it is argued that instead of being driven by the needs and desires of the client or service-user, public services were driven by certain professional groups, in pursuit of their own professional agendas. Second, it is thought that state-owned and operated services are essentially irrational; lacking a coherent principle to guide their functioning (Butler and Pirie 2001; Savas 1987). Policies implementing privatisation and marketisation, it is argued, offer a solution to these problems (Megginson and Netter 2001; Sheshinski and López-Calva 2003). Competition forces these services to act resourcefully and weeds out the weaker competitors, while the guiding principle of profit ensures that service providers act in internally rational ways. Marketisation is also attached to the notion of the 'consumer' who has the power to 'choose' the best service (Beesley and Littlechild 2003;

Kirkpatrick 2006). Each individual citizen has increased power to influence services they use. Often alluding to these logics, successive policy changes since the Griffith's (1988) report have embedded these principles within social care and elderly social care systems and services. The 'mixed economy' of care has developed rapidly in the last twenty years, and in elderly social care in particular, the vast majority of residential elderly care services are provided by private sector, profit-making providers (Laing and Buisson 2005).

Over the course of this thesis I have shown that the everyday reality of care 'on-the-floor' at Meadowvale diverged greatly from the picture of profit motivated care that supporters of privatisation paint. This thesis has provided an ethnographic account of elderly residential care work looking at the organisation of care labour, the pressures on workers which lead to dirty and unsafe working practices, the emotional labour required on behalf of the workers, the failure of policy to regulate the industry effectively and the implications of this system of care for rights of residents and care workers.

The conclusion to this thesis argues that there were a series of difficulties which prevented Moonlight Care from easily realising achieving business success. It is an attempt to move towards a more holistic structural account which explains other arguments made throughout the thesis. Firstly, it explores how Moonlight Care has attempted to overcome those constraining factors which inhibit them from easily accruing surfeit value from their operations. Secondly, I will show that the constraints which prevented the successful restructuring of Moonlight Care's services are also implicated in structuring poverty, exclusion and rightlessness for care workers and elderly residents. Thirdly, I briefly state the reasons for why regulation fails to ensure a good quality of care. Fourthly, I suggest that the increasing marketisation and privatisation of elderly social care can be linked to a process of welfare state retrenchment. In the final section I argue for a sociological version

of rights which emphasises the need for society to commit greater resources to the area of elderly social care.

Constraints on the Profitability of Elderly Residential Care

There were a number of obstacles which Moonlight Care were faced in the course of running their operations. As I will argue here, these limitations are to a degree inevitable but are also highly likely to lead to business 'solutions' which centre on reducing the costs of production.   It is difficult therefore to theoretically align improvements in living conditions for residents or working conditions for employees with the objective of increasing wealth for shareholders. This therefore questions the neo-liberal assumption that all parties involved in privatisation (service users, employers, managers and owners) all benefit. The factors limiting profitability relate to two main arguments: firstly, there are the current funding levels, and secondly there are the intrinsic features of care work which make it difficult to reorganise into a standardised labour process.

Firstly then, the state has a major role in constraining Moonlight Care's ability to align itself with profit orientated goals. The state's role, however, is conflicting because any profitability Moonlight Care does achieve is also *due* to the state; the state is strongly involved in the existence of a market in the first place. In chapter three I described how the system of funding operates for elderly residential care. This represents a major barrier. Most of the revenue of Moonlight Care comes from local authorities who set the rate for care, in other words, the cost of care does not emerge from a process of competition. Even when individuals are privately financed they can still expect to pay the same rate as set by their local council (Age UK 2010). This price setting means that elderly residential care companies simply receive the fees set by the council and then must deliver the service *and* skim of profit, from this rigid amount.

Governmental agencies also determine the type of service that the companies are required to deliver. For instance, regulation restricts the care companies from cutting the service even further, such as reducing staffing levels below the one care worker to five residents standard, even if current regulation fails to assure a quality service for the residents. Care workers were forced to act like 'street-level bureaucrats' (Lipsky 1980) in attempting to implement political narratives which enabled personalisation and choice whilst resisting abuse. These political idealisations were essentially impossible to implement under the organisational constraints which permeated Meadowvale – staffing levels were simply insufficient. Nevertheless, while regulation, in many respects, fails to ensure a quality service, it still prevents Moonlight Care from radically reducing the current provision of elderly care through lowering costs.

The second set of factors which prevent Moonlight Care from accruing a good return from their operations is that care work can be understood as a form of 'body work' (Twigg 2000; Wolkowitz 2006). Cohen (2011) argues that labour processes which are centrally concerned with work on bodies meet a number of challenges when they are organised into a system of production. The physical presence of bodies, their unpredictability and their sensitivity means they are difficult to organise into a production process not defined by high levels of labour. Transforming the production process is problematic partly because technology is of limited use and tends to focus on health and safety rather than increasing efficiency. Tasks performed on or with bodies almost always require at least one worker per body. Reducing the high labour intensive nature of care work without leading to forms of neglect is a challenge. A reoccurring theme in this thesis was the consistent and unrelenting pressure that the workers found themselves subject to. I showed how the work set out in formal documentation was impossible to complete and the workers were forced to engage in a range of labour saving strategies. The labour intensity of care work is reflected in the numbers of people the company employs. In 2009

it employed more than 42'000 employees yet catered for the lower bed-number of around 37'000. Many of these beds are also empty, meaning that plainly put, the numbers of people the company employs are greater than the numbers of people that it provides services to. This is a reflection of the hugely labour intensive nature of care work, something that is also made visible by the fact that in 2009, wage costs were £500 million, more than 50% of Moonlight Care's revenue.

Resolving the constraints of profitability

As stated in chapter three, in recent years, Moonlight Care has failed to make great profits (although it should not be forgotten that certain actors have accrued great wealth from the operations of the company). Moonlight Care is now also considered to be in considerable period crisis (Guardian 2011). Nevertheless there are a number of strategies which they have embarked on since their entry into the UK market which are an attempt to overcome the constraints just described.

i. Increasing the economies of scale and 'Care-telisation'

The profitability of Moonlight Care in recent years has either been small or non-existent, however, they have continued to systematically expand their business operations. They have continued to build homes and acquire homes from other providers. Meadowvale itself had been procured by Moonlight Care roughly six years before the research took place; it was previously owned by a much smaller regional provider. In the care industry the low profitability seems to have led to an ongoing process of conglomeration with a smaller number of large companies emerging as the major players (Scourfield 2007a). Moonlight Care's growth represents possibly the best example of this process of monopolisation in the elderly care sector, not only are they one of the largest providers, their rate of growth has been extremely fast.

