

**The Costs of Care: An Ethnography of
Care Work in Two Residential Homes
for Older People**

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Dedication

This thesis is dedicated to Albert Oscar Ernest Gale, who showed me how to pursue knowledge without forgetting my roots.

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The mistakes and problems remaining in this work are mine alone.

Abstract

This thesis is an ethnography of care work conducted in two differently priced private residential homes for older people in Southern England. Drawing upon around eight hundred hours of participant observation and interviews undertaken with thirty care workers, I examine the everyday interactions, routines, and rituals of care work. I identify how political-economic factors, working conditions, material resources, and workplace cultures produce particular kinds of care and I consider the contribution which social theory can make to sharpening our understanding of the care industry. I begin by exploring how work is divided-up, scheduled, and allocated to care workers and how, by defining what activities are of value, these forms of organising work shape the content and nature of caregiving. I extend this analysis of the everyday rituals and routines of care work by focusing in particular on care workers' attitudes and practices concerning hygiene and bodily waste, and dying and death. Here, care workers' ideas about the private and the public, the dirty and the clean, and the profane and the sacred, are established and reaffirmed by marking out boundaries between materials, spaces, and persons. The research shows how the availability of material resources, by facilitating or impeding such symbolic work, shapes care workers' ability to show respect and moral regard towards the individuals in their care. Whilst it is undeniable that the funding of care is directly linked to the quality of the service provided, this research argues that we also need a cultural and material architecture of care that is sensitive to our need for moral and symbolic treatment.

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Fieldnote Conventions

'Words used by participants'

"Participants quoting other people"

Data have been edited to preserve anonymity

All names of people and places are pseudonyms

Abbreviations

BBC	British Broadcasting Corporation
BME	Black and Minority Ethnic
BSA	British Sociological Association
CAQDAS	Computer-Aided Qualitative Data Analysis Software
CCTV	Closed-Circuit Television
CSCI	Commission for Social Care Inspection
CQC	Care Quality Commission
ENRICH	Enabling Research in Care Homes
EU	European Union
GP	General Practitioner
HMRC	Her Majesty's Revenue and Customs
HRM	Human Resource Management
IBD	Inflammatory Bowel Disease
IELTS	International English Language Test System
ISP	Individualised Service Plan
LGA	Local Government Association
NCSC	National Care Standards Commission
NHS	National Health Service
NIHR	National Institute for Health Research
NMDS-SC	National Minimum Data Set for Social Care
NMW	National Minimum Wage
NMS	National Minimum Standards
NVQ	National Vocational Qualification
ONS	Office for National Statistics
PAI	Public Assistance Institution
SD	Standard Deviation
UK	United Kingdom
US	United States

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Chapter 1: Introduction

Improvements in life expectancy over the twentieth century have resulted in a substantial increase in the number of older people living in the UK. In England, the number of people aged over sixty-five rose by 1.7 million between 2006 and 2016, a decadal increase of over 21 per cent (Age UK 2017a). Within the older subsection of the population, the greatest proportional growth over the decade was of those aged over eighty-five, which increased by around 31 per cent (Age UK 2017a). This ageing of the population does not show signs of slowing down. Last year, the number of older people living in the UK reached 11.8 million, of whom 1.6 million were aged over eighty-five (Age UK 2018).

Since older people are more likely to experience ill health, this expansion in the number of older people living in the UK – and particularly in the number of those aged over eighty-five years – has meant a higher prevalence of disability, disease, and chronic conditions (Christensen *et al.* 2009; Marengoni *et al.* 2011). Moreover, whilst improvements in health care have boosted longevity, which has radically destabilised notions of old age and ageing (Jones and Higgs 2010), the years of life gained by older individuals are unlikely to be spent in good health (Age UK 2017a; Kingston *et al.* 2017). When compared to those who were aged sixty-five in 2001, the average number of life years gained by those aged sixty-five in 2011 was 4.7 for men and 4.1 for women. Of these additional years, however, men spent an average of 1.7 years without care needs and, for women, this ‘independent’ period averaged less than three months (Kingston *et al.* 2017). On average, men now spend 2.4 years and women now spend 3 years with medium or high dependency¹ care needs in later life (Kingston *et al.* 2017).

‘Care needs’ and levels of ‘dependency’ have been conceptualised and categorised in many ways by researchers, policy makers, and professionals (Dijkstra 2017;

¹ In Kingston *et al.*'s (2017) study, older people who were categorised as ‘high dependency’ required 24-hour care and had at least one of the following: unable to get to or use the toilet, bed bound or chair bound, needs help feeding, frequent incontinence, needs help dressing, and/or has severe cognitive impairment. Those categorised as ‘medium dependency’ required care at regular times each day. For example, they required help with preparing meals or with putting on shoes and socks.

Lawton and Brody 1969; Mahoney and Barthel 1965). In the UK, an individual's care needs are often measured in terms of whether they are able to undertake certain 'activities of daily living' (ADLs): tasks or actions relating to personal care (dressing, feeding, washing, using the toilet) and mobility that are 'basic to daily living'² (Jones 2016: 6). In 2016, the Health Survey for England (Jones 2016) reported that 21 per cent of men and 30 per cent of women aged over sixty-five living in England required assistance with at least one ADL and, worryingly, that 37 per cent of men and 60 per cent of women aged over eighty-five had an *unmet*³ need for assistance with at least one ADL. These figures raise critical questions concerning how, where, by whom – and, indeed, if – older people's care needs are being attended to.

Though the majority of care received by older people living in England is provided by relatives or friends (Cottell 2017), Wittenberg and Hu (2015) estimated that, in 2015, 679,900 English older people used some kind of formal social care provision. This figure included those who received direct payments⁴ for their care from their local council, home care users, and those living in care homes. These forms of social care provision operate as part of a mixed economy. Whilst local authorities are responsible for assessing older people's care needs and purchasing care on behalf of those deemed financially eligible and eligible in terms of need, most formal care is now provided by the independent sector, which consists of for-profit and not-for-profit providers (Wittenberg 2018).

In the UK, 421,100 people aged over sixty-five currently live in care homes (Age UK 2018). As well as providing accommodation, care homes offer twenty-four-hour supervision from care workers or nurses, meals, and assistance with personal

² The Health Survey for England (Jones 2016), for example, uses the following ADLs: having a bath or shower, using the toilet, getting up and down stairs, getting around indoors, dressing or undressing, getting in and out of bed, washing face and hands, eating (including cutting up food), and taking medicine.

³ An individual was categorised as having an unmet need if they were able to manage an ADL with difficulty, only with help, or not at all, but they did not receive help with that ADL in the last month.

⁴ Direct payments are payments made by local councils/trusts to individuals in their area who have been assessed as being eligible (financially and in terms of need) to receive help from social services, but who have opted to arrange and pay for their own care and support services rather than receiving them directly from their local council.

care, which includes dressing, washing, toileting⁵, and feeding. The term ‘care homes’ refers to both residential homes – which do not provide nursing care – and nursing homes, which have registered nurses on duty at all times. In 2017, there were 6,023 residential homes and 4,699 nursing homes for older people in the UK (Age UK 2018). The vast majority of these nursing and residential homes are operated by for-profit organisations (Skills for Care 2016). In 2010, for example, over 90 per cent of residential care placements for older people were to homes in the independent sector; around 60 per cent of these placements were publicly funded and 40 per cent were privately funded (Forder and Allan 2011).

A higher prevalence of frailty and ill-health, coupled with a reduction in the availability of informal care⁶, has resulted in increased demand for formal health and social care services (Christensen *et al.* 2009; Hyde *et al.* 2009; Kingston *et al.* 2017; Wanless 2001). Surprisingly, however, this trend is not reflected in the amount of residential care provision available for older people in the UK (Kingston *et al.* 2017). Whilst, more recently, the number of care home places has started to increase, their numbers saw a year-on-year reduction between 1999 and 2009 (Forder and Allan 2011). This decline, resulting from care home closures, has been attributed to policy and market changes (such as increased regulation and monopolisation), rather than altered public sentiment regarding residential care (Johnson *et al.* 2010a; Netten *et al.* 2005; Scourfield 2012). Concerns have been expressed that, in fact, the supply of social care is not keeping up with rising demand (Cottell 2017). Furthermore, as the population ages, the shortfall in residential care provision in particular is expected to intensify. Kingston *et al.* (2017) estimate that, even if the proportion of older people with care needs who

⁵ ‘Toileting’ refers to the act of assisting an individual with their elimination needs. For care workers, this can include: assisting someone with getting to or using the toilet, using a bedpan or portable urinal, changing incontinence pads, emptying a catheter bag of urine, changing a colostomy bag, and/or cleaning up urine and faecal matter.

⁶ Informal care is ‘given by one person, such as a family member (child or adult), friend or neighbour, on a regular basis to another person without financial payment, though such care does incur (in)visible costs’ (Theodosius, in Gabe and Monaghan 2010: 183). A key feature of population ageing is an increase in the old age dependency ratio (the number of people aged over sixty-five divided by the number of people at working age). An increase in this ratio, rising female employment, and increased geographical mobility have resulted in a ‘care deficit’ (Yeates 2009): that is, a reduction in the availability of informal care.

choose residential care remains the same, population ageing will necessitate the provision of an additional 71,215 care home places by 2025.

Tied to concerns about the growing shortfall in the supply of care homes for older people is the knowledge that the public funding of care is also declining. Humphries *et al.* (2016) report that, between 2009 and 2013/4, there was a 26 per cent reduction in the number of older people receiving local authority funded social care. This is despite the fact that the number of older people with care needs is increasing. Cutbacks in local authority funded care provision have taken place against a backdrop of austerity, which saw the funding provided to local governments by central government fall by 37 per cent in real terms between 2010/11 and 2015/16 (Humphries *et al.* 2016; National Audit Office 2014). Such austerity measures – coupled with increased demand for services and a rising complexity of older people’s needs – mean that, in England, the funding gap facing adult social care is now growing by an average of over £700 million per annum (LGA 2015). It is in this context that, in 2015, the Local Government Association (LGA 2015: 4) warned:

Inevitably, the care market is becoming increasingly fragile, and this adds a further risk to the system. These risks are illustrated by high turnover of staff, suppliers leaving the market, and increasingly slim margins for those that remain ... Funding for adult social care must keep pace with these growing demands and costs if we are to avert widespread market failure and the consequent impact on the lives of some of the most vulnerable members of our society.

Local governments and policy analysts have described the funding and provision of social care as ‘huge challenges for society in general’ (Age UK 2017a; Cottell 2017: 2). Public concerns about the sector, on the other hand, tend to focus on the quality of care being provided in residential homes, which is often thought to be poor (Community Care 2013). In a tracking study which surveyed public perceptions of social care in England each year between 2000 and 2014, for example, the annual percentage of respondents who agreed that people were treated with dignity and respect when they used social care services never surpassed 52 per cent (Quigley *et al.* 2015). Media portrayals of care homes for older people are similarly discouraging; usually focusing on either the financial

failure, parsimony, or avarice of care home providers, or on instances of neglect, abuse, and indignity experienced by residents⁷ (Mulley 2011).

The conditions of work faced by staff in the sector – and, specifically, those experienced by care workers⁸ – have also been the subject of increasing media attention over the past decade. This includes coverage of the number of care workers on ‘zero hours’ contracts (Guardian 2016); low pay (BBC 2017b); high turnover (Independent 2017); and the employee exhaustion caused by having to compensate for consequent staff shortages (BBC 2017a). England’s social care sector has an annual staff turnover of 27.8 per cent (Skills for Care 2017a). In the country’s residential care home sector (care homes without nursing), this percentage is even higher: 30.5 per cent of 170,000 care workers⁹ left their jobs in 2016/17 (Skills for Care 2017b). Little is known about the reasons for this high turnover¹⁰. What we do know is that social care providers are failing to plug the gap created by poor staff retention. On average, 6.6 per cent of adult social care roles in England remain vacant at any one time (90,000 vacancies), a figure which Skills for Care (2017a: 5) says ‘indicates that employers are struggling to find, recruit and retain suitable people to the sector’.

The media coverage of care homes over the past decade has also included the documentation of a series of scandals. Lloyd *et al.* (2014) have drawn attention to how for-profit care provision has been a key factor in the emergence of *all* media scandals involving care homes. In the UK, the most notable scandal of this kind in recent years was that surrounding the 2011 collapse of Southern Cross, a major

⁷ ‘Residents’ refers to people who live in care homes.

⁸ ‘Care worker’ is a broad term used to describe an individual who is paid to support, assist, or supervise frail, disabled, vulnerable, or unwell people. Care workers may also be referred to as care assistants, carers, support workers, care home assistants, or health care assistants (HCAs).

⁹ Skills for Care (2017a, 2017b) distinguishes between ‘care workers’ and ‘senior care workers’. Both groups of workers carry out direct care tasks (such as washing, toileting, and transferring residents) but ‘senior care workers’, as the name implies, work in more senior roles. On average, ‘senior care workers’ also receive comparatively higher pay, have more experience, and possess more care-related qualifications than ‘care workers’. In total, 305,000 individuals were employed in residential homes in England in 2016/17, of whom 225,000 were either ‘care workers’ or ‘senior care workers’.

¹⁰ In the independent social care sector as whole, the most commonly reported causes for leaving a job were ‘personal’ or ‘undisclosed’ reasons (35 per cent of leavers). Just 3 per cent of staff reported leaving their jobs due to low pay (Skills for Care 2017a).

for-profit corporation which, at the time, operated over 750 care homes. Though the media attention placed on Southern Cross predominantly focused on its financial difficulties, concerns were also raised about care standards in several of its homes (Jackson 2010; Lloyd *et al.* 2014).

Since the collapse of Southern Cross, the picture of social care painted by the mass media, non-profit organisations, and market analysts alike is, more often than not, one of a sector in crisis which is failing older people (Age UK 2017b; Jolley 2011; UNISON 2017). Troublingly, the view of the Care Quality Commission (CQC), which inspects all registered social care services in England, does not depart far from these portrayals. In its most recent 'State of Care' report, it warned:

[The] future quality [of health and social care] is precarious as the system struggles with increasingly complex demand, access and cost. The efforts of staff have largely ensured that quality of care has been maintained – but staff resilience is not inexhaustible, and some services have begun to deteriorate in quality. (CQC 2017b: 4)

A key concern expressed by the CQC (2017b: 9) was that 'there is too much variation' in the services being provided to older people. Though not alluded to in the CQC's report, some of this variation in service provision has been explained by statistical analyses of the association between the Inspectorate's quality ratings and the features of inspected care homes and their residents. Barron and West (2017), for example, used data from 15,000 inspections carried out by the CQC between April 2011 and October 2015 and found that for-profit providers had lower quality ratings than non-profit and public providers. Gage *et al.*'s (2009) analysis of the CQC's quality ratings for the 258 care homes operating in Surrey in 2002-2003 was even more illuminating, demonstrating that care homes had a higher probability of failing a quality standard if they were a for-profit small business and if they accommodated publicly funded residents. Better quality ratings, on the other hand, were associated with homes which were corporate for-profit and those which charged higher maximum fees. Since publicly funded residents are likely to be charged lower fees than private paying residents, we can assume that these high-cost care homes accommodated a higher proportion of private paying residents than their low-cost counterparts (Forder and Allan 2011).

Whether this inequitable relationship between the ownership, cost, and funding of care and its quality is present elsewhere in the UK or using alternative measures of quality, however, is currently unknown.

In sum, already regarded as under strain, the residential care sector for older people is likely to encounter considerable challenges over the coming decades: the need to create a possible 71,215 additional care home places by 2025 (Kingston *et al.* 2017); an anticipated overall funding gap of £5.8 billion by 2019/2020; an estimated shortfall of over one million care workers by 2037 (Franklin and Brancati 2015), and, not least, the need to secure the future quality and equity of service provision. Social care for older people, by all non-academic accounts, is at a watershed moment. It is vital, then, that we continue to subject care and care work to comprehensive academic and empirical inquiry. Below, I briefly outline some of the research that has been done in these areas to date¹¹, before locating my own study within these works.

Previous Research

Health and social care research is not the province of a single academic discipline. It draws upon a range of frameworks and methodologies; from business studies, Human Resource Management (HRM), and economics, to medical and healthcare sciences, public health, social gerontology, policy studies, sociology, and anthropology, among other fields. Despite the complexity of this literature, however, it has some common themes and points of congruence. Most often, its focus is on one of three core and interrelated aspects of social care, which I outline below.

First, there are a proliferation of studies focusing on the quality of care which is provided to older people (Cameron *et al.* 2012; Goodman *et al.* 2016; Hoe *et al.* 2006; Mozley 2017; Netten *et al.* 2012; Parker *et al.* 2004; Sutcliffe *et al.* 2007; Van Malderen *et al.* 2013; Zimmerman *et al.* 2015). ‘Quality’, in a large number of these studies, is measured in terms of either the prevalence of clinical outcomes –

¹¹ A more thorough examination of the literature on social care is undertaken in chapter two.

pressure sores, falls, incontinence, mortality – or older people’s own quantitative assessments of their quality of life or wellbeing.

Second, there is growing body of literature on paid care work (Baines 2004, 2006; Chou and Robert 2008; Cooke and Bartram 2015; Folbre and Nelson 2000; James 1992; Stacey 2005; Yeates 2009). A large portion of this literature is produced by those interested in the workforce issues associated with care work: workforce demographics (Anderson and Shutes 2014; Yeates 2009); recruitment, staffing levels, and turnover (Burns *et al.* 2016; Hussein *et al.* 2016; Rubery *et al.* 2011); pay (Hussein 2009; Low Pay Commission 2013; Rubery 2017); and training and qualifications (Cangiano *et al.* 2009; Coffey 2004; Gospel 2015; Gospel and Lewis 2011; Mcfarlane and Mclean 2003; Somerville 2006). Within the literature on paid care work, there is also an emerging body of work on how care workers experience and negotiate their labour (Duffy *et al.* 2015; Stacey 2011). Here, emphasis has been placed on the emotional and affective aspects of care work (Berdes and Eckert 2007; Gillespie *et al.* 2011; Ungerson 2005); its physical and ‘dirty’ nature (Stacey 2005; Twigg 2000, 2006); and on how – given these conditions – care workers might be motivated by and find dignity in their work (Folbre and Nelson 2000). There is also a small, but growing, body of literature which explores how care and care work are (or should be) understood, defined, and conceptualised and which, in turn, considers the implications of these things for how we value care and care work (Baines 2006; Dodson and Zinavage 2007; England 2005; England *et al.* 2002; Folbre 2006; Meagher 2006).

Third, there is a wealth of studies on the political-economic context of social care: its marketisation and commodification (Andrews and Phillips 2000; Claassen 2011; Fotaki and Boyd 2005; Higgs and Jones 2009; Pellegrino 1999; Scourfield 2005); privatisation and changing patterns of ownership (Drakeford 2006; Johnson *et al.* 2010a); competition (Forder and Allan 2011; Scourfield 2007); funding (Burns *et al.* 2016; Hancock *et al.* 2013); and its policy and regulatory context (Furness 2009; Haynes 2007; Reed *et al.* 2003). This literature, in the most part, comprises scoping studies (which enumerate the number and variety of social care services, workers,

or recipients), economic analyses of the social care market, and critical examinations of the policy landscape for social care.

Taken together, these bodies of work extend our understanding of social care in many ways but also present some notable gaps, disparities, and unknowns. First, few studies on social care bridge the divide between the three thematic areas outlined above: care quality and outcomes, care work, and the wider context of social care. Whilst there are some notable exceptions – studies examining the link between working conditions and care outcomes (Dodson and Zinavage 2007; Eaton 2000), for example – each area of research tends to remain siloed. Second, a large portion of the literature focuses on social care in general, rather than on the specific contexts in which it takes place: older people's own homes, residential homes, nursing homes, hospices, hospitals, and other settings. Nursing homes and residential homes have distinct workplace hierarchies, funding mechanisms and costs, and residents, for example, yet they are often grouped together under the term 'care homes' in the research literature (Szczepura *et al.* 2008).

A third issue is that, whilst there is considerable empirical research on the quality of care and conditions of work in the sector, this research is predominantly quantitative in nature. As such, an in-depth, nuanced understanding of the less measurable aspects of care and care work is often absent. Counting pressure sores and falls gives us an indication as to whether individuals are receiving adequate physical or medical treatment, but it reveals little about how those individuals are interacted with or whether (or why) they feel valued, respected, and cared for. Likewise, quantitative research has told us a great deal about the (easily measured) conditions of work experienced by care workers (staffing, pay, training), but much less about *how* such conditions are experienced or negotiated.

Finally, in the literature on social care as whole, there is an unhelpful divide between empirical and theoretical/conceptual accounts of care and care work. Even where we do have access to qualitative accounts of care workers' perspectives and experiences, for instance, the theoretical inquiry required to make sociological sense of these experiences (and to move beyond descriptive accounts of specific contexts and events) is often missing. Likewise, there is much

rhetoric concerning 'dignity', 'compassion' and 'care' in the policy literature, and discussion about how they are best conceptualised in the research literature. It is only recently, however, that empirical studies have begun to move such debates beyond the realm of theory, in order to establish how 'dignity' is given and experienced in tangible social care interactions; see, for example, Tadd *et al.*'s (2011) study of dignity in acute NHS trusts. These more recent works have demonstrated that taking account of various theoretical contributions, in conjunction with empirical research, offers sturdier foundations from which to build an understanding of, and proposed resolutions for, social care.

My own desire was, therefore, to carry out a study of social care that bridged the theoretical/empirical divide. My aspiration to undertake this research also had a second stimulus. Between 2006 and 2011, I worked in several residential homes as a cleaner, kitchen assistant, and care worker and, in 2011-2012, my interest in care work led me to research the training of care workers in a private residential home. My previous experiences of social care both fuelled my academic interest in care work and illuminated some of the gaps in the literature which I have identified above. In particular, drawing upon my own experiences made me conscious of the short supply of empirical accounts of the everyday practices, routines, and interactions of care workers. Whilst we have considerable knowledge of extraordinary and scandalous occurrences in social care – instances of abuse and financial collapse, for example – less is known about the mundane and unremarkable practices of residential care work with which I was familiar.

This Study

This ethnographic study takes steps towards addressing the deficiencies and limitations of the existing literature on social care outlined above. Specifically, I examine the provision of care to older people living in residential homes by focusing on the everyday interactions, routines, and rituals of care work. A close ethnographic examination of the ordinary practices and encounters occurring in residential homes reveals the respective roles played by political-economic factors, working conditions, material resources, and workplace culture, among other things, in producing particular types of care.

The study took place in one local authority area in the South of England, which I have named Esterton, and data collection was primarily carried out in two differently priced private residential homes for older people, which I have named Millstead and Shorefield. In total, around eight hundred hours of participant observation were undertaken over the course of two years, where I consecutively took on the role of care worker for twelve months at low-cost Millstead and twelve months at high-cost Shorefield. In addition, thirty in-depth interviews were undertaken with care workers who worked in other residential homes in Esterton. I report on this study over the course of the next six chapters.

Following this introductory chapter, chapter two is dedicated to providing a sturdier empirical and theoretical foundation for this study. The chapter begins by tracing the evolution of residential care for older people in the UK, considering its features and key turning points over the twentieth and twenty-first centuries. Next, and again elaborating on the account of social care which I provide in this chapter, I draw attention to the key issues which the residential care sector faced when this study began: concerns about population ageing, austerity, and inequities in the quality of care provision. Following this account of residential care, I explore the empirical literature on care work in more depth, highlighting where links have been made between the conditions of work experienced by care workers and the quality of care provided to care home residents. Next, I explore how researchers have made sense of care workers' motivations to care, how these motivations might be exploited, and their suggested alternatives to current conceptions of 'good care'. Finally, I outline the research questions which emerged from this review of the literature and which, in turn, drove my own study.

In chapter three, I summarise the study's methodological approach, outlining why and how I selected and gained access to Millstead and Shorefield and how data were collected and analysed. It is in this chapter that I reflect on some of the ethical issues that emerged before, during, and after data collection and upon my own role in the field. In chapter four, I start by providing a more detailed description of Millstead and Shorefield; how each home costed and charged for care, the services and facilities they provided to residents, and other noteworthy

features. A central focus of this chapter is the organisation of work at the homes: how it was divided-up, scheduled, and allocated to care workers. I examine how these forms of organising, by defining what activities were to be valued, shaped the nature and quality of care work and caregiving. In doing so, I begin to move beyond a human resources-based analysis of care work, focusing on the identity work of care workers and the normative and symbolic culture of residential care work.

In chapter five, I look at the everyday rituals and routines at low-cost Millstead and high-cost Shorefield in more detail by focusing on care workers' attitudes and practices concerning hygiene and bodily waste. Drawing upon Douglas' work on pollution beliefs and Durkheim's theory of moral individualism, I explore how care workers' ideas about the private and the public, the dirty and the clean, and the profane and the sacred were established and reaffirmed through the marking out of boundaries between materials, spaces, and persons. In doing so, I consider how differences in the availability of material and symbolic resources in the two homes resulted in two very different forms of care being provided to the residents who lived there.

In chapter six, I extend this analysis of the symbolic work undertaken by care workers at Millstead and Shorefield by considering how dying and death were dealt with in the two homes. Informed by Durkheim's work on mourning rituals, together with more recent accounts of death and dying, I explore how care workers' routines and rituals surrounding dying and death functioned to either show honour or disregard for residents. In undertaking this analysis, I consider what symbolic resources – beliefs, rituals, vocabularies – are available to care workers and what implications the presence or absence of these resources has for the kind of care which is provided to residents before and after they die. Finally, in chapter seven, I consider, in light of my study, how we might think about 'good quality care' and what is essential for its accomplishment.

Taken together, these chapters tell a story about the everyday routines and rituals of care work in two differently priced residential homes for older people in the UK. The care workers at both low-cost Millstead and high-cost Shorefield encountered

a range of moral, emotional, and material stresses which they (and their employers) negotiated and managed in different ways. Using social theory to make sense of data concerning the practices and interactions of care workers, I examine the normative and symbolic culture of work at the two homes. In so doing, I consider the consequences which the political-economic landscape of social care in England – by impacting upon the availability of material and symbolic resources in certain residential homes – has for both care workers and the care which they provide to older people.

Chapter 2: Background

In this chapter, I provide a background to this research, which examines the organisation of care work in two differently priced private residential homes in England. I begin by providing a brief history of residential care in England, then explore some of the important issues facing the sector today as identified in both the sociological literature and other literature on social care. Finally, I look at some of the ways that care work has been conceptualised, before outlining the research questions that drove this study.

The History of Residential Care

Before assessing the empirical literature on the provision of residential care today, it is worth examining how it is that residential care came into being, as well as how it has altered and transformed over time. It is by reflecting on this complex history that we are able to meaningfully think through the present state of residential care for older people. Like many social phenomena, the provision of residential care for older people does not have a definitive birth date and, likewise, has developed sporadically and non-linearly. The following account presents an attempt to find some clarity and linearity in this disorderly history so that we might grasp the main forces and events which have made residential care what it is today.

Poor Laws

Some form of organised care provision for older people has existed in England since the 1601 Poor Law, which required that each parish collected funds to care for older individuals without children. Residential care for older people originated in the Poor Law asylums and workhouses of the nineteenth century, which were characterised by their institutional practices of depersonalisation, segregation, regimentation, and batch treatment. These Poor Law institutions, which lasted into the twentieth century, offered an austere system of care that aimed to discourage and stigmatise those in need (Bland 1999). The Local Government Act (1929) transferred power from the guardians of workhouses to local authorities, whose Public Assistance Committees became responsible for the administration and management of the, now renamed, Public Assistance Institutions (PAIs).

Though considered a half-hearted move towards reform, the intention of the Act was to create a system of general hospitals to support those individuals who were already managed by local authorities (Townsend 1962).

It was not until 1948, when the Poor Law was abolished, that the reportedly authoritarian relationship between PAI managers and older people, which had done little to improve workhouses, was transformed. The 1945 Labour Government vowed to provide 'hotel-like' residential placements for the working classes (Johnson *et al.* 2010b), where older people would be treated like guests (Bland 1999; Townsend 1962). The Government envisaged that the movement of older people into residential care would not be a result of indigence but would reflect a choice on the part of the older individual to spend their pension on care (Bland 1999; Means and Smith 1983).

The NHS and the Ideal of Community Care

The establishment of the NHS in 1948 required that a distinction be made between the 'sick' elderly, who were placed in hospitals, and those who required 'care and attention not otherwise available', who were placed in former workhouses – now renamed 'residential homes' (Bell *et al.* 2010: 53). The health authorities became responsible for 90,000 older people – who were placed in hospitals – whilst local authorities became responsible for providing residential services to 42,000 older people (based on means testing) (Bell *et al.* 2010). This administrative divide between health and social care, established by the National Assistance Act (1948), has been the focus of ardent debate since its introduction (Cameron and Lart 2003; Lewis 2001). Such debate is, in the most part, due to the resource implications of defining health care and social care as separate entities as, whilst the NHS is free at the point of delivery and funded by taxation, social care is a 'mixed economy' which has been subject to means-testing since its inception (Lewis 2001).

The post-war social care system was characterised by the public ownership of production, public financing, and centralised planning and service delivery (Fotaki and Boyd 2005). Soon after the 1948 National Assistance Act, it became clear that the funding required to construct new, 'hotel-like' residential facilities was not

available and most retirees' pensions were too small to fund their care. In consequence, public subsidies were required to fund admissions into residential care, and the system continued to be based on statutory assessments of the health and social needs of the older individual rather than upon their personal choice or preference. In 1962, The National Assistance Act was amended in order to encourage local authorities to promote care in the community¹², a move that was considered to be in the best interests of both older people and the public purse. Likewise, the Health and Public Service Act 1968 enhanced the power of local authorities to provide community care services and made the provision of domestic help mandatory. The discourse of care in the community had been present since the National Assistance Act in 1948 but, even as the 1960s drew to a close, there was a clear lack of conceptual, statutory, or financial substance to the ideal and, in consequence, the political promise of community care had failed to materialise (Player and Pollock 2001).

The 1960s also saw the publication of Townsend's (1962) classic text – 'The Last Refuge' – which uncovered widespread problems in residential care homes across England and Wales. Whilst Townsend's focus was on the delivery of care in the, then expanding, public sector, and upon his belief that the state had failed in surmounting the final traces of the Poor Law, he also surveyed private and voluntary residential care homes. One of Townsend's principal concerns was that, in failing to replace former workhouses with smaller, purpose-built residential homes, the post-1948 Labour and Conservative Governments had 'helped to perpetuate a form of discrimination between human beings which was neither efficient nor moral' (1962: 433). For Townsend (1962), this inequality in living conditions centred around the distinction between the 'old stock' of communal residential homes – where up to fifty residents shared single dormitories – and new, purpose-built local authority, voluntary, or private homes, which often accommodated just ten to twenty individuals in private living quarters. Multiple problems in all types of residential homes were identified by Townsend; from

¹² Care in the community or community care refers to deinstitutionalised formal care-giving, where older and/or disabled people are treated and cared for by paid care workers in their own homes (domiciliary care), at day centres, or by respite services.

workers' threatening, insensitive or indifferent attitudes towards residents, to under-staffing, high staff turnover (up to 100 per cent annually), and a lack of training.

Townsend (1962: 179) suggested that, at the time of his study, older people had come to see paying for care as a means to preserve their privacy and lifestyle – likening it to paying for hotel accommodation. However, he questioned whether these expectations were realised in the private sector. When outlining why he felt that the private residential homes which he visited had failed to live up to the expectations of their residents, Townsend indicated that there was a conflict between owners' roles as proprietors – whose aim was to secure the financial stability of the homes – and as matrons – whose aim was to meet the care requirements of their residents. Overall, of the forty-two private residential homes where Townsend conducted interviews and observations, he found over one third to be 'seriously deficient', either in terms of the quality of proprietors and staff or in terms of physical amenities (1962: 208).

The Rise of Private Provision

Despite Townsend's concerns about residential care and the Labour and Conservative Governments' emphases on care in the community in the 1960s and 1970s, in 1980 (and again in 1983), the Conservative Government increased social security entitlements for those entering private or not-for-profit care homes. These changes to social security entitlements, albeit unintentionally, substantially increased the number of older people opting to move into residential care homes (Fotaki and Boyd 2005). Although some argue that it is unclear whether such increases were due to rising care needs or older people's changing care preferences (Bland 1999), others label the Government's funding changes 'the single most important factor underpinning the boom' in the private residential care sector (Andrews and Phillips 2000: 601). This is because older people who entered private or not-for-profit care homes, regardless of whether they had a need for care, became entitled to *greater* social security benefits than those who chose to stay at home or enter local authority care homes (Fotaki and Boyd 2005). Essentially, the changes in social security entitlements – which took effect in 1983

and remained unchanged for a decade – provided *guaranteed* full state funding for *all* older people entering *private* residential care homes who were deemed financially eligible. As well as increasing the number of older people opting to move into private residential homes, this move financially secured the residential care sector by minimising the economic risks involved in operating a residential home. Perhaps unsurprisingly, Andrews and Phillips (2000: 601) note that, following these changes in social security entitlements, ‘residential care businesses became known for their financial security and profit-making potential’.

The 1980s saw such policy changes coupled with several other conditions which made the residential care market appeal to both existing and aspiring entrepreneurs. For example, Andrews and Phillips (2000) highlight legislation which relaxed planning controls and property tax exemptions on residential homes, as well as the almost unceasing property boom of the 1980s, which led property ownership to be considered as a profitable investment. In coastal areas, the stock of large properties made available following the decline of British seaside resorts meant that it was easy to make these investments. Furthermore, increased retirement migration to coastal locations, as well as the Government’s policy emphasis on closing long-stay geriatric wards, ensured that there was no shortage of potential residents. The result was an increase in the number of people – sometimes nurses or sometimes individuals with experience in hospitality or property investment – opting to open residential care homes for older people and run them as private enterprises (Andrews and Phillips 2000), particularly in coastal areas.