The repercussion of the emergence of large-scale providers in this sector jeopardises the very principles of privatisation by contravening the notion of competition. Scourfield (2007a) shows how the suppliers of elderly residential care are becoming increasingly organised around a small number of large players. While there is yet no clear evidence of cartelisation amongst the major care providers of elderly residential care, he points to a process of 'care-telisation'. Cartelisation is the activities of monopolistic companies agreeing to fix prices amongst themselves in order to shape the conditions of the market. While there is still a large number of smaller operations in the sector, the growth of the top ten providers went from 6% of the market in 1993 to 22% (Laing and Buisson 2004) with the continuing financial failure of smaller firms seems likely to sustain the high levels of mergers and takeovers (Laing and Buisson 1999). For Scourfield, this process of care-telization represents the interrelated trends of 'the increasing concentration of both ownership and power in the hands of the few' and 'the situation where, increasingly, providers have demonstrated that they are both prepared and able to shape the terms of the market' (2007a: 265). Owners of the larger care home providers are progressively combining forces to campaign central and regional government for higher rates. The English Community Care Association (ECCA) represents a unified voice for care providers and one of its main activities is to lobby central government and local councils for better fees (Scourfield 2007a). Moonlight Care has stated in successive annual reports that they are currently pushing for higher rates of pay from local authorities. They are also members of the ECCA.

Scourfield (2007a) suggests that the care-telization of elderly residential services is likely to have some serious implications for people accessing care services. He argues that the rationalisation of costs (exemplified by the low rates paid by local authorities) and the conglomeration of care companies represent a threat to the quality of care generally as well as the very principles which justify marketisation. Care companies are also

increasingly forming regional strongholds where one or two large providers own most of

the homes in that area. This represents a major challenge to 'choice' because in one

locality all the homes might be owned by the same provider. Consumer power itself rests

on the ability find the same product or service elsewhere. Accountability over the quality

of services is also diminished under the current system of marketisation, according to

Scourfield (2007a). In the first instance, people who rely on care services are often

vulnerable due to physical and mental disability. Aside from this, those who enter elderly

care services do so from different funding contexts. Many elderly people will rely on the

full amount of their fees to be paid by the local authorities while some will be self-funded.

　　　　Furthermore, and as Scourfield describes, there are a whole host of different

groups of stakeholders in elderly care services: 'the owners, the directors, proxy customers

(local authority commissioners), self-funding individuals and care home residents who are

subsidized by the state' (2007a: 170). Indeed, the workers providing the services, various

professionals who refer patients to the service and the family members of the service users

are stakeholders not mentioned by Scourfield. All these different groups are likely to have

quite distinct, and often conflicting, interests. The proponents of privatisation often

represent the benefits of competition as emerging from a better provider-client

relationship (Beesley and Littlechild 2003) but this represents the role of public services

rather crudely. Lipsky (1980), for example, argues that it is not always clear who the clients

of public services actually are. If we, for example, consider education which is a commonly

state-provided public service, which also has potential scope for privatisation, then it

become clear that the 'user' of such service is obscure. Is it the child being educated? Is it

the parents of that child? Or, if we consider that a well educated workforce will benefit

wider society, is it the general public? The privatisation of other services, such as utilities,

is more easily imagined as leading to efficiency gains across the whole of society. If

capitalist modes of production do lead to greater efficiency, say in the production of

drinking water, then consumers win (through cheaper water and less taxes or water charges), the state benefits (they can either reduce taxes or spend the money on alternative services) and the private sector experiences profits. I am not necessarily suggesting that this is actually what has happened in the privatisation of utilities in the UK, but the interests of different groups can be theoretically aligned. However, in elderly care who is it that benefits from a more profitable service and can the different interests be aligned?

Due to the nature of care work as a form of labour intensive body work (Cohen 2011) any increases in profit are likely to emerge from lowering staffing levels, decreasing wages, decreasing food costs or decreasing other costs involved in production. However, any increase in profit (and therefore decrease in spending on the service) may benefit the state, through lower fees, and the for-profit organisation will certainly gain greater profits, but it seems these interests oppose the interests of those who use the service. Reductions in spending will ultimately degrade standards within the service.

This process of monopolisation in the elderly residential care sector may have actually been encouraged by certain structural conditions inherent in the elderly care market. One of the few prospects available to achieve business success is to increase the economies of scale. The difference between the money taken in and the money spent on the service is marginal. Increasing the size of overall operations means that profit is greater although the margins continue to be small. This peculiarity of the elderly care sector explains why Moonlight Care holds a tight grip on expansion objective. For example, in 2009, despite reporting significant losses, the company acquired or opened ten new homes and in total added another 900 beds to its portfolio. Expansion is usually associated with increasing profitability not a struggling margin. It seems the expansion is crucial to their long-term plan to make a business out of elderly care.

Contrary to the modernist and developmental discourse surrounding privatisation; 'care-telisation' represents a discrepancy between pro-privatisation discourse and the policy practices which enable and govern privatisation. While it is argued that unleashing market values on public sector organisations will unlock the potential of people and organisations by promoting efficiency; the policy which regulates privatisation seems to be built on a separate logic. Regulation is underpinned by the idea that if market values are set *completely* free they will also fail. So while successive policy discourses have constructed the market for social care as one which increases choice for the users, in real terms the users have little choice over which service they access and what the actual nature of these services are. The local authorities are strongly implicated in granting access to care services and determining which care services are offered in each area. With limited budgets, local authorities continue to shape the availability and in many senses they remain the fundamental purchaser *and* consumer of care services. Despite the rhetoric surrounding personalisation which conceives citizens accessing welfare as empowered consumers, the main market relationship is between local government organisations and the different providers. The problem which emerges from this market relationship is that the local authorities have one major concern – cost – which, it can be assumed, diverges from the interests of those consuming the service who will have quality high on their list of preferences.

One of the major strategies used by Moonlight Care in an attempt to achieve success was to increase the scale of their operations and, as I argued, the need for this strategy emerges directly from the conditions of the elderly residential care market and the inherent nature of care work. However, the problem with the operation of this 'market' is that it does not compete over the level of service provision. It seems that the competition between providers orientates around which provider can offer local authorities the cheapest service; not necessarily the best service or even the best value for money.