Prior to 1983, the rate of growth in the private residential care sector in England had surpassed that in the public sector. The average annual increase in the number of private residential homes between 1975 and 1982 was 11.2 per cent, which compared to an average 1.2 per cent increase in local authority care homes (Phillips *et al.* 1986). Following the Government’s changes to social security entitlements, the rate of growth in England’s private residential care sector accelerated further, and fewer local authority and not-for-profit homes were opened. Between 1982 and 1984, just 2,000 local authority residential homes

were opened whilst 14,000 private homes were opened (average annual increases of 0.95 per cent and 19.5 per cent, respectively) (Phillips *et al.* 1986). The consequence was that, by 1998, the private sector accounted for more than half of the residential care market (Player and Pollock 2001).

The growth of the private residential care home sector in the 1980s was accompanied by new academic research, as the mixed provision of public and private residential care was raising some important issues (Haynes 2007; Johnson *et al.* 2010a). Building upon Townsend's ground-breaking study of residential care in the 1960s, such work paid increasing attention to what was being provided for those in need of care, who was making these provisions, and the quality of such provision (Brearley 1985). Concern was expressed about the ability of state services to control and plan for provision in what was becoming an increasingly plural system. For example, Bird's (1984) research, which examined one social services department's role in supervising and subsidising private care providers, pointed towards the increasing portion of public funds being injected into the private sector. Both Bird's (1984) research and that of others (Grundy 1987; Phillips *et al.* 1986) identified that the sector's biggest problems revolved around the seemingly paradoxical goals of policies which encouraged care in the community, whilst simultaneously increasing the level of public funding being directed towards for-profit residential homes.

These concerns in the 1980s placed pressure upon the Government to increase the regulation of the private residential care sector and, in 1984, the Registered Homes Act made it possible for regulations to be made concerning the condition and running of private and non-profit residential homes. Discursively, policies began to shift their focus towards affirming residents' quality of life rather than focusing on their frailty (Bland 1999). The growth in the number of people opting to move into residential care homes in the 1980s had also caused a substantial rise in the public cost of residential care which, as the decade came to a close, was deemed unsustainable. In fact, the social security budget for residential care (for both older people and individuals with a disability) had risen from £6 million in 1978 to a staggering £1.3 *billion* by 1991 (Andrews and Phillips 2000).

Creating a Market for Social Care

The NHS and Community Care Act 1990 was designed to combat the growing public cost of residential care through the introduction of a quasi-market approach to the delivery of care (Fotaki and Boyd 2005; Gospel and Lewis 2011). In the new system, local authorities were given the responsibility of buying care packages from a 'mixed economy' of care providers on behalf of older people (Holden 2002). Reflecting the Conservative Government's faithfulness to market capitalism, the 1990 Act aimed to increase consumer choice and competition which, in turn, was expected to improve the cost effectiveness and quality of service delivery (Gospel and Lewis 2011; Haynes 2007).

In addition to introducing competition within the sector, and in response to ongoing concerns about quality, the 1990 Act also set standards for all social care providers which would be enforced through inspections. The fail-safe income enjoyed by proprietors of private residential homes in the 1980s became somewhat more precarious as they were now required to comply with the Act's standards, whilst also competing 'with each other in a market for finite clients funded by limited social budgets held by local authority purchasers' (Andrews and Phillips 2000: 599). One effect of the 1990 Act was, then, to undermine proprietors' relatively secure fiscal environments (Knapp *et al.* 2001). As the principal purchasers of care, local authorities were able to exert market pressure on private care homes to maintain low fees and, inevitably, it was smaller care home providers who buckled under the new competitive conditions (Holden 2002). Initial consolidation in the sector, which began following the 1990 Act, was thus marked by the acquisition of small, family-run residential homes by large corporate providers.

There is a general consensus that the principal objective of the 1990 Act was to curtail the surge in public spending which would have been necessitated by the UK's increasingly ageing population (Johnson *et al.* 2010a, 2010b; Means *et al.* 2008; Scourfield 2012). Following the key recommendations of the 1988 Griffiths Report, the 1990 Act aimed to reduce government spending on private residential care by allowing local authority social service departments to operate as 'case

managers' – rather than as providers of care – supporting people to choose their preferred method of care, which was usually community care (Gott *et al.* 2004; Leathard 2000). The grant provided to aid this transition from central government funding to local authority case management was solely to be spent on community care and, moreover, 85 per cent of the grant was legally required to be spent on private sector providers (Player and Pollock 2001). This made relying upon local authority residential homes increasingly problematic. Although this budgetary ring-fencing was discarded in 1999, by then, contracting out to the private sector had become the norm for local authority case managers (Player and Pollock 2001).

The 1990 Act meant that older people now had to be assessed both financially and in terms of need if they sought state funding for residential care. Local authorities, though confined by central Government's declining resource allocation, were given the responsibility of purchasing services on behalf of those with a need for care; from the state, the private sector, or the not-for-profit sector (Fotaki and Boyd 2005). Following the Act, there was a substantial decline in the number of residential care places provided by the statutory sector. In addition, the share of the UK's residential care market held by the private sector rose from 42.7 per cent (£971 million) in 1988 to 55.6 per cent (£2,103 million) in 1998 (Player and Pollock 2001). The 1990 NHS and Community Care Act is, therefore, often considered a crucial turning point in the history of residential care as, following its implementation in 1993, the marketisation and privatisation of provision significantly increased (Scourfield 2012). Indeed, we will see shortly how, by 2010, over three-quarters of nursing and residential care placements for older people were accounted for by the private sector (Forder and Allan 2011).

In the late 1990s, concern was once again expressed about the need to appropriately regulate the private provision of care, which led to the introduction of a new statutory framework – The Care Standards Act 2000 – designed to both train the social care workforce and to catalyse a shift in HRM practices within the sector (Gospel and Lewis 2011). The Care Standards Act established the National Care Standards Commission (NCSC) to regulate and inspect all social care services against several National Minimum Standards (NMS). Within three weeks of the

NCSC's introduction, however, the Government announced that it would be renamed the Commission for Social Care Inspection (CSCI). In response to care providers' claims that rigorous national standards were unrealistic and resulting in extensive closures, it was announced that the NMS's requirements would be diluted in 2002. This led to subsequent concerns that the Commission was watering down standards and, in response, the changes to the requirements were not implemented (Drakeford 2006).

There was an increase in the number of closures of private residential homes in the UK in the late 1990s and early 2000s. There are a number of likely causes of this, including the new NMS, alongside the introduction of the minimum wage in 1999, the policy shift towards the promotion of care in the community, and the transfer of financial responsibility for care provision to local authorities, which resulted in lower fees being paid to service providers (Johnson *et al.* 2010a; Scourfield 2012). Such closures, most often, reflected financial decisions based around the increasing costs of adherence to NMS and staffing, reduced levels of financial support, and changing property values – with some uninhabited homes now worth more than those which were operating as businesses (Johnson *et al.* 2010a). Following an extensive examination of the care home closures which took place in England between 2000 and 2001, Netten *et al.* (2005: 333) concluded that it was 'not poor quality homes', but rather 'smaller private homes and organisations with just one or two homes' which were the most likely to have closed voluntarily. There were also early signs of industry consolidation at the top-end of the social care market, as some of the bigger providers bought out their direct competitors. There was a drop, for example, in the number of for-profit providers owning more than three homes (from 295 to 285) between 1996 and 1998 and a halving in the number of quoted companies¹³ (from 11 to 6) in the same period (Player and Pollock 2001).

¹³ Companies whose shares are listed on the official stock exchange.

Residential Care Today

Residential care in England has a complex and thorny history but that is not to say that the sector or the context in which it operates is any less complex today. As we saw in the previous chapter, the kinds of concerns about residential care provision that were highlighted by Townsend's (1962) study in the 1960s continue to be reflected in political, media, and public discourse. Today, the sector also faces new challenges, including tendencies towards market monopoly, cuts to social care funding, and population ageing. Below, I present a more detailed picture of what the residential care sector looked like in January 2013, when fieldwork for this study commenced.

Though the first signs of industry consolidation were present in the late 1990s, it was not until 2004 that the residential care market began to display clear tendencies towards monopoly and standardisation (Drakeford 2006). In the decade prior to 2010, the share of residential and nursing care placements managed by the private, for-profit sector had risen by 25.3 per cent to 77 per cent (Forder and Allan 2011). Moreover, by 2009, the share of the residential care market (measured by for-profit beds operated) held by the four largest private providers stood at 24.1 per cent (Laing and Buisson 2010, cited in Scourfield 2012). This reflects a wider shift towards market concentration in the sector, whereby providers operating at least three care homes saw their market share increase from 5 per cent in 1989 to 41.9 per cent in 2010 (Forder and Allan 2011). Scourfield (2007, 2012) has used the term 'caretelization' to describe this corporate penetration of the care home market, which has occurred in the UK since the late 1990s. Despite this 'caretelization', however, in 2010, 45 per cent of all care home beds in the UK's private sector were still being provided by small-scale providers¹⁴ (Forder and Allan 2011). When the fieldwork for this study commenced, then, the UK's market of social care remained a particularly plural one, a reflection, perhaps, of the multitude of needs, preferences, and budgets amongst those whom it targeted.

¹⁴ Small-scale providers are companies which operate just one or two care homes.

A Question of Quality

Whilst there have been concerns about the quality of residential care since its inception, Scourfield (2007) has suggested that inadequacies in the sector run the risk of being exacerbated by these processes of privatisation and consolidation, which replace values of public service with business values. As Drakeford notes:

The world of equity specialists, venture capitalists and buy-out deals may seem remote from the day-to-day operation of social welfare and of social policy analysts. Yet the line that links the person in the day room and the person in the boardroom is a direct one and the language that it speaks is that of cash flows, more than care, and of the quantity of earnings, much more than the quality of service. (2006: 936)

Drakeford's (2006) analysis of research evidence leads him to argue that, despite continual structural change, national regulation has still not succeeded in enhancing service delivery or quality. Using the quality ratings of all private residential homes in England, Johnson *et al.* (2010a) determined that, in 2005-6, 29.5 per cent of homes did not meet the (then CSCI's) national standards. The quality ratings of private homes were, in fact, considerably lower than those afforded to not-for-profit homes, where just 12.5 per cent did not meet national standards. As we saw in chapter one, this disparity between the quality ratings of private and not-for-profit homes has been confirmed by others (Gage *et al.* 2009).

Also of concern is the accuracy and reliability of the (now titled) Care Quality Commission's (CQC) quality ratings of UK care homes. Netten *et al.*'s (2012) study, which measured social care-related quality of life outcomes¹⁵ for 366 residents living in 83 English care homes inspected during 2008, concluded that there was only a limited association between the quality ratings of residential homes and the quality of life scores of their residents¹⁶. The study also pointed towards an inability of residential homes to move beyond meeting the 'basic' needs of older people (such as personal hygiene) to adequately address 'higher-order' needs

¹⁵ Residents' 'social care-related quality of life' was measured using the Adult Social Care Outcomes Toolkit in seven domains: personal cleanliness; food and drink; safety; accommodation; cleanliness and comfort; control over daily life; occupation; and social participation and involvement (Netten *et al.* 2012: 513).

¹⁶ The reported difference in social care-related quality of life outcomes for residents in one-starred and two-starred residential homes, for example, was described as relatively small.

(such as social participation). Netten *et al.* warned that residential homes' inability to address such 'higher order' needs might be due to the cost of care (in terms of fees being charged to local authorities and/or residents) being too low.

As I noted in the previous chapter, concerns about the quality of social care provision in the UK have also been fuelled by media reports, which have made visible the tensions between 'the logic of care and that of the market' (Lloyd *et al.* 2014: 13). Most notable amongst recent public scandals was the financial collapse of, and service failures, at the large for-profit care provider Southern Cross in 2011 (Lloyd *et al.* 2014; Scourfield 2012). Such scandals both reflect and shape public perceptions of residential care. It is perhaps unsurprising, then, that the UK public reportedly consider social care institutions as a 'homogenous and universally negative category' (Johnson *et al.* 2010: 217), which presents a 'last resort' for older people with a need for care (Lee *et al.* 2013: 48).

Population Ageing and the Age of Austerity

In 2012, just before fieldwork for this study began, there were an estimated 414,000 older people living in residential care in the UK, which reflected a 2.2 per cent annual increase from 2011 (Age UK 2013). On further examination, however, this increased demand is shown to result not from the increased likelihood of an individual aged over sixty-five years entering residential care¹⁷ but due to demographic change over that year, where the number of people in the UK aged over sixty-five years rose by 3.7 per cent (from 9,296,100 to 9,642,400) (ONS 2012). As we saw in chapter one, this rise is part of a wider pattern of demographic change over the past six decades, whereby there was an 80 per cent increase in the population aged over sixty-five years between 1951 and 2011 (Rutherford 2012). Moreover, the percentage of the population aged over ninety rose by 32.7 per cent in the decade to 2012 (ONS 2012). A quantitative transformation of the population aged over sixty-five years has therefore been coupled with what might be regarded as a qualitative shift, whereby the growth in the number of 'oldest

¹⁷In 2011, 4.54 per cent of the population aged over sixty-five years were living in residential care, whereas in 2012, 4.48 per cent of the population aged over sixty-five years were living in residential care (ONS 2012).

old' individuals (those aged over eighty) has exceeded the speed at which the broader 'old' section of the population is expanding (Myles 2002). It is this section of the population who are most likely to have high care needs¹⁸. Moreover, the ability of those considered as 'traditional caregivers' – female relatives provided 75 per cent of informal care in 1996 (Myles 2002) – to meet these needs has declined alongside increasing female employment. Whilst demographic change has undoubtedly allowed the private residential care market to expand, the ever-increasing demand which it places upon the private sector has perhaps altered the competitive forces which the 1990 Conservative Government had hoped would secure quality in provision.

The UK's ageing population has put increasing financial pressure upon local authorities who, in 2011, remained legally responsible for commissioning and paying for 60 per cent of private care provision (Forder and Allan 2011). Furthermore, at the time that this study began, the social care sector had certainly not been left untouched by government spending cuts which, allowing for inflation, reduced spending on adult social care by 1.7 per cent in 2010/11 (Charlesworth and Thorlby 2011). Whilst, even before the 2010 spending review, government expenditure was barely keeping pace with demand for adult social care, in 2011, The Dilnot Commission estimated that, in the four years to 2012, demand for adult social care had outgrown government spending by 9 per cent (Charlesworth and Thorlby 2011).

Though there is only piecemeal evidence of how local authorities have responded to the financial pressures created by this shortfall, Charlesworth and Thorlby (2011) suggest that the three options available to local authorities are: to restrict

¹⁸ Most commonly, age is used as a proxy to estimate the number of individuals in a population with high care and/or support needs. The Joseph Rowntree Foundation's Better Life programme categorises older people with higher support needs as those who 'need a lot of support associated with physical frailty, chronic conditions and/or multiple impairments (including dementia)' (Katz *et al.* 2011: 9). Others define high support needs as 'having one or more of dementia, confusion, challenging behaviour, dual incontinence, severe hearing or visual impairment or total dependence in mobility' (Lievesley *et al.* 2011: 7). BUPA suggests that 90 per cent of its care home residents would fit into this category (Lievesley *et al.* 2011), but less information is available regarding residents living in smaller and/or for-profit residential homes.

access to care; to raise the productivity of social care; or to reduce the quality of care services. In 2011, Forder and Allan's review of the literature on competition in the UK's residential care sector indicated that the profit margins reported by private residential homes in England were 'very tight' (2011: 9). One study, in fact, concluded that local authority commissioners were failing to pay the level of fees necessary to sustain a residential care sector which met all of the most recent National Minimum Standards (NMS) (Laing 2008).

As the primary purchasers of private residential care, local authorities are able to enforce competition between providers in order to secure lower care fees. Reporting upon research which examined the link between care home competition and level of fees, Forder and Allan (2011) note how this arrangement discourages the provision of anything more than basic levels of care:

There is a tentative suggestion in these results that homes compete on price to a greater extent than on quality. A more nuanced argument would be that once homes have attained minimum quality levels (as defined by CQC minimum standards) then public purchasers are more interested in purchasing from the lowest cost bidder. The self-pay [private pay] market is presumably more concerned with quality, not least because we see significant vertical price differentiation in the market. (2011: 15)

The result is a dichotomous and deeply inequitable residential care market which is marked by low quality, low-cost care for publicly funded residents at one end and by high quality, high-cost care for private payers at the other¹⁹. As we saw in chapter one, there is some empirical evidence of this relationship between the source of a resident's funding, the cost of their care, and the quality of the service which they receive²⁰ in the academic literature (Gage *et al.* 2009). Indeed, Johnson *et al.* (2010a) identified the uneven quality of private care provision as a key continuity from Townsend's era, where structural inequalities ensured that 'different living standards [were] enjoyed by different people with similar needs'

¹⁹ Forder and Allan (2011) also discuss research which shows that home closures are reported to occur because of low fees charged to publicly funded residents. These closures are concentrated among smaller, single home providers, suggesting a link between market concentration and home closure.

²⁰ Measured in terms of CQC quality ratings.

(1962: 432).²¹ Since this research was undertaken, and as outlined in the previous chapter, the Care Inspectorate (CQC 2017b) has similarly drawn attention to problematic variation in the quality of care received by older people living in different care settings.

Research on Care Work

Concerns about the quality of residential care provision have existed since its inception, yet the conditions experienced by those who work in the social care sector have only come under academic and public scrutiny over the past three decades. Moreover, little has been done to empirically examine the links between conditions of work in the sector and the quality of care being provided to older people. In the academic literature, for example, care work is often examined by those with an expertise and interest in Human Resource Management (HRM) and, more recently, the sociology of work and employment. *Care provision*, on the other hand, is more likely to be studied by those working in the fields of social policy, social gerontology, or medical sociology. Below, I explore some of the critical issues that have been identified by employment studies of paid care work and, where empirical evidence is available, the links that have been made between these issues and the quality of care provision.

Eaton's (2000) research, which examines the link between HRM, work organisation, and patient care quality in nursing homes in the United States, aims to make a link between these two critical themes dominating the literature on social care: the quality of care provision and the conditions of paid care work. Eaton's (2000) observational research in twenty settings led her to identify a hierarchical typology of models of work and care in nursing homes. The ideal type which Eaton described as 'low service quality' was used to refer to homes characterised by an antiquated, labour-intensive work system with minimal training and supervision of care workers, low wages, a high turnover of staff, and poor quality care. In some of these homes, the managerial response to care

²¹ Since fieldwork for this study was undertaken, evidence of such inequities in care provision has mounted. See, for example, Barron and West's (2017) analysis of care home quality ratings, which was referred to in chapter one.

workers being unable to complete their work due to staff shortages was to encourage workers to do a faster and cheaper job – to ‘speed-up’ caregiving. Eaton noted that,

In lower quality nursing homes, staff often feel overwhelmed by the demands confronting them and appear to manage as though cost efficiency is the overriding goal, with quality care defined as not violating regulations, and front-line workers viewed as replaceable and unskilled. (2000: 601)

Eaton (2000: 598) divided the ownership type of these low quality nursing homes into ‘mom and pop’ (family-run homes) and ‘for profit chains’. When referring to the reimbursement arrangements of low quality homes, Eaton used the term ‘Medicaid mills’, indicating that the homes had a high number of residents whose care was funded through state subsidies. In the UK, these homes might be compared to those with a high number of local authority (publicly) funded residents and few private paying residents.

Those homes which Eaton (2000) categorised as ‘high quality’ were often non-profit and/or religious and, if for-profit, were ‘high end’ homes which targeted the private pay market. Rather than the high quality of these homes being a result of their profit status, Eaton (2000: 601) attributed such quality to the homes’ managerial philosophies and related work organisation systems. Notably, however, Eaton’s high quality homes were not short staffed, workers had higher starting wages than those in low quality homes, and were much more likely to be unionised. These homes also had a much lower staff turnover than low quality homes, more trained staff, more training, greater continuity of care²², and better quality outcomes²³. Given that the cost structure of Eaton’s high quality homes was greater than that of low quality homes, we can assume that these HRM

²² There is poor conceptual clarity around the term ‘continuity of care’ (Sweeney *et al.* 2016). In this thesis, the phrase continuity of care is simply used to consider the quality of care over time. This can refer either to a resident’s continuous caring relationship with a care worker or care workers or, more generally, to care which is integrated, coordinated and involves the sharing of information between every individual who is involved in a resident’s care (Gulliford *et al.* 2006).

²³Quality outcomes included less pressure sores, less hospitalisations, absence of odour, higher resident activity levels, and increased social engagement.

practices and more progressive managerial philosophies were required to be paid for with higher resident fees.

Though the focus of Eaton's research is the nursing home sector in the United States, her ideal-typical account of care organisations draws attention to the polarising effects which ownership and funding arrangements can have on HRM practices and, in turn, on the quality of care which is provided to older people. Below, I supplement Eaton's account with the wider literature on conditions of work in the social care sector.

Worker Dissatisfaction

Redfern *et al.* (2002), whose study drew upon data gathered from twenty-two residents and forty-four care workers in a London nursing home, found a significant positive correlation between care workers' job satisfaction and the quality of care which they provided. In order to add to the nominal amount of literature on the links between worker satisfaction and the quality of care provision, a member of Redfern *et al.*'s research team worked in the nursing home for a month, as well as gathering data through the use of questionnaires and interviews. The study found that 50 per cent of the home's care workers were dissatisfied with their jobs; particularly with low pay, poor job security, and few opportunities to use their abilities. Notably, these low satisfaction levels had a negative impact on care quality and resident morale. High levels of commitment of care workers to their place of employment were also found to correlate strongly with increased employee satisfaction and high care quality. To what extent job satisfaction encourages workers to care well, and to what extent the capacity to care well encourages workers to feel satisfaction in their jobs, was left unexamined in this study.

Given the importance which Redfern *et al.* attribute to worker satisfaction, as a correlate of quality caregiving, we should take seriously Kemper *et al.*'s (2008) research in the US, which indicates that the high levels of dissatisfaction uncovered by Redfern *et al.* are not case-specific. Kemper *et al.* examined what changes in managerial practices might improve the experiences of care workers. Asking care workers from five American states what would improve their jobs,

Kemper *et al.* found that 76 per cent of the residential care²⁴ workers whom they interviewed made recommendations as to how their jobs could be improved. As was the case in Redfern *et al.*'s study, the workers' principal recommendation was for higher pay or better benefits, with 47 per cent of care workers mentioning increased compensation.

The second recommendation made by the care workers in Kemper *et al.*'s (2008) study was the need for improved work relationships, with 19 per cent of residential care workers making this recommendation. This included listening, appreciation, and respect, and, in the most part, appeared to refer to the care workers' relationships with their supervisors. This is supported by Chou and Robert's (2008) research which reports that job satisfaction is negatively associated with role overload and positively associated with instrumental and emotional supervisory support. Kemper *et al.* (2008) noted how the language used by respondents in the part of their survey which asked about workplace support and work relationships was much more personalised than that employed when discussing other recommendations. They suggested that this was due to the high level of stress which poor work relationships placed upon the care workers. Several care workers in Kemper *et al.*'s study also made calls for improved management systems, referring to the purchasing of equipment, availability of training, and work scheduling. Several other researchers (Macpherson *et al.* 1994; Proctor *et al.* 1998) have also noted the impact which organisational pressures such as staff shortages, scarcity of resources, and inadequate training can have upon psychological stress amongst care workers.

Staffing, Recruitment, and Turnover

Kemper *et al.* (2008) also found that several care workers called for more or better staffing. A common way to reduce costs, low staffing has been criticised for causing care workers to struggle to keep up with basic care activities, undermining their efforts to individualise caregiving and, in turn, causing exhaustion and stress (Dodson and Zinavage 2007; Lloyd *et al.* 2014). Insufficient staffing has also been

²⁴ Termed 'assisted living' in Kemper *et al.*'s (2008) US-based study.

linked to poor health outcomes for residents, such as avoidable incontinence, increased physical restraints, the development of pressure sores, fractures, and infections (Eaton 2000). Past research examining the impact which short staffing has upon the quality of care provided to residents (in the US) noted how residents spent an average of just 4 per cent of their day being directly cared for, and most of their time sat waiting to be washed, dressed, toileted, or fed (Mt. St. Vincent Providence 1994).

One explanation for low-staffing in residential care homes may be the difficulties which managers encounter when attempting to recruit employees. Whilst the predominant recruitment strategy for care staff in the US is 'word of mouth' (Ball *et al.* 2010), care homes in the UK are reported to have substantial recruitment difficulties and employ an eclectic mix of informal and formal methods of recruitment (Rubery *et al.* 2011; Skills for Care 2017a). Likewise, as we saw in chapter one, the turnover of care workers in the UK is high, particularly in the private residential care sector. Hussein *et al.*'s (2016) longitudinal study of the National Minimum Dataset for Social Care (NMDS-SC), for example, found that, between 2008 and 2010, care worker turnover amongst private providers stayed at around 25 per cent, whereas in the public sector this figure was around 10 per cent. They attributed this to the (generally) less favourable working conditions and lower levels of pay in the private sector.

In the US, researchers have linked high staff turnover to lack of care continuity and poor patient care outcomes (Eaton 2000). Simonazzi (2008: 21) attributes the 'severe' problems of workforce retention in the UK care sector to 'low wages, a negative public image of social care work, organisational aspects which reduce job satisfaction ... and the stress of the work'. She suggests that increased privatisation within the sector, which has led to cost-reduction strategies that advance the development of a casualised and low paid workforce, exacerbates these problems.

Training

A substantial amount of research outlines the relationship between the training of care workers and the quality of care provision (Ball *et al.* 2010; Eaton 2000; Gospel and Lewis 2011; Meagher 2006; Miller and Mor 2006). In 1998, the White Paper

'Modernising Social Services' recognised this link between the training of care workers and the quality of caregiving, and drew attention to the lack of training and qualifications of UK social care workers – 80 per cent of whom had no formal qualifications or training. It was following the 1998 White Paper that the regulatory and policy frameworks within which the sector operates were altered with a view to 'modernising' social care. The Care Standards Act (2000), which was implemented in response to concerns regarding the quality of care within the sector, introduced National Minimum Standards (NMS) on the training and development of care workers. The Act has been shown to have had a positive effect on the level of training and qualifications of residential care workers (Gospel and Lewis 2011). Cangiano *et al.*'s (2009) analysis of Labour Force Survey data from 2007 also indicated substantial improvements, with 66 per cent of care workers reporting that they had achieved at least an NVQ Level 2 qualification. It is important to note that, whilst the Labour Force Survey reports on the general qualification *level* of care workers, the intention of the Care Standard Act (2000) was to increase *care-related* qualifications. The uptake and awarding of the Health and Social Care NVQ has, however, similarly increased (Cangiano *et al.* 2009).

Nonetheless, few residential homes have matched their compliance to regulations directly concerning training and skill development by showing a commitment to other HRM practices; such as financial reward for attaining qualifications, job security, career prospects or improvements in pay, job design, and career structures (Gospel and Lewis 2011). Furthermore, several employers interviewed by Gospel and Lewis (2011) complained that the implementation of the training called for by the CQC – that an NVQ Level 2 qualification was achieved by 50 per cent of workers – in most cases acted as a certification of existing competencies, rather than a stimulus for workers to acquire superior knowledge and skills which would enable them to improve the quality of their caregiving. Employers' perception of the redundancy of qualifications may also explain why care workers with certified training get a limited wage premium for their efforts (Cangiano *et al.* 2009).

Pay

The low level of pay received by care workers relative to workers in other sectors has been recognised both in public and academic accounts of care work (BBC 2017b; Low Pay Commission 2013; Rubery 2017). The most recent data available when the fieldwork for this study commenced indicated that the average wage of care workers was not far above the minimum wage (Hussein 2010). Using the NMDS-SC (2009) – which was completed by employers in social care and contained data on 438,973 workers – Hussein (2010) calculated that the mean hourly wage for care workers in England in 2009 was £6.69 (median: £6.45, SD. 1.11). The mean hourly wage for senior care workers was £7.28 (median £7.00, SD. 1.43). Whilst these averages are slightly above the National Minimum Wage (NMW) – which was £5.73 for adults at the time the NMDS-SC was completed – the care workers' hourly pay rates ranged from just £3.02 to £14.24. Hussein (2009) notes that, prior to the introduction of the £3.60 NMW in 1999, approximately 40 per cent of care home employees were earning under £3.60 per hour. The introduction of the NMW caused an instant increase in care workers' wages to £3.60, but it is reported to have had few spill over effects and their average wages, at the time this study commenced, remained close to the NMW (Hussein 2009; Low Pay Commission 2013).

Hussein (2010) also notes how there is a substantial pay gap between care workers working in England's public and private sectors. Whilst the average hourly pay for a local authority direct care worker²⁵ in 2010 was £8.48 (SD. 1.86), direct care workers in the not-for-profit sector received £7.39 (SD. 1.04), and private sector direct care workers received just £6.30 (SD. 0.59). Hussein attributes these differences to the lower degree of regulation in the private sector and, also, to differences in workforce demographics between the sectors. The Low Pay Commission (2009) has also drawn attention to the prevalence of care workers being paid at, or below, the NMW in the UK's private sector. By 2013, whilst community care had become the focus of particular scrutiny, the Low Pay

²⁵ 'Direct care workers' refers to those who carry out hands-on tasks (such as washing, toileting, and transferring residents) for/with individuals with a need for care. Both care workers and senior care workers are 'direct care workers'.

Commission (2013) suggested that there was growing non-compliance with the NMW amongst care providers in general. In fact, the Trades Union Congress (TUC) named social care the 'single biggest sector where evasion of the NMW occurred' and noted that this evasion 'continued to spread through practices such as the misuse of zero hours contracts' (Low Pay Commission 2013: 125). Evidence provided to the Low Pay Commission by the, then coalition, Government indicated that, in 2013, Her Majesty's Revenue and Customs (HMRC) were investigating 120 UK care providers for NMW non-compliance.

Of the 74,021 direct care workers surveyed in the NMDS-SC, 86.8 per cent were female and of the 6,212 managerial or supervisory staff, 82.9 per cent were female. There was only a slight difference between the average hourly earnings of male (£6.92, SD. 1.35) and female (£6.81, SD. 1.24) direct care workers doing the same jobs (-1.59 per cent)²⁶. A care worker's ethnicity, on the other hand, was found to have more of an affect on pay differentials, whereby the mean hourly wage for Black and Minority Ethnic (BME) direct care workers (£6.48) was 6 per cent lower than that of white care workers (£6.89) doing the same jobs (Hussein 2010). A similar ethnicity-based pay gap was seen to exist at all occupational levels of the social care workforce.

The devaluation framework has been used to explain the comparatively low levels of pay received by those working in the social care sector. The framework argues that a society that views women as inferior to men will tend to undervalue the work which women are more likely to partake in (England 2005). By cognitive association, such cultural ideas of gender supremacy, thus, give rise to normative assumptions regarding the relative value of 'male' and 'female' work, as well as to the framing of 'female' tasks as antithetical to profit-oriented goals (England 2005). In addition to being predominantly undertaken by females, the activity of care is also culturally considered as characteristically feminine. The view of several feminist scholars is that, when caring is gendered as a female activity, this further

²⁶ The pay differentials between male (£12.82, SD. 4.14) and female (£11.75, SD. 3.97) managerial staff doing the same jobs within the sector was more substantial (-8.35 per cent)

extends its devaluation (Cancian and Oliker 2000; England 2005; England and Folbre 1999; England *et al.* 2002).

In addition, Ball *et al.* (2010: 251-2) note how low pay within the sector has an impact upon the characteristics of those workers who are attracted to care work – defined by Ball *et al.* as ‘those with few other options’ – as well as upon the criteria for hiring care workers. They suggest that this is why employers feel entitled to emphasise candidates’ personal qualities rather than their professional and educational competencies. The effect of this strategy, however, is that it bolsters occupational gender segregation because the qualities which employers seek are themselves considered as ‘natural’ female qualities (Ball *et al.* 2010).

Workforce Demographics

Gospel and Lewis (2011) indicated that, in 2011, there were just over one million care workers in the UK (this included all types of care workers), of whom 85 per cent were female, 50 per cent were part-time workers, and 65 per cent were aged over thirty-five. Fotaki and Boyd (2005) note that, by encouraging cross-border workforce mobility within European Union (EU) member states, EU laws²⁷ may have had an indirect impact on residential care, increasing the proportion of recent UK migrants in the workforce. In fact, in 2007/2008, approximately 18-19 per cent of all care workers in the UK were migrant workers (Cangiano *et al.* 2009) and, in 2009, an estimated 68 per cent of care workers in London were born outside of the UK (Hussein *et al.* 2011). The percentage of workers in the care sector who are migrants, thus, surpasses the percentage of migrant workers in the overall labour force which, in 2009, stood at 13 per cent (Cangiano *et al.* 2009). In 2009, the top five countries of birth of migrant care workers were Poland, Zimbabwe, the Philippines, Nigeria, and India. Migrant workers, and recent migrants in particular, are more likely to work in for-profit care homes than their non-migrant counterparts. In 2007/8, 79 per cent of recent migrant care workers

²⁷ Such as those which followed the 2004 enlargement of the EU, which allowed Eastern Europeans from the ‘accession 8’ countries to work in the UK.

were employed by private organisations, but this was the case for just 54 per cent of UK born care workers (Cangiano *et al.* 2009).