Regulation establishes a certain base level of service but the level of regulation is insufficient to secure quality care, and as I showed earlier in the thesis, the resources available mismatch the policy expectations of the service. The market for elderly residential care is not one defined by empowered users making informed decisions between a diverse set of providers. In contrast, the market seems to serve the wishes of the local authorities' and profit motives, *not* the service users.

II. 'Parasitic' accumulation

Throughout the thesis I explored how the form of 'discount' care that prevailed at Meadowvale consistently defined the working practices, the organisation of labour and the failure to implement regulatory principles. I want to suggest that this system of production at Meadowvale can be defined as a form of 'parasitic' capitalism. Profit, unfortunately, is largely made through maintaining low costs in production. Consequently, increasing profitability requires reducing the costs of delivering the service even further. This process is parasitic because, as described above, the nature of care and its method of funding, means that there are few options to increase the amount of profit that the company makes through reorganising production, innovation or acquiring more revenue.

One of the key gains thought to be gained from instilling profit motives into previously state owned organisations is increasing efficiency (Beesley and Littlechild 2003; Megginson and Netter 2001; Savas 1987; Sheshinski and López-Calva 2003). Such authors usually point to the process of 'x-efficiency' (Leibenstein 1966) as the crucial factor in driving the improvements associated with privatisation. X-efficiency refers to ways in which market competition leads to those with the most internally rational and cost-effective style out-competing all other providers. However, some economists also talk about the concept of 'Pareto efficiency' (Jackson and Price 1994). When efficiency gains are aligned to Pareto efficiency this means that a firm's restructuring or reorganisation

leads to increasing margins but without another incurring social or economic costs. If a particular business' operation leads to costs for another group (these are sometimes called 'externalities') then Pareto efficiency has not been achieved. For instance, if a factory decides to start disposing of dangerous by-products in a river to save on the costs of safe disposal of these substances, but in the process pollutes a river and destroys the fishing for the surrounding community, then Pareto efficiency has not been gained. The operations of such a business have led to social costs, even if they have meant that certain groups have benefitted through profits. Thus, such a company may have achieved greater x-efficiency but not Pareto efficiency.

Due to certain factors inherent in care labour processes which are focused on attending to the complex needs of vulnerable individuals, most of the efficiency gains accomplished align with x-efficiency but not with Pareto efficiency. In chapter three I showed how prevalent the process of reducing the costs of production had become. Staff lunches were withdrawn, food costs for the residents were being reduced and the entertainment budget was halted. The rest of the data chapters discussed the low staffing levels resulted in costs for both workers and residents. The supporters of privatisation often miss this important aspect of efficiency. Indeed many of the pro-privatisation publications tend to focus on the economic impact of privatisation without looking in depth at the transformations in the nature of service provision. Most simply discuss overall issues such as funding and taxation (see Megginson and Netter's (2001) comprehensive review of the literature assessing privatisation). The form of accumulation that I observed at Meadowvale could be tagged as parasitic because any gains in efficiency are essentially *not* of the Pareto sort: restructuring brings with it social costs for residents and front line workers.

Associations of Rightlessness

This form of parasitic capitalism, I will argue, continues to structure certain, albeit

longstanding, inequalities. In chapter seven I argued that the poorly resourced system of

care and the processes of profit accumulation sustained inequality and poverty for two

groups. Both the rights of the workers and the residents were related to processes

occurring within the context of Moonlight Care as well as wider political and economic

processes. Not only was care work dirty and emotionally and physically difficult labour but

the wages were also extremely low. Poor remuneration is a well documented facet of care

work and arises out of the conception of feminised skills as essentially naturally occurring

(Bubeck 2002; England 2005; Hartmann 1979). However, Meadowvale paid minimum

wage or just above but offered no extra entitlements and the conditions of labour also

seemed to be eroding even further. During my time at Meadowvale the staff lunches,

perhaps the only 'perk' of the job, were halted. The erosion of labour rights seems to

support the proposition that Moonlight Care's profit processes rested on reducing costs,

including costs associated with the conditions of the work.

Meadowvale home, like much of the care sector, was heavily reliant on migrant

labour (Cangiano *et al* 2009). Managed migration has operated as a policy system for

attracting certain forms of labour and even shaping the employment relations within

certain sectors (Anderson 2010; Anderson *et al* 2006; Anderson and Ruhs 2010; McGregor

2007). The managed migration process can be linked to wider welfare state issues.

Anderson (2010) argues that immigration policies fashion various forms of precariousness

for migrant workers. This vulnerability is created through three main processes: the

'creation of categories for entrant, the imposition of employment relations and the

construction of institutionalised uncertainty' (Anderson 2010: 301). Many of these

processes were observable at Meadowvale.

Firstly, in the case of one migrant worker at Meadowvale, Tala, immigration policies had defined her as a particular type of entrant who was unable to realise her full potential in the labour market. The company had effectively trafficked her using a combination of deception and immigration status, which not only tied her to Moonlight Care, it also prevented her from acquiring her PIN registration entitling her to higher wages and better opportunities. Moonlight Care had acquired her experienced labour for less than what they could have expected to pay a British worker who had no restrictions on where they could find employment. Other workers, including nurses and care assistants, were in similar situations although, as far as I could determine, not as severe as Tala. However, many were tied to working in the social care sector through their immigration status.

The state was not only important in understanding working experiences of migrants through the creation of immigration statuses. Secondly, many workers, due to immigration status, could not claim benefits from the state (Maher 2002). The countries they leave, and the family members they leave behind, are not protected by the same levels welfare protection as are afforded to citizens of the receiving country– they are essentially more vulnerable to market forces than British workers. These workers at Meadowvale were often sending a large proportion of their wages to support family members in foreign countries. They often worked a superhuman amount of hours in order to earn enough to support themselves and their families. In this way the low wages can be conceptualised as a form of compulsion to work longer hours – if wages had been dramatically higher the need to work so many hours would be removed. More to the point, however, migrant workers' families were also denied access to many welfare rights that full British nationals can claim. This is an important point, because workers such as Rosin, who could have claimed all the welfare benefits that a UK citizen can, was forced to work extremely long hours to support family members abroad who had not managed to

acquire access to the UK. Burawoy (1983) describes how the role of the state is crucial in defining the compulsion to engage in paid employment and is in turn linked to specific forms of labour processes and management control. The stories of the migrant workers at Meadowvale emphasised various factors which had pushed them into care work or had coerced them into working unusually long hours. The factors related both to formal restrictions imposed on the workers through immigration controls and pressures emerging from international inequalities. While British workers often entered the care sector from a disadvantaged position they were generally more enabled to claim welfare benefits for themselves, or for their families, and thus rarely worked as long hours as their migrant counterparts.