Drakeford (2006) suggests that the heavy reliance which employers in certain areas have upon immigrant labour indicates an attempt to maintain low wages, even in hard-to-fill jobs. In fact, Townsend's extensive study of residential care homes in 1962 demonstrates that there were a significant number of migrant care workers working in private residential homes even in the 1960s. Though Townsend found that staffing ratios in private homes were, on average, better than in other homes, he highlighted their use of migrant workers:

Compared with other types of homes the staff often comprised an odd mixture. There was ... the Polish refugee from a Nazi concentration camp; mentally subnormal girls on license from local hospitals and young girls from Spain and Germany. The qualities of these people were of course emphasised by their employers ... they "could see the funny side of things"; they didn't "expect everything to be just so" [and] they "mucked in" without worrying about their status ... But of course there was another side to some of these qualities. Such persons were often content with a small wage. (1962: 187)

Hussein *et al.* (2011) demonstrate how the profile of UK-born care workers is dissimilar to that of migrant care workers, who are significantly younger and often hold higher qualifications relevant to social care, such as medical or nursing qualifications. The presence of advanced qualifications amongst migrant care workers perhaps reflects the difficulties which they face in having their qualifications recognised when they arrive in the UK. Equally, the manner in which the recipients of care evaluate the merits of caregiving may lead to a devaluation of care provided by migrant workers. Cangiano *et al.*'s (2009) extensive research on migrant care workers, for example, found that both migrant care workers and care recipients placed overarching value on the caregiver-care recipient relationship when evaluating the quality of care. In focus groups conducted by Cangiano *et al.*, older people defined a 'good carer' as someone who they could talk to. Similarly, migrant care workers described a good caring relationship as one which was 'familial' or marked by friendship. Both the migrant workers and care-recipients in all focus groups referred to the impact which language and communication barriers had upon the development of these good quality

relationships. Moreover, employment in the care sector was seen to be a *hindrance* to the migrant workers' training in English language proficiency because long work hours impacted upon their attendance of English language courses which they had independently enrolled on.

Conceptualising Care

Residential care work in the UK continues to be amongst the lowest paid and most poorly esteemed jobs (Twigg 2000, 2006). It is unsurprising, then, that the focus of much academic research on the subject has been on the prevalence of poor work conditions, the impact which such conditions have on staff retention, turnover, and workforce demographics, and, in turn, the sector's need for improved HRM practices (Stacey 2005). There are, moreover, a number of important studies which take steps towards reaching an understanding of what motivates individuals to do the job of care (and to continue doing so), despite their work being undervalued and underpaid. Particularly since the early 2000s, academics have explored how care workers in different settings (residential homes, nursing homes, community settings) experience, negotiate, and find meaning in their work (Duffy *et al.* 2015; Rodriguez 2014; Stacey 2005; Twigg 2000, 2006). Such exploration calls for a more qualitative examination of care work, which focuses on the everyday tasks of caregiving, the perspectives of those undertaking these tasks, and their interactions and relationships with the recipients of care. Below, I extend the brief review of the literature on social care which I presented in chapter one, by examining some of the concerns, points of contention, and absences which are raised in conceptual accounts of paid care.

The Moral Wage and Prisoners of Love

Twigg (2000, 2006) notes that, whilst the hands-on activities of washing, bathing, and other forms of personal care are the principal tasks carried out by care workers in their day-to-day work, such 'bodywork' has tended to be downplayed in accounts of care work which, instead, emphasise the social, emotional and

interpersonal elements of the job²⁸. Twigg demonstrates that, in their everyday interactions with bodies and their wastes, care workers must negotiate and deal with 'aspects of bodily existence that modern society is reluctant to acknowledge openly' (2000: 397). This reluctance meant that, for care workers in Twigg's study, there was 'little or no symbolic protection against the polluting nature of their work' (2000: 403).

Borrowing from Hughes (1971), Stacey (2005) uses the term 'dirty work' to describe the activities carried out by home care workers in her study. In contrast to the concerns of Twigg's study, the home care workers described by Stacey reported a sense of pride, and even moral authority, from undertaking this 'dirty work', work that 'most people won't even talk about, let alone perform' (2005: 849). For Stacey, this pride allowed the home care workers to derive dignity from their work. In expressing their sense of dignity, care workers emphasised the relational nature of their work. This included the (often intimate) social interactions and constant contact which they had with the recipients of their care, as well as the resulting bonds which they formed. For Stacey's home care workers, there was pride and honour to be found in taking responsibility for tasks which few others would do, and which they saw as essential for humanising and promoting the wellbeing of their 'clients'.

As the work of Twigg (2000, 2006) demonstrates, we must also be conscious that, as researchers, we do not emphasise the emotional elements of care work at the expense of examining its physical aspects. Twigg notes that researchers' over-reliance on the research literature on unpaid care which was written in the 1980s and 1990s has distorted our understanding of paid care work. Such distortion is, for Twigg, compounded by the semantics of the term 'care' which, in the UK, tends to connote tenderness, warmth, and love. Earlier in the thesis, I identified the importance which both older people and paid care workers place upon 'good caring relationships' (Cangiano *et al.*'s 2009), which has been mirrored by

²⁸ This reflects broader confusions, discrepancies, and absences in definitions of care work in the literature, which have led some to conclude that there is no overarching concept of care to analyse the activity across different settings (Thomas 1993).

participants in several other studies (Ball *et al.* 2009; Eckert *et al.* 1999; Karner 1998; Mattiasson and Andersson 1997). In reference to Mattiasson and Andersson's (1997) research on residents' assessments of the quality of care in nursing homes, Meagher (2006) points towards this inextricable link which the cared-for make between the caregiver/care recipient relationship and the quality of caregiving. As Folbre and Nelson (2000: 129) note, it is widely assumed that it is the possession of caring feelings by a caregiver which both provides her/him with the motivation for carrying out care activities and ensures that s/he provides good care. Though there is much debate as to what 'good' care might entail, Folbre and Nelson (2000: 129) suggest that 'ideally a care recipient should feel authentically "cared for," nurtured, recognised and valued as an individual, emotionally supported, emphatically connected, or in shorthand, loved'.

Studies have shown that, in their assessments of the quality of their care, residents tend to value what they perceive to be particular moral and motivational dispositions of care workers – such as being 'genuinely caring' (Mattiasson and Andersson 1997; Meagher 2006: 35). Likewise, the relationship-based elements of caregiving have often been linked to job satisfaction (Meagher 2006: 36). It is in this context that the, often tacit, assumption has arisen – both in the academic literature and amongst those operating within the sector – that care workers who genuinely 'care' about their clients, and gain intrinsic job-satisfaction from doing so, will provide better care than those who are primarily motivated by financial reward (England 2005). This assumption that 'altruistic' care workers will provide better care than those who are 'financially motivated' has been repeated in care workers' own valuations of their labour (Johnson 2015; Lee-Treweek 1997). These beliefs are, in part, what has allowed neoclassical economists to explain the low wages paid to care workers in terms of compensating differentials – that is, in terms of the assumption that 'if the marginal worker sees the intrinsic properties of the work as an amenity, this permits a lower wage' (England 2005: 389).

In his study of a victim advocacy and counselling service in the United States, Kolb (2014) used the term 'moral wages' to describe the positive feelings and sense of satisfaction that, for his participants, came with seeing themselves as caring and

compassionate people. In my own previous research (Johnson 2015) in a private residential home, managers were aware of the presence of this 'moral wage' and even alluded to it in training videos and staff manuals. Using the term 'second paycheque', the residential home's managers were able to draw upon the care workers' own definitions of their work as something which was 'natural' and, in turn, they were able to frame that work as something which could be naturally, as opposed to economically, remunerated.

Ball *et al.*'s (2010: 225) research, based on interviews with administrative workers in residential care, found that the principal quality which employers looked for when hiring care workers was compassion, whereby an individual with compassion was described as having 'a caring spirit' or 'a heart for caregiving'. The administrators often described this compassion as an innate or natural trait which could not be taught. Ball *et al.* wrote:

In the ideal, a worker's commitment to caregiving goes beyond the need for a paycheque. To many administrators this level of commitment is crucial to lasting in the field. (2010: 227)

Several administrators interviewed by Ball *et al.* (2010) disclosed that the lack of financial compensation for being a care worker heightened the need for care workers to be motivated by feelings of compassion. In the eighteen for-profit and not-for-profit nursing homes examined by Dodson and Zincavage (2007) in the US, this 'compassion' required of care workers was often expressed in the language of a 'family model' of caring. A managerial discourse which stressed the need for care workers to 'bond' and establish authentic relationships with residents was infused at all levels of the nursing homes. In all of the eighteen homes, the discourse of family consistently emerged as central to both the design and understanding of caring for older residents. The homes encouraged care workers to 'adopt' residents, in an attempt to promote empathy and patience, and also evaluated the care worker's work in terms of her/his ability to 'fill in' as a family member (2007: 912, 914). Dodson and Zincavage's research draws attention to how the ideology of the family model may be used to exploit low-income care workers by encouraging them to work (unpaid) beyond the formal requirements of their jobs.

Dodson and Zincavage's (2007) discussion of the family model of care leads them to propose that a version of familial relationships *is* at the heart of gratifying care work and of good care. They do propose, however, that the kinship model must be rooted in an ethic of reciprocity if it is to avoid becoming exploitative. They state that 'a critical concern for dignified and family-like care' of older people 'does not justify sacrificing the humanity of another, in this case, those who do the job of caring' (2007: 924). One problem with the family model, then, is that it can lead care workers to experience tension between the requirement that they show unbounded commitment to care for fictitious family members, and the reality of the job – which necessitates that such displays of kinship are unreciprocated (Dodson and Zincavage 2007).

Much like the 'second paycheque' in my previous study (Johnson 2015), the family model, by building a morally obligated and emotionally devoted worker, is both 'good for business' and for residents (Dodson and Zincavage 2007: 921). Dodson and Zincavage's care workers often described their attachments to residents as one of the most gratifying aspects of their work. The institutionalised self-sacrifice encouraged by the family model, however, led them to frame their work in terms of non-market motivations and presented them with a, sometimes overwhelming, emotional challenge. For example, participants reported worrying about residents when they were away from work, three fifths of the 105 care workers reported working over-time without pay, and four fifths reported working through their breaks so as to provide adequate care to a dozen 'grandparents'. Dodson and Zincavage proposed that their participants 'saw concern for the well-being of residents not as acts of accommodation to managerial demands, but as a reflection of ethical beliefs about caring for vulnerable fictive kin' (2007: 916).

Folbre (2008) argues that the emotional connections and caring obligations between care workers and care recipients, which benefit the recipients of care, arise from the *process* of doing care work rather than being determined by the market. This is similar to the argument made by Stacey (2005) that it is the intimate nature of caring that allows care workers to find dignity in their 'dirty' work. Strong emotional attachments can, however, increase the vulnerability of

care workers, who risk becoming, what Folbre (2001, 2008: 376) has termed, 'prisoners of love'. Folbre's argument is that, when a care worker's relationship with the recipient of her/his care comes to signify more than a basic exchange relationship, the care worker finds it more difficult to leave that relationship²⁹.

Beyond the Family Model: Meagher's Moral Realism

Such arguments lead Meagher (2006) to question the kind of ideal that family care provides. She suggests that the apparently inescapable 'natural' commitment between the giver and receiver of care within the family is unsustainable, unrealistic, and unreasonable to expect within paid caregiving relationships. In challenging the appropriateness of the family model, Meagher (2006) proposes that high quality paid care would be better facilitated by means of the development of a well-thought-out range of normative resources that can be drawn upon in both recipients' and providers' interpretations of good care. She proposes three ideal typical bonds that paid care might draw upon which privilege cognitive understandings of caring motivations, rather than assuming that a paid care worker's feelings for the cared-for are what count. These are contract, professional duty, and compassion, all of which are briefly examined below.

Meagher (2006) identifies three aspects of the contract of employment, which brings a care worker into contact with the cared-for, that may give rise to positive caring relationships. First, a contract, as a money-mediated exchange, can spell out what a good caring relationship should entail (i.e. the characteristics of the service that is being paid for). Second, when care is paid for, the purchaser of care and the provider of care have *chosen* to enter into interaction with each other³⁰. Meagher (2006: 39) argues that such a 'freely chosen interaction between autonomous equals' provides a moral foundation for the provider of care to appreciate the human dignity and individuality of the care recipient. The payment

²⁹ In a similar argument to others (Dodson and Zinbarg 2007; England 2005; Johnson 2015), Folbre suggests – with reference to a *Journal of Health Economics* article, which explicitly argued that a poorly remunerated nurse is a good nurse – that the value of intrinsic motivations are often turned against caregivers, with arguments that they 'do a better job when they work for love, rather than for money' (2008: 736).

³⁰ In the case of residential care, this would only explain the contracts which private payers and private care home owners enter into (2/5 of residential care placements in the UK).

of money may also prevent the recipient from feeling indebted to the care provider and grants that recipient the freedom to exit the care relationship at will. Third, the interaction involved in contracting with another is underpinned by trust. Here, we trust that that other will play by the rules which we all agree to when we participate in social and market exchanges. This trust, which underpins a successful contract, may assist the care provider and care recipient in bridging the gap between the public and private which paid care necessarily entails.

In addition to contractual arrangements, Meagher (2006) points towards both specialised training and care workers' commitment to a professional code of ethics as aspects of professionalism which may provide normative resources that paid care workers might draw upon in their work. Meagher suggests that a care worker's commitment to the standards of their profession allows them to develop a supra-contractual bond with the cared-for, which motivates them to have a sense of responsibility for, and to respond to the needs of, those in their care. She demonstrates how the explicit moral codes of professional care, formalised in codes of ethics, express the professional's commitment to values of human dignity which align with the ideals of good care expressed by both paid care workers and care recipients. Meagher points out that the exercise of professional duty, which is both devoid of dependence upon a familial relationship and which expresses an *obligation* rather than a good to be exchanged, can enable a care worker to safely go beyond what is stipulated in a contract. Unlike a contractual relationship, the relationship between a professional care worker and the recipient of their care is not presumed to be equal. For Meagher, professional codes of ethics are designed to shield care recipients from the risks which can result from this inequality. As Gorz (1989: 155-6) argues, these codes can also function to protect the care worker 'from the desires of his/her clients and against being reduced to servant status'.

Finally, Meagher posits that a further non-familial bond – compassion – can resolve the contradiction between moral equality, which arises in contracts because they presume an equal relationship, and practical inequality, which arises in professional relationships because they are inherently unequal. She suggests

that this is the case because compassion entails both the recognition of people in need of care *and* their human dignity. Diverting from more orthodox accounts of the gift which consider it as embedded in relations of reciprocity, Meagher proposes that, when a bond based on compassion is enacted in a paid caring relationship, the recipient experiences it as a gift from a virtuous person, which need not be requited. Nonetheless, she does suggest that the recipients of compassion are perhaps, in response, morally obliged to work with the caregiver to achieve the goals of their care. This suggestion has also been made by other well-established scholars of care-work (Kittay 1999; Tronto 1993), who argue that care is not a one-directional relationship of dependency, but a relational one whereby mutuality and respect is shared by both parties.

Meagher's optimistic argument that paid care relationships can have a strong moral component without being simultaneously harmful to care workers is compelling but, unfortunately, is yet to be explored at an empirical level. It does, however, lead one to question what normative resources are realistically available to care workers working in residential homes and what impact the cost of care has upon the availability of these resources.

Summary

This chapter has shown how studies of the residential care sector over the last few decades have revealed a number of socially relevant concerns. One is that something so basic and important as care in later life is subject to wide variations in quality, and that people who are reliant on the public funding or subsidising of their care are at much greater risk of receiving an inadequate care service. This is occurring against the backdrop of an ageing population and a shortfall in public funding, and in a society where a 'mixed economy' of public and private funding and provision seems likely to prevail for the foreseeable future. Despite its importance to the wellbeing of the more vulnerable in society, care work remains low paid work which is physically and emotionally demanding, and which gives few opportunities for skill development, education, and career progression. The link between poor working conditions and poor care is an obvious one, though the

details of how job satisfaction and client satisfaction are related have yet to be investigated in any depth.

Research also suggests that, as more care work becomes privatised and commercialised, care workers are vulnerable to having their moral and emotional commitment to their work exploited. There are suggestions that, in some respects, this commitment both compensates for what would otherwise be worrying deficiencies in the provision of care, and, to the extent that it makes care work meaningful to the care worker, compensates for, or at least helps employers to justify, the low level of pay in the sector. Conceptual approaches have started to consider the moral and affective dimensions of care work, and the tension between what has become an increasingly commercialised enterprise and the need which the recipients of care have for dignity and compassion. But these approaches are often short on empirical evidence and application, and, as we saw in chapter one, the research on care as a whole displays a problematic divide between empirical and theoretical studies. In addition, empirical research often fails to consider both the specific and the wider contexts in which care takes place and has a tendency to focus on quantifiable outcomes rather than on the everyday experiences of care workers and the older people they care for.

The present piece of work is a study of two private residential homes for older people in England which builds on the current field of knowledge, but also attempts to address some of its deficiencies and limitations. It seeks to answer the following research questions:

1. What do residents who pay for high-cost care, and those who receive low-cost care, actually get in the homes they live in? Is there a clear link between the price of care and its quality?
2. What factors contribute to the provision of good and bad quality care? What respective roles are played by management, training, material resources, and the normative and symbolic culture of work?
3. What moral, emotional, and material stresses are experienced by care workers, and how are these stresses negotiated and managed, both by care workers and their employers?

4. What contribution can sociological theory make to our understanding of the practices and experiences of care workers in residential homes today?

Chapter 3: Methods

In this chapter, I outline the methodological approach of this research, which was an ethnographic study of residential care work in Esterton, a seaside town in Southern England. In what follows, I briefly describe the geographical area in which interviews and observations were undertaken and discuss how I selected two residential homes within this area as objects of study. After outlining how I gained entry to these settings and how data were collected and analysed, I reflect on the ethical issues which emerged before, during and after data collection. Finally, I reflect upon my own role as both a researcher and a former care worker. Having worked in a number of residential care homes in the years prior to beginning this study, it was my role as an insider which prompted me to carry out this research. Equally, my experiences of being a care worker guided my methodological decisions, shaped the relations which I developed in the field, and, inevitably, had some impact on the data which I generated in ways which I consider here.

As discussed in chapter one, a great deal of research on both the conditions of work and the quality of care provided in residential homes for older people has been quantitative in nature. Though useful in providing a broad picture of conditions within the sector as a whole, as well as measuring the medical outcomes of older people residing in different settings, this research has its limits. Notably, there are few accounts of the day-to-day lives and experiences of those living and working in residential homes. Where research on residential care has employed qualitative methods, there has been an over-reliance on the use of interviews to establish how work is experienced by care workers. Though important in highlighting care workers' perceptions and understandings of employment practices, this reliance on care workers to paint a picture of their workplace needs complementing with a more detailed and systematic sociological inspection of the industry of residential care.

It was with this in mind that I chose observation as my principal methodological tool. Approximately eight hundred hours of participant observation were carried

out in two residential homes over the course of two years. The resulting data was supplemented with interview data gathered in thirty semi-structured interviews with care workers. Together, these techniques were employed to gain an in-depth, ethnographic understanding of the role that material, human, and moral resources played in contributing to the provision of care in two residential homes, whilst also examining the moral, emotional and material stresses experienced by care workers who worked in the same local authority area.

An Ethnographic Approach

As is the case with many longstanding traditions in the social sciences, 'ethnography' is a contested term, with some defining it as an approach to research, whilst others consider it a method in itself (Hammersley and Atkinson 2007; Scott 2009). In the context of this study, I agree with the broad definition of ethnography as an approach which aims to reach an 'in-depth, interpretative understanding of the way of life found in a particular cultural or subcultural context from the perspective of the people within it' (Scott 2009: 193). This approach requires that, whatever techniques she uses, the ethnographer must immerse herself in her field of study so that she might gain an insider's perspective on the everyday rituals and routines of that social setting, as well as on the broader social order which underpins them (Mannay and Morgan 2014; Scott 2009). Employing an approach which would allow me to take seriously the complex factors which contribute to the provision of good and bad quality care, as well as establishing how these factors were routinely negotiated and managed by care workers and their employers, was fundamental to the aims of the research. Researching ethnographically was an inimitable way to gain a comprehensive, interpretative understanding of the respective roles played by management, training, material resources, and the normative and symbolic culture of work in shaping the quality of residential care. This, as such, was an appropriate method for addressing my core concerns, posited as research questions at the end of chapter two, which included: examining the links between the cost of care and its quality, establishing what factors contribute to the provision of good and bad quality care, and considering what stresses are experienced by care workers.

Ethnographies can employ a variety of methodological techniques, from the more traditional (observations, interviewing, and documentary analysis) to the more novel, such as visual, digital, and participatory approaches (Hammersley and Atkinson 2007; Mannay and Morgan 2014). In this case, the method which best allowed me to gain an insider picture of everyday life in residential homes was participant observation. Arguably, it is only by observing the actions of those whom we study that we are able come closest to seeing what actually happens in practice (Gobo and Marciniak 2016). Interviews, though not without their merits, always rely on participants' own accounts of their actions. In the case of this research, interviews with care workers in Esterton were considered as a useful means to understand the perspectives of those being studied – allowing me to establish the meaning-making behind what I observed – as well as to further explore the themes which were emerging in my analysis of observational data. My observational data, however, formed the core of my analysis and my subsequent writing, and it is the data that I draw on predominantly for this thesis.

Participant observation, though an important methodological tool of the ethnographer, comes with varying degrees of participation (Scott 2009). In the case of this study, observations were carried out in a 'covert' manner, where I took on the role of a care worker and worked alongside those whom I studied. Covert research has a rich history in sociology and is a methodological tool which has certainly not been without its criticisms (Herrera 1999). Before turning to the ethical considerations of carrying out this type of research, I will briefly spell out here why covert ethnographic research was considered the most appropriate methodological approach for this study of care work.

Access to the social care sector for overt ethnographic study is certainly not impossible. This is particularly the case in the US, where Henderson and Vesperi (1995: 2) went as far as to describe nursing home ethnography as a 'distinctive genre' in the 1990s. Though far less common, ethnographic studies of residential and nursing homes have also been carried out in the UK (Lee-Treweek 1997). Yet, ethnographic research in care homes has often seen the researcher adopt the position of a passive observer. These observations have also frequently been

limited to the 'front stages' – reception areas, lounges, dining rooms – rather than the 'back stages' – bedrooms, bathrooms, kitchens, laundry rooms – of care homes, where care workers carry out the majority of their work. As Bosk (2001) has noted, observing the front stage alone is a grave sampling error as it mistakes a part for the whole. It was important for my research to involve me being within the residential homes and observing both the front and back stage of care, since the former only represents one component of this world. In order to gain access to the less visible spaces and practices of residential homes, without causing great changes in the behaviours of those whom I observed, a covert approach was necessary. This required that I took on the role of participant from the outset of the research, gaining access to the residential homes by gaining employment within them. Participating in the field by working as a care worker also gave me a more substantial, 'embodied' understanding and appreciation of the moral, emotional, material, and physical stresses experienced by care workers (Monaghan 2004).

Though covert research is not a common method in the social sciences, there are instances where, if it were not employed, whole spheres of social life might be inaccessible to researchers (Hammersley and Atkinson 2007). Within the social sciences, covert research has sometimes been depicted as inherently unethical or, more often, as an ethically questionable 'last resort' (Bulmer 1982). The British Sociological Association, in its statement of ethical practice, states that, although 'there are serious ethical and legal issues in the use of covert research', the use of covert methods may be justified when:

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... [It] should be resorted to only where it is impossible to use other methods to obtain essential data. (BSA 2017: 5)

In the criminological literature, it has been argued by Wells (2004) that discussion about covert research should concern itself with these more practical matters – that is, with the quality of data produced by the research and the necessity of using a covert approach – rather than more emotive, normative debates. Unlike Wells,

I believe that discussion about ethics and morality should be central, rather than separate to, the design of covert research (Calvey 2008; Spicker 2011). Nonetheless, Wells' concern for these more practical matters is not redundant. Covert research must be justified in terms of necessity and the quality of data which can be expected from employing such an approach (Hammersley and Atkinson 2007). I will first provide justification on the grounds of gaining access to the field before discussing the quality and variety of data which I expected a covert approach to yield, data distinct from that likely to be gathered using an alternative, more 'overt' approach. Towards the end of this chapter, I will deal with the somewhat thornier ethical questions and considerations which arose before, during, and after carrying out this research.

In recent years, several 'research ready' residential homes have been established in the UK. The Enabling Research in Care Homes (ENRICH) initiative, which is funded by the National Institute for Health Research (NIHR), for example, encourages care home managers to sign up to its network of research sites. Whilst a great facilitator of research in residential care homes, the manner in which these homes are recruited presented an obstacle to the undertaking of this research. This was because those homes which consider themselves low quality (either in terms of HRM or care provision) are unlikely to open themselves up to scrutiny by volunteering to become research sites. Indeed, a recent evaluation of ENRICH found that all of the care homes involved in the initiative had above-average CQC assessments (Davies *et al.* 2014). Likewise, poor quality homes are likely to be more inaccessible to individual researchers, who have very little to offer managers in the way of fiscal incentives or the possibility of positive publicity.

It would be fair to assume that care workers and care home managers have good reason to be suspicious of inquisitive outsiders. In the years leading up to this study, and during the period when the research was being undertaken, residential care homes were often painted in a negative light in the media (BBC 2013; The Telegraph 2012). Increasingly, media coverage of the sector focused on poor-performing care homes and, moreover, a number of investigations by undercover journalists led to the broadcast of exposés on national television (Hayes 2016).

Such investigations, which often used hidden cameras, heightened the public attention being given to the abuse of vulnerable adults by care workers and to the use of covert surveillance as a potential means to prevent it (Fisk 2015). In Hayes' (2016) study of the work experiences of homecare workers, care workers indicated that various factors, such as the possible use of closed-circuit television (CCTV), amplified their sense of insecurity and vulnerability to criticism. This sense of insecurity resulted in care workers developing an awareness of the need to exert self-discipline and remain circumspect. A similar circumspection was evident when I attempted to recruit care workers for interviews by visiting residential homes. Just one of the thirty participants whom I interviewed was recruited in this manner, despite thirty-six residential homes being visited. In several homes, I was asked if my research was being carried out for 'the news' or a local newspaper and, despite explaining my research, care home managers in particular appeared apprehensive about my desire to talk to their employees.

Whilst negative media coverage of care environments has likely reduced the overt accessibility of residential homes to outsiders, for those who are able to gain access, such coverage has also had an impact on the level of rapport which researchers are able to develop with staff and on the subsequent insights which they are able to gain. Several scholars have pointed out the uneasy relationship which care workers and managers have with official visitors to residential homes. Furness (2009), for example, has commented on the responses of care home providers to inspectors, noting that this relationship may be characterised by resistance, reluctance and/or a ritualistic compliance with recommendations. Such changes in the behaviour of care staff upon the entry of outsiders into residential care homes were familiar to me from my previous employment as a care worker, where outsiders were often viewed with suspicion, if not animosity. These kinds of changes in the behaviour of individuals upon the entry of outsiders into their working environments are well documented in the wider methodological literature, and form a key criticism of overt ethnographic studies (LeCompte and Goetz 1982). Likewise, an ethnomethodologically-inspired concern with reducing observer effects and gaining access to the spontaneous

lived experiences of those being studied is what has informed other researchers' choices to research covertly (Calvey 2008; Hammersley and Atkinson 2007).

This is not to say that care environments – or, for that matter, any social setting, phenomena, or group – can be studied (overtly or covertly) without being changed or contaminated by the researcher, not least because the researcher (whether primarily observer or participant) is part of the world which she studies (Hammersley and Atkinson 2007). Whilst a perfect naturalism will always be out of reach, however, adopting the role of a care worker for this research minimised the effects of my presence on the setting. Researching covertly also allowed me to view and experience the back stages of residential care and to learn about the aspects of care work which managers, or care workers themselves, might want to keep outsiders from knowing. Nonetheless, the approach was not employed with the intention of producing an exposé but, rather, a detailed account of everyday life in two residential homes and the, often mundane and less visible, rituals and routines of those who worked in them. I will now outline how these two sites for observation were selected, before explaining in more detail what I sought to observe and how data were collected.

Choosing Sites

The data in the subsequent chapters is drawn both from my fieldwork in two residential care homes for older people – that I have named Millstead and Shorefield – and from interviews with care workers, who worked in residential homes in the same local authority area (Esterton) as these two homes³¹. Though I am unable to provide a precise account of this local authority area due to the need to maintain anonymity, Esterton is similar to other British seaside towns in terms of its residential care market. As was touched upon in chapter two, the decline of visitors to British seaside resorts and the abundance of former guest houses and private hotels available to buy in the 1980s created a low-risk market for those wishing to open residential homes in seaside towns (Andrews and Kearns 2005;

³¹ Although, again, my focus in the subsequent chapters of this thesis is mostly on data gathered in observations.

Corden 1992). It was at this time that, alongside its southern counterparts, Esterton became a major site of retirement migration.

With a population under 200,000, there were thirty-eight private residential homes for older people³², seventeen private nursing homes, and numerous private community care services in Esterton when this study commenced. Within the Esterton area, two sites were chosen to represent distinct ends of the private residential care home market. The focus here was on private, as opposed to public, residential homes. Principally, this was because all residential homes in Esterton were operated by either private or non-profit providers. As there is some variability in the cost of care, occupancy rates, and physical facilities between non-profit and private residential homes (Curtis 2009), Esterton's two non-profit residential homes were also eliminated from the initial sample to reduce the number of variables which might relate to the cost of residential care.

In order to choose two residential homes as sites of study, data were requested from Esterton local authority concerning all thirty-eight of the area's registered private residential homes for older people. This included information about the cost to the local authority of placing a resident in each home and the number of publicly funded residents who resided in each. This data was combined with data gathered online, which included the number of places (beds) in each home, the cost of a care placement to private payers, CQC quality ratings, and postal addresses. Taken together, this data allowed a broad picture to be established of the residential care market in Esterton, from which sites for participant observation could be selected. The homes chosen as sites of study were Millstead, a low-cost home, and Shorefield, a high-cost home. Homes from distinct ends of Esterton's care market were chosen with the intention that this would allow me to explore the links between the price of care and its quality. Though a more in-depth analysis of these two residential homes will be presented in the following chapters, it is useful to provide a brief description of the homes here in order to

³² This figure does not include residential homes which also accommodate adults under the age of sixty-five years.

justify my choice of sites and to explore some of the main methodological considerations of the research.

Operating in the same local authority area, Millstead and Shorefield were just 1.5 miles apart but were located in different wards. In the 2010 indices of deprivation, Millstead's ward was ranked among the top 5 per cent of most deprived wards in the UK, whereas Shorefield's ward was ranked in the bottom 50 per cent. Some of the factors which made Millstead and Shorefield distinct were apparent prior to my entry into each fieldwork site and, alongside the availability of work at the two homes, guided my decision to seek employment within them. Other differences became visible as the research progressed. It is the former which will be dealt with here, the latter being presented as part of my analysis in the subsequent three chapters.

Millstead

Millstead was a private residence in the 1890s before operating as a hotel in the 1930s. In the 1950s, it was purchased by the local authority's welfare services and, subsequently, taken over by the county's welfare services, which also took ownership of the neighbouring residential property. At the time fieldwork began, Millstead was a single, private residential home, which accommodated thirty-three residents. The residential home was owned and managed by a family who also owned a large number of leasehold properties in Esterton. Millstead was identified as low-cost due to the low fees which it charged to its twenty-four local authority, and nine private paying, residents. Of the thirty-eight residential homes for older people in Esterton which formed the initial sample, the average price paid by the local authority for a funded place at Millstead was the fourth lowest at just £448 per week. The home's stated price for private payers was from £466 to £600 per week, which (using the lower end of this range) was the twelfth lowest stated price charged to private payers in Esterton. Unlike data available on local authority payments to Esterton's residential homes, the data which I was able to gather concerning private payers was harder to access, sometimes incomplete, and often showed a range in fees charged. For ease of comparison, the two

residential homes chosen as sites of study were selected based on the fees which they charged to the local authority.

The price differentiation between the fees which Millstead charged to the local authority and to private payers was common across homes in Esterton and has been identified as a UK-wide phenomena in the literature (Hancock and Hviid 2010). Such discrepancies provide support for claims that commissioners' bargaining power allows them to secure lower fees which either require 'topping-up' by the families of publicly funded residents or subsidisation by higher paying private payers (Forder and Allan 2011; Netten *et al.* 2003; Passingham *et al.* 2013).

During my initial contact with Millstead's manager, Brian, he had warned that being a care worker at Millstead would involve more than carrying out personal care. This warning was justified, as the job involved being a pot washer, cook, cleaner, bed-maker, launderer and, at times, carrying out additional domestic work for Millstead's owners. Millstead had a simple division of labour. Brian was officially in charge of the home, though rarely present. His mother, 'Mrs G', who owned the home with her husband, was often at Millstead and was more direct in her approach to management. Adelina was employed by the home and, as 'head carer', was in charge of ordering medication and generally overseeing our work if Mrs G was not present. Below Adelina in the workplace hierarchy were five 'seniors', one of whom led each shift as well as dispensing medications, completing records, and carrying out handovers³³ between shifts. There were, at most, ten non-senior care workers employed by the home at any time. These 'carers' carried out the majority of physical tasks at Millstead³⁴. There were also four cleaners and one cook, who worked from around 9am to 1pm. The shifts for carers at Millstead ran from 8am-2pm ('early'), 2pm-8pm ('late'), and 8pm-8am ('night'). The table on the following page indicates how many care workers were scheduled to be present during each shift at Millstead.

³³ Handovers are a period of time between shifts where care workers gather together to exchange information and, often, to be assigned tasks and/or duties for the upcoming shift.

³⁴ This included personal care, bed-making, laundry, serving in the dining room, cooking evening meals, washing up, cleaning the dining room, laying tables, hoovering hallways and restocking supply cupboards.

Shift	Number of 'seniors'	Number of 'carers'	Residents per care worker
8.00am-2.00pm	1	4-6	5-7
2.00pm-8.00pm	1	3	8
8.00pm-8.00am	1	1	17

Table 1: Staff numbers for each shift at Millstead in January 2013 when fieldwork at the home began (33 residents)

Shorefield

Unlike Millstead, Shorefield was a large-scale corporate care home provider. In January 2013, it provided care to 99 residents and the cost of receiving care at the home varied depending on which room a resident occupied as well as the individual's assessed care needs³⁵. The lowest priced fee – which included accommodation, meals, and activities but not direct care – was £750 per week. At Shorefield, a resident whose care required the use of a hoist³⁶ and who experienced urinary and faecal incontinence would expect to pay around £1,000 a week for their personal care, in addition to the cost of their room. Of the thirty-eight homes in the local authority which formed the initial sample, the cost of care for private payers at Shorefield was the highest, even before taking personal care charges into account. Of the 99 residents at Shorefield, just four received funding from the local authority, which paid an average of £540 a week for their care. Although this required that the relatives of publicly funded residents 'topped-up' the cost of their care, these residents received more financial support from the local authority than residents at any other residential home for older people in Esterton. At Shorefield, 33 residents, who were formally diagnosed as having dementia, resided in a separate, secured part of the building. The unsecured part

³⁵ Residents were charged around £43 for each hour of direct care which was provided to them by a single care worker.

³⁶ Hoists provide a mechanical means by which an individual can be moved or transferred from one position or place to another (such as from a bed into a wheelchair). For safety reasons, two care workers are usually required to operate a hoist.

of the building, where 66 residents who did not have a formal diagnosis of dementia were accommodated, had a separate workforce of care workers and was the area in which participant observation was undertaken.

Shorefield was a purpose-built residential home which marketed itself as a luxury alternative to more traditional care homes. The home's marketing, for example, borrowed terms from the hospitality industry to describe the high-end facilities and services which it offered. Whilst Shorefield's advertisements mentioned the 'individualised care' which residents would receive, for example, they placed greater emphasis on the numerous complementary activities, entertainment, cuisine, and hotel-like facilities which the home offered.

At Shorefield, there was a more complex division of labour than at Millstead, with several divisions and sub-divisions of the workforce. Below the General Manager, Amanda, were eight further managerial members of staff who managed separate aspects of the home, such as the kitchen, housekeeping, sales, and activities. Two care managers were responsible for care workers, one of whom was based in the separate, secured part of the building where residents with dementia were accommodated, whilst the other – Patricia – managed care workers in the non-specialised area in which participant observation was undertaken. Below Patricia were ten lead care workers, or 'leads', who managed each shift and were responsible for handing over information to workers on the following shift. Next were 36 'carers' who were responsible for the personal care of residents, serving in the dining room, and completing 'daily notes'³⁷. The leads performed the role of carer if another lead was in charge and, equally, certain carers sometimes 'acted up' as leads if no one was available to lead the shift. The shifts for care workers at Shorefield ran from 7am-2.30pm ('morning'), 2pm-9.30pm ('afternoon'), and 9pm-7.30am ('night'). The table on the following page indicates how many care workers were scheduled to be present during each shift (in the non-specialist area) at Shorefield.

³⁷ 'Daily notes' are completed by care workers during each shift. They document what assistance a resident is given, how a resident has spent their time, and any incidents which have occurred.

Shift	Number of 'leads'	Number of 'carers'	Residents per care worker
7.00am-2.30pm	1	11	6
2.00pm-9.30pm	1	8	7
9.00pm-7.30am	1	2	22

Table 2: Staff numbers for each shift at Shorefield in January 2014 when fieldwork at the home began (66 residents)

In what follows, I will elaborate on how I gained access to Millstead and Shorefield and comment upon the practicalities of collecting data within these environments.

Collecting Data

Data were predominantly collected via observations of the routines and rituals of work and interaction at Millstead and Shorefield, where I was employed as a care worker. I spent every other week in the field for a period of two years, spending alternate weeks undertaking academic work and teaching. Fieldwork was carried out at Millstead during the first year (January-December 2013) and Shorefield during the second year (January-December 2014). Throughout this period, I also undertook interviews with care workers who worked (or had worked) in other residential homes in Esterton.

Before entering the field, an unrefined plan of who and what to examine was created. Though I intended to enter the field free of predetermined analytical criteria, I was aware that observing and noting down everything would be impractical. Malinowski's distinction between 'preconceived ideas' and 'foreshadowed problems' makes clear the importance of entering the field with an awareness of what one might find whilst, at the same time, being open to the emergence of new ideas:

The Ethnographer has not only to spread his nets in the right place, and wait for what will fall into them. He must be an active huntsman, and drive his quarry into them and follow it up to its most inaccessible lairs ... Good training in theory, and acquaintance with its latest results, is not identical with being burdened with “preconceived ideas”. If a man sets out on an expedition, determined to prove certain hypotheses, if he is incapable of changing his views constantly and casting them off ungrudgingly under the pressure of evidence, needless to say his work will be worthless. But the more problems he brings with him into the field, the more he is in the habit of moulding his theories according to facts, and of seeing facts in their bearing upon theory, the better he is equipped for the work. Preconceived ideas are pernicious in any scientific work, but foreshadowed problems are the main endowment of a scientific thinker, and these problems are first revealed to the observer by his theoretical studies. (Malinowski 1922/1978: 7)³⁸

Having worked in the residential care sector for a considerable period of time prior to entering the field – as well as having studied it for an earlier piece of research (Johnson 2015) – I could certainly not claim to be unacquainted with the subject matter. My identification of residential care work as an area worthy of empirical attention was, itself, an expression of values and, as Weber (1919/1958) noted, without such presuppositions, research cannot justify its existence nor experience itself as a meaningful activity. Despite being unable to enter the field ‘value-free’, however, openness was required so that new areas of analytic interest might arise. In an attempt to achieve this, a broad plan of what to observe (informed by both the literature presented in chapters one and two and my past experiences as a care worker) was created before my first shift at Millstead. This plan was subject to continuous revision according to the data which arose in both observations and interviews. In what follows, I will outline my main areas of initial observational interest, as well as exploring the methodological complexities of researching covertly in a residential care environment.

³⁸ The gendered pronouns which Malinowski uses are, to the modern reader, grating. At the time of writing, Margaret Mead had yet to break the exclusively male monopoly of cultural anthropology. But even if Malinowski had been writing a decade – or even four decades – later, the linguistic convention of using masculine pronouns would probably not have been perceived as sexist.

Pre-Fieldwork

Prior to my physical entry into the field, I began writing a daily fieldwork diary in order to document the process of identifying and gaining access to my sites of study. This was both a practical means to keep track of whom I had spoken to and what I had said, and a form of data collection in itself. This task of taking notes prior to formally entering the field may be termed 'pre-fieldwork fieldwork' – an adaptation of Cohen's (1992) notion of post-fieldwork fieldwork. The initial contact which I had with Millstead and Shorefield, as well as the subsequent processes of gaining employment in the two homes, were markedly different. The data which I gathered during these phases of pre-fieldwork documented the homes' HRM practices, the behaviours and personal characteristics of the homes' managerial staff, and my initial perceptions of the homes' practices, cultures, and materialities.

As noted previously, my role as a covert participant observer required my adoption of a cover story prior to contacting Millstead and Shorefield. Without exposing my position as a researcher, however, I wanted the account which I gave of myself to be as accurate and as honest as possible. My first formal contact with the field occurred when I applied for the position of 'carer' at Millstead via its website. I was asked to upload a C.V. and to provide basic personal details, such as my name and address. I remained truthful, yet this document mostly drew attention to my care experience rather than my academic qualifications. I was asked to attend an interview with Millstead's manager, Brian, two days later, where I was asked where I had worked before, told which tasks I would be expected to carry out, and asked when I would be available to start working at the home.

I expressed to Brian my preference that I work alternate weeks, due to my study commitments in Cardiff. He was pleased that I would be happy with being called 'as and when' I was required to work. Brian did comment upon his surprise that a PhD student was applying for a care work position and asked why I was interested. As well as mentioning my need to 'earn extra money' and how I 'enjoyed working with older people' (both of which were true), I told Brian that my PhD was based

on the care of older people and that gaining experience in the sector would be a good way to develop an 'understanding of what things are like on the ground'. Brian asked no further questions. I responded in a similar way to care workers at Millstead and, later, at Shorefield, who asked why I had decided to work alternate weeks and who showed an interest in my studies in Cardiff. Though researching covertly, I was able, to an extent, to be truthful about my identity, my motivation for asking what one care worker called 'funny questions', and my reason for being absent from the homes for days at a time. Lugosi (2006) has argued that these kinds of negotiations about concealment and disclosure take place throughout the ethnographic fieldwork process, regardless of whether it is officially deemed 'overt' or 'covert'.

At the end of my recruitment interview at Millstead, Brian suggested that I work four unpaid 'shadow shifts'³⁹, 'just to see you get on' and to avoid the need to complete any paperwork until I was 'sure that you want to stay'. When I asked Brian if new care workers left the job quickly, he replied 'some people just can't do it ... they realise that straight away'. I was not asked by Brian to complete a Disclosure and Barring Service (DBS) form or to provide formal identification or bank details. In order to verify that I was legally entitled to work with vulnerable adults, I completed a DBS check myself with an external agency, but I was not asked to present confirmation of this DBS check during my year at Millstead.

Shorefield's recruitment process was relatively formal compared to that at Millstead. Initially, I completed an application form, which I collected from the home after noticing that they had a 'carer' vacancy online. The application asked about my previous employment, my motivations for becoming a care worker, and included an equal opportunities monitoring form. Two weeks after returning this application form, I was asked to participate in a group interview with three other applicants.

³⁹ A shadow shift is an initial shift where you observe another care worker. I undertook shadow shifts at both Millstead and Shorefield. I was not paid for these shifts at Millstead but was at Shorefield. In both homes, but to varying degrees, I took part in providing direct care on these shifts.

I was offered a 'bank'⁴⁰ carer position at Shorefield three days later and was asked to collect a DBS form from the home to complete and return with relevant identification. I was asked to attend an induction training session a further two weeks later and, in the meantime, was asked to complete compulsory online training. This was organised through an external company and included 'modules' in food hygiene, infection control, challenging behaviour, health and safety, and fire training. Shorefield's face-to-face induction training was one day long and covered moving and handling residents, health and safety, and fire training. Here, I was able to take a wealth of fieldnotes – both about the content of the home's induction training and the interactions which I had and observed – without raising eyebrows, as the trainer encouraged everyone to take notes. Following this induction training, I completed three 'shadow shifts'. I was paid for these shadow shifts, as well as for the online and in-house training which I had completed. Having worked as a care worker before, I was often used as what Shorefield's care workers called, 'an extra pair of hands' on these shadow shifts to lighten the workload of the other care workers on duty.

Taking Notes: Facts and Fictions

As Hammersley and Atkinson (2007) note, fieldnotes are always selective, not least because it is impossible to capture everything. During the very early stages of fieldwork, the focus of my note-taking was more closely linked to the 'foreshadowed problems' which stemmed from my previous experiences of care work and my existing academic knowledge of the field. Key *foci*, for example, were Millstead's recruitment process, (lack of) training, and work organisation practices. As my interest was in the everyday practices and rituals of residential care, much of my subsequent note-taking focused on the mundane; that is, the order, timing, and content of the daily tasks which care workers carried out; the content and nature of interactions which I had with and observed between care workers, managers and residents; and the materiality of the two homes. I also, however, focused upon moments which were more out of the ordinary – such as

⁴⁰ Much like my position at Millstead, being a bank care worker meant that I was assigned shifts when an extra care worker was required and I was available to work.

the deaths of residents, inspections, and social events – as well as important changes and developments in the organisation of work, the composition of the workforce, and the broader context of residential care. Both the focus and detail of my fieldnotes changed and developed throughout the course of fieldwork. This was, in part, because once I had noted down the routine aspects of care work in the two homes, I was left with the intellectual and temporal space required to think more critically and analytically about the culture and practices of the homes.

In reflecting on her ethnography of an international accountancy firm, Coffey (1996) commented on how the ‘field’ is always a social and textual construction and creation of the researcher. That is, in this study, the fields of Millstead and Shorefield are constituted in the ways in which I have remembered, recorded, and retold what I observed. My accounts of Millstead and Shorefield are undoubtedly tied to my own memory. Unable to recall or jot down everything, I was required to make decisions about which occurrences were memorable and, by extension, worth recording and retelling. These choices about what to record, as well as those I made about *how* to record, inevitably shaped the story which I told about the two homes (Coffey 1996; Hammersley and Atkinson 2017).

Equally important in shaping this story was the process of writing itself. Hammersley and Atkinson (2007) note, for example, how language is an analytical tool rather than a transparent medium of communication. In converting our experiences of the social world into an academic text, we construct and reconstruct that social world. Though writing about the fields of Millstead and Shorefield required interpretation and literary imagination, this is not to say that the resulting text is a ‘fiction’ (Atkinson 1993; Coffey 1996). Whilst I attempted to avoid embellishing or distorting facts, however, there was also a complementary need for me to censor, redact, and rephrase certain information in order to protect the anonymity of my participants. This sometimes required careful consideration. Despite adopting pseudonyms in order to protect the anonymity of Millstead and Shorefield, for example, I came to realise in the process of writing that the identity of one of the homes could be revealed by searching for select words, phrases, and euphemisms on the internet. Since these discourses were

critical to the distinctiveness of the culture of the home, and an important part of the story which I wanted to tell, I was required to use my imagination in order to convert them into a narrative form that was both anonymous and as candid as possible about what I observed.

In both residential homes, recording what I saw was sometimes challenging. This was due to a number of factors including: the length of the shifts which I was required to work; a lack of free time; my responsibility towards those I was caring for; and the unfeasibility and inappropriateness of note-taking. One daily occurrence where the process of note-taking was inconspicuous was handover, a period of time between shifts where care workers gathered together to share information. Handovers proved a fertile period for data collection because of the opportunity they gave the workers to talk to one another. Here, care workers took *notes*, but I took *fieldnotes*. My fieldnotes, though perhaps more thorough, were not dissimilar from those being taken by the care workers and, if anything, conspicuous writing activity was met with approval, as I appeared conscientious and eager to learn. However, aside from handovers, note-taking in the field was often challenging. During quiet periods, where I was not required to care directly for residents, I would sneak to the toilet to note down important conversations and happenings. As other ethnographers have experienced (Hammersley and Atkinson 2007; Walford 2009), and perhaps more so working amongst a group of care workers who are required to monitor residents' bowel habits, these toilet trips became a source of humour amongst the care workers.

Fieldnotes were usually made in a small notebook which I carried in my pocket. At both homes, care workers were encouraged to carry pens and notebooks on their person in order to note down what tasks they had undertaken, residents' food preferences, and other significant information. During breaks, I was sometimes able to make notes on my mobile telephone whilst chatting to other care workers. Using mobile phones during break times was standard and did not arouse suspicion. Note taking was a great deal more difficult during busy periods, and these periods were a lot more common than breaks or handovers. During these times, I would sometimes note down individual words in my notebook which I

would later use to recall an event or, more often, I would be required to rely on my own memory to recall what had happened until my next toilet break. This inevitably meant that some important conversations which I had with and witnessed amongst care workers – particularly those taking place during the carrying out of care activities – were not recorded verbatim. Here, I relied on memory to recall the gist of conversations, notable expressions, words, and intonations.

At times, producing fieldnotes was testing, particularly when I was aware of a care worker saying something poignant or telling, but when my ability to recall these discussions with precision failed me. It was not until I left the residential homes each day that I was able to piece together the short jottings, handover notes, and memories which I had collected into coherent fieldnotes. This, in itself, was a tiring process, particularly after completing long shifts (up to fifteen hours at Shorefield). The practical realities of being both a care worker and an ethnographer meant that, at times, the comprehensiveness of data was compromised. As Atkinson (1995) notes, there is always the risk of trading breadth for depth. It was best, I decided, to have a smaller amount of detailed fieldnotes than a larger collection of sketchy and incomplete accounts. Despite some detail being lost, I firmly believe that what was lost is rectified by a subsequently deeper, and more acute, view of everyday life in residential care homes.

Leaving the Field

In total, approximately four hundred hours of participant observation were undertaken in each residential care home. In each home, the process of data collection – from the date of my recruitment interview to my last day working as a care worker – took around a year, with fieldwork taking around two years altogether.

My decision to leave the field, at both sites, took some thought. At low-cost Millstead, this decision was primarily based on data saturation, if not overload. Additionally, as I had accumulated more experience working in the home (and as several more experienced members of staff left), I was increasingly being asked to work alone. This limited my opportunities to observe the interactions of other care

workers. Towards the end of my year at Millstead, there were shifts when I had so few interactions with the care workers that moved beyond task-oriented discussions that I would write very few fieldnotes. My decision to leave the field was also a personal one. The poor level of care which I witnessed at Millstead, and my difficulty in addressing it when employed as a care worker in the home, was a source of disquiet and frustration for me. Though working at Millstead had given me a glimpse of the sense of powerlessness felt by those who carried on working there, as well as the horrible and degrading conditions sometimes experienced by residents, my own position as a funded researcher meant I could safely leave, with no serious financial repercussions. Leaving the field at Shorefield was a more practical decision. Having worked at the residential home for the period of a year, fewer new topics of interest were arising in my data collection, and I had more than enough data to complete my analysis.

Interviews

Fieldnotes of observations, however descriptive, are always a construction of events by the writer (Hammersley and Atkinson 2007). In order to consider alternative interpretations of events, it was beneficial to supplement my notes from the field with care workers' own accounts of their work. Interviewing care workers at Shorefield and Millstead may have provided the best data in terms of examining the motivations and experiences of those who worked in the two homes. However, there were two reasons why interviews were not undertaken with these care workers. The first was practical: the covert nature of my observations meant that formally interviewing care workers during the course of undertaking fieldwork in the two homes would have blown my cover and, in turn, likely brought a premature end to my observations. Secondly, the possibility of debriefing and, in turn, interviewing care workers at Millstead and Shorefield after leaving the field, was ruled out following discussions with Cardiff University's School of Social Sciences' Ethics Committee, who approved the study. The Committee stated that, by revealing myself as a researcher to those I was observing, I would be damaging their sense of trust, as they may feel upset that they had been misled or, worse, deceived. Hardie-Bick (Hardie-Bick and Scott

2017) had a similar concern during his (initially) covert research on skydivers. After 'coming out' as an overt researcher, Hardie-Bick believed that participants felt betrayed, duped, and 'insulted by the presumption of their gullibility' (2017: 254). Though, in consequence, formal interviews were not undertaken with care workers working at Millstead and Shorefield, I was still able to gain some understanding of their perspectives by means of informal conversations and everyday interactions in the field.

In order to gather the kind of data which would allow me to fully explore the different perspectives of care workers and, in turn, provide an adequate picture of care work in residential homes, I undertook interviews with other care workers working in Esterton. These interviews took place between May 2013 and February 2015. Interviewing care workers who – though not employed at Millstead or Shorefield – worked in the area of Esterton, provided me with the opportunity to further explore the themes which were emerging during the analysis of my fieldnotes. Interviews, therefore, took the form of confirmatory devices: were similar practices occurring in other residential homes in Esterton? Were such practices related to the cost of care, the culture of care, and/or the normative and symbolic culture of work? What other issues emerged in other residential homes? In what follows, I will spell out my approach to these interviews, how I recruited participants, the variety of forms which they took, and how the resulting data were analysed.

My initial sample for interviews was formed from the dataset which I had compiled in order to choose sites for observational study. This sample consisted of the thirty-six residential homes for older people located in the Esterton area which were registered with the Care Quality Commission and where I had not undertaken observations. Using this sample allowed me to treat Esterton as a broader case site for the research, ensuring that I understood the geographical and policy context of the care workers' work. All residential homes which formed the sample were mapped geographically and a walking route was planned between the homes. An information sheet, which took the form of a poster, was created to give to care workers and managers to display in staff areas of the

residential homes. This poster, which described me as a PhD student, explained that I was interested in residential care for older people, and invited care workers to participate in interviews lasting approximately an hour for a payment of twenty pounds. At the time of creating this poster, the average hourly wage of care workers working for private care providers in England was £6.96 (Skills for Care 2015b).

Though, in the most part, care workers whom I encountered when visiting Esterton's residential homes were very welcoming and appeared interested in the research, this enthusiasm did not translate into the recruitment of care workers to interview. I expected that, on those occasions where care workers had willingly taken posters to place on staff notice boards, their managers were perhaps less eager for their staff to be interviewed. This assumption was based upon both my previous experience of working in residential homes and the reserved, if not frosty, reception which I received when it was a manager, as opposed to a care worker, who answered the door to me. After visiting all thirty-six residential homes in Esterton which were not sites of observation (sometimes on more than one occasion), I had directly recruited only one participant and, using this participant as a gatekeeper, seven others indirectly. At this stage, I decided to change my recruitment strategy.

I was aware that care workers at Millstead and Shorefield often sought additional, informal work⁴¹ on classified advertising websites, such as Gumtree and Esterton's local news site. I wrote and uploaded an advertisement to the former, with the expectation that it would reach more potential participants. The content of this advertisement replicated that of the poster which I had previously distributed to residential homes in Esterton. The result was a surge in recruitment. However, the sample of respondents was more diverse than originally anticipated. Within twenty-four hours of the advert's publication, twelve individuals had expressed an interest in the research but, of these, just seven were interviewed. Several people

⁴¹ These jobs usually involved providing personal assistance or care to older people living in their own homes.

who responded to the advertisement, both in the initial twenty-four hours and thereafter, did not have experience of working in private residential homes for older people⁴², did not or had not worked in Esterton, and/or did not respond to my follow up emails once they had expressed an initial interest. Email exchanges, in which I asked about respondents' care work experience, were therefore required prior to formally arranging each interview. In total, twenty-two interview participants were recruited online, one participant was recruited directly from a residential home, and seven participants were recruited via word-of-mouth.

Initially, interviews were carried out face-to-face, often in care workers' own homes, but it quickly became apparent that finding a time and location which was convenient for thirty care workers to be interviewed would be particularly arduous. This was, not least, because their working hours were often unsociable, unpredictable, and extended without warning. Offering participants the option of being interviewed over the telephone lessened this difficulty by enabling me to interview care workers at short notice, and without the need for travel. The impact which these two changes in approach – recruiting participants online and interviewing over the telephone – may have had upon the kind of data acquired in the interviews merits attention. Firstly, though an effort was made to keep the demographic of my online recruits as close as possible to that of my initial sample of care workers, this was not always achievable.

One notable distinction between the respondents who formed my initial sample and those whom I recruited online was that the latter group expressed greater dissatisfaction with their (sometimes former) jobs. This was, perhaps, unsurprising given that the majority of online recruits would have come across my advertisement (placed in the 'jobs' section of the website) when they were seeking some form of employment. This dissatisfaction meant that online participants' responses to my questions, though often detailed and unrestrained, sometimes

⁴² Some respondents to the advert worked in nursing homes, in the community, in hospitals, or cared for relatives. In order to remain on-topic, these care workers were not interviewed. There seemed to be some confusion here regarding my use of the term 'residential care home' in the advertisement. Some respondents took this to mean a private home and some had not heard of the term.

took the form of venting sessions. For example, one care worker who was recruited online said that she found the interview 'cathartic', and others expressed that they were pleased to be able to talk to someone about their negative experiences of care work. Those care workers who were recruited via residential home visits, snowballing, or word-of-mouth were more likely to still be employed in the residential home which they were discussing and/or less likely to want to leave their current jobs. In turn, these care workers seemed to respond to questions in a more reserved manner and paint a more positive picture of their workplace; or, arguably, they may have felt deeper obligations to – or feared criticising – their employers.

Though these differences may raise questions about which group of respondents provided a more accurate picture of work in residential homes, I took each respondent's account as a perspective, as opposed to something which could be treated as 'real' or as 'truth'. To recognise why different respondents' accounts may be distinct is not to say that any one is more truthful or meaningful than another. That is, these are 'accounts' rather than truth statements – not transparent indices of people's personal worlds but, rather, valuations and/or interpretations of them. As Sayer (2011) suggests, however, values are not merely subjective preferences, nor are they simply derived from the internalisation of social norms. As sentient individuals, who have the capacity to both flourish and suffer, participants' views of the world are not beyond reason; they are substantially evaluative and deserve to be taken seriously.

Interviews with care workers ranged in length from around forty minutes to two and a half hours and were carried out face-to-face and via telephone. Respondents worked (or had worked) in a range of homes, from low-cost to high-cost, small to large, and single-owned homes to homes owned by national companies. Several had worked in a number of homes in Esterton and, in these instances, provided comparative accounts. Most respondents were female migrant workers and their ages ranged from twenty-one to sixty-three.

Often, English was not the first language of participants and, at times, this complicated the interview process. When participants felt unable to explain what

they wanted to say in English, they were given the option of responding in their first language. Though this would have required translation when it came to transcribing the interview data, it allowed participants to express what they wanted to say. One participant, who spoke very little English, was interviewed alongside his wife (another care worker) who translated my questions and his responses into Chinese and English respectively. A translator undoubtedly brings their own assumptions and concerns to the interview and, consequently, such an approach risks producing an 'interpreter version' (Temple and Edwards 2002). Likewise, whilst Filep (2009) suggests that how an interpreter positions themselves in the interview is less important when they are known to the respondent, the very presence of a partner may have changed the account given by this participant. Though there is a possibility that elements of the participant's account were re-interpreted or lost in translation, the use of an interpreter was a practical reality that was unavoidable.

With the consent of participants, all interviews were audio-recorded using a Dictaphone and subsequently transcribed verbatim. In all instances, interviews took a semi-structured form. Using a flexible interview schedule allowed me to gather data concerning the themes which were arising in my observational analyses and allowed care workers to talk about what they felt was significant about their work. For example, questions about handwashing routines and the movement of incontinence products around residential homes seemed unusual to the care workers and, having arisen from my own observations, seemed rather absurd to most respondents (who were sometimes unsure of how to respond). When I asked respondents more open-ended questions, however, new areas of inquiry sometimes emerged. It was due to such newly emerging themes, arising in both my own observations and interviews, that interview schedules were revised and adapted after each interview. Initial interviews, for example, did not explore the use of space in residential homes, the significance of which transpired during my observations. Being open to emergent themes required a constant conversation both within and between the interviews and observations, allowing each to inform and refine what data were collected as the study progressed.

The Waiting Field

As Mannay and Morgan (2014: 2) note, there has been a recent tendency for qualitative researchers to become preoccupied with the techniques which they employ at the expense of espousing an ethnographic imagination; 'there is so much emphasis on the tools that the tool box of ethnography becomes invisible'. One antidote to this, proposed by Mannay and Morgan, is to recognise the unexpected and unpredictable as key moments of insight in research. Thus, an appreciation of what Mannay and Morgan term the 'waiting field' – that is, those instances which precede, interrupt or follow the implementation of a planned research technique – was crucial to my approach to the study. Just as I had taken notes on my interactions with Millstead and Shorefield's staff outside of formal 'shifts', I made notes on the interactions which I had with interviewees before, during and after formal interviews.

The fieldnotes which I made following interviews which were carried out in care workers' own homes were particularly illuminating. On arriving in two homes, for example, I was offered a pair of slippers, introduced to care workers' families, and offered food or drinks. These occurrences both facilitated the development of rapport between myself the care workers (allowing for more open interview responses and the possibility of snowballing) and were analytically interesting in their own right. Several interviewees went to great lengths to make me feel comfortable. One put the heating on as I was a 'guest', several apologised for the poor maintenance of their rented accommodation, lack of milk, drying washing, and so on. These were all markers of the fiscal and temporal constraints of the care workers' work, both of which meant that their homes were not as they wished them to be.

On other occasions, instances occurring in 'the waiting field' triggered conversations in the interview which may not have arisen otherwise. On one occasion, for example, a care worker's son spent the length of the interview playing on a mobile telephone. The care worker commented on her own addiction to games like 'candy crush saga', which allowed her to both unwind after a shift and feel a sense of gratification which she was lacking at work. Due to this

exchange, I went on to ask other care workers about what they would do after work and several mentioned their use of similar repetitive games. Though less prominent, the 'waiting field' was not absent from the telephone interviews either. Several care workers whom I interviewed over the phone had young children and, when these children interrupted the interview with cries or speech, an insight was given into these care workers' lives. Again, this 'waiting field' (Mannay and Morgan 2014) triggered further areas of conversation as well as being analytically interesting in its own right.

Though the data gathered in these interviews (both face-to-face and telephone) was valuable, the main claims and insights in this thesis come from my observational data. This data provided a deeper and more detailed understanding of the mundane, everyday work practices of care workers. I will now discuss my approach to analysing the data gathered in observations and interviews, and the analytical relationship between the two data types.

Analysing Data

In research, a compromise must always be found between the scope of a project and the detail which it provides. In line with my ethnographic approach, my aim was to gather data which would allow me to provide a rich picture of the everyday, taken-for-granted practices taking place in two residential homes. Nonetheless, my intention was also to produce data that, in Atkinson's (2013a: 404) terms, 'transform[ed] the base materials of observation into analyses that transcend[ed] the particularities of the here-and-now' and spoke to 'generic themes of social action, organization, and knowledge'.

In paying attention to the mundane, everyday practices of care workers, my approach, in some ways, drew upon the principles and practices of ethnomethodology, which often relies upon conversation analysis as its primary means of analysing data (ten Have 2004). It was decided, however, that conversation analysis was not the most appropriate analytical method to employ in this case. On a practical level, my fieldnotes, which rarely included verbatim quotations, were not amenable to this kind of analysis. Though data produced in the interviews with care workers was transcribed verbatim, it was felt that

employing the techniques of conversation analysis, which focuses primarily on dialogue and linguistic forms, was out of step with the aims of the research, which sought to establish what factors contribute to the provision of good and bad quality care and what moral, emotional, and material stresses are experienced by care workers. Attending to the intricacies of interactions (e.g. fillers, full-stops, pauses) would direct attention away from the experiential and contextual content of the care workers' accounts. As Hammersley and Atkinson (2007) note, an ethnographer's analytic mentality requires that they consider the circumstances in which individuals act alongside seeking to understand their views.

In addition, due to my previous experience of using computer-aided qualitative data analysis software (CAQDAS), it was decided that data would be coded by hand. It was felt that, much like the use of conversation analysis techniques, the use of CAQDAS would abstract from the broader narratives encompassed in the data and the 'real work of creative analysis' (Atkinson 2013b: 58). I was also concerned that the use of this software would encourage an unhelpful 'quantification' of the rich qualitative data which I had gathered. Roberts and Wilson (2002) have similarly argued that there is an inherent contradiction between computer technology and the goals of qualitative researchers. Whilst the former 'assumes a positivistic approach to the natural world that sees it as being composed of objects that humans can study, understand and manipulate', qualitative researchers intend to see things from the perspectives of those whom they study (2002: 5). There is a concern, as such, that the use of CAQDAS can cause researchers to overlook the nuances of qualitative data (Coffey *et al.* 1996; Rodik and Primorac 2015).

My iterative approach to analysis required a constant conversation between theory and data, rather than an early formulation of codes which might limit subsequent analysis. Here, I was conscious of the temptation to jump to analytical conclusions, a temptation which I believe would have been easily slaked by formulating analytical codes and sorting my data into these hastily created categories. This commitment to delaying the formulation of hypotheses has been identified as crucial to the ethnographer's analytic mentality (Hammersley and

Atkinson 2007), and without it, several noteworthy observations which I made during the extended length of time which I spent at Millstead and Shorefield might have been overlooked. Though I was wary of making premature conclusions, analysis did occur alongside the collecting of data, both in observations and interviews. I used this analysis to guide areas of subsequent inquiry but did not allow it to rule out the possibility of new themes emerging.

Practically, my analytical approach involved the reading (and re-reading) of fieldnotes and interview transcripts and the creation of analytical notes. In the case of my observations, these analytical notes were made alongside my handwritten notes in my fieldwork diary. In order to distinguish between data and analysis, a simple process of using different coloured pens was employed (where black notes signified those from the field and red signified my own analytical notes). This distinction, however, was sometimes more complex. For example, towards the end of my fieldwork in each home, when I had a more accurate idea of what I was looking for, my fieldnotes became more focused and, at times, became a form of data analysis in themselves.

Throughout the subsequent three chapters, I mostly provide lengthy quotes lifted out of fieldnotes and interviews, rather than short snippets of data, in order to avoid the fragmentation of accounts. These have been condensed and ‘tidied up’ (i.e. removing all of the false starts, pauses, etc.) to, again, avoid detracting attention from my main observations. I also wrote memos alongside the transcript of each participant’s interview. These one-page memos – which noted basic demographic data, summarised the content of each interview, and commented on any noteworthy use of tone, intonations or pauses – were viewed alongside the transcripts. Alternative approaches to analysis (conversation, content, discourse) were, therefore, not discarded but, rather, used to complement my core analytical approach: thematic analysis. This analysis entailed identifying, studying and documenting patterns in the data, as well as recognising the similarities and differences between my observations in each site and the accounts of the care workers whom I interviewed.

Ethics

As Lowton (2016) recognises, the potential for risk and harm runs throughout the research process, from its inception to the dissemination of findings, and possible follow-up studies. Though the covert observational element of this research was perhaps more ethically complex than my interviews with care workers, the latter were not without their own ethical considerations. As mentioned previously, interview respondents were recruited via care home visits, online advertisements, and word of mouth. Describing the research via posters and advertisements ensured that respondents were informed about the research prior to opting to contact me. In each instance, further information was provided to the participants upon contact being made and, again, prior to the commencement of the interview. Consent was provided verbally by the participants, who were informed that they would be audio recorded, that they were able to withdraw from the research at any time, and how the data they provided would be used. If participants became upset during the interview, which did happen on several occasions, they were offered the opportunity to withdraw and/or continue at a later point. No participant accepted this invitation.

Ensuring anonymity was also an important consideration of the research. This was particularly important when writing up observational data, where the publication of identifying material may have led to details of participants or residential homes being uncovered – and, indeed, the participants themselves discovering that they were the subjects of a research project. As well as issues of anonymity, researching covertly presented a range of other ethical concerns. A consideration of ethics is central to the day-to-day undertaking of all studies (covert or otherwise), not least in the social care sector (Leathard and McLaren 2007). Central to these considerations was the role which I would be taking as a covert participant observer, namely, that of a care worker. This required that I did far more than *act* the part of ‘participant’. I was being employed to care for older people and my provision of this care had to take priority over the goals of the research at all times. Being a researcher was a role that had to be secondary to the roles which I adopted as a participant; that is, care worker, employee, and colleague.