The costs of delivering care for the workers, however, surpassed issues relating to labour market mobility. The *practice* of engaging in care work at Meadowvale itself represented a major cost to the workers. I described in chapter five how the pressures of care work involved an emotional cost for many of the workers. In Lee-Treweek's (1997) description of care workers engaging in callous, unsympathetic and even cruel emotional displays and care practices she employs the concept of resistance to explain their actions. I argue that at Meadowvale certain practices were embedded within caring routines, especially the need to remain calm in the face of an intense workload. Often the apparently cold or harsh disposition of the workers was actually aligned with the goals of the organisation rather than being a form of resistance. Furthermore, due to the low staffing levels and a workload that was impossible to complete, the care workers were forced to make difficult decisions about which care tasks to carry out. This pressure was emotionally problematic for some workers.

Care is an undeniably relational form of activity (Finch and Groves 1983; Tronto 1989) and accordingly, any environment which is problematic for workers is likely also to

be problematic for care recipients (and vice versa) (Lopez 2006). The residents at Meadowvale persistently suffered a denial of even basic rights. Firstly, the constant low staffing meant that there was an overwhelming preoccupation with completing physical care tasks with little time left for building emotional ties. Even the residents' access to basic assistance for their bodily functions was often not provided. Low staffing levels essentially meant that staff were consistently prioritising tasks and leaving many undone. The daily routine for certain residents was determined by the need to constantly rationalise the workload. So as I described in chapter seven, many of those processes observed in care homes which can be linked to cultural norms regarding death, old age and decline, can also be linked to organisational factors. Social death, for instance, emerges in large part from the limitations of care organisations. Similarly the 'organisational incontinence' described in chapter five represents a comparable process. Increased risk of incontinence is linked to biological changes occurring as part of the ageing process, but the practices and rituals associated with care work play an important role in the experience of incontinence. The notion that incontinence is an unavoidable part of ageing naturalises those institutional practices which allow frequent incontinence to be an acceptable part of life in elderly residential care homes.

From this description of the relationship between ageism and the nature of residential care it is possible to theorise a sort of circular process whereby cultural ideals of what it means to be elderly are reinforced through policy, politics and economic distribution (Townsend 1981, 2006; Walker 1980, 1981; Williams 1999). The very fact that elderly care services have been open to increased private sector involvement is a reflection of the status of the elderly.

Privatisation, it is often argued, has a series of benefits associated with it, although not often discussed is why then, not *all* public services become privatised. For instance,

there is not much support in the UK for privatised education system and the NHS has, so

far, has remained surprisingly resilient to true privatisation. Social care for the disabled,

including residential care, has not been subject to the same levels private sector

involvement. The classic studies in the structured dependency of the elderly in the UK

focused on welfare as an important aspect in configuring poverty amongst the elderly

(Walker 1980, 1981; Townsend 1981). These ideas remain significant. Priestly (2003)

argues that different welfare rights and citizen obligations are ascribed to people on the

basis of their stage in the life course. However, the emergence of the 'mixed economy' of

care complicates how we envisage the source of inequality for the elderly. In this study it

would have been wholly wrong to consider how the search for profit and the activities of

Moonlight Care are implicated in the often poor care provided at Meadowvale without

reference to the role of the state. In other words, the abuse, neglect and general lack of

rights of the residents at Meadowvale is as much to do with the poor fees paid by the state

as it is the processes of profit accumulation. It seems that social and cultural prejudices

regarding what the elderly are entitled to, not only defines the continued lack of resources

in elderly care, but also explains why private sector involvement has been so high in the

area of elderly residential care.

The discrimination of the elderly essentially felt as a lack of access to resources, the

devalued status of care work as a feminised sector of the labour market and the existence

and use of immigration policy to stream workers into the of elderly social care are clearly

interrelated social trends. Immigration policy contextualises various forms of

precariousness and vulnerability, denying workers the appropriate access to the labour

market and welfare rights for themselves and for their families, both of which compels

them to find less attractive work. State policies reinforces the employment of migrant

workers in order to secure a form of cheap, highly exploitable (and often well-qualified)

labour – essentially, care for the elderly is delivered less problematically than it would be if

the sector relied exclusively on British workers. Simultaneously, however, the rightlessness

of migrant workers emerges in tandem with the rightlessness of the elderly people who

receive care. Becker (1997) argues that social policy, while traditionally thought as a form

of protection against poverty, inequality and hardship, is in fact strongly implicated in

structuring the continued poverty of certain groups (such as the disabled, the elderly or the

unemployed). At Meadowvale, the poor wages and difficult working conditions correlated

with the persistent denial of care rights to residents in that both were related to the poorly

resourced, profit driven system of care.

The Failure of Regulation

Part of the logic behind privatisation that changing ownership from state to private sector

leads to greater efficiency. Drakeford (2006) argues that the politics of the New Labour

Government can be situated firmly within this ideology. The public are not concerned with

ownership; they are only concerned with real-world outcomes. However, along with the

shift in ownership of services comes the rise of the 'regulatory state' (Chapman, Miller and

Skidmore 2003; Moran 2001). So while the state no longer delivers elderly care it does

exert large amounts of effort and spending endeavouring to ensure that providers of

services deliver the appropriate quality. Attaining a high level of care, however, is

essentially dependent on funding (which remains low).

In addition, a care company's agenda is not necessarily in-line with the aims of

regulation. For instance, a private sector provider inevitably has a desire to increase profit,

and managing risk may come second to this. It might have an interest in reducing the costs

of production, through decreasing staffing levels and other costs, ultimately decreasing the

quality of the service. The regulation of the care sector continues to prevent complete race

to the bottom while simultaneously failing to secure acceptable care across the whole

system. Nevertheless, a recent BBC Radio 4 programme (2011) highlighted the deficiencies

of the regulatory system for elderly residential care. Not only is inspection relatively infrequent but punitive measures that inspectors can take when homes are failing are insignificant. A number of factors inhibit the proper regulation. Firstly, local authorities are reluctant to take over care homes from failing private organisations. Closing is only seen as a viable option in the most severe situation because then residents have to be re-housed. This can have negative impacts for the residents. Secondly, courts are hesitant in issuing large fines to companies because profit margins are low in social care. It is argued, for instance, that the residents and the workers suffer even more through punitive fines for malpractice. Even courts seem to adhere to this outlook and there is evidence of this in the relatively low fines which Moonlight Care received for various instances culpability in the mistreatment of residents.