The ethical concerns with carrying out covert research have been well reported in the literature (Herrera 1999; Homan 1991; Spicker 2011). For some, the omission of informed consent in covert research means that it can never, or rarely, be justified (Hammersley and Atkinson 2007; Herrera 1999). Others have problematised the idea of truly informed consent (Corrigan 2003), by showing that the realities and intricacies of fieldwork (overt *and* covert) mean that ensuring that all participants are fully informed and that they consent all of the time is, at best, unrealistic (Bosk 2001; Calvey 2008). In addition, we can argue that the ethical superiority of 'overt' research over explicitly covert research is often exaggerated. Hammersley and Atkinson (2007), for example, note that, even in overt research, participants are not always fully aware of, or alert to, the intentions of the researcher. On many occasions, and particularly in busy settings such as care environments, the ethnographer cannot always gather written consent due to the chaotic and disordered nature of the field (Hammersley and Atkinson 2007).

For Spicker, undisclosed research, on certain occasions, 'has to be accepted as a normal part of academic enquiry' (2011: 118). Researchers rarely disclose everything about their research to their participants and, in the case of ethnographic research, they cannot always predict what lines of inquiry may arise once the research has begun (Lugosi 2006). The line between covert and overt research can be viewed as a blurred one, which is subject to movement during the course of research (Lugosi 2006; Roth 1962). Viewing overt research as inherently good, and covert research as inherently bad, is, thus, an oversimplification which risks detracting from a more nuanced examination of the ethics of research. Likewise, whilst ethical reviews are required to limit harm, there are increasing concerns around the bureaucracy of ethics review and what Haggerty (2004) identifies as an 'ethics creep'. Lowton (2016) argues that the potential implications of this are that some researchers may avoid undertaking projects which they are passionate about and invested in, or projects which expose harmful situations.

For Spicker (2011), it is the fact that covert research is often (incorrectly) muddled with deception which results in it being regarded as inherently unethical and, although this criticism arises from a legitimate concern for the rights of

participants, it should not be over-generalised. In addition, the rights of research participants do not automatically take priority over others (Spicker 2011). In the care homes I observed, for instance, the rights of the vulnerable residents were, to me, of equal importance to those of the workers, and I did not want my respect for the rights of these workers to prevent me from studying the abuse of the rights of the more vulnerable.

Rather than employing a position of ethical absolutism, I endeavoured to situate my ethical thinking, and my subsequent methodological decisions, within the research context (Hammersley and Atkinson 2007). Borrowing from Weber (1919/1946), we might term this approach 'an ethic of responsibility'. For Weber, a clear distinction between facts and values led him to conclude that this ethic was best suited to the domain of political life, rather than science. Today, however, we have a much clearer idea of the ethics of scientists and researchers and, as such, we can make good use of Weber's 'ethic of responsibility'. Contrasting the 'ethic of responsibility' with an 'ethic of ultimate ends' – which is unyielding in its commitment to particular values – Weber demonstrated the importance of having a willingness to make compromises whilst also keeping sight of the ethical values that one considers important.

Ethics is never something which starts and finishes at the design stage in any research (Guilleman and Gillam 2004). This is even more the case when the site of research is also the home or workplace of those being researched. Residential homes are not static sites; they are unpredictable, messy hubs of activity. This meant that, in this study, ethical dilemmas could arise at any time, not least because the research sites were places where vulnerable adults were in receipt of care. One ethical dilemma which arose within the field (at Millstead) was the reported physical abuse of residents by a member of staff. Having anticipated that incidents of abuse on the part of care workers may have been observed during the course of the research, I had pre-planned my response to such events. My plan was to report these to the home's management and, if this did not result in the appropriate action being taken, to report such incidents to the Care Quality

Commission (CQC). This was considered to be a robust plan prior to the undertaking of the research, but the reality was far more ethically complex.

With only secondary evidence of abuse available to me⁴³, my initial step was to advise those care workers who had witnessed incidents of abuse to report what they had seen to the home's management. This, however, did not result in the expected outcome. Two care workers who spoke to the home's manager reported being told that they should not speak of what they knew again and that they would lose their jobs if they were to do so. Likewise, the care worker accused of abusing a resident was not subject to investigation or disciplinary action. This demonstrates the complexity of ethics in the field, where a choice often needs to be made, not between help and harm but between different degrees or types of harm to different people. In this case, the quality of life of the residents, the care workers' jobs (and, in turn, their wellbeing and their families), the possibility of future harm to the residents, the completion of the research project, and my own ethical integrity as both a researcher and a care worker were all tied up in my decision to report the practices at Millstead to the CQC.

This concern also highlights how ethnographic research, and research more generally, is both an empirical and an emotional accomplishment (Coffey 1999; Scott *et al.* 2012; Wellin and Fine 2007). As Scott *et al.* (2012) note, qualitative researchers are increasingly acknowledging the role which emotions play in intellectual research and reasoning, and the impact which they have on the relationships which are developed with participants. Considering the role of the researcher in the field is both an epistemological concern and an ethical one (Hammersley and Atkinson 2007). Below, I reflect upon my role as a covert participant observer, and as an interviewer who was also a former care worker, and document some of the tensions and conflicts which these roles gave rise to.

⁴³ This included suspicious bruises on a resident's body, care workers claiming to have witnessed another care worker abusing a resident, and residents reporting that they were 'frightened' of a care worker.

Reflexivity: 'Truth', Emotions, and Making the Familiar Strange

Reflexive accounts have become a common feature of the ethnographic craft. Rather than being read as self-indulgent, a reflexive perspective is crucial for showing how a researcher's position, status and role plays a part in the research process. Throughout my time in the field, and prior to entering it, I kept a research diary which provided me with the reflexive space in which to consider my own thoughts and feelings about the two homes. In this diary, I reflected upon how I felt each time I entered the field, my emotional responses to events, and how my own personal history may have guided my observations and what I, in turn, noted down. This reflective diary was useful in helping me to think through my own position in the field, where I shared the 'care worker' identity of those I was researching and yet was a (potentially critical) outsider.

Whilst adopting a covert approach was necessary in order to gain access to the less visible spaces and practices of Millstead and Shorefield (and without causing great changes in the behaviours of those I observed), being truthful about my identity and my intentions for seeking employment in the two homes was important to me. My passing as a legitimate insider, without being deceptive or dishonest, was facilitated by my previous experience of being a care worker. This experience provided me with the vernacular language, practical know-how, and shared behaviours required to perform the role and, as Hammersley and Atkinson (2007) suggest, was a valuable foundation for establishing mutuality with my participants.

Hammersley and Atkinson (2007) have commented on the strain which an ethnographer's adoption of a covert role, particularly when carried out over an extended period of time, can place on their dramaturgical capacities. As Spicker (2011) points out, however, not all covert research involves the researcher pretending to be, or becoming, something different. As a former care worker, adopting the care worker role did not leave me feeling guilty of betrayal, or what Lugosi (2006: 557) described as a 'perpetual sense of dishonesty'. Gaining access to the field and performing the role of care worker did not require that I engage in deception or subterfuge. For example, I informed the management and care

workers in both homes that I was undertaking a PhD related to the care of older people and was truthful about my interests and previous experiences.

There was, however, some information which I did not disclose to the managers, care workers, or residents at Millstead and Shorefield. Though care workers in both homes were aware that my intention was to learn more about residential care work, for example, they were not aware that this learning involved observing and writing about their behaviours, interactions, and conversations. Likewise, my specific research agenda – to explore the factors contributing to good and bad quality care – was not mentioned to the homes' managers or care workers. Lugosi (2006: 557) recommends that, as ethnographers, we need to consider how we distinguish between 'those concealments that are necessary or unavoidable ... and those that represent dangerous or irresponsible moral transgressions'. Concealing my specific research intentions and methods of data collection was necessary for both gaining (and sustaining) access to the field and reducing the impact which I had on the behaviours of my participants. Several ethnographers have remarked upon the inescapability of concealing this kind of information, even in 'overt' research (Fine and Shulman 2009; Lugosi 2006). Concealing core elements of my identity – that I was a PhD student and that I had an academic interest in care work – on the other hand, was felt to be both practically impossible⁴⁴ and unnecessarily deceitful.

There were occasions, however, where my own views and beliefs – closely linked to my academic interests – were at odds with my participants. As Hammersley (2005) notes, it can sometimes be necessary for ethnographers to tolerate situations, behaviours, or individuals that they disagree with or find offensive. This need to be tolerant, so as not to expose myself as a researcher or to bias the fieldwork by only interacting with those whom I agreed with, sometimes required the suppression of my own feelings, opinions, and beliefs. At times, however, I was deeply troubled by what I observed. Where possible, I took practical measures to

⁴⁴ Searching my name online, for example, would have returned information about my academic interests. Equally, my role as PhD student was what allowed me to explain my bi-weekly absence from the field.

address such concerns, such as informing the CQC of substandard care, reporting the illegal underpayment of care workers to HMRC, and discussing poor work conditions and care quality with the care homes' managers.

Even when specific problems or concerns did not emerge, I often found the fieldwork to be mentally exhausting and emotionally draining. During the study, there were occasions where I became angered by (what I observed as) practices that denied both workers and residents their dignity and respect, or I was upset by the suffering and/or death of older people living in the two homes. In addition, as was the case for several care workers whom I interviewed, I often thought or worried about residents after work, and I felt frustrated and ashamed when the constraints of the job prevented me from providing the best possible care to them. Though not always pleasant, attending to my emotions in the field also provided me with a valuable insight into the common pressures, tensions, and anxieties experienced by care workers.

My close identification with the care worker role also presented intellectual challenges. I was comfortable in carrying out the daily tasks of care work, and yet it was this ease with which I performed the tasks of caregiving which constituted a potential barrier when it came to data analysis. The difficulties of rendering strange that which is, or has become, familiar have long been explicated in ethnographic accounts of fieldwork, particularly where the researcher has played the part of participant (Delamont and Atkinson 1995; Desmond 2008). Several strategies aided my production of an analytic understanding of what I observed. The most beneficial of these strategies was my decision to undertake fieldwork on a week-on, week-off basis. The alternate weeks which I spent away from the field allowed me the time and distance required to emotionally recuperate, to read over and think through my fieldnotes, and to solidify my interpretations by examining the literature and discussing my findings as they emerged.

Other researchers have reported similar difficulties associated with occupying dual identities in the field. Morriss (2015, 2016), who carried out research on social workers and identified as a social worker herself, notes how ethnomethodological concepts might be employed to conceptualise and make sense of the complex

position of those who are, at once, both researcher and fully-fledged participant. Drawing upon Garfinkel's (1967) definition of 'group members', Morriss comments upon how the identity which she shared with her participants caused them to respond to interview questions in a very particular way; namely, through the use of atrocity stories. Similar responses occurred in my own interviews with care workers, particularly where the 'dirty' aspects of care were discussed. Several participants commented that, given that I was also a care worker, they would provide me with a 'warts and all', honest account of their work. Sharing the group membership of those I interviewed, thus, provided me with the appropriate capital with which to access such candid tales, which might have been unobtainable by an outsider.

I shared several characteristics and interests with the majority of care workers whom I worked with and interviewed, but there were also differences in identity between myself and my participants which could not be managed or eliminated. I am a white British female and was in my mid-twenties when fieldwork for this study was undertaken, yet the majority of participants were migrant workers, some were male, most were older than me, and few had qualifications. Whilst inevitably playing some role throughout the research, however, I do not believe that these differences presented any serious impediment to either collecting data or to my subsequent portrayal of residential care. The potential impact which the impossible-to-manage aspects of my identity may have had on the research was perhaps mitigated by my 'insider' status as a (former and current) care worker.

Much like the homecare workers in Hayes' study (2016), several care workers whom I spoke to in the course of this research commented upon the poor reputation of care work and the stigma and sense of scrutiny which they felt as a result. Sharing these experiences, and having read vilifying accounts of care work, I was mindful of how my work would be read, particularly in instances where I was discussing the ill treatment of residents. Presenting an account which is realistic, yet may not reflect upon participants favourably, is always a concern for ethnographers (Bourgois 1995). But this threat – of participants, many of whom I liked, reacting disapprovingly to a warts-and-all tale – was heightened by the fact

that I was researching covertly. Whilst, at times, this thesis reports on problematic events and practices, it also points towards the often difficult (and sometimes perilous) circumstances in which care workers undertake their labour. My objective here was not to write a provocative tale of what Foner (1994: 245) called 'saints or monsters' but, rather, to present an account of residential care work which appreciates its nuances and complexities, and is fair and true to my own interpretations. Of course, negotiating the identities of self, researcher, and care worker – in the field and outside it – was not without its challenges. Yet combining these roles (and reflecting upon them) facilitated my production of a text which is both sympathetic toward residents and care workers but also critical, where necessary, of the arrangements and practices that I witnessed and heard about.

Conclusion

In this chapter, I have sketched out my methodological approach of carrying out ethnographic research in two residential care homes. After outlining my approach, I discussed how I came to decide upon my research sites and provided some further information about their make-up and structure. In what followed, I described how I collected data both by means of participant observation in residential homes and by undertaking interviews with care workers. Following a brief account of how I left the field, I identified my data analysis strategy and the ethics of undertaking interviews with care workers. The subsequent section unpacked the ethical dilemmas that emerged when carrying out this research, especially those stemming from assuming a covert strategy. Finally, I discussed my own place in the field and the effects which my past and more recent experiences had on the study. In the following chapters, I will present my findings, beginning with an exploration of the organisation of care work at Millstead and Shorefield, and how care workers – and, in turn, residents – were encouraged to spend their time in particular ways.

Chapter 4: The Organisation of Care Work

As we saw in chapter two, the cost of care, the work conditions experienced by care workers, and the quality of care provided by a residential home are all linked, yet we know very little about how this relationship works in practice. Focusing on how the organisation of care work differed at low-cost Millstead and high-cost Shorefield, in this chapter, I take an initial step towards understanding this relationship. I begin by exploring the cost of care at the two homes in more detail, examining the total price paid for care and, also, what services were being paid for and by whom. Next, I consider how the scheduling and allocation of work – conveyed in rotas, formal routines, and handovers – structured the care workers' time at work, the tasks and activities which they undertook, and the skills which they developed. In the second half of this chapter, I explore how the care workers constructed and marked out their identities within the confines and constraints of their jobs. In particular, I consider how the allocation of resources – human, temporal, and material – acts to demarcate what counts as work and, in turn, what or who is valued. In doing so, I begin to move beyond an administrative (e.g. HRM) examination of care work, focusing on the identity work of care workers and on the normative and symbolic culture of work at Millstead and Shorefield.

Costing and Charging for Care

When examining the potential links between the cost of care and its quality, it is not simply the average price paid for a care placement in a particular home which we must take into account. The cost of a residential care placement can reflect what facilities and services a home offers, who it provides these services to (the degree and nature of residents' care needs, for example), and the source of payments.

Agreements about how much is to be paid for care play a role in shaping care work because, contractually at least, they specify what care is to be provided and/or to whom. Given that such agreements shape a residential home's revenue and the size and characteristics of its resident demographic, we can assume that they are

closely tied up with managerial decisions about staffing levels, as well as the order, content and pace of work, and the culture and ethos of a residential home. For this reason, understanding the routines and rituals of work at Millstead and Shorefield requires an appreciation of how the provision of care to residents was assessed, costed, and paid for in each home. In both homes, though to a greater extent at Millstead, my role as a care worker did not grant me complete access to information concerning care fees and resident admissions⁴⁵. Information about these processes was, however, gained from my day-to-day discussions with the homes' staff, formal information requests to the local authority, materials available online, and, at Shorefield, by reading resident care plans. Taken together, this data, summarised below, provides an important backdrop to the analysis that follows.

Millstead: High Care Needs in a Low-Cost Home

In January 2013, twenty-four of Millstead's thirty-three residents were funded by the local authority, who paid an average of £448 per week for their accommodation and care. Millstead's private paying residents, on the other hand, were charged between £466 and £600 per week. During the year which I spent at Millstead, very little information concerning the source or size of residents' care fees was relayed to care workers. In consequence, care workers (and I as a researcher) were unable to discern whether there was a clear relationship between the cost of a resident's care and the human, temporal, and material resources used in providing that care.

During my year at Millstead, there were only a couple of occasions where I observed care workers discussing the relationship between care needs and care fees. One of these occasions occurred during my fourth month at Millstead, one month after Harry, a male resident who displayed challenging behaviour, moved

⁴⁵ Nearly every care worker in Esterton whom I interviewed reported a similar lack of knowledge about the amount of money being charged for care in the residential homes where they worked. When I asked Frankie about the cost of a placement where she worked, for example, she said 'the financial side is kept secret. If you're a carer, you don't know nothing'.

into the home. I took the following fieldnote after a shift where Harry's behaviour had been discussed in the morning (pre-shift) handover:

Pamela, a carer, mentioned that Harry, a new resident, had called out to her in the lounge, asking if she 'had breasts like the "page 3 girl" he was looking at' and 'if he could see them'. Adelina (head carer), who happened to be in the dining room whilst handover was taking place, overheard Pamela and approached the table at which we were sitting. Adelina said that we should inform her of all instances where Harry behaves inappropriately and advised us to 'tell them [the residents] "you have rights, but we have rights too"'. Since Harry moved into the home, four weeks ago, several care workers have claimed that he was expelled from his previous residential home due to sexual misconduct. There have been several incidents of this nature involving Harry over the past four weeks. When sitting on a chair in the corridor, for example, Harry sometimes uses his walking stick to prod the buttocks of passing care workers. Similarly, whilst care workers have attempted to assist Harry with washing and dressing, he has touched and grabbed them in a way which they have perceived to be inappropriate. Several care workers have mentioned these instances to Adelina in passing but, as far as I am aware, no formal documentation regarding them has been produced. Instead, Adelina has told 'young' female care workers to avoid providing care to Harry unless they 'have to'. Altering who provides care to Harry appears to have done little to address his challenging behaviour. Following Adelina's plans to alter who provides his care, Harry has begun to defecate in his bedroom and smear it on the walls and furnishings, though he is both continent and mobile. After handover, Cera, another carer, tells me that reporting Harry's behaviour is 'pointless' because Millstead 'gets more money for the ones [residents] no one else wants'. 'He can do what he wants to us, [because] they [Millstead's management] don't care'.

Millstead Fieldnotes

Cera's assumption that Millstead's readiness to take on residents who exhibited challenging behaviours – particularly those with a known history of unsuccessful placements in other care homes – was a profit-seeking practice appeared to be shared by other care workers at the home. A few months later, following a shift where a female resident, Lucy, had suffered a psychotic episode in which she believed someone had killed her child, I walked part-way home with another carer, Rosanna. As well as carrying out our usual duties, Rosanna and I had spent the morning's shift attempting to reassure Lucy, gaining access to the communal toilet in which she had locked herself, and removing her from two private bedrooms, where she wailed and grabbed hold of residents. Despite the visibility and

audibility of these occurrences, they were not mentioned during the day's handovers. Likewise, when Rosanna and I expressed to Adelina our concerns about Lucy and the impact which her distress was having on other residents, Adelina's response was to reassure us that Lucy would 'be back to normal in a few days'. As I walked home alongside Rosanna, who had resigned from Millstead one year previously before deciding to return to work more recently, she expressed her frustration with what she referred to as Adelina's 'downplaying' of Lucy's behaviour. Rosanna suggested that this 'downplaying' was indicative of the way that Brian, Millstead's manager, favoured care placements which brought in a higher revenue, even when such placements were unfitting or, worse, not properly resourced. Indeed, Adelina told us that she did not want Lucy to be assessed by a community psychiatric nurse because this would likely result in her being admitted to the local psychiatric hospital, an event which, Rosanna indicated, had previously resulted in Lucy's care placement at Millstead (and its associated fees) being retracted.

When an older person has an intellectual disability or displays challenging behaviour, local authorities are likely to pay more for their care, both due to the higher costs with which it is associated and the difficulties of finding a provider who is both suitable and willing to take them on (Allen *et al.* 2007; Knapp *et al.* 2005). Whether higher fees are converted into appropriate care – appropriate for the care workers as well as the resident – is not entirely clear, however, and there is no doubt that residents who exhibit challenging behaviours may offer some care homes an opportunity for profiting financially (Scourfield 2007).

During my walk with Rosanna, she spoke about her belief that Brian was 'on some kind of mission' to admit residents who exhibited challenging behaviours. Though not formally quantified by (or for) Millstead's care workers, the overall level of care needs at Millstead – particularly those related to challenging behaviour – did seem to increase over the course of my year at the home. In January 2013, when I started working at Millstead, I was aware of just one resident (Lucy) who had a mental health issue which might lead to challenging behaviour and one resident who had an intellectual disability. By December 2013, the home had accepted a

further three residents who exhibited challenging behaviours (including Harry) and two residents with intellectual disabilities.

In itself, this evidence of increasing care needs at Millstead is not particularly noteworthy. It has been well documented that there has been a significant increase in the care needs of older people moving into residential care environments over the past decade (Matthews *et al.* 2016). More intriguing is that, in Millstead's case, these increased needs appeared to be predominantly emotional and psychological, as opposed to physical or medical. It is a fact that emotional and psychological needs are often less visible and, in turn, their neglect usually leaves a less visible trace. The invisibility of labour carried out to meet emotional and psychological needs (talk, providing comfort or reassurance), as opposed to that required to meet physical needs (washing, dressing, bowel and bladder care), means that the former can more inconspicuously be ignored. The emotional and psychological nature of the needs of Millstead's new residents, in this way, allowed the home to boost its revenue without similarly increasing the costs incurred in care provision.

As Rosanna later observed, the new intake of residents at Millstead was not followed by any change in staffing, additional training, or any managerial acknowledgment of care workers' altered or enhanced workload. Whilst taking on residents with additional care needs likely boosted Millstead's revenue, staffing levels remained the same throughout my year at the home, and staff pay only rose to £6.31 per hour during October 2013, in accordance with a rise in the National Minimum Wage.

Shorefield: Low Care Needs in a High-Cost Home

In contrast to Millstead, the cost of care at Shorefield in January 2013 was a great deal higher. Just four of Shorefield's ninety-nine residents received funding from the local authority, which paid an average of £540 per week for their care. Private payers, on the other hand, paid upwards of £750 per week for their place (room, meals, and activities) at Shorefield, before paying for any formal care provision. Unlike care at Millstead, which was not clearly quantified and costed for, the cost

of residency at Shorefield was directly linked to the amount of care which residents were contractually expected to receive.

Though Shorefield's lead care workers were responsible for assessing and documenting the care needs of residents prior to their entry into the home, it was the company's sales team who, following these assessments, negotiated care 'packages' with residents and/or their families. These contractual agreements, alongside the size and features of the room occupied by a resident, determined how much would be paid for their placement. The amount of care – in thirty-minute increments – which care workers were expected to provide to a resident reflected their care package, which was formalised in a resident's 'Individualised Service Plan' (ISP). ISPs contained a wealth of information on each resident including their medical condition, care needs, preferences, personal histories (often written in the first person), hobbies, religious affiliations, emergency contacts, and a photograph. Each resident's ISP was filed alongside any other documentation concerning them – daily notes which care workers made at the end of each shift, incident forms, and/or medical charts – and, located in the care office, was accessible to care workers at all times.

Though care workers' access to resident files meant that they were aware of how much care time each resident was paying for, they did not closely examine or adhere to these timings. There were, in fact, several occasions where care workers expressed surprise upon finding out that residents were paying for more care than they actually received. I was similarly surprised when looking at residents' ISPs at the end of a shift around three months into my fieldwork at Shorefield:

It is the end of our morning shift and we are in the care office making notes in residents' files. I open Gill, a resident's, file and glance at her ISP. I have spent about twenty minutes with Gill, assisting her with applying cream to her legs and putting on stockings. Gill's ISP states that she requires assistance with washing, dressing and transferring between spaces (from bed to bath, etc.) and that this amounts to 2.5 care hours per day. I observed Gill being cared for during one of my shadow shifts, three months ago, and the care which she received was very similar to that which I provided today. I ask Will, another carer, if there has been some reduction in Gill's needs, given that the care needs specified in her ISP do not seem to match up with the care which she is provided with. He tells me that Gill's

needs have remained the same since she moved to Shorefield six months ago, but that Gill's family want 'reassurance' that, if she does request additional assistance, this will be provided. I check the ISP for each other resident whom I am responsible for before writing their daily notes and there are several similar cases of mismatches between specified care needs and actual care provided. Frank's ISP, for example, states that he requires 1.5 hours of care per day, but I have never seen him being assisted with personal care activities and his daily notes most often report that he is 'fully independent' or 'did not require assistance'.

Shorefield Fieldnotes

Following the events outlined above, I made a habit of cross-checking each resident's specified care hours with the descriptions of care provided to them in their daily notes. It appeared that Shorefield's sales team's quantification of a resident's chargeable caregiving hours frequently exceeded the quantity of care which they received. Most care workers were aware of these disparities but did not discuss them in any detail. This lack of discussion was perhaps because, whilst residents received less (timed) care than they paid for, this appeared to result from their care needs being over-estimated and over-costed for rather under-estimated or unmet. Workers, in turn, seemed to perceive that they could respond to residents' needs within the time available to them. My perception was also that the residents were content with the care which was provided to them. Since I did not observe attempts to manipulate residents' use of call bells or expressions of (dis)satisfaction, my inclination is to treat this contentment as *bona fide*⁴⁶.

On the rare occasions where a resident was in receipt of more care than they were paying for, on the other hand, the relationship between specified care needs and actual care provided was discussed in handovers. Shorefield's care workers would be repeatedly reminded to detail the content and timing of each instance of unspecified (and therefore un-costed) care which they were providing in their daily notes so that an increased (and costlier) package of care could be negotiated. This detailed note-taking was framed by Patricia, the care manager, as being in the interests of care workers because 'we can prove why we need more care workers on shift then'.

⁴⁶ Of course, there is no way to tell whether some residents' disgruntlements remained unspoken.

Whilst care workers' access to residents' ISPs meant that they were aware of the hours of care that were paid for by each resident, they were often not aware of how much each resident paid for their accommodation or care package altogether. It was only after I had worked at the home for several months, for example, that I was first told by Jane, another carer, how much residents paid for each hour of care which they received:

Jane and I have just finished assisting Pauline into her nightclothes and into bed, and we walk back to the care office. Jane tells me that Pauline's family have asked her to travel with them to Lourdes so that she can assist Pauline, who they plan to take with them. Jane had hoped to carry out this work by taking annual leave from Shorefield and receiving a one-off payment from Pauline's family but has been told by Patricia, our manager, that payment for her work would have to go 'through the books'. Jane tells me that she wishes that Pauline's family had not informed Shorefield of their plans because they would have spent less money and she (Jane) would have received more money. Jane tells me that residents at Shorefield pay around £43 per hour for their care and that she 'wouldn't have wanted a quarter of that for a free holiday and only one resident to care for'.

Shorefield Fieldnotes

Whilst the costs associated with care provision are not limited to staff pay, given that care workers at Shorefield were paid from just £7.20 per hour, it is likely that Shorefield generated a profit from the £43 which it charged for each hour of direct care provision. Taking on residents with high care needs may have boosted Shorefield's profits, yet the home's marketing strategy was not based on securing local authority funding or placements for residents with high or complex needs. This was made clear during a quiet afternoon shift where I was asked to assist Cliff, Shorefield's sales manager, in his office:

Whilst I am tasked with stuffing envelopes, Cliff receives a telephone call from the family of a prospective resident whose current residential home is facing closure. Shorefield's employees are regularly told not to inform prospective residents or their families of the cost of care at the home until they have visited for a pre-arranged tour and meeting with Cliff or his assistant. Cliff, however, tells the prospective resident's family that care at the home is likely to 'significantly exceed' what they're paying at the moment. Following the call, I ask Cliff if the prospective resident will be visiting Shorefield for a visit. He replies 'probably not. I've had a few ringing from there and they're not the Shorefield type'. Cliff proceeds to tell me

about the low-cost and low-quality of care at the local residential home which is closing, before informing me that trying to attract this home's residents is 'a waste of time' as they will not be able to afford a place like Shorefield.

Shorefield Fieldnotes

During my year at Shorefield, it became clear that the 'Shorefield type' of resident was, most often, a wealthier individual (or couple) who would be ineligible for publicly funded care provision, both in terms of need and finances. Most of Shorefield's incoming residents had no, or few, care needs, and many residents who did pay for direct care provision required what Shorefield's employees referred to as 'prompting', 'encouragement' or 'company', rather than hands-on assistance with their personal care or mobility. Most residents at the home who had high care needs had developed these needs after moving to Shorefield, due to increasing frailty, illness, or falls. The low level of residents' physical care needs at Shorefield, coupled with the fact that their more 'social' needs and wants were sometimes formalised into care-time in their ISPs, had implications for the amount and type of work undertaken by care workers. Some residents, for example, paid for assistance with applying make-up, walking their dogs, or making phone calls to their families.

Admitting residents with high care needs may have boosted Shorefield's income, but this approach was presumably rejected by Shorefield on the grounds that it would undermine its alternative, more profitable marketing strategy. Targeting the high-end of the market, Shorefield's marketing portrayed the home as a community of active, sociable, and sophisticated older people; a community which was worth paying to be a part of. This lifestyle, however, required an abundance of residents who were able to engage with others, to take part in (sometimes formal) events and activities, and to spend time in communal areas of the home. The value-added by these 'Shorefield type' of residents was greater than that which would have been generated by taking on residents with more complex needs, particularly those with social or behavioural issues. Shorefield, in part, was able to charge a higher price because it was offering residents a place in a community of what they were able to portray as healthier, wealthier, and more

civilised and sociable neighbours than other residential homes. Part of the 'service' consumed by residents, then, was provided *pro bono* by the residents themselves.

Whilst the ratio of care workers to residents on each shift was alike at Millstead and Shorefield, this is not to say that the amount or type of work undertaken by care workers in the two homes was similar. This was, in part, due to differences in the care needs of residents in each home but, also, a result of their different routines, philosophies of care, and ideas about what tasks and activities should be undertaken by care workers. I explore these differences in the remainder of this chapter.

Routinised or Responsive Care

A notice board in Millstead's kitchen was used to display a weekly rota, which named the care workers (carers and seniors) who were required to work each shift. Running from Monday-Sunday, this rota was often not placed on the notice board until after 8pm on a Sunday evening, which meant that care workers working on a Sunday night would receive multiple calls from colleagues, waiting at home, unsure whether they would be working in the morning. This last-minute issuing of the rota was a source of much frustration amongst the care workers, who (without contracted hours) were unable to plan anything in advance, and several of whom were left unsure of how much money they would make each week.

Whilst Millstead's care workers were unable to foresee or plan for time ahead, things were a great deal more predictable for the home's thirty-three residents. Each day at the home followed a strict routine, organised around residents' predetermined meal times. A basic outline of this routine was displayed ubiquitously on posters placed in communal spaces and staff areas (see a version of this on the following page).

Breakfast	7.30am
Morning Tea	10.00am
Lunch (Early Eaters)	11.30am
Lunch	12.00pm
Afternoon Tea	2.30pm
Supper (Early Eaters)	4.30pm
Supper	5.00pm

Table 3: Daily routine at Millstead

For care workers at Millstead, each of the events listed in the table above conveyed an expectation of what work should be completed in what timeframe. ‘Morning tea’, for example, indicated the deadline for the completion of the morning’s personal care activities: toileting, washing, and dressing residents. The order of daily tasks at Millstead was similar to that described by many other care workers at other residential homes in Esterton, some of whom described their workplaces’ daily routines as completely inflexible or what Kate, one interview respondent, called ‘set in stone’. At Millstead, Mrs G, the home’s proprietor, and senior carers regularly reminded carers of the fixed nature of the deadlines by which they should complete particular tasks. When Mrs G was present, the daily routine was, therefore, followed as closely as possible, as a failure to meet its specified deadlines would result in a scolding by Mrs G or the seniors.

When Mrs G was not present, on the other hand, both Millstead’s seniors and carers treated the time-table with more flexibility. Morning tea, for example, would often take place at 10.30am rather than 10.00am. Equally, In Mrs G’s absence, care workers would bring supper forward by thirty minutes. After supper, care workers would assist residents into their nightclothes and into bed. This self-management of time meant that, unlike on days where Mrs G was present, care workers were able to leave work on time, but also that some residents would be ‘put to bed’ long before evening (sometimes as early as 4.30pm).

During the morning shift at Millstead, which ran from 8am until 2pm, carers were assigned a 'side' of the building (left or right) and were responsible for 'getting up' either 'singles' or 'doubles'. The home's managers and care workers used the term 'singles' to refer to residents who required assistance from one care worker, and 'doubles' to refer to residents who required assistance from two care workers at a time (for example, if the use of a hoist was required to assist a resident). If fully-staffed, three carers would be assigned to each side of the building, with two carers caring for 'doubles' and one caring for 'singles' on each side. Due to short-staffing, however, a single carer would often be responsible for assisting 'singles' on both the left and right sides of the building. Likewise, the senior care worker would usually assist with 'doubles', as well as being responsible for dispensing medication, completing paperwork, and handover.

Ordinarily, the senior and three carers from the morning shift would stay on for the afternoon shift, working a 'long day' (8am-8pm). In the afternoon, one carer would be responsible for serving tea and biscuits in the lounge as well as washing up, cooking supper, serving in the dining room, and catching up on laundry. The remaining two carers were responsible for the personal care of all thirty-three residents as well as 'moving' them between the lounge, dining room, and their bedrooms at the times specified in the home's schedule. This is similar to the work of the nursing auxiliaries in Lee-Treweek's (1997: 53) study whose 'main work ... was to create a sanitised "lounge standard" patient, fit to be placed in the front stage of the home'.

Structured around mealtimes, Millstead's daily routine categorised residents into groups: 'early eaters', who required assistance with eating, and 'late eaters', who did not. In the same way, care workers' activities were allocated based on residents' care needs: whether they required the assistance of one ('singles') or two ('doubles') care workers. Classifying residents in this manner was a form of ordering which functioned to routinise work in a way which minimised the effects of short-staffing. As we know from previous studies, forms of categorisation like this can function not only to divide or speed-up work but, also, to convey the value, or lack of value, of those being cared for. Researchers have noted how in other

care settings, such as hospitals, staff's categorisations can, intentionally or unintentionally, classify the social worth of patients and determine the care which they receive (Glaser and Strauss 1964; Hillman 2014; Jeffrey 1979; Roth 1972).

The categorisation of residents and their needs, whilst necessary from a functional point of view, always carries with it the danger of legitimising a hierarchy of worth and deservingness (Roth 1972). To use Douglas' (1966: 4) terms, categorisations or classifications can carry a 'symbolic load' which convey a view of and reinforce a particular social order. For example, in her work on nurses' classifications of patients in an acute medical unit, Latimer (1997) noted how the categorisations of particular patients – namely, as either 'social' or 'medical' problems – shaped the nature of their care. This was the case at Millstead, where early eaters, who 'needed feeding' or who 'needed hoisting' were distinguished from those who did not require such assistance. As Latimer (1997: 171) points out, this 'constituting of classes' conveys not only forms of care but, also, patients' identities as dependent, dying, difficult, or otherwise. At Millstead, residents were acutely aware of the 'class' assigned to them: those who ate unassisted often denounced the 'early eaters' and disliked being mistaken for one.

Millstead's carers similarly expressed a preference for being assigned 'singles' (who were rarely 'early eaters'). This was perhaps fuelled by the carers' knowledge that caring for residents categorised as 'singles' often meant less lifting and manoeuvring, less contact with bodily fluids, and, since they would be working alone, increased control over the pace and sequencing of their labour. In short, categorising certain Millstead residents as 'early eaters' or 'doubles', whilst a way to organise the care workers' labour, also marked the former out as problematic, as a nuisance and, in turn, as less deserving of their attention.

Unlike care workers at Millstead who had little forewarning of when, and for how many hours, they would be required to work, most care workers at Shorefield were contracted to work a set number of hours at the home each week. These hours were distributed according to a rota which was displayed in the home's care office six weeks in advance. This rota had a recurrent pattern so that, unless a care

worker was on annual leave, unwell, or undertaking overtime or 'bank' work, they would repeat the same shifts during each two-week period.

Whilst Shorefield's care workers' working hours and patterns were more predictable than those of Millstead's care workers, the reverse was true for the home's daily routines, which were a great deal more flexible than those at Millstead. At Millstead, day-to-day activities – eating, washing, using the toilet – were brought into line with the home's schedule. In contrast, at Shorefield, it was residents' needs and preferences which tended to dictate both the order and nature of care workers' activities. Each meal time at Shorefield, for example, was scheduled over the course of two to three hours in order to afford residents a degree of choice over when and where to eat. Equally, residents could choose when to receive assistance from care workers and how to spend their time. Such choice was facilitated by the residents' possession of 'pendants'. These pendants, when pressed, sent requests for assistance to care workers' pagers.

At the beginning of each shift, one carer would be allocated to each colour-coded 'corner' of the home (red, blue, yellow, or green) – and would be responsible for residents whose bedrooms were in that area of the building. Carers who were allocated to corners would be provided with a 'daily assignment sheet', which detailed the care needs of each resident on a particular corner. On both the morning and afternoon shifts, two carers would be allocated the role of 'med tech', which meant being tasked with dispensing medication. In the mornings, two carers were allocated 'breakfast' (serving in the dining room) and three were 'floaters'. 'Floaters' were tasked with assisting with the care of residents who required the assistance of two care workers and with answering residents' pendants. In the afternoons, one carer would be a 'floater' and one would be assigned to the dining room.

All care workers – other than 'med techs', who we were told should not to be interrupted – carried a pager, which was connected to residents' pendants, and a walkie-talkie. Together, these two technologies allowed care workers to contact each other when assistance was required and to keep track of which residents required assistance without returning to the care office.

Assigning care workers to corners encouraged them to take responsibility for particular residents on each shift. Both Shorefield's managers and care workers, however, stressed the need for care workers to answer pendants and assist care workers in other parts of the home. Here, emphasis was placed on the need for flexibility. This was made apparent on a shift where one care worker, Francesca, having assisted residents on 'her corner' into bed, began writing her daily notes before other care workers had finished working. Francesca was publicly scorned (and privately berated) by other care workers for mistaking her corner for a bounded assignment of work which, when complete, would relieve her of her duty to care.

Many sociologists of work have problematised the assumption that increasing the responsibilities of workers is empowering and that it, in turn, boosts workplace satisfaction. Vidal (2007), for example, notes that whilst employee involvement entails 'substantial new responsibilities', it can also 'bring pressures and psychological tensions that are experienced as burdens rather than challenges' (2007: 249). Though Vidal's focus was on manufacturing, his observation is perhaps more pertinent to an analysis of those working in residential homes, for whom responsibility is centred on the care of vulnerable human beings.

At Shorefield, care workers' expectations of what kind of care they should provide to residents were, in part, shaped by their induction training, which emphasised the need to treat residents 'as if' they were family members. Likewise, both the home's service principles (which were taught to care workers) and marketing materials used phrases with familial undertones, focused on 'individualised care' and 'resident choice', and borrowed terms from the hospitality industry. Furthermore, each resident was assigned a 'designated carer', who would be responsible for updating their individualised service plan (ISP) over time, informing other care workers of any changes in need or preference, and assisting these residents to outside appointments or events when required. Together, these training practices, philosophies and marketing strategies, and forms of assigning responsibility motivated Shorefield's care workers to advocate on behalf of their designated residents, encouraging each other to provide individualised care.

Though, on first sight, more autonomous than care workers at Millstead, however, the care workers' time at Shorefield was often dictated by the needs (or desires) of residents who were framed as autonomous consumers, and whose satisfaction was a primary responsibility of their designated carer.

Responsibility, Accountability, and Trust

At Millstead, work was allocated to care workers during a handover, which was scheduled to begin fifteen minutes before the beginning of each shift and which, though not remunerated, all care workers starting a shift would be expected to attend. Handover at the home was rather informal; it did not follow a set routine and its content was heavily dependent on which senior had been in charge of the previous shift. The following fieldnote describes what happened during one morning handover in my second month at Millstead, though the muddled nature of the occurrence was typical of most handovers which I observed at the home:

It is 7.50am and I am sat at a table in the dining room with Rosanna, Lidia and Agata. Monica, who was the senior on the night shift, is sat at a computer in the corner of the room. The senior for the morning shift, Jennifer, and a fifth care worker have not yet arrived. Lidia and Agata are talking to each other in Polish and Rosanna is sipping coffee and eating a packet of crisps. Monica keeps turning from the computer to check the door, awaiting Jennifer's arrival. Jennifer arrives two minutes later. She takes off her coat, apologises to Monica and takes a seat at the dining table. Monica joins us and takes a small notebook from her pocket. 'Really busy night', says Monica, 'just [call bells] ringing, ringing, ringing all night. Mahesh [is] with number ten but nobody else up'. Agata sighs and mutters something in Polish to Lidia. If the night staff have not managed to provide personal care to any residents then that means more work for the morning staff and we are still unsure if a fifth carer will arrive. Monica rubs her eyes as if to keep herself from falling asleep. 'Bowels' she says 'Hilda, Roger and Fred'. At 7.55 am, Pamela, the fifth carer, rushes into the room. 'Sorry, sorry, sorry' she says. 'Again!' remarks Monica, rolling her eyes. Pamela's frequent 'lateness' is often the subject of the other care workers' discussions, despite her arriving at work five minutes before we begin being remunerated for our time. Jennifer rises from the table and says 'thank you' to Monica, who has finished listing residents who had a bowel movement in the night, before walking towards the dining room door. Agata calls after her 'which sides [of the building] are we on?' Jennifer turns to say 'you and Lidia, left' before leaving.

Millstead Fieldnotes

At Millstead, handover was used to convey basic information about the condition of residents during the previous shift. This often entailed the senior carer from the previous shift listing which residents had had a bowel movement. As is apparent in the case above, however, handover was often predominated by carers waiting tentatively to find out how much work they would be required to complete on the following shift. This workload was dependent both on how many tasks had been carried out during the previous shift – often measured in terms of the number of residents who were washed, dressed, and in the communal lounge – and how many carers had arrived for the following shift.

A set number of carers (and one senior) were scheduled to work each shift at Millstead, but this number was often not reached. Staff frequently left the home without giving notice or called in sick so, until handover was complete, care workers would be unaware of how short-staffed a shift would be. When there were fewer than the required number of carers on a shift, Brian (Millstead's manager) would refuse to employ staff from a care agency, despite the care workers' requests. Instead, care workers would be told to 'spread out' and 'make do'. This was an unconcealed cost-saving strategy. As Brian often reminded us, agency workers are notoriously costly to employ (Castle 2009).

Short-staffing meant that Millstead's carers were often expected to undertake additional tasks and responsibilities. Even when short-staffed, however, there was one area where the carers at Millstead were clearly not trusted and where they were effectively deskilled: note taking. (Non-senior) carers were responsible for carrying out several physical activities on shift, yet they were not responsible for any technical tasks (applying dressings or distributing medications, for example). In my year at Millstead, carers were only ever asked to complete resident turning charts⁴⁷, which required writing just one letter⁴⁸. This was dissimilar to the work carried out by some other care workers in Esterton, who reported having 'so much

⁴⁷ Turning charts were completed to document when a resident had been repositioned. 'Turning' involves repositioning a resident in their bed at set times in order to reduce the risk of pressure sores, to wash and dress a resident, or to change their incontinence pad.

⁴⁸ At Millstead, care workers were required to document the positioning of residents using the following letters: 'B' if they were lying on their back, 'L' if they were lying on their left-hand side, or 'R' if they were lying on their right-hand side.

paperwork to do' (Sally) that it impacted upon their ability to spend time with residents. At Millstead, in contrast, daily notes were completed by the head carer, Adelina, on a computer in the dining room at the end of each shift. Adelina was also responsible for distributing medications. When Adelina was not present, a senior would take her role for the shift and their work would be checked by Adelina upon her return. The 'paper trail' of events and practices occurring at Millstead could subsequently be carefully managed by Adelina.

There were several occasions where Adelina openly manipulated documents. This was also the case for carers and seniors who completed resident turning charts. Once, when completing a turning chart which was present in a resident's bedroom, Sorin waved the sheet of paper in the air and said 'this is all science-fiction'. When I asked what this meant, he replied: 'It's all made up. It's all totally pointless'. Sorin's observation was correct; most entries on the turning chart must have been fictitious, since the stated positioning of the resident rarely corresponded to their actual position. Whilst Millstead's culture of (feigned) compliance may have pulled the wool over the eyes of the CQC, it did little to improve actual standards of care.

Several carers at Millstead could not read or write in English and, by eliminating the task of note-taking from the carers' list of duties, the impact of any language barrier could also be reduced. Similar practices of adapting work to prevent any disconnect between the skills of migrant workers and the requirements of the job have been observed in other sectors. Dutton *et al.* (2008), for example, found that hotels have introduced measures, such as colour-coded cleaning fluids, so that migrant workers employed as room attendants are able to adhere to health and safety regulations. Notably, adapting the carers' work in this manner would also have allowed Millstead's manager, Brian, to recruit new carers without having to specify 'ability to read/write in English' as a requirement of the job. One consequence of this elimination of written tasks, however, was that carers (and, to a degree, seniors) were not aware of the care needs of residents. Unlike carers and leads at Shorefield, who were encouraged to develop a good knowledge of the needs of each resident by reading their ISPs, care workers at Millstead knew

very little about each resident's health status, let alone their personal preferences, religious affiliations, or personal histories. This is not dissimilar to care workers working in the US nursing homes which Eaton (200: 597) categorised as 'low quality', who received 'virtually no information about the condition of the residents' they were assigned, even when they specifically requested it. Eaton attributed this withholding of information to a lack of trust on the part of managers, who viewed care workers as unreliable, irresponsible, and lacking in confidence.

At Millstead, a further effect of Brian's elimination of paperwork from the carer and senior roles was that the jobs were deskilled and, in turn, the care workers' opportunities to develop their language skills were reduced. Three migrant care workers at Millstead – Jennifer (senior), Monica (senior), and Mahesh (carer) – had previously been nurses in hospitals in their countries of origin. All three had chosen to become care workers in order to develop their language skills, their aim being to pass the International English Language Test System (IELTS) required to register as nurses in the UK. What was planned as a stepping stone, however, had become permanent: they had worked at Millstead for twelve, ten, and two years respectively. The same threat to migrant care workers' aspirations was apparent in my interviews with care workers. Yu, for example, spoke about her reasons for becoming a care worker after moving to the UK from China:

If you want become a nurse in the UK you have to pass exam. But that's why. So I looking for job which related my skills and my knowledge. So obviously care home. I can still be used ... I thought it would probably be okay especially with my hard working. Especially if improve my English or something ... But sometimes you just feel hard with working, surviving, and study. It's difficult to juggle two things together. But I'm trying to do that. I feel frustrated sometimes but I'm getting over now.

Yu, Pleasant Lodge

Like Mahesh at Millstead, Yu was still attempting to balance work and study in order to convert her nursing qualification for use in the UK. Lan, who was also from China and worked in the same residential home as Yu, on the other hand, spoke about how she had dropped her aspiration to pass the IELTS exam after several

years of studying. When asked whether she had completed such examinations, Lan said:

I never tried (laughs). I thought I can't pass. I know. I knew it. I love nursing, you know, job. It's very, very proud yourself ... I would like to be a nurse but it's quite *hard* yeah. Quite hard language. Actually I could try. I could study hard English [laughs]. But probably I just lazy or no ambitions (laughs).

Lan, Pleasant Lodge

It appeared that, for care workers at Millstead and elsewhere, there were insufficient opportunities to learn English to the level required by hospitals. Much like care workers in Cangiano *et al.*'s (2009) study, employment in the care sector was, in fact, a hindrance to care workers' training in English language proficiency. For Millstead's care workers, processes of deskilling (such as removing written elements of work), limited opportunities for training, and a lack of time for study outside of work, left few options but to remain working at the home, despite their original aspirations. Rather than extending the remit of the care workers' job roles in a way which might boost their job prospects, Millstead opted to task care workers with completing the additional 'unskilled' tasks of cooking, cleaning, and serving.

In contrast to Millstead's care workers, who were not required to undertake reading or writing tasks, Shorefield's care workers spent a great deal of time writing notes, completing forms, and reading information about residents. Many of these tasks were undertaken in preparation for, or during, handovers. Whilst at Millstead handovers took place prior to care workers' formal (paid) working hours, at Shorefield, there was a planned crossover of shifts to allow for a thirty-minute period where handover could take place. This meant that, when care workers started their paid morning shift at 7am, they would be able to attend handover for up to thirty minutes before being required to work on the floor. When handover took place, those present on the previous shift were expected to continue working on the floor until the end of their shift, though they spent the majority of this time writing daily notes in the home's care office. The lead and all carers starting their shift would gather in the care office or the office of Patricia, the care manager,

which was in an adjoining room to the care office. Handover would be led by the lead carer who had managed the previous shift. This lead would be responsible for collating information from carers during the previous shift and, in turn, disseminating this information to those beginning their shift. At Shorefield, handover followed a set routine and often took a full thirty minutes. One thing which was notable about handover at Shorefield was the careful balance between professionalism and good humour which was often displayed by the care workers. This balance is clear in the following fieldnote, taken during a morning handover at Shorefield:

It is Sunday at 7.05am and nine carers and I are sat in Patricia's office. Georgina, the lead carer from the night shift, is sat in Patricia's office chair. Sue, the lead for the morning shift, distributes assignment sheets to us, which detail residents' needs in our designated sections of the home. We are also each given a 'resident list'⁴⁹. Georgina calls for everyone to be quiet and opens another file. The file is full of A5 slips of paper which have been added by various members of staff over the past few weeks. Georgina reads each piece of paper before turning to the next: 'Mildred lost 4kg and is now on a fortified diet. Please complete food charts'. The care workers turn to Mildred's name on their resident list and make note of this information. 'Please don't put yellow bags in the sanitary waste bins⁵⁰, take them outside'. The care workers do not respond, as though this does not apply to them. 'Roland wants to be woken up at seven thirty from now on'. Rhian chips in: 'he changes his mind every day!' The other care workers nod and laugh in agreement, but make note of Roland's change in preference. Georgina continues, 'Lorraine needs to be ready for Sally Army by eight every Sunday'. Georgina tears an item out of the folder and screws it up. 'Please read Shorefield's policy on clothing. Carers shouldn't be wearing open shoes, leggings or jewellery on shift'. The item has been read out in every handover for over a week. Several carers roll their eyes and groan. I ask Georgina how long an item remains in the folder before being removed and she responds, 'until everyone listens to it' and laughs. After listing several more items, Georgina opens the red 'handover file' which contains information which she has written about the previous shift. 'We found Terry on the floor at around three this morning. He's not in pain. An incident form has been written. Please inform family this morning'. The carers look surprised, 'was he trying to get to the toilet or something?' asks Josie. 'I think he just slipped out of bed. He's okay', says Georgina. 'Oh good', says Josie, and the other care workers mumble in agreement whilst making notes. Ada and Maddie are now talking amongst themselves and

⁴⁹ The 'resident list' was a two page document which alphabetically listed the name of Shorefield's 66 residents, next to a blank space in which we could write notes.

⁵⁰ Sanitary waste bins are used for the disposal of soiled incontinence pads, wipes and gloves.

Georgina shoots them a look before continuing. They look up, grinning, before quietening down. After detailing events which have happened during the night, Georgina reads each resident's name, followed by any details regarding them, from her resident list. The carers take notes on their own resident lists accordingly. 'Jill Angus, fine; Norman Arnold, in hospital; Marjorie Bell, fine; Rita Brown, doctors at eleven, escort needed; Ethel Evans, fine, ...' Once Georgina has finished reading, the room fills with noise and the care workers slowly start to stand up from the floor to be assigned a pager and a walkie-talkie by Sue, who is simultaneously writing notes on a new recruit's assignment sheet so that she knows what additional assistance she may need to provide to each resident.

Shorefield Fieldnotes

Whilst Shorefield's daily routine was more flexible than that at Millstead, we can see here that the reverse was true for handovers, which took place at scheduled times and followed a clear routine. Handovers at the home involved the exchange of information, a great deal of documentation, the use of medicalised language, and a faithfulness to procedural rules. Furthermore, the mutual learning, decision-making, and support observed in these handovers indicated that Shorefield's care workers had a shared professional identity. Meagher (2006) has noted how care workers' commitment to the standards of the profession can motivate them to have a sense of responsibility for those in their care. We can see this sense of responsibility above, when care workers made a note of Mildred's need for a fortified diet and expressed concern at Terry's fall, for example. As Gorz (1989) suggested, professionalism can also protect care workers from the desires of their clients and, in turn, from being reduced to servant status. Though Shorefield's care workers responded to both the 'needs' and 'desires' of residents, they were also able to make moral distinctions between the two. We see above, for example, a contrast between the care workers' responses to news about Terry's fall and news of Roland's change in waking preferences – 'he changes his mind every day!' – which, though not ignored, was treated with humour.

The emphasis of handovers at Shorefield was on the relaying of information concerning residents' physical and emotional needs, but there was also a more informal exchange of anecdotes, chit-chat and jokes, often concerning the care workers themselves. The discipline which the care workers' commitment to their profession required was, thus, accompanied by a sense of camaraderie. This arose,

in part, out of the care workers' shared frustrations and grievances; their dislike of Shorefield's clothing policy, for example. Interestingly, however, these frustrations were openly alluded to, discussed, or joked about in handovers. Researchers who have examined handovers in medical settings have suggested that, when ritualistic and collaborative in nature, handovers allow for the containment and support necessary to deal with the distressing elements of caring work (Hopkinson 2002). The freedom of Shorefield's care workers to overtly express and joke about their concerns and grievances in handover functioned as a kind of catharsis and boosted solidarity. Shorefield's tolerance of eye-rolling, groaning, and laughing, however, may have also reduced the risk of the care workers' responding to their grievances with more direct and productive forms of resistance.

The Content of Caregiving

Whilst care workers at Shorefield were able to attend handover – and, in turn, come together to share their tribulations and contentments – for an uninterrupted thirty minutes during each shift, Millstead's care workers were expected to have finished handover and be 'on-the floor' by the time their shift officially started. As a result of short-staffing and Brian's refusal to employ agency workers, care workers at Millstead were required to begin undertaking direct care activities both as soon as, and as quick as, possible. The need for care workers to save time therefore had implications for both *when* and *how* tasks of personal caregiving were carried out. Most notably, Millstead's care workers frequently attempted to save time by moving backward and forward between residents whilst carrying out care tasks.

The absence of a detailed division of labour meant that care workers at Millstead were responsible for carrying out all of the stages and aspects of each resident's care. The combination of a high volume of work and a shortage of staff, however, meant that time did not allow for the integration of the various stages of this care into a single, unbroken process. Instead, the process of caregiving was continually interrupted, stalled and left in temporary abeyance, if not abandonment. The

following fieldnote, which describes my first paid shift at Millstead, makes clear the fragmented nature of work and care at the home:

Lidia and I are responsible for washing and dressing thirteen residents this morning. Usually [and officially], there would be a third carer to wash and dress the 'singles', but due to two carers leaving in the last two weeks, we are short staffed. Lidia and I must therefore work together to care for seven 'doubles' and six 'singles', as well as making sixteen beds and answering residents' call bells. It is 8.10am and we must complete this work before 10.30am. Lidia suggests that, in order to complete our work at a faster pace, we should hoist more than one resident onto their commodes, work separately to wash each resident, before finding one another to hoist the residents from their commodes into their wheelchairs. Lidia is aware that the only element of our work which we must complete together is the hoisting of residents. Lidia and I hoist two residents from their beds onto their commodes and separate to wash and dress each resident. This seems to work well. Deidre, whom I am assisting with personal care, seems to appreciate not having two people present whilst she is washed. I wash Deidre's face, torso, and limbs but am unable to wash her loins yet, as this will require hoisting. I help Deidre into a dress and tuck the bottom of the dress into her collar to keep it from falling into the commode. Deidre is ready to be hoisted, washed, and transferred into her wheelchair but there is no sign of Lidia or the hoist. I apologise to Deidre and leave her room to find Lidia. She is not in Jim's room, where I left her, but Jim, like Deidre, is half-washed and half-dressed and is sat on his commode. After checking several residents' bedrooms, I find Lidia with Judith. Judith is bed-bound and, though she does not require hoisting today, two care workers must assist with her personal care because she requires turning. Lidia has started washing the parts of Judith's body which she can reach. As I enter Judith's bedroom, the call bell (which is more like a siren) starts to ring loudly in the hallway, where a room number is displayed on a screen, and I go to answer it. Geoff, whose room is upstairs, asks me to help him onto his commode. Another resident presses the call bell as I slowly walk with Geoff towards his commode, but I am unable to answer it. When I have finished with Geoff, I return to help Lidia with Judith but she has left Judith, half-clothed, in order to answer the other call bell. When Lidia returns, we return to 'the doubles' to complete their personal care.

Millstead Fieldnotes

This fieldnote is indicative of how care was carried out during the early mornings at Millstead. Work at the home was chaotic, messy, and unpredictable, leaving carers with little option but to muddle through their daily tasks as quickly and pragmatically as possible. Often, several residents would be left half-way through the personal care process until two carers became available to hoist or turn them. Meanwhile, the call bell would ring continuously. Residents pressed their call bells

when they required assistance and the result was a loud, repetitive alarm sounding along the home's corridors until the bell was answered. Most often, care workers would be occupied (undertaking personal care with other residents, for example) when the alarm sounded, and the result was that carers would rush backwards and forwards between residents – often just to deactivate the alarm. The answering of residents' call bells was one of the few daily tasks at Millstead which was not amenable to the daily schedule: it was both unpredictable and unquantifiable. As such, Millstead's care workers frequently complained when residents pressed their call bells, made clear to such residents that they were felt to be a burden, and made attempts to dissuade them from requesting assistance again. Other care workers in Esterton described their colleagues as having a similar approach to residents who asked for additional care, or requested that their care was carried out in a different way. Grace, for example, described how her colleagues would respond to residents' requests for 'something [to be] done in a specific way' by saying that the residents were 'a pain' or 'really horrible'. Similarly, Norma disclosed that her colleagues would respond to some residents by saying 'oh, ignore her. That's just what she does. She's just seeking attention'.

At Millstead, as the time ticked closer to Mrs G's imposed deadline of 10.30am, it would feel as though our list of tasks was growing longer. This resulted in care workers adopting increasingly elaborate time-saving measures. Different care workers employed different strategies to save time when giving personal care. Jennifer and Erica, both seniors, would frequently hoist residents alone if they were unable to find their 'double'. Sorin and Mahesh would try to implicitly persuade residents to say that they did not need to be washed or claim that residents had been given a 'thorough' wash on the previous day (particularly when a resident was forgetful). In all of these cases, washes became quicker and less thorough, soap was not rinsed off residents, and having privacy when using the commode – which was a normal expectation at Shorefield – was a privilege only granted when care workers were summoned elsewhere. In my interviews with care workers, they described how this sped-up, or what Grace called 'slap dash',

care work results in long, slow periods of neglect and unfinished care for residents.

One care worker, Jess, said:

You start from one end of the corridor and you go through and you put everyone on the commode or toilet. After we've done the whole floor, you go back to the first one and you do it one-by-one. You wash and dress them, wash and dress them but you don't do it together, you do it separately. Everything is just all in a row.

How many residents do you have to do that for before you go back to the first one?

Umm ... eighteen. So the first one is sat there [on the commode] for a very long time. The first one is probably there about an hour and a half, an hour and forty-five minutes. Then you've got them ringing on the bell. And then you've got to keep going and turning the bell off and telling them they've got to wait because you can't hoist on your own.

Jess, Shell House

Jess's account of care work at Shell House was not a one-off case. Several other workers spoke about how the care they provided to residents consisted of 'literally just a quick wash, quick dress, get them their breakfast, move onto the next person' and 'running backwards and forwards' (Mark). It was unsurprising, then, that, when asked if they had enough time to care for residents as they wanted to, many interview respondents explained that, whilst they might have enough time to carry out the physical or direct tasks of care, they did 'not [have] enough time to give residents quality time' (Donna). Others responded by describing their work as 'not caring ... just business' (Norma). One less harmful way to save time at Millstead would have been to reduce the time spent on housekeeping tasks like bed-making. However, puzzlingly, this was the one time-saving measure which carers were reproached for by Mrs G, Adelina, and the seniors. One senior, Erica, would often express her anger at the carers' bed-making skills. This was perhaps because, though poor bed-making had little impact on the residents, it was one time-saving method which had an aesthetic impact clearly visible to visitors and inspectors.

In their study of how organisational culture affects care home residents' experiences, Killeth *et al.* (2016) stressed the importance of managers being able

to ameliorate the impact of external pressures – financial, regulatory, or those from owners and families – on care workers’ daily work. In some homes which Killett *et al.* examined, these pressures – such as the push by regulators to complete paperwork – were transferred directly on to care workers and, in turn, the quality of care which was provided to residents suffered. Much of Mrs G and Brian’s warnings to the care workers, when focused on improving the quality of their work, made reference to the CQC or to potential customers. As such, housekeeping tasks – such as bed-making – were prioritised, sometimes over the care needs of Millstead’s 33 residents; the *appearance* of care, in these instances, was regarded as just as, if not more, important than the *substance* of care.

Despite the lack of time which Millstead’s care workers sometimes had to undertake all of the tasks and activities assigned to them, there were also periods of time when the home was less busy. Afternoon shifts, for example, were usually quieter than morning shifts. Despite more time being available to care workers in the afternoon, however, this time was not ordinarily spent caring for or talking to the home’s residents. The following fieldnote, taken during an afternoon shift at Millstead, describes some of the typical activities undertaken by care workers when there was a short supply of personal care tasks:

It’s 3.00pm in the afternoon and Pamela and I finished ‘toileting’ the residents around half an hour ago. Most residents are napping in the lounge. The other carer on shift, Benedita, has finished clearing up the remainders of the residents’ afternoon tea. Pamela and I have been pacing up and down the home’s corridor. I see Pamela at the other end of the corridor as she walks towards the laundry room empty-handed. I pass by the lounge and can see Benedita, who is crouched behind a kitchen unit which is located in the corner of the room. The cupboard stores large jars of biscuits for the residents which staff are forbidden from eating. Benedita appears to be rearranging cups and saucers in the cupboard. Obscured by the lounge door and the cupboard, what she is actually doing is dragging cups backwards and forwards along the cupboard’s shelf with one hand whilst holding and eating a biscuit with the other. I ask Benedita if there is anything I can help with and she tells me that ‘everything is done’ and that I should ‘find something to do because [of] Mrs G’. The care workers often use the presence, or anticipated presence, of Mrs G as a rationale for undertaking work which they believe is meaningless. I go to offer Pamela help in the laundry room but, on the way, I find her sat in Judith’s bedroom with an open file on her lap. We completed the file, which documents

whether we have turned Judith, earlier. Behind the file, Pamela is texting on her mobile phone. Judith is lying awake in bed beside her but they do not appear to have acknowledged each other.

Millstead Fieldnotes

During the afternoons at Millstead I was often told by both seniors and carers to 'look busy' or 'just wander around'. Care workers were not allowed to sit down in the lounge and, on occasions where I did talk to residents, I was often told that I needed to 'find some work'. This search for, or creation of, work was a more common occurrence when Mrs G was present in the home, though when she was not present, her arrival was always anticipated. At Millstead, 'finding work' or 'looking busy' always entailed physical movement that could not be misconstrued as rest. Often, care workers would simply pace up and down the home's corridor, popping in and out of bedrooms which they knew were empty as though they were looking for someone or something. Another strategy was to keep out of sight completely. Mrs G, though often present in the kitchen and dining room, would never venture into residents' bedrooms or upstairs. The result was that care workers would often fill time by taking long trips to the toilet located upstairs or by claiming that they were caring for a bed-bound resident when, in reality, they were eating a snack or using their mobile phone in an empty bedroom or, even, a bed-bound resident's bedroom.

Mrs G made several attempts to control the care workers' routines – by keeping a key to the 'staff toilet' next to her seat in the kitchen, for example, and by moving the 'staff room' from the second floor to a ground floor location next to the laundry room – but these had little effect on the carers, who would devise new strategies of looking busy. Mrs G's preoccupation with appearances, and her apparent indifference towards the actual content of care, appeared to have filtered down to the care workers, who joined her in playing the game of appearing to work in order to snatch time for themselves. Following the relocation of the staff room, for example, I more regularly observed carers taking residents' clean laundry toward the laundry room claiming that it was soiled. One constant here was that 'finding work' never entailed spending more time with residents. This was in contrast to care workers working in other homes in Esterton who, rather

than playing a game of cat-and-mouse with their managers in an effort to grab time for themselves, reported struggling to grab time to spend with residents:

I actually had to ask permission to do this ... but when the laundry was done and things like that we actually didn't have anything to do. And I said 'can we just go and sit and talk with them [the residents] or read books with them or can we put music on or can we sort of just paint people's nails and stuff like that' ... but the thing is though, she [the manager] was really funny about it so most of the time we'd just be trying to find other stuff to do.

Catherine, Trilby House

For others, the inability to satisfy their impulse to care – to 'look after residents as [they] ... would really like to' and 'make them happy' (Maria) – resulted in feelings of shame, guilt and demoralisation. Whilst one interviewee, Clarissa, described how she felt 'like crying on [her] way into work every morning', another care worker, Jess, said:

I would have to explain [to friends] I didn't have time for the residents and stuff like that. And it just makes you sound bad yourself. And you can't get it across enough how much you hate it and you wish you had more time.

Jess, Shell House

Several care workers in Esterton reported finding it difficult to care well within the temporal constraints of a home's daily routines. Shorefield's daily routine, on the other hand, was less strictly imposed upon the home's care workers or residents. Moreover, lower resident needs and an over-estimation of required care times reduced the need for care workers to rush or hurry residents along. As is the case in most care environments, including Millstead, the early part of the morning shift was the busiest time of the day at Shorefield and the time when most personal care took place (Peace and Holland 2001). In the training of care workers, however, emphasis had been placed on 'encouraging independence' and 'valuing individuality' which, in practice, meant adhering to the preferences of (and following the pace of) the residents. At Shorefield, personal care took time – sometimes over an hour with each resident – and this time was rarely fragmented, sped up, or split between residents. The following fieldnote describes the act of giving care to one resident, Beatrice, during a morning shift at Shorefield. The

event, which lasted around an hour, involved myself and another carer, Helena, carrying out both physical and emotional labour:

This morning, I have been assigned to one area of the home, green corner, and so I am responsible for the care of nineteen residents. Twelve of these residents are either independent with all personal care or require prompting to come to meals and/or to dress themselves. Of the remaining seven residents, three require assistance from two care workers (using the hoist). Helena, another carer, has been assigned as my 'floater'. She will assist me with tasks which require two care workers, will answer 'pendants' (call bells), and will be responsible for residents in the green corner when I am writing daily notes. After handover, Helena goes to collect the hoist from the storage cupboard and tells me that she will meet me in Beatrice's room. I head straight to Beatrice's room, wish her a good morning and ask her if she would like a bed-bath or a shower. Beatrice decides upon a bed-bath. I prepare two bowls of warm water, wipes, gloves, and a clean incontinence pad. Whilst I am in Beatrice's *en suite*, Helena knocks and enters Beatrice's bedroom and asks her what she would like to wear. We stand on either side of Beatrice's bed and undress her. Helena wipes her down with a soapy flannel, followed by a non-soapy flannel and then I use towels to dry Beatrice's arms, legs and chest. Beatrice tells us stories about her career as a GP whilst, turning her from side to side, we wash and dry her buttocks. We apply creams and perfume to Beatrice's body before dressing her in her chosen clothes, explaining with each step what is happening. We then hoist Beatrice onto her armchair. Helena boils the kettle and assists Beatrice with inserting her dentures and applying make-up whilst I clean up and make Beatrice's bed. 'Homes Under the Hammer' is on television and Beatrice tells us how sad she is that she has had to sell her house. We sit and comfort her for around five minutes, asking if there is anything we can do to help. Beatrice thanks us and hugs each of us, joking that we should live with her. We tell Beatrice that we will come back to make her another cup of tea soon.