It seems then that the creation of profit in private sector elderly care services differs significantly from the creation of profit as it might be understood in an orthodox system of production. Any profit is simply surplus monies left over after productions costs have taken off. The company is allowed to continue receiving money from local councils on the basis that the service does not fall below a certain level. Providers are not enabled to continue delivering services because consumers deem it to be of good or excellent quality or because they have managed create a more (Pareto) efficient service.

Indeed, one of the contradictions of the contemporary state in relation to social care seems to be that the state is itself aware that leaving the market to 'run its course' will lead to serious failures. Humphrey (2003) argues that the regulation of social care rests on a particular logic. Central government, who retains control over funding, still ultimately retains the power over social care systems. The funding distributed to local councils is far below level of care that they are expected to ensure in the regional areas. Simultaneously the councils that are charged with delivering this care pass the responsibility onto the

individual care providers. At Meadowvale this responsibility was passed on again to each individual worker by the care company. As 'street level-bureaucrats', the care workers at Meadowvale were charged with providing a certain style of care. As I showed in chapter six this was evidently impossible with the resources available.

Welfare State Retrenchment?

Whether privatisation represents a true erosion of the welfare state is difficult to determine. Arguments around welfare state transformation attempt to suggest, that since the 1970s, or thereabouts, globalisation and political ideological changes have forced a downwards pressure on the number and quality of welfare rights and services which Western citizens can access. This rests on the assertion that social rights have objectively eroded, and that the protection offered by the welfare state is less than what it was 20 years ago. Perhaps surprising, however, is the number themes which continue to define the way elderly people are treated within care home; for instance, routinisation (Goffman 1961), bureaucratic control and sequestration (Douglas 1966; Elias 2000, 2001) are processes easily identifiable in today's profit driven care homes as well as yesteryear's state run institutions (Bereford 2005).

However, the thesis is not historically comparative and methodologically limited by its case study approach and therefore cannot make conclusions regarding whether elderly residential care services are better or worse than they were 30 years ago. For this reason, the thesis has orientated the argument around the rupture between the supposed benefits of privatisation and the failure to deliver good elderly care services at Meadowvale and not welfare state retrenchment. The various logics, discourses and rationales behind privatisation are inherently flawed because the interests of business cannot be aligned with the interests of service users.

As a concluding remark of the thesis, however, I want to explore how the observations of life at Meadowvale might have implications for understanding welfare state transformation. The opening up of elderly care services to profit making private care companies represents a form of commodification or recommodification. Esping-Andersen (1987) described the process by which different national welfare states protect the individual from market forces – in other words, processes that determine whether people within a given nation state are able to obtain an appropriate standard of living regardless of their participation in the labour market. The privatisation of elderly care can be viewed as a process of recommodification of this aspect of social life. When elderly residents in a care home are forced to sit in soiled incontinence pads for longer periods of time, when the level of care does not meet their needs or desires or when they confined to their room because there are insufficient staff to situate them in the lounge area, then these failures can be linked to the pursuit of profit and not only the failure of the state to offer suitable welfare rights to its citizens. When staff are no longer allowed free meals or when their wages are so low that they are forced to work an extreme amount of hours then this also emerges from profit-orientated motives of the organisation. Welfare states used to be defined by their role as providing protection from the market, even if this protection was not always that successful, however, when welfare rights are delivered within a market and for-profit then the market is redefined as the solution to welfare problems (Beresford 2005).

At various points during this thesis I have highlighted the effects of the distinctive policy and market conditions surround care which determines how the processes of accumulation. The creation of surplus value (if it could be called surplus value) at Meadowvale departed from how traditional business processes function. In a restaurant, for example, the consumers of the service enter into the exchange of money for goods and services. They will either choose to return to the establishment or not based on a

combination of factors which include the disposition of the staff, the ambience of the

surroundings and the quality of the food. Inevitably, the ability of the staff to present

themselves in the correct manner – put on the right emotional display and ensure that the

experience of the patrons is the right balance of attentiveness – is important to the success

of that business. It is difficult to think of care in the same way. For instance, in chapter

four I showed the contradictions in the management of care which attempted to pressure

workers into completing a certain number of tasks, but turned a blind eye to the inability of

the workers to complete their workload. Also, in chapter five I showed that it was not easy

to identify a particular form of emotional labour which underpinned organisational goals,

rather emotion work was multifarious. It aligned and departed from accumulation goals at

different times.

This reveals the crux of tagged the 'parasitic' form of accumulation which prevailed

at Meadowvale. With fees being set by local councils (albeit based on the funding that they

receive from central government) yet with stringent codes in relation to the style of care

they are supposed to deliver, Moonlight Care is left with little option. Sustaining and

heightening both the poor conditions of the work and the deficient standard of care are

major opportunities for increasing and continuing profitability. Accordingly, the interests

of the state and the for-profit care providers are simultaneously aligned and contradictory.

The state has an interest in maintaining systems of care which are inexpensive but are

simultaneously 'not-in-their-hands'. When care fails they can shift responsibility to non-

state actors. Secondly, because elderly care does not operate in the way that many other

markets do and because direct accountability to individual service users is limited, reducing

the costs of the service is directly linked to greater business success. This thesis has

consistently shown that care work is distinctively labour intensive. It requires great effort

and is defined by the sheer number and variety of different often difficult, emotional and

dirty tasks that it demands from its workers. This means that slashing labour costs through

increasing intensity and decreasing the rewards for frontline workers, is often the company and state's gain, just as it is a loss for the workers and the residents.

Rather than becoming empowered consumers of care, enabled to make demands, choose alternative lifestyles or exercise control, elderly residents seemed to simply be reduced to another cost in production. In this sense, elderly residents at Meadowvale were commodified in a way that it would not be possible to conceive of in state-operated system of care. Any gain by the company is the loss of the resident. The workers also were subject to the forces of the market that under a state-led system of care would also not have been possible. Increases in the intensity of their work, decreases in the opportunities to deliver gratifying affective care and the erosion of their labour rights were also the company's gain.

Improving Elderly Residential Care: The Case for Sociological Rights

The snapshot of life at Meadowvale care home presented here is undoubtedly grim, bleak and depressing. Inevitably, this raises the question of whether improvements are possible and whether this study can contribute to such a debate, or whether these writings purely serve as unequivocal disapproval.