Shorefield Fieldnotes

Caring for Beatrice usually took between thirty and fifty minutes each morning. As was the case when caring for other residents, this time was not rushed, involved talking to the resident as well as carrying out physical tasks, and was adapted to the needs and preferences of each resident. It was not timed and did not require an awareness of time. Though there were occasions where the 'floater' would leave the room to answer a pendant, the resident would never be left alone during this time unless they requested it.

During the afternoons at Shorefield, particularly when residents were engaged in activities, there were often very few physical care tasks to carry out. If this was the case, care workers would usually sit and talk to residents or take hot drinks and snacks to residents' bedrooms. Care workers at Shorefield – in contrast to Millstead – were explicitly and actively encouraged to use any available time at work 'getting to know' the residents. This involved both talking to the residents and reading their ISPs. Shorefield stressed the importance of 'knowing the residents' and this was part of one of the home's 'service principles' which it marketed to potential residents: celebrating individuality.

Just as Shorefield encouraged its care workers to treat residents 'as if' they were family members, it persuaded them to view each other as a 'team'. One motivational poster in the care office, for example, read 'keep calm and team work', a play on the motivational poster reading 'keep calm and carry on' produced by the British Government in 1939 in preparation for the Second World War (and which has been re-appropriated in recent times). Other care workers in Esterton whom I interviewed also noted the importance of 'working as a team' and 'mucking in together' (Pauline).

At Shorefield, it was common for care workers to refer to themselves as a team, be it in the form of a thank you from lead carers ('good work team'), as a form of encouragement ('go team!'), or in a more formal capacity ('team meetings'; 'team Christmas party'). Care workers and the wider staff at Shorefield – who often referred to themselves as 'Shorefielders' – had a clear collective identity which, though in part linked to that of the company, went beyond the formal requirements of the job. It was perhaps Shorefield's emphasis on team work and a familial caregiving environment that had prompted several of the care workers to become good friends outside of work. They would take care of each other's children, cook meals for each other, organise parties for each other's birthdays, and contact one another regularly. In fact, the care workers' connections to both each other and, more notably, to Shorefield as a company, appeared to be much closer than those observed at Millstead. This was apparent on the day of one lead care worker, Sophie's, wedding:

I have not worked a shift at Shorefield in several weeks where Sophie's wedding has not been mentioned by one of the care workers. Bridesmaids' shoes have been ordered and tried on at work. An announcement was placed on the staff notice board inviting everyone to attend Sophie's 'hen do' and evening reception. Care workers, other members of staff, and residents have been informed of the day's schedule and have been shown pictures of cakes, dresses, and shoes. The wedding is taking place today in a local hotel. Most of the full-time care workers are attending Sophie's wedding. Sophie, with the agreement of Shorefield's management, will be arriving at Shorefield on her way to her wedding ceremony. A note has been left in the handover file which informs us of the route that Sophie will be taking through the building – in through the back door and out through the main doors by the lobby – and tells us that we must make sure that residents are in the lobby at the correct time so that they can see Sophie in her wedding dress. Sophie makes her way down the curved staircase into the lobby. Her bridesmaids, Jenny and Charlotte – two carers – hold the train of her dress as she descends down the stairs. Residents and staff wait at the bottom applauding. The receptionist, Margaret, is crying, as are two residents. Sophie's wedding photographer takes pictures of Sophie with each resident. As Sophie steps back into her wedding car at the front of the building ten minutes later, members of staff wave tearfully from the car port. Several mention that they are disappointed that they cannot attend the wedding ceremony. The care workers shuffle back inside and begin to respond to the calls on their pagers, which have been buzzing for ten minutes.

Shorefield Fieldnotes

What was clear at Shorefield was that the care workers had come to associate their private lives very closely with work. This linking of self and role was something which was encouraged by Shorefield's management. Members of staff were encouraged to bring their pets into work for the day, for example, and those who were on maternity leave were encouraged to visit with their children. Shorefield told its care workers that this would benefit residents: holding a care worker's baby would give those with dementia a real-life form of, what Shorefield's activities manager termed, 'doll therapy'. Equally, other residents would have their spirits lifted by such a visit. Though Shorefield's encouragement of team work and family-like relationships had an ethical dimension, at times, it was in danger of being ideological. One consequence of bringing children, pets and family events into work, for example, was that the boundary between work and home became blurred for Shorefield's care workers. A similar blurring of boundaries was apparent in the accounts which some other care workers in

Esterton gave me of their labour. For example, one care worker, Alison, described how following her maternity leave, the residential home where she worked created a nursery for her son, complete with a crib, so that she could continue working, and because 'the elderly love it [having her son in the home]'

Nippert-Eng (2008) has written about how workers and employers make decisions about what times and spaces are appropriate for specific activities, people, and objects. For Nippert-Eng, in 'public' temporal and spatial areas – such as workplaces – we are normally accessible and accountable. However, in 'private' territories – such as the home – we are relatively inaccessible and unaccountable. For care workers, the extent to which aspects of self – work, pets, children, and weddings – are shared between home and work has important implications. We know from previous research, for example, how care workers who are encouraged to see residents as family members are inclined feel accountable for, think and worry about them when at home (Dodson and Zinbarg 2007). Likewise, as care in the home is predominantly undertaken by women out of love or moral and social obligation, blurring the boundary between home and work may make it harder for care workers to appropriately recognise and mark out the boundaries and economic value of their labour (Johnson 2015; Palmer and Eveline 2012).

Carers, Cooks, Cleaners

The boundaries of care work at Millstead and Shorefield also varied in terms of the variety of roles which workers were expected to undertake at work. At Millstead, there was a very simple division of labour which meant that care workers undertook a multitude of tasks during each shift. The following fieldnote, taken during an afternoon shift around six months into my fieldwork at Millstead, makes this clear:

It's 3.40pm at Millstead and I have been asked to walk to the shops to buy packs of potato waffles for the residents' supper, which Henrietta and I must prepare before 4.00pm. Care workers at Millstead are responsible for cooking supper every day, since the cook leaves at 1pm, but sometimes there are not enough ingredients in the kitchen. Brian, Millstead's manager, seems to be adding tasks, outside of direct care activities, to our job role more frequently. As Brian told me during my recruitment interview, being a carer at Millstead involves doing 'a lot more than what carers do in other homes'. This week, I

have worked as a kitchen porter, cook, cleaner, bed-maker, launderer, and I have been asked to chop vegetables for Mrs G's private dinner party. Monica, a senior, tells me 'when you have been here longer, you'll be allowed to work at Mrs G's house too'.

Millstead Fieldnotes

At Millstead, the boundaries between care work and other kinds of work – cleaning, cooking, and serving – were increasingly blurred. That is, workers at the home were tasked with carrying out duties which are normally undertaken by other low-paid workers: cleaners, kitchen assistants, and other domestic workers. These duties included: washing, drying, sorting, folding, and returning clothes to residents' bedrooms; tidying storage cupboards; unpacking food and linen deliveries; restocking gloves and paper towels; peeling vegetables; making breakfasts and suppers; serving meals; cleaning the kitchen; cleaning the dining room after each meal; washing up; making and changing beds; cleaning toilets and commodes; and emptying bins. Whilst some care workers whom I interviewed were keen to classify these tasks as beyond the remit of their role, others described carrying out about a similarly broad array of activities at work. Tracy, for example, claimed that:

You're not *just* looking after residents. You have to prepare vegetables. You have to lay up the trays. You have to do the cleaning. You have to do the ironing. This is all a carer's role. So you're doing ten jobs and, like I said, they're not bringing in the staff. If they're like pulling the laundry person ... 'oh that's alright, the carers can do it'. But there's more work then for us.

Tracy, Lark Lodge

Like Tracy, carers at Millstead undertook some cleaning tasks, yet there were also four members of cleaning staff at Millstead, all of whom worked part time and spoke very little English. Just as carers were expected to double-up as cooks and cleaners, so too the cleaners (who had received no formal training in caregiving practices) would often be asked to 'fill in' as carers for the day. One cleaner in particular, Sancha, was often found assisting with personal care, even when she had been assigned a cleaning shift. Aside from Sancha's tabard, which was a different colour to both those of the carers and seniors, there was very little to distinguish Sancha's work from that of the carers. Two other care workers in Esterton described how the number of cleaning tasks they carried out had

increased following their managers 'giving cleaners the sack' (Grace). One care worker, Angela, also described how she initially started her job in a residential home as a cleaner, before her role blurred into that of a care worker: 'my manager would phone me up, tell me to wear a skirt and whatever, because she wanted me to be a care worker that day'. Several care workers expressed frustration at having to undertake cleaning tasks – articulating that they had 'chosen to be [a] care worker, not [a] housekeeper' (Maria). Thus, for care workers at Millstead and elsewhere, whilst the daily tasks of care work were blurred, so too was the definition of what/who a care worker was and what/who the subject/object of their labour was.

Together with the specificities of the carer role being unclear at Millstead, there was also little distinction between care workers who worked in the day and those who worked at night. Monica, a senior, was the only employee who opted to only work during the night. This was due to having diabetes, as Monica felt that there was not enough spare time during the day for her to take insulin. Millstead's management (Brian, Mrs G, and Adelina) wanted all care workers to switch periodically between day and night shifts. Mrs G conveyed her thoughts on night shift working to the care workers during one handover, where I took the following fieldnote:

There are nine care workers present in handover after the morning shift⁵¹, much more than usual. Mrs G enters the dining room as the handover starts. She has not been in the home all morning. Pamela fetches a chair for Mrs G from another dining table and pulls it up to the table we are sat at. Agata, who is showing Lidia a picture on her phone, sits up in her chair and places her phone back in her pocket. Mrs G remains silent whilst Jennifer, the senior for the morning shift, informs those coming on shift of who has had a bowel movement in the morning. Mrs G taps her long, manicured nails on the table and looks out of the window. When Jennifer has finished, those who have worked the morning shift begin to shuffle in their chairs and Agata lifts her coat from the back of her chair. It is 2.10pm and our shift was due to end at 2pm. Mrs G starts to talk and everyone stops what they are doing to listen to her. 'You all need to work night shifts'

⁵¹ Handover did not regularly take place between morning and afternoon shifts at Millstead as, since care workers often worked both the morning and afternoon shift, Adelina would claim that no information was required to be exchanged or passed on. On the day which I wrote this fieldnote, none of the care workers on the morning shift were scheduled to work on the afternoon shift, so a handover was required.

she says, 'If you want to work here, you can't choose which shifts you want'. Rosanna looks towards Mrs G and checks, 'not me though?' Mrs G responds, 'no, not if you have young children'. Mahesh screws up his face but does not say anything. He has already told Mrs G that he has children who prevent him from being able to sleep in the day following a night shift but, given that Mahesh is not a single parent and is male, Mrs G says that this is 'not a valid reason' for him to be excused from working nights.

Millstead Fieldnotes

Despite Mrs G telling Millstead's carers that they must work the night shift, some carers were never scheduled to work during the night, myself included. Various reasons were given by Brian and Mrs G for this, which included: lack of experience, having young children (if female), and simply being 'needed in the day'. Others would be assigned to a variety of day and night shifts. The lack of carers assigned to work the night shift, as well as a lack of staff overall, meant that some care workers, such as Mahesh, were regularly assigned to work for up to nine nights in a row.

The assignment of carers to the night shift reflected a broader gendered division of labour at Millstead. Mrs G often mentioned that there was a need for more male care workers, particularly at night, due to their perceived ability to care for larger and/or heavier residents without the assistance of a second care worker. Equally, in my year at Millstead, male care workers were never asked to work in the kitchen or in the laundry room. This was, in part, in response to the two male carers themselves, who often remarked that cleaning or cooking should not be carried out by men. A similar gendered division of labour was reported by care workers working in other residential homes in Esterton. One male care worker, Dai, reported that 'being a man in a care home' meant that he was assigned 'very heavy work', such as moving furniture, rather than 'just look[ing] after residents'. What was interesting at Millstead was that, whilst Mrs G and Brian were happy to assign *tasks* based on care workers' (sometimes gendered) preferences, the same did not go for assigning *shifts*. This was perhaps because very few care workers had a preference for working the night shift, not least because the rate of pay (which tracked the minimum wage) was identical to that paid to those working in the day. The adverse effects which night shift work, particularly rotating night shift

work, can have upon a workers' health has been well documented in the medical literature (Ramin *et al.* 2015; Vetter *et al.* 2016). Whilst other care workers in Esterton described the lack of financial compensation they received for working night shifts as something that 'shouldn't be so' (Donna) and as an explanation for their 'morale [being]... so low' (Norma), this did not appear to deter them from working during the night.

At Millstead, high turnover and frequent absences from work, coupled with Brian's determination not to employ agency workers, meant that the home's care workers were also frequently asked to work on their days off, to stay at work after their shift had officially ended, or called into work just after a (short-staffed) shift had begun. These acts – which left care workers unable to plan activities outside of work, caused them to be awoken in the early mornings of their assigned days off, and resulted in some of them working up to eighty-two hours in a week – were, surprisingly, not only accepted, but embraced by several of the care workers. As one senior care worker at Millstead, Monica, said when I asked why she was so delighted to be asked to cover my shift: 'that is food for my family. I need it. Thank you. Thank you. Thank you'. Being employed in such low-paying jobs meant that some care workers welcomed more work – even if this was simply born of economic need. This was also the case for other care workers in Esterton several of whom, in my interviews, reported working 'around seventy to ninety hours a week' (Grace) and 'beyond human endurance' (Frankie). As this section has shown, it was expected that the work, in turn, would entail more than what the literature has traditionally classified as 'care work'.

Whilst care workers at Millstead were expected to clean, and the cleaners were often involved in providing care, care workers at Shorefield and other care homes in Esterton, in contrast, had a much stronger worker identity and made a more concerted and collective effort to defend the specificity of their jobs. During interviews, for example, some care workers were keen to make a distinction between their role and that of catering or cleaning staff. One care worker, Maggie, said:

Obviously with the cleaners, their job is to clean and make sure that the room is tidy. Whereas we *talk* to the residents and basically when you're with a resident ... you're dealing with a human being. Sometimes the cleaners don't engage in conversation. They just clean. I'm there with them for twelve hours. I need to engage in conversations with them. It's not my job to clean.

Maggie, Primrose Court

At Shorefield, similar ideas about what was and what was not part of the care worker role were facilitated by the home's complex division of labour, which consisted of several divisions and sub-divisions, as outlined in chapter three. Though most cleaning tasks were undertaken by Shorefield's housekeepers, when I first started working at the home, the carers were responsible for conducting morning 'room checks' on resident bedrooms which were not scheduled for housekeeping. These room checks entailed emptying sanitary waste bins, making beds, and cleaning sinks and toilets. Six months after I started working at the home, room checks became the responsibility of the housekeepers. Another three months later, after the housekeepers had repeatedly told Shorefield's management that they were overworked, room checks were passed back to the care workers. The following fieldnote documents the care workers' resistance to being asked to complete these room checks once again:

Several carers have mentioned that they are unhappy about having to complete room checks, which they believe should be the responsibility of the housekeepers. Room checks usually take less than five minutes per bedroom, but carers are assigned up to twenty-three bedrooms on a shift and, sometimes, all of these rooms must be checked by an individual carer. I have been told by Jade, a carer, to 'just not do a very good job of it' when making residents' beds. The carers are aware that several of the housekeepers are very meticulous when checking the residents' bedrooms and believe that doing a poor job of making beds will result in room checks being made the housekeepers' responsibility again. This appears to be working: several messages from the housekeepers regarding 'how to do hospital corners', 'who likes their bed sheets tucked in', and 'when to change sheets' have been passed on to the carers in handover. Each time, the carers respond by telling the lead who is running the handover, that 'we just don't have time to do it properly.' Josie, a carer, tells me that some housekeepers have started 'room checking [carers'] room checks', which 'takes longer than if they just did it themselves in the first place'.

Shorefield Fieldnotes

The carers' undermining of Shorefield's management's attempts to change their responsibilities was not the only form of collective action which the care workers engaged in. Other, often new or abruptly enforced rules – such as the need to wear particular clothing at work – were also resisted by the care workers. What was interesting was that, in the case of room checks, the care workers' attempts to take control over their work were successful: several weeks later, room checks were again made the responsibility of the housekeepers.

The tasks of bed-making and bedroom tidying, though not the official responsibility of the care workers anymore, were often still carried out by the care workers, but it had become an act of kindness, a 'gift' to the housekeepers. The following fieldnote was taken following the re-allocation of room checks to Shorefield's housekeepers, during a well-staffed morning shift:

Ada and I have been assigned to the blue corner this morning and several of the residents we are responsible for have gone on a minibus trip to a local church. All other residents are at the weekly knitting club or in their bedrooms. There is not much work to do. Ada suggests that we collect the bin trolley from the cleaning cupboard and start emptying residents' bins 'to surprise [the housekeepers] Carla and Tricia'. When we've finished emptying the bins, we make three residents' beds before returning to the care office to complete our daily notes.

Several hours later, I noted:

When Carla and Tricia notice that Ada and I have started room checks in the blue corner they come to find us to say thank you. Carla asks if we'd like a hot drink from the resident Café. Tricia makes a joke about carers 'finally learning how to make beds when it's not your [carers'] job anymore' and we all laugh.

Shorefield Fieldnotes

Shorefield's care workers were happy to carry out extra cleaning tasks when these tasks were the outcome of their autonomous decisions but not when they were a formalised requirement of the job. Indeed, care workers appeared to perform the task of bed-making with a great deal more care and precision when the task was carried out as a gift or favour to the housekeepers. Though care workers at Shorefield had a strong sense of collective identity when it came to defending the demarcations of their jobs, they did choose to enter into a kind of 'moral contract' with the housekeepers. In her study of domestic and care workers in Italy, Näre

(2011) noted how this form of moral economy can arise in highly personalised, or family-like, labour relationships (such as those between a home-owner and a domestic assistant). What was notable about care workers at Shorefield, however, was that these moral acts were not carried out on behalf of the residents, nor for their employer, but for each other.

Nonetheless, care workers enacted small acts of separation – often ‘buried in habit’ (Douglas 1966: 9) – to distinguish what they perceived as ‘proper’, legitimate, and valued care-work. Workers established a clear idea of what tasks resembled the ideal or symbolic work of their own profession and, in so doing, also marked out which tasks did not belong to them, or were considered to be a nuisance or inappropriate to their role. Doing this, in conjunction with close relationships with colleagues, allowed Shorefield’s care workers to carve out some sense of positive professional identity.

Despite Shorefield’s care workers’ positive relationships with the home’s housekeepers, there were sometimes tense relationships between the care workers themselves, particularly between care workers who worked in the day and those who worked at night. As was the case at Millstead, care workers working the night shift at Shorefield were paid at the same rate as those working in the day (from £7.20 an hour based on training and experience). All permanently employed care workers, however, were contracted to work either day or night shifts. The result was that there were only two slots of thirty minutes each day when the two groups of workers were in contact with each other – the morning and evening handovers. Each was, therefore, viewed by the care workers themselves as a separate group of employees. There were, for example, several occasions where the night staff made attempts to establish themselves as different to the day staff. This often entailed criticising the day staff’s work, but on one occasion, it involved clothing, a more obvious marker of identity:

Over the last few shifts I’ve noticed that the night staff have been wearing the same blue patterned t-shirts as each other. The first time that I saw two carers wearing the same t-shirts I thought that it might be a coincidence. The next evening, two other carers were wearing the same blue patterned t-shirt. Today, I asked Sara, one of these night care workers,

about this. At first, Sara laughed and pretended that she was not aware that they had been wearing the same t-shirts. I probed Sara further. She explained that the night staff are annoyed that Shorefield's management will not allow them to wear leggings or trainers at work. This has angered the night staff because they often see the day staff wearing 'jewellery and low-cut tops' – which break Shorefield's dress code. They also feel that there is not a valid reason for this rule, as there are not any visitors to the home in the night and 'residents can't see what we're wearing [in the dark]'. The night staff's response has been to buy the same blue patterned t-shirt which they will wear on every night shift. 'You should buy one and join us' says Sara 'it's only a tenner [£10] in Asda'.

Shorefield Fieldnotes

This wearing of matching clothing was a creative way for the night staff to express their frustrations to the management without breaking Shorefield's official dress code. Shorefield specifically asked workers not to wear a uniform in order to make Shorefield 'feel like the residents' home'. By wearing the same patterned item of clothing with plain black trousers, the night staff had created their own unofficial uniform without breaking any of Shorefield's clothing rules. In doing so, the night staff had also visually separated themselves from the day staff. In my interviews with care workers, several respondents mentioned similar discordances between care workers who worked during the night and those who worked in the day. Kristina, for example, said:

Sometimes there can be a little bit of a thing between day staff and night staff. In my previous home it was more like that because, again, it wasn't personal. It was bigger ... So day staff were thinking 'oh night staff can do more'. Night staff was thinking 'oh day staff can do more'. So it's more like they didn't really know who was doing what and they say the night staff not doing anything.

Kristina, Meadowlands (previous home)

As Kristina's account makes clear, conflict between groups of care workers often arises out of 'bigger' problems with the organisation and allocation of work. Paradoxically, however, such conflict can undermine the supportive co-worker relations which are essential for sustaining resistance to the conditions which cause it (Hodson 1997). As was the case with other forms of collective action at Shorefield – such as the care workers' half-hearted carrying out of room checks – the night staff's uniform wearing was directed as much against other staff as it was against Shorefield's management. In fact, whilst Shorefield's management did not

react to or mention the night staff's uniforms, it was a source of much discussion and some annoyance amongst the day staff, who felt that they would not 'get away with' similar attempts to bend the uniform code.

What is clear, however, is that care workers at Shorefield had distinctive understandings of what their role was, and how this should be undertaken. Although I have outlined several attempts by workers at Shorefield to distinguish themselves from colleagues, in the majority of cases, a collective identity was enacted in which workers mostly felt able to define what they perceived to be 'normal' or 'expected' care work. This contrasted with care workers at Millstead who carried out multiple tasks beyond what is most often seen as a care worker's role – and whose resistance was done individually and typically at the expense of the residents. A superficial observer might see Millstead's care workers' acts of resistance as ineffective and petty or, worse, as selfish. It was not long after I started working at Millstead, however, that I realised the preciousness of having moments to yourself and, even, having time to eat. There was an occasion, for example, when, having worked for more than nine hours without having the opportunity to eat, I ate a resident's uneaten sandwich in the home's elevator. Whilst, for care workers at Shorefield, acts of resistance like poorly making beds allowed for greater control over the boundaries of their work, the resistant acts of Millstead's care workers were more often degrading than empowering.

Conclusion

Empirical studies of workplaces sometimes overlook the fact that the workplace is not only the location in which various physical activities take place but is, also, a community. This is particularly the case for residential care homes like Millstead and Shorefield which are, by definition, homes as well as workplaces. Recognising that residential homes are communities means that, when thinking about work organisation, we need to consider the impact which forms of organising work have upon the quantity of work which gets done *and* the attributes and experiences of these communities as a whole; including on members' sense of belonging and on shared understandings and shared rituals. Particular forms of organising work have the potential to both reduce the time available to carry out the practice and

tasks of care and to displace more time-consuming rituals. Unlike the practical tasks of personal caregiving – which produce clean, presentable residents – the symbolic aspects of care work are not so easily made visible and, in turn, measurable. Thus, the risk is that, being immeasurable or, even, invisible, the symbolic work of care workers will always be superseded by the practical requirements of the job in a performance-driven environment, particularly when those managing that environment are focused on driving down costs.

At Millstead, forced to carry out their work in a routine, task-oriented manner, care workers were left with little time to talk to residents and, where time was available, attempts were made by the care workers to snatch this time for themselves. Equally, there was little sense of shared identity amongst care workers at Millstead. The former were, perhaps, symptoms of an anomic working environment. Though not without its own problems – such as its tendency to encourage care workers to blur boundaries between home and work – Shorefield fostered a sense of collective identity amongst its employees, who had a shared sense of professional duty and, at times, their own moral economy. It is in considering these features in more depth that we are led in the direction of a more symbolic analysis of the rituals and routines of caregiving. In chapter five, I therefore extend my examination of care work at Millstead and Shorefield by exploring how care workers' ritual marking out of boundaries between materials, spaces, and persons functioned to establish and reaffirm particular ideas about the value of those in their care.

Chapter 5: Dirt, Decency, and the Symbolic Boundaries of Care

Although researchers have emphasised the changing sites in which the care of older people takes place, particularly in the shift from medical settings to residential or private spaces (Williams 2002), the quantity, quality, and use of space in residential caregiving environments has rarely been examined. Having explored the temporal ordering and dividing-up of work at Millstead and Shorefield in chapter four, in this chapter, I will examine the spatial and material organisation of care work in the two homes.

In many ways, this chapter responds to recent calls for attending to the mundane materiality of care environments (Bates *et al.* 2016; Martin 2016; Martin *et al.* 2015)⁵². Although the role of material culture has been an important analytical focus for scholars in science and technology studies and human geography, a critical analysis of the role of architecture and design, objects, and technologies as regards care environments remains in its infancy. There are some important exceptions, including: work on the social implications of the design of hospitals (Adams *et al.* 2010; Bromley 2012; Prior 1988); birthing rooms and family planning clinics (Fannin 2003; Gillespie 2002); GP surgeries (Rapport *et al.* 2007); surgical theatres (Fox 1997; Rawlings 1989); nursing departments (Allen 2015; Sandelowski 2003); intensive care (Nimmo 2014); emergency departments (Hillman 2014); and various medical and alternative medicine clinics (González-Santos' 2011; Pedersen *et al.* 2016; White *et al.* 2012). However, such explicit explorations concerning the central role of material culture in care environments are still relatively rare. This chapter builds upon this literature by examining how care workers at Millstead and Shorefield navigated the buildings, 'props' (Goffman 1959), and persons that they came into contact with.

⁵² See, for example, a recent special issue on 'materialities of care' in *Sociology of Health and Illness* (Buse *et al.* 2018).

I begin this chapter by outlining the key theoretical tenets which I draw upon to guide my subsequent analysis. Residential care homes are complex environments and making sense of the materiality of everyday life at Millstead and Shorefield requires the use of more than one theoretical lens. As such, I contextualise my arguments by discussing the work of four theorists: Mary Douglas, Émile Durkheim, Georg Simmel, and Erving Goffman. Taken together, these works allow us to understand the spatial dynamics of care in a manner which, alone, each would not allow. Collectively, they help us grasp how care workers' use of materials and spaces might function to convey value. That is, they show how practices which sustain or disregard material and/or spatial boundaries function to uphold or undercut the symbolic expression of virtues, including dignity, privacy, and respect.

In what follows, I explore the boundary work of care workers at Millstead and Shorefield. My focus here is on the everyday rituals and routines of care work in the two homes and, for this reason, I principally draw upon fieldwork observations. Though the topics of personal care, bodily waste, and hygiene also arose in my interviews with care workers, getting the interviewees to talk at length about the more mundane aspects of their work sometimes proved difficult. Often, for example, the care workers framed their accounts of dealing with bodily waste in terms of either humour or (one-off) horror stories which, though interesting, did not shed a great deal of light on the taken-for-granted, routine elements of care work.

The focus of this chapter is on care workers' attitudes and practices concerning hygiene and bodily waste and, in turn, on how these ideas are established and reaffirmed through the marking out of boundaries between materials, spaces, and persons. Central to understanding the care workers' establishment of, or inattention to, these boundaries is an awareness of the material, temporal, and cultural conditions of work at Millstead and Shorefield. For this reason, this chapter builds upon material presented in chapter four, capturing how variances in the availability of resources and the formal organisation of work, as well as the

distinct layout of the two homes, impacted upon the kind of care which was provided to residents.

At Shorefield, care workers' practices took a symbolic form. Drawing upon Douglas' (1966) work on 'matter out of place', I explore how care workers at Shorefield were able to enforce strict boundaries concerning the management of 'dirt'. In comparing practices at Shorefield to those at Millstead, it becomes clear that the lack of material, spatial and temporal resources available to care workers meant that they were able to do little to establish boundaries between 'clean' and 'dirty' matter. Employing Durkheim's concept of 'moral individualism' – which refers to an attitude that is characterised by respect for the boundary which protects and sacralises the individual – I consider how such boundary work can function to maintain not only hygiene standards but, also, more interpersonal virtues, such as dignity and respect. Understood in this way, care workers' attempts to enforce boundaries concerning 'dirt' can be viewed as an indication that it is possible for paid caregiving in residential homes to have a strong moral component. Below, I outline the theoretical work which I draw upon in this chapter.

Theoretical Foundations: Douglas, Durkheim, Simmel, and Goffman

In *Purity and Danger* (1966), Douglas argues that notions of purity are central to all societies, acting to reaffirm and uphold social order by drawing boundaries that give shape and unity to our experience:

In chasing dirt, in papering, decorating, tidying, we are not governed by anxiety to escape disease but are positively re-ordering our environment, making it conform to an idea. There is nothing fearful or unreasoning in our dirt avoidance: it is a creative movement, an attempt to relate form to function, to make unity of experience. (1966: 3)

Society's ritual marking out of that which is clean from that which is dirty acts to establish, reaffirm, and restore social order. Notions of pollution and purity are part of a wider symbolic system of classifications which give collective meaning to the everyday experiences of social actors. Our ideas of what constitutes dirt express symbolic, rather than simply hygienic, systems:

If we abstract pathogenicity and hygiene from our notion of dirt, we are left with the old definition of dirt as matter out of place. This ... suggests two conditions: a set of ordered relations and a contravention of that order. Dirt then, is never a unique, isolated event. Where there is dirt there is system. Dirt is the by-product of a systematic ordering and classification of matter, in so far as ordering involves rejecting inappropriate elements. This idea of dirt takes us straight into the field of symbolism and promises a link-up with more obviously symbolic systems of purity. (Douglas 1966: 44)

For Douglas, what we consider as dangerous pollution is never absolute. Matter only becomes dirt when it confuses or negates our valued classifications. Dirt is relative. Boundaries do not function simply to control pathogens or maintain hygiene; they carry a symbolic load. Bodily orifices, for example, might act as symbolic representations of 'points of entry or exit to social units' (1966: 4).

Douglas writes:

All margins are dangerous. If they are pulled this way or that the shape of fundamental experience is altered. Any structure of ideas is vulnerable at its margins. We should expect the orifices of the body to symbolise its specially vulnerable points. Matter issuing from them is marginal stuff of the most obvious kind. Spittle, blood, milk, urine, faeces or tears simply issuing forth have traversed the boundary of the body... The mistake is to treat bodily margins in isolation from all other margins. (1966: 150)

Here, the materiality of the body's boundaries might be used to symbolise community boundaries. In societies which attach a strong moral value to the integrity of the body – in those which forbid physical violence, for example – we would expect the boundaries of the body to play a prominent symbolic role in the maintenance of social cohesion, and vice versa. This was, in fact, an insight central to Durkheim's theory of 'moral individualism'.

Durkheim's sociology is famous for its stress on the importance of social solidarity and the primacy of the 'collective conscience' and, for this reason, he is often thought of as a conservative thinker who is opposed to the growth of individualism. However, this is an inaccurate and unhelpful reading of Durkheim. In 'Individualism and the Intellectuals' (1898/1969), Durkheim established that individualism is not always egoistic in form. Borrowing from Kant and Rousseau, Durkheim developed an account of a form of individualism which has at its core a

concern not for the individual *per se* but, rather, for persons *in general*. Durkheim posited that, for Kant and Rousseau, duty entailed:

averting our attention from what concerns us personally, from all that relates to our empirical individuality, so as to uniquely seek that which our human condition demands, that which we hold in common with all our fellow men [*sic*]. (1898/1969: 21)

Although Durkheim applauded the moral displacement of the ‘empirical individual’, this is because, for him, moral realities can win human respect only when they transcend profane, empirical existence. Respect, compassion, and care for actual persons, in other words, can only be a by-product of the collective belief in the sacredness of *all* individuals – the ‘individual in general’:

The sentiments which protect human dignity touch us personally. Assuredly, I do not mean that we only respect the life and property of our peers out of utilitarian calculation and in order to obtain a just reciprocity from them. If we reproach acts that are deficient in this respect, it is because they violate the sentiment of sympathy which we have for man [*sic*] in general, and these sentiments are without self-interest precisely because they are a general object ... [The object of moral conduct] is humanity in general, abstracted from the concrete and diverse forms in which it presents itself for observation. (Durkheim 1899/1978: 174)

Moral individualism makes the human person – the individual in general – the object of its morality, and virtue arises from those thoughts, beliefs and actions which take humanity seriously. Here, the human person is deemed sacred:

It is conceived as being invested with that mysterious property which creates an empty space around holy objects, which keeps them away from profane contacts and which draws them away from ordinary life. And it is exactly this feature which induces the respect of which it is the object. (1898/1969: 21)

Respect for this ‘empty space’ – a respect which is not a product of the uniqueness of one’s character or personality but, rather, of the idea of a common humanity – acts to maintain the individual’s integrity. It protects those inviolable elements of the individual which are common to all persons. A defence of the rights of the individual – a demarcation of this empty space – is therefore, simultaneously, a defence of the vital interests of society. For individualism’s motive force is:

not egoism but sympathy for all that is human, a wider pity for all sufferings, for all human miseries, a more ardent desire to combat and alleviate them, a greater thirst for justice. (1898/1969: 24)

When the sacredness of the person is not upheld – when the protective space around the individual is traversed – moral anarchy will ensue because society's common sentiments are being violated. For Durkheim, the human diversity characteristic of differentiated modern societies entails that the integrity and autonomy of the individual is the only commonality which remains. The preservation of the sacredness of the individual is the only end which we can all hold in common.