Glucksmann develops a theory of economic rights of care and suggests that different care contexts have 'respective logics of rights' (2006: 67). For instance, care where the recipients are exchanging cash for a service could, potentially, be associated with certain consumer rights – such as the right to sue, complain or find another service. In fact Bland (1999) finds in a comparison of different care homes with a 'service approach' which conceives the residents like guests and the workers like hotel employees was successful in providing dignified care in certain instances. At Meadowvale it is difficult to visualise care rights in this way. Those closest to the service – the residents – suffered with conditions like dementia undoubtedly affecting their powers to exercise 'voice' and 'exit' in

the face of organisational failure (Hirschmann 1970). Many of the residents had no family members acting as guardians and most had no access to private funds in order to buy better care. Concurrently, as I showed above, there is outright failure to regulate the care industry properly so this also shows that the state fails to provide the necessary protection.

This thesis suggests future policy developments should follow Benton's (2006) sociological version of rights which emphasises each individual's access to resources as critical in determining their citizenship status. His version of rights elevates the importance of wider economic, political and social context in understanding how individuals are able to claim entitlements and realise 'life plans'. This understanding of rights shrinks the importance of legal definitions and questions typical liberal notions of individual rights. Liberal rights are usually geared around protecting the individual from certain low standards of living, such as ill-health or extreme poverty, and they pay very little attention to how social structures contextualise the experience of different groups in society. The vision of liberal rights that was channelled through various training courses at Meadowvale failed spectacularly to improve care in any respect. This thesis has shown that links can be made quite easily between the nature of care and caring relations, the organisation of labour and systems of management control, on the one hand, with more general economic and political trends. This emphasises the need to link organisational factors that determine the qualities of care and care work, with the motives of organisations and the role of regulation and state intervention.

Throughout the thesis I emphasised the continual pressures experienced by the care workers. They were consistently forced to engage in practices which ran contradictory to other ideals of care – either their own conception of what caring was supposed to be like or how policy discourses constructed worthwhile care. They had little control over how their work was done and little power to provide alternative styles of care. This is a crucial

point for understanding how sociological rights can an understanding of the nature of residential care as it is and the appropriate thinking for improving care.

Policy discourses which revolve around choice and personalisation are unlikely to have much effect on care-giving without the necessary resources also being committed. Much of this thesis has shown that the pressures of the organisational context, which inevitably emerged from the political economy of care, are what determined care giving and receiving on a day-by-day basis. For this reason, improving care rests on highlighting and transforming the organisational and institutional factors, not on promoting the ideology of the individual. Good care does not primarily emerge from the capability of an organisation to provide choice – choice itself is dependent on what is available. Presented with the choice of quality care or a service which defines its quality on its ability to offer orange or black-current squash, most of us would opt for better quality care.

It is evident that privatisation of elderly social care does not lead to the improvements suggested by its proponents. This thesis has shown that the processes of accumulation and competition do not inevitably lead to superior care services. Furthermore, the system of regulation also fails to ensure that care services reach even a basic level. Perhaps most concerning, however, is that it is too easy to construe the motives of profit as diametrically opposed to the interests of the elderly people who live in care homes. Profits materialize from reducing the costs of care and therefore rising wealth for the company is to the detriment of the workers and the residents.

Improving the rights of both care workers and residents is likely to rest on committing more of society's resources to elderly care systems. As Benton (2006) suggests, the rights of individuals emerge from the political, economic and social circumstances which they find themselves in. Accordingly, improvements in elderly residential care require greater resources to ensure that better respected staff, who are well paid and not

forced to work a herculean number of hours every week, are the frontline workers. A

greater ratio of carers-to-residents would improve the chance of care recipients' realising

their needs, desires and wishes. Future scholarly accounts of care and care work should

continue, I believe, to emphasise the social and economic conditions which structure the

day-to-day practice of care giving and receiving.

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APPENDIX 1: Staff Composition/Division of Labour

Job title	Duties and role in care home	Numbers on payroll (total = 26-42)
Care Assistant	The care assistants did the hands-on physical caring tasks including toileting, bathing, feeding, basic health care and moving residents around the home (from their bedrooms to the lounge and so on). However, part of carrying out these tasks involved general cleaning and tidying. It was their role to ensure that bedrooms were clean and tidy, although deep cleaning such as vacuuming and dusting was left to the domestic staff. Part of their task was also to put away clean clothes in the residents' bedrooms and changing bed-sheets (which was a requirement throughout the day). Also, care assistants made constant trips to the sluice to dispose of dirty incontinence pads and wipes and to the laundry to leave dirty clothes and pick up clean ones. It was also the care assistants' duty to tidy away dishes from the lounge and dining area. The care assistants were expected to fill in the care charts which recorded which caring tasks had been completed on each resident. This included record keeping on what each resident had consumed and excreted and noting all the caring tasks that had occurred throughout the day.	10-15
Senior Care Assistant	The senior care assistants carried out all the same tasks as the care assistants. However, they had also had a supervisory role and it was their job to look over the rest of the care assistants. They were supposed to check that the care records were correctly filled in and completed. A further task that was particular to the senior care assistants was completing documentation for new admissions to the home. Each resident also had a care plan, which recorded important information such as their personal preferences, their religion and their funeral plans, and it was generally the senior care assistant's role to ensure that these were regularly updated.	5-10
Nurse	The home was almost completely reliant on agency nurses and only kept a few as permanent staff. Nurses in this home did very few of the direct caring tasks. However, when they did do hands-on work it was the more medical-technical procedures: changing catheters, changing peg-feeds and dressing wounds. Perhaps their most time consuming tasks, however, was dealing with medication. This included keeping track of all medication; dealing with pharmacies and other NHS agencies to ensure that all residents received the right prescriptions; and ensuring that all residents actually consumed the appropriate medication. Indeed, nurses often complained that a too much of their time was devoted to issues of medication. Their other major responsibility was to monitor the health status of the residents and decide if a doctor or an ambulance was needed. This was the part of the job that concerned them the most, if they failed to monitor the condition correctly then they would be held accountable if there were serious consequences, however, hospital staff and GPs often complained if they were unnecessarily called.	2-3

Home Manager	The home manager was responsible for the general running of the home: hiring, firing, organising training, dealing with families if they had serious concerns and dealing with the regulatory authorities. It is likely that there many other tasks, but these were not observable. However, the manager responsibilities were generally bureaucratic in nature, and they did not exercise consistent or regular supervision over the other workers. They spent most the time in the office, and rarely strayed further than the lounge or kitchen. While I was at Meadowvale the home had a very high turnover of managers and there were a total of four different managers in the eight months I worked there.	1
Domestic Staff	The domestic staff were employed to clean the home. They generally did deeper cleaning than the care assistants. Domestics did the vacuuming, mopping, carpet shampooing, dusting, wiping, cleaning the toilets and made sure that there was soap, wipes and toilet roll in all the necessary places.	2
Launderer	For the home to operate successfully an enormous amount of laundry needed to be done every day (including the weekends). As such every day at least one person, but usually two, were employed from 8am until 3pm. However, this work was often done by care assistants who wanted extra shifts and as such the home only employed 1 or 2 people who worked exclusively in the laundry	1-2
Housekeeper	One housekeeper started working in the home towards the end of my time there. His day to day work was a combination of doing the laundry and doing the work that the domestics did, however, he took a supervisory role and was responsible for organising the stock of some of the day-today items needed for care work (such as wipes, soap, tissues and gloves) and all the cleaning products. He also organised the rota for the domestic staff and laundry workers.	1
Chef	The chefs were employed to cook three hot meals a day, serve the meals and keep the kitchen clean.	1-3
Head chef	The head chef largely did the same work as the chef. However, his extra responsibilities included designing the week's menu and ensuring that each resident with special dietary requirements was catered for. His job also included managing the food stock, budgeting food costs and arranging the rota for all kitchen staff. The head chef was the home's Union representative.	1
Kitchen Assistant	Kitchen assistants assisted the head chef and the chefs with food preparation, dish washing and serving the meals.	1-3
Handyman	The handyman had a number of responsibilities. He was employed to ensure the general upkeep of the home environment. This included periodically renovating different parts of the home. He was also charged with ensuring that the care machinery (set out in *appendix 2*) was maintained. Sometimes he would fix the machinery himself but if task was too complex he would be the person in communication with the companies that provided maintenance. Much of the machinery, like the hoist and the stand-aid, needed to be tested by the manufacturers every so often, and it was the handyman's role to arrange this. He was also expected to pick up all the prescribed pharmaceuticals from the chemist.	1

Equipment name	Description	Intended function	Use in the home
Incontinence pad	White nappy-like pads which come in a range of sizes and strengths of absorbency.	In training courses delivered by the Primary Trust, incontinence pads were supposed to be used in order to prevent the odd accident from happening. It was intended that pads would only be for the odd accident, and that if residents were assisted to the toilet frequently, they would rarely need to be changed.	Pads were commonly used as a labour saving strategy by the care workers. Residents who were often incontinent, especially those with the most serious cognitive and physical disabilities spent and much of the day in bed, were left to urinate and defecate in incontinence pads. This meant staff did not need to toilet the residents. Incontinence pads were perhaps the most important labour saving strategy at Meadowvale.
Hoist	The hoist is a crane-like piece of equipment. It has a large arm with hooks on which either a sling or a toileting sling is attached (see below). The whole structure sits on a base which is on wheels. It has an electric motor which operates off a rechargeable battery which slots into the back of it. The hoist in operable without a sling. The person is manoeuvred into the sling and then the sling is attached to the hoist. There is a button on the back of the machine which controls the arm of the hoist and allows the operators to raise or lower the arm.	The hoist is intended for moving people with severely restricted mobility. It is the last resort for people who have virtually no mobility. The hoist is used to move people to and from their bed, armchair, wheelchair and toilet. Its correct function was to transfer care recipients short distances, i.e. from a bed to a wheelchair, not from a bed, down a corridor and to the toilet. The hoist formally requires two people to operate it. One to control the hoist by lowering and raising the arm and then pushing the hoist so as to position the person above the wheelchair, armchair, bed or toilet so they can be placed on it. The second person is there to ensure that the person who is in the sling does not swing erratically.	The hoist was the most commonly used mobility aid in the care home. Despite this, the hoist was a supposed to be a last resort and was the most dangerous of all the equipment used. It was easy to knock someone's head on the metal frame of the hoist, and if the sling was not attached correctly the care recipient could fall out. On occasion care assistants would use the hoist without the assistance of another. This entailed the worker keeping the resident in the sling steady with one hand while manoeuvring the hoist with the other. Some of the more experienced care workers became adept at this, but it was nevertheless extremely dangerous, potentially resulting in serious accidents for the care recipient and back injuries for the care giver. The hoist, on less frequent occasions, was also used to transfer patients larger distances than was safe. This was also unsafe but could save time.
Slide sheet	The slide sheet is for moving care recipients when they are on the bed. The slide sheet is made of two pieces of non-resistant plastic sheeting.	The slide sheet is used when you want to move a care recipient up or down the bed. Usually it is used on people with very limited mobility who are unable to push themselves up the bed. After an incontinence pad has been changed or the care recipient has been given a body wash it is necessary to reposition them on the bed to ensure their comfort.	Despite the insistence in training courses that slide sheets should be used whenever a resident was to be moved on the bed, the reality was they were only employed very rarely. The home only had a few slide sheets so finding one usually took five or ten minutes. When care assistants were required to move residents around the bed they usually did not use any mobility aid. The technique they did use required two care assistants. Each care assistant would put a hand under the shoulder and one under the knee and then after a count of "one two three" would move the recipient up the bed. This technique can result in back injuries for workers and care recipients.