This account of moral individualism, as a morality which is characterised by respect for the boundary which protects and sacralises the individual, is not exclusive to Durkheim's work. The importance which Simmel (1950) attaches to the 'total personality value' of the individual in his discussion of discretion, for example, bears close resemblance to Durkheim's account. For Simmel, discretion:

consists by no means only in respect for the secret of the other, for his [*sic*] specific will to conceal this or that from us, but in staying away from the knowledge of all that the other does not expressly reveal to us. It does not refer to anything particular which we are not permitted to know, but to a quite general reserve in regard to the total personality. (1950: 320-1)

For Simmel, to refrain from pursuing knowledge about those elements of the person which she or he does not freely reveal, 'corresponds to the feeling that an ideal sphere lies around every human being' (1950: 321). Infringement upon this ideal sphere is a violation, for it will result in the destruction of the 'personality value' of the individual. Discretion is the attitude that a person must be allowed a degree of privacy; it is 'the feeling that there exists a right in regard to the immediate life contents' (1950: 322). In Simmel's account, a person's right to discretion is not individualistic in an egoistic sense. The boundary which protects the individual's right to privacy 'requires the conditions and forces of the social

milieu' (1950: 322), forces which may also intrude upon that right in the interests of social interaction⁵³.

Goffman's (1956) account of 'deference' and 'demeanour', which drew upon the work of both Durkheim and Simmel, allows for further development of the concept of moral individualism. Goffman explored several ways in which the person might be assigned a kind of sacredness which is presented and reinforced in symbolic performances. Whilst Durkheim saw the performance of the sacred as an exceptional break with mundane reality – marked by ritualised gatherings of the community and an escalation of emotional energy that he called 'collective effervescence' – Goffman's focus was on the rules of conduct which pervade everyday social interaction and which, by means of their enactment, secure the honour of persons or things.

Displays of deference are marks of devotion which act to convey appreciation and respect towards persons or towards the symbolic matter which is considered as belonging to the recipient. Deference can take the form of presentational rituals – which comprise acts which allow the actor to convey positive regard for the participant – or avoidance rituals – which concern the keeping of distance from the recipient's 'ideal sphere' (1956: 482). Demeanour, on the other hand, is the performance of reliability and self-control by which actors show that they are deserving of others' deference. It is what Durkheim, in *Moral Education*, referred to as 'self-mastery' and the capacity for 'internal restraint' (1925/1961: 45). Goffman wrote:

It is therefore important to see that the self is in part a ceremonial thing, a sacred object which must be treated with proper ritual care and in turn must be presented in a proper light to others. As a means through which this self is established, the individual acts with proper demeanor while in contact with others and is treated by others with deference. It is just as important to see that if the individual is to play this kind of sacred game, then the field must be suited to it. The environment must ensure that the

⁵³ Simmel gave examples of instances where the duty of discretion recedes before practical requirements; such as when an employer hires someone or when an individual accepts someone into their social circle. In these instances, Simmel said, the individual must have the right to 'learn or infer those aspects of the other's past and present, temperament, and moral quality on the basis of which they can act rationally in regard to him or, reject him' (1950: 323). Indeed, Simmel pointed out that the beginning of a relationship, and its development, rests upon reciprocal knowledge.

individual will not pay too high a price for acting with good demeanor and that deference will be accorded him [*sic*]. Deference and demeanor practices must be institutionalized so that the individual will be able to project a viable, sacred self and stay in the game on a proper ritual basis. (1956: 497)

Here, Goffman points towards the importance of institutional environments for ensuring the sacred treatment of persons. The task now is to explore how, and to what extent, the institutional environments of Millstead and Shorefield yielded symbolic systems promoting respect for the self. In what follows, I briefly explore how, or if, care workers in the two homes distinguished between ‘private’ and ‘public’ spaces and materials as they went about their work. Informed by the theoretical foundations outlined above, I demonstrate how the mundane activities of caregiving might be used to demarcate or infringe upon the ‘ideal sphere’ or ‘empty space’ around individuals. Next, I examine how care workers’ ideas about what constitutes ‘dirt’ – and their resulting treatment of boundaries – conveyed broader institutional beliefs about the value of those being cared for. Here, I demonstrate how a routine commitment to the maintenance of spatial, material, and human boundaries can allow care workers to convey respect, dignity, and compassion for those in their care and each other.

Boundaries Between Residents: Private and Public Spaces

The ways in which the ‘empty space’ around individual residents was regarded at Millstead and Shorefield was markedly different. At Shorefield, the space of each resident was marked out by means of name plates outside each resident’s room. ‘Memory boxes’, containing photographs and other small personal items, were made by residents or their families upon moving into the home, and were displayed above these name plates. These memory boxes were markers of individual identity and, interestingly, were displayed at the boundaries between communal and private spaces.

Residents’ rooms at Shorefield were treated as their own private spaces, the entrance to which was monitored by the residents themselves, who sometimes locked their doors and carried keys. Though care workers had master keys to residents’ rooms, such keys would not be used without knocking and waiting for a

response from a resident. There was also no sharing of items between residents' private spaces at Shorefield. This is made clear in the following fieldnote, which describes how I and another care worker were required to respond to a request for a commode from Poppy, a new resident:

Poppy, who arrived yesterday with very little warning, has given us [the care workers] a long list of her requirements. One request is that Poppy uses a commode, rather than the toilet in her *en suite* at night. There are several Shorefield-owned commodes in rooms adjacent to Poppy's but we are not allowed to use these. Commodes are cleaned after each use but Patricia, our manager, says that Poppy should have her own commode, as they are not to be shared between residents or to be wheeled up and down the corridors. Jade, another care worker, and I spend over an hour searching for a new commode to place in Poppy's bedroom.

Shorefield Fieldnotes

In my year at Shorefield, the taking of time to ensure that residents had their own care equipment was commonplace. The event described in the fieldnote below, for example, surprised me at first but, within days of working at Shorefield, I recognised that it was common practice:

I am helping Karina to wash and dress Mrs Penton⁵⁴ ready for breakfast. After washing, drying and applying cream to Mrs Penton's buttocks, we are ready to put on a new incontinence pad. Karina goes into the *en suite* to fetch a pad and calls out that there are not any there. I can hear Karina removing her gloves, washing her hands and leaving the bedroom. As Karina is fetching a new pad, I cover Mrs Penton's unclothed lower half with a towel and tell her that Karina should not be a minute. I know that there is a pack of the required pads in Marjorie's room next door. Ten minutes, and a long description of Mrs Penton's family tree later, Karina returns to the room with a large pack of incontinence pads. She puts on a new pair of gloves and returns to the task of dressing Mrs Penton. Rather than going into the next bedroom, Karina has walked across the building to the supplies cupboard. When I ask Karina why we cannot take pads from Marjorie's room, she says 'we can't just take stuff in and out. They're Marjorie's'.

Shorefield Fieldnotes

In order to avoid the stopping and starting of personal caregiving described above, several of Shorefield's care workers would gather all of the items which they

⁵⁴ Though I am using pseudonyms, I switch between using first and last names intentionally. At Shorefield, residents were referred to using their preferred name.

required before beginning a personal care task. Regardless of the situation in which an item – incontinence pads, wipes, buckets, toilet paper – was required or the convenience of entering an adjacent room, these items were never taken from another resident's bedroom. It is important to stress that these practices concerning ownership were not related to who had purchased an item – Shorefield purchased soaps, incontinence pads, and wipes in bulk – or to whether the item was disposable but to where an item was located. Such items became possessions of a resident when they were placed in that resident's room.

At Shorefield, material items – even mundane items such as incontinence pads – were used to symbolise and show respect for the separate identity of individual residents. As was the case for items contained within residents' bedrooms, items which were removed from a resident's bedroom at Shorefield, such as laundry, were also clearly separated. Each garment owned by a resident had a small label, which had been discreetly sewn into its lining by Shorefield's housekeepers. Laundry was placed in individual, named bags and was washed in individual cycles. Even clean laundry was folded, stacked and returned to residents' bedrooms individually.

At Millstead, on the other hand, this ethos of moral individualism, which requires that respect is shown to the 'ideal sphere' surrounding persons, was painfully absent from the day-to-day activities carried out by care workers. Very few distinctions were made between individual residents. Instead, as mentioned in chapter four, residents were often referred to in groups based on their needs – 'early eaters' or 'late eaters', 'doubles' or 'singles' – and care tasks were divided and allocated accordingly. Care workers would rarely be asked to help one particular resident. Instead, workers would be made responsible for 'toileting the singles' or 'feeding the early eaters'; the residents, here, signify 'packages' of work. This categorisation of residents was also often at the expense of the use of residents' individual names. Even when referring to an individual resident, care workers would often use their room number rather than their given name. We should not forget, in our focus on the use of material objects as symbolic systems,

that language is, for human beings, the symbolic system par excellence. I will return to the use of language later in the chapter.

Just as care workers at Millstead made little distinction between residents as individuals, there were very few boundaries enacted between residents' bedrooms or possessions. The lack of private space available to residents surprised me when I first started working at the home, as the following fieldnote, taken during my first shift working alone, demonstrates:

Today I have been tasked with washing and dressing seven residents. I quickly notice that working alone to care for a resident does not necessarily mean that I will be assisting residents without the presence of other care workers. This is particularly clear when I am washing Pat in her bedroom. Rather than giving residents baths or showers, we are told to use buckets of warm soapy water and Millstead-owned flannels. On one side of the building, there is only one room with a ready supply of hot, clean water – Pat's bedroom. Elsewhere, the water is either cold or discoloured. The carers therefore enter Pat's room each time that they need to fill a bowl with warm water – twelve times a morning. As Pat is sat on her commode and I am washing her, two other carers rush in and out of Pat's room to fill up their bowls. They do not knock on the door or acknowledge the presence of Pat or I in the room and they both leave the bedroom door open after they have left. On my shadow shift, I was told that I must only use one hand-sized towel per resident, per day. This means that, whilst I am washing Pat, there is no means to cover up her damp body, either to keep her warm or to protect her privacy. Though I apologise to Pat, unlike me, she appears unfazed by the coming and going of the other carers.

Millstead Fieldnotes

As I continued to work at Millstead, I noticed that the use of residents' bedrooms as communal spaces was common. Pat's room was freely used for its hot water supply, a commode in Billy's room was used as a communal toilet during the day – due to its proximity to the resident lounge – and Judith's room was used as a storage space for large lifting equipment and spare wheelchairs⁵⁵.

It was not just the residents' bedrooms which were treated as public spaces at Millstead; material items were also used collectively. Both disposable items (such as unused incontinence pads) and more personal possessions (such as trousers,

⁵⁵ As I showed in the previous chapter, Judith's room was also used as a space for carers to take an unofficial break, out of sight of Mrs G.

socks, underwear, and combs) were regarded as communal items by the care workers. Most often, this sharing of items was made necessary by the lack of material, temporal, and spatial resources available to care workers. Sometimes, for example, residents would move into the home without possessions or additional clothing and, since Millstead's management did not buy items for residents, care workers were left with little option but to borrow items from other residents.

At Millstead, the sharing of personal items between residents was a source of contention between the care workers and some residents' family members, who would painstakingly label, count, and list their relative's clothing in an attempt to prevent items from 'going missing' within the home. The fieldnote below describes why, despite the disgruntlement of residents' family members, these practices continued:

When changing residents into their nightclothes, we carry a large plastic laundry basket and a big yellow clinical waste bag around with us. Residents' clothing – soiled or dirty – is placed in the basket to be washed and soiled incontinence pads are placed in the yellow bag. At the end of the shift, we carry the laundry basket to the laundry room at the back of the home and one carer sets off the washing machine. The laundry often gets mixed up but, whilst this bothers some residents' family members who try to label their relative's clothing, there is little time available to correctly sort and distribute the laundry. Several residents are short on clothing – particularly underwear – and the care workers' solution to this is to redistribute undergarments to reduce the need to do the laundry so regularly.

Millstead Fieldnotes

The sharing of undergarments between residents and, also, the washing of both soiled and un-soiled items of clothing together were made necessary by the lack of time and resources available to Millstead's care workers. There was just one washing machine and one tumble dryer at the home and, moreover, just one carer would be responsible for washing, drying, folding, and re-distributing laundry (as well as undertaking other care activities) during each shift. This carer was also the first to be asked to carry out additional care tasks when another staff member was absent.

It was perhaps understandable why Millstead's management prioritised tasks of personal caregiving over the washing and sorting of laundry. Yet neglecting the latter still had implications for the treatment of the home's residents. One care worker whom I interviewed, Frankie, described her attempts to mitigate the effects of a lack of clean clothes for residents in her care – namely, by buying them herself:

When residents end up with two shirts or one pair of trousers, it's disgraceful. You wouldn't do that to yourself ... it's really upsetting ... it's just not fair and I can't help myself. I give a couple of anonymous gifts here and there and leave them in places.

Frankie, Plainton Grange

Like other practices at Millstead, which I explore in more depth in the remainder of this chapter, the disregard for resident's clothing and possessions both broke procedural rules concerning hygiene and infection control and did away with the symbolic work required to show deference to individual residents, to respect their 'empty space', and to uphold their dignity as human persons.

Bodily Waste

As we saw in chapter two, care workers routinely have to deal with 'the negatives of the body' – dirt, decay, decline, and death – yet these aspects of the job are often overlooked in sanitised and unapologetically upbeat conceptualisations of care work (Twigg 2000: 393). Care workers at both Millstead and Shorefield came into close contact with bodily waste – faeces, urine, saliva, vomit, blood – every day. For care workers in both homes, dealing with unbounded, leaking bodies was a crucial part of the job. The manner in which tasks involving bodily matter were organised and carried out, however, varied markedly between the two homes. In what follows, I explore how care workers at Shorefield enforced and upheld strict spatial boundaries concerning bodily waste.

At Shorefield, there were numerous physical boundaries – doors, corridors, walls – between spaces where the care of residents' bodies took place and other, communal, areas. When these boundaries were crossed, care workers performed particular rituals to mark the transition from 'unclean' to 'clean' spaces, and vice versa. Whilst some of these techniques followed national guidelines on infection

control, others were more obviously symbolic. These more symbolic techniques were often passed on between care workers in shadow shifts and reaffirmed in daily practices.

I have used the floor plan on the following page to indicate how different spaces at Shorefield were used. In terms of size, the area depicted presents around one quarter of the home – one half of the ground floor – though, in terms of composition, the area contained the most communal spaces, the fewest resident bedrooms, and the largest staff area. I have used colour-coding to indicate how various spaces were used. Red spaces show residents' bedrooms (including *en suites* and kitchenettes) and communal toilets; green spaces depict other communal areas (dining room, lounge, corridors); and blue spaces mark out areas which were only entered by members of staff (kitchen, laundry, staff room, offices).

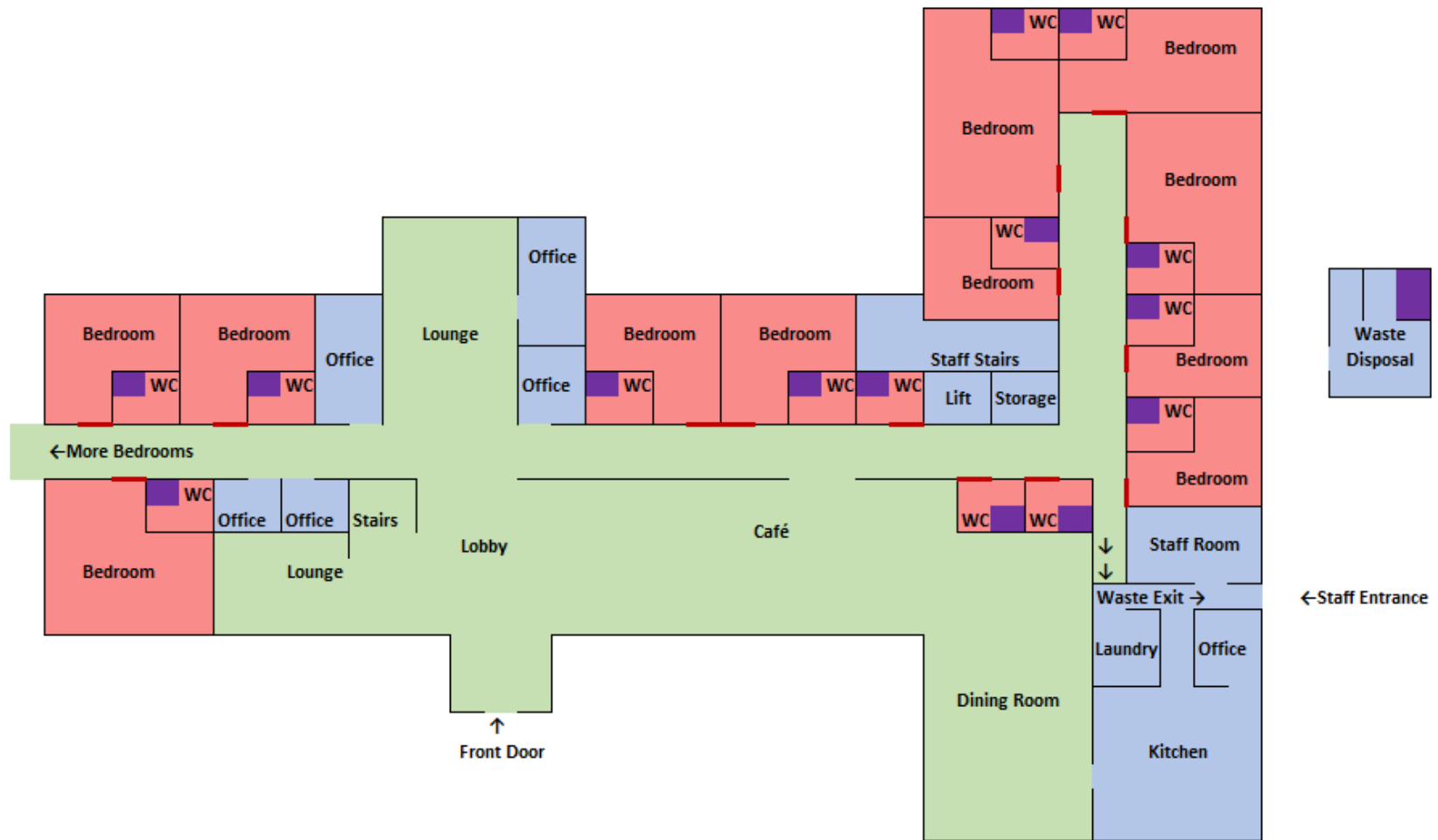


Figure 1: Floor plan depicting one half of the ground floor at Shorefield

At Shorefield, personal care took place in residents' private spaces and, very occasionally, in communal toilets (both depicted in red). Purple squares show where the waste resulting from the tasks of personal caregiving – soiled incontinence pads, used gloves, wipes, and aprons, among other things – were temporarily disposed of in sanitary waste bins, before being permanently discarded in an outdoor waste disposal area (also marked with a purple square). As the colour-coded floor plan makes clear, no area in which personal caregiving took place (red space) was devoid of a sanitary waste bin (purple square). In practice, this prevented bodily waste products from crossing the boundaries (marked by doors) that separated private areas from communal areas after each act of personal caregiving. This clear architectural and material separation of spaces, according to activities, was indicative of Shorefield's strong institutional beliefs about one form of matter that constituted dirt: namely, bodily waste.

Spatial and material boundaries concerning bodily waste were reaffirmed in the daily practices of Shorefield's care workers. For example, before passing from a private area into a communal area – such as when leaving a resident's bedroom – gloves were removed, hands were washed, and certain materials were ordered, concealed, and/or disposed of. The following fieldnote, which describes the final activities which Julie, a carer, and I carry out before leaving a Shorefield resident's bedroom, documents this ritual and the near-contravention of it:

Julie and I have finished washing, dressing, and hoisting Gwyneth and she is seated in her wheelchair, ready to be taken to the dining room for her breakfast. Julie begins pushing Gwyneth's wheelchair past her kitchenette and reaches the closed door which opens out onto the upstairs corridor. She stops, leaving Gwyneth seated and facing the closed door, and says 'Sorry Gwyn. We won't be a moment. Just need to finish up in here'. Julie turns around and shakes her gloved hands at me, indicating that she has nearly forgotten to remove her gloves before leaving Gwyneth's bedroom. I collect the final toiletries and towels from Gwyneth's bed area, where we have given her a bed bath, and return them to her *en suite*, where Julie is now standing. Julie uses one gloved hand to pinch the wrist area of the outside of her other glove and pull it off, avoiding contact between the glove and her skin. Next, she places the index finger of her un-gloved hand beneath the wrist of the remaining glove and pulls it off, this time avoiding contact between her un-gloved hand and the outside of the second glove. Julie opens the lid of the sanitary waste bin and places the used gloves in

it before turning a small green handle on top of the bin. This twists the top of the bin bag, which she proceeds to push downwards, in effect, creating a new bin bag at the top of the bin. Julie closes the lid of the sanitary waste bin and proceeds to wash her hands very thoroughly with liquid soap in Gwyneth's bathroom sink before returning to take Gwyneth to the dining room. I leave the room after Julie and Gwyneth, returning the hoist to its storage room.

Shorefield Fieldnotes

For Julie and other care workers at Shorefield, the doors to residents' bedrooms marked the boundary between areas in which 'dirty' work took place and clean, communal spaces. Crossing this boundary required the careful performance of a series of rituals: waste disposal, glove-removal, and hand-washing. Before leaving a resident's bedroom, all material items used in personal care would be disposed of in a particular order – incontinence pads, plastic aprons, and then disposable gloves – before care workers would wash their hands. This series of tasks did not solely concern the spread of pathogens; it entailed the symbolic treatment of the (temporary) spatial boundary between 'dirty' bedroom and 'clean' communal space. Julie, for example, touched the handles of Gwyneth's wheelchair with both (unhygienic) gloved and (hygienic) un-gloved hands without notice, yet she was careful not to pass into the communal corridor without carefully completing the series of hygiene rituals documented above.

As was my responsibility in the case outlined above, any products used during the washing of residents would be returned from the resident's bedroom area to their *en suite* upon the completion of personal care activities. Likewise, lifting equipment (such as hoists) would be removed and returned to designated storage cupboards off of the communal hallways. Here, the bedroom was a transmutable space which moved from being a clean and restful place, to being the 'dirty' site of personal care, before being sanitised and restored to its former state.

Outside of residents' *en suites*, there was no indication that the activities undertaken by care workers at Shorefield involved dealing with residents' soiled bodies. There were no wall-mounted glove or apron dispensers and, even in communal toilets, gloves were kept hidden in cupboards or drawers. Moreover, there was little visible movement of either clean or dirty incontinence pads.

Instead, when moved from residents' *en suites* to the external waste disposal area, items which had come into contact with bodily waste – incontinence pads, gloves, wipes, and aprons – were placed in yellow clinical waste bags and concealed within (what appeared to residents and visitors as) a large linen trolley.

What was striking about Millstead, in contrast to Shorefield, was how 'dirt' was accepted as normal in all parts of the home. So much was apparent even when passing the building; the home's clinical waste bin was visible to pedestrians and was often open and overflowing with bags of soiled incontinence products. It was not just the boundaries of external waste bins from which matter pertaining to bodily waste overflowed. This 'dirt' spilt out from the confines of lavatories and residents' bedrooms into all communal areas of the home. That Millstead was a site where acts of personal caregiving took place was clear upon first entering the home for my job interview; there was a strong smell of urine and a filled clinical waste bag lay open on the floor in the entrance corridor.

It was not until I first worked 'on the floor' at Millstead, however, that I realised how few attempts were made by the home's care workers to erect spatial boundaries concerning bodily waste, to abide by deference rituals, and to respect the empty space marking out the dignity of the person. After my first shift at Millstead, I wrote:

Personal care at Millstead seems to be a complete free-for-all. There is no peace, no retreat from the chaos. There is no attempt to conceal what is happening. Residents are left sitting naked and soiled on commodes in the middle of cold rooms with their doors open for all to see. Care workers walk in and out of residents' bedrooms as they are being changed or bathed without acknowledgement. Yellow bags full of faeces and stale, urine-soaked pads are left on the floors of the corridor and are lugged in and out of bedrooms and up and down the stairs. Residents shout out for assistance but are often ignored. The care workers appear unmoved by the sights, sounds, and smells which I find overwhelming.

Millstead Fieldnotes

Having worked in residential homes before, I had perhaps come to take my own pollution beliefs for granted. Millstead's lack of spatial boundaries with regard to residents' bodily wastes made me feel uneasy, for it undermined the symbolic system which, as a trained care worker, I had previously been taught to express.

Given the working conditions of the care workers at Millstead that I described in the previous chapter, their acceptance of dirt should not be read as indicative of wickedness or moral failure on their part. Instead, as we will see below, the lack of spatial boundaries concerning bodily waste at the home can be better understood as a product of insufficient training and, moreover, of the spatial, material, and temporal structuring of care work in the home.

Emulating the colour-coding of the floorplan of Shorefield I presented earlier, the floorplan on the following page marks out how different spaces were used at Millstead. Spatially, this floorplan presents the entire ground floor of the two-story home, which contained the majority of communal spaces, staff areas, and bedrooms. The red spaces depict areas where personal care predominantly took place (residents' bedrooms and communal toilets), green areas show communal spaces (lounge, dining room, hallways), and blue areas show spaces which were only accessed by members of staff (kitchen, laundry room, staff room). The two purple squares indicate the home's two sites where soiled incontinence pads could be disposed of. The square to the left of the image depicts the large external clinical waste bin mentioned above and the purple square in the centre depicts a large plastic bin lined with a yellow clinical waste bag, which was located in a communal toilet by the home's front entrance. In order to avoid the repeated moving back and forth between sites of personal care and these disposal areas, most care workers opted to carry yellow clinical waste bags with them as they carried out their work. In order to save money, Millstead's manager restricted the allocation of these yellow bags to two per shift and, as such, they would regularly be left in the corridors for several hours until they were completely full before being disposed of in the external clinical waste bin.

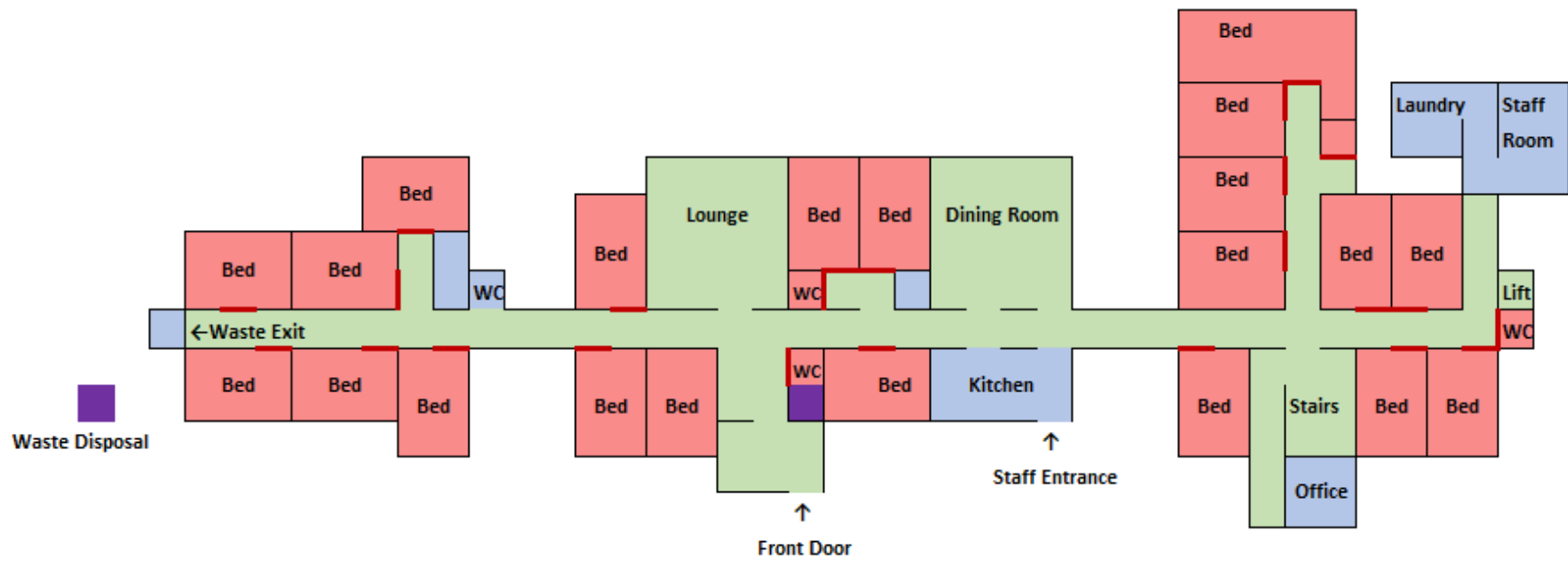


Figure 2: Floor plan depicting the ground floor at Millstead

The internal organisation of space at Millstead made it particularly difficult to contain dirt. The small number of toilets and waste disposal facilities, small private living spaces, and long corridors made the discreet movement of soiled incontinence pads, garments, filled bedpans, or 'unclean' residents almost impossible. The unfeasibility of maintaining boundaries concerning bodily waste at Millstead is made clear when, using the floorplan on the previous page, a route is traced from a red space – where human waste was primarily dealt with – to a purple square – where such waste could be disposed of. Physically, the architecture and materiality of the home meant that such a task could not be completed without entering a green, communal space.

Categorising, Containing, and Dismissing Dirt

At Shorefield, in contrast to Millstead, there was a clear spatial marking out of 'dirty' areas from 'clean' areas. Moreover, there was also a categorisation and ordering of different kinds of 'dirt'. In the following fieldnote, taken during my second shadow shift at Shorefield, I note how one lead care worker, Sarah, strictly categorised not only bodily and domestic waste but, also, the activities and materials associated with each:

It is 8pm and Sarah and I are changing Barbara, a resident, into her nightclothes and assisting her into bed. We remove Barbara's soiled incontinence pad and I go to take a spare bin bag from Barbara's household waste bin to put the soiled pad into before disposing of it in her sanitary waste bin. I push down the foot-pedal of the bin and reach to pick up the bin bag. Sarah immediately stops me, exclaiming 'don't do that ... that's crossover!' She explains that I should not touch the household waste bin or the bin bags whilst we are carrying out personal care because this will contaminate the household waste bin, which we will then have to clean. I have touched the inside of the bin bag with my gloved hand and Sarah seems quite unnerved, pulling a face as she tells me to make sure that I do not let the same thing happen again.

Shorefield Fieldnotes

For care workers at Shorefield, like Sarah, dirt was relative (Douglas 1966). There were numerous types of dirt, each of which required distinct forms of boundary maintenance. Of all categories of dirty matter, however, it was bodily waste that called for the most symbolic work. As Sarah's exclamation about 'crossover' indicated, other dirty matter could be polluted by bodily waste. Bodily waste, on

the other hand, could not be polluted by anything: it was the most impure of all matter.

This categorising of dirt meant that ‘food’ waste, as well as ‘household’ waste, was treated differently to ‘bodily’ waste, and different members of Shorefield’s staff were responsible for the handling and disposal of each. Likewise, each group of workers had a different response to different categories of waste. The home’s kitchen staff, who were responsible for the disposal of food waste, for example, expressed outright disgust when bowel habits were discussed. These same staff, however, would express pleasure when trying to elicit disgust reactions from the care workers by means of playing with or discussing regurgitated, chewed, or blended food. Several of Shorefield’s care workers, though unfazed by faeces and urine when carrying out personal care – that is, when such matter was in place – would respond accordingly:

By the door of the kitchen, there is a food waste disposer. When care workers enter the kitchen with plates of uneaten food, they use cutlery to scrape this food into the waste disposer. Plates are then stacked between the disposer and the sink and Chris, the kitchen assistant, rinses the dishes before loading them into the dishwasher. When the waste disposer begins to fill up, Chris runs water down the shoot and turns the grinder on to blend and dispose of the food. Today, Bob (the chef) and Chris are in the kitchen. When Chris comes to empty the food disposer, he laughs and fills his bare hands with food waste from the grinder. He brings the food up to his mouth pretending to eat it frenziedly. The three care workers who are in the kitchen shriek. Josie shouts out that Chris is ‘revolting’. Maddie begins retching and moves to the other side of the kitchen. Karina tells Chris that he’s ‘gone too far’ before leaving the kitchen and re-entering the dining room. Georgina, the lead on shift, who is in the dining room, hears the commotion and enters the kitchen to tell everyone to be quiet because ‘the residents are trying to enjoy their dinner’. By this point, Chris has returned, giggling, to the sink.

Shorefield Fieldnotes

Within Shorefield’s kitchen, chefs and kitchen assistants often played with food and, in response, the home’s care workers reacted with disgust. Sometimes, much to the annoyance of the lead care workers, the products of the kitchen staff’s jokes – material or vocal – would spill out of the kitchen doors. It was not uncommon, for example, for carers to realise, once they have passed into the dining room, that

sausages and mashed potatoes had been made to resemble male genitalia or that pureed meat had purposely been plated in the shape of a stool. The carers' response was, most often, to return to the kitchen to rearrange the meals. Outside of the kitchen, food was never handled by care workers. Here, the door between the kitchen and dining room represented a boundary which was strictly policed by the lead care workers, who reaffirmed the separation of the two spaces by limiting the categories of dirt which were allowed to cross over into each. Other care workers in Esterton spoke about the importance of maintaining a boundary between food and bodily waste in their work. Donna, for example, described the discomfort she felt when working in a residential home where care workers were responsible for both cooking and caring: 'you'd go and do personal care and then go back into the kitchen. It just didn't seem right to me'.

At Shorefield, both building design and care workers' practices promoted a spatial categorising