Sling	The sling is a piece of equipment that is used in conjunction with the hoist. It is a piece of material which completely encompasses the care recipient while they are being lifted in the hoist. Slings come in different sizes for different sizes of care recipients.	The major difficulty in using the sling, and therefore the hoist, was getting the strap underneath the resident. There is a special technique for placing a person in a sling and this is different depending on whether they are sitting in a chair or lying in a bed. If they are lying in a bed then they are rolled to one side and then the sling is placed underneath them and then they are rolled back over onto the sling. If the resident is sitting in a chair or a wheelchair then they need to lean forward, and the sling is slid down their back and then under their legs.	At Meadowvale there was only a limited number of slings and they needed washing regularly. Often it was difficult to find a sling and regularly care assistants would use a sling that was of the wrong size for the recipient because there was not an appropriate one at hand. This was very dangerous for the resident who could potentially slip out; however, finding a sling of the right size could take as long as twenty minutes.
Toileting sling	The toileting sling is the same as the sling, talked about above, but it has a large space around the crotch area so that residents can be placed directly onto the toilet. They can then use the toilet and be lifted off without needing to remove or replace the sling.	The use of the toileting sling is the same as the normal sling.	The home only had a small number of toileting slings and they were rarely used. Managing incontinence through the use of incontinence pads was the norm and the residents who could have used the toileting sling were rarely toileted.
Stand-aid	The stand aid is a frame placed on wheels and serves a similar function to the hoist. It has a padded board which the care recipient rests their knees on. There is also a strap which is attached to the frame of the stand-aid and goes behind the recipients back. It has two handle which jut out from the frame and the recipient needs to hold on to these with their hands. The machine, like the hoist, relies on a chargeable battery and has an electric motor.	The stand-aid is intended for use by people who have severe mobility issues. Generally these people rely on wheelchairs. However, the stand-aid is alternative to the hoist but requires that the care recipient has a certain amount of strength in their arms and legs. Stand-aids raise people from a sitting into a standing position and they can then be moved to and from the bed, toilet, wheelchair or armchair. The stand-aid is a similar machine to the hoist but is generally preferred because it is more dignified and less dangerous than a hoist.	The stand-aid only required one care worker to assist the person using it. The malpractice which occurred with the stand-aid did not relate to its actual usage, rather its improper use related to the fact that workers attempted to use it on residents who did not have enough leg or arm strength. This was also to save time because it only required one person to operate it, rather than two, like its alternative, the hoist.
Strap	The strap was simply a canvas padded belt with handles on it. It had a plastic buckle to link it together. The strap was wrapped around the recipient's upper body, just under their arms and around their chest, which then allowed the care assistants to grip the handles and move the resident.	The strap is supposed to be used by 2 care assistants in tandem. A care assistant takes a handle on each side of the strap and lifts the resident to or from the bed, wheelchair, armchair or so on. For the strap to be used the recipient must have a certain amount of strength in their legs and they must be in the sitting position. However, in the moving and handling training we were informed that we should not use the strap at all as it was dangerous for recipients and workers. Using the strap put both workers and residents at danger of back injuries. There was also the danger of dropping residents.	Despite being informed that the strap should not be used it was consistently used. While it was ineffective on larger immobile people, it was a speedy way to move residents who were either light or had enough strength in their legs. Despite the official that we should not use the strap, no manager ever attempted to remove the strap. Also, if it was a particularly light resident, care workers would often use the strap on their own. If management did say that the care workers should not use the strap, or not use it on certain residents, this was usually reacted to with disapproval. The strap allowed care assistants to work quickly and easily with residents who had mobility problems.

APPENDIX 3: Job Description

JOB DESCRIPTION

JOB TITLE: **Care Assistant**

REPORTING TO: Qualified Nursing Staff (Nursing Care Centre)
Deputy Home Manager / Senior Care Assistant (Residential Care Centre)

JOB PURPOSE: To assist in the provision of care and work as part of a team to achieve required standards. To ensure Clients retain their dignity and individuality. To be involved in the general activities of the Care Centre / Unit.

SKILLS, KNOWLEDGE & QUALIFICATIONS

Required:

- Genuine interest in working within a caring environment
- Ability to communicate effectively at all levels
- Team player
- Willingness to participate in Vocational Training Programmes
- Satisfactory Police Check and check against the POVA List (where applicable)

Desired:

- Relevant Vocational Qualification (achieved / working towards)
- Experience of working with the relevant Client group

MAIN RESPONSIBILITIES

Care:

1. Ensure the highest possible levels of care are maintained by supporting/assisting Clients, when required, with washing, toileting, dressing, undressing, and all other aspects of daily living.

2. Assist Clients in all aspects of their care needs (e.g. physical, emotional and spiritual). Provide attention when needed, whilst ensuring Clients retain their comfort and dignity.

3. Pay particular attention to assisting Clients who have limited mobility, or physical / learning difficulties, making the best use of aids provided.

4. Closely monitor Clients who may be confused and / or who have behavioural problems.

5. Assist in the promotion of continence.

6. Assist in the delivery of care for Clients who are dying or who have a progressive illness. Assist with last offices.

7. Observe care planning needs for Clients and complete written daily records as instructed and in line with the Company's policies and procedures.

8. Assist in framework of social activities by interacting with Clients and helping them continue with hobbies and activities in the Care Centre.

9. Answer Nurse call system, giving assistance as required. Answer the door and telephone appropriately. Respond accordingly, and pass on messages promptly.

10. Under the supervision and guidance of senior Care Staff, report on the well-being of Clients.

11. Carry out regular checks on Clients at intervals determined by senior Staff Members.

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JOB DESCRIPTION - CARE ASSISTANT continued...

12. Make Visitors feel welcome. Provide refreshments/assistance as and when required.

13. Make and change beds, ensuring that rooms are clean and tidy, and commodes are empty, in line with the Care Centre's disposal of waste policy. Ensure the Care Centre's resources are used appropriately.

14. Clean and maintain equipment used by Clients / Relatives e.g. wheelchairs, hearing aids, spectacles etc. Ensure the Care Centre is kept clean and tidy, in line with the Company's attention to detail philosophy.

15. If applicable, care for Clients' clothing and rooms as named, and ensure that all clothing is recorded and clearly marked.

16. Ensure full privacy and dignity is maintained for the dying and the bereaved, in line with the Company's policies and procedures.

17. Assist Clients who need help during meal times (be aware of swallowing difficulties, dietary requirements etc). Assist with serving of food / drinks as requested / required. Wash up as requested / required.

18. Escort Clients travelling to and from the Care Centre e.g. on social outings, hospital visits etc.

19. Practice maximum integrity in all dealings with Clients' personal and financial affairs, and avoid abuse of the privileged relationship that exists with Clients.

Communication:

20. Participate in Staff and Client meetings as and when required.

Training & Development:

21. Maintain professional knowledge and competence.

22. Attend mandatory training days/courses, on or off site, as and when required.

23. Participate in relevant N/SVQ training to achieve required qualifications.

Health & Safety:

24. Report immediately to the Home Manager, or Person in Charge, any illness of an infectious nature or accident incurred by a Client, colleague, self or another.

25. Understand, and ensure the implementation of, the Care Centre's Health and Safety policy, and Emergency and Fire procedures.

26. Report to the Home Manager, or the Handyperson, any faulty appliances, damaged furniture, equipment or any potential hazard.

27. Promote safe working practice within the Care Centre.

General:

28. Promote and ensure the good reputation of the Care Centre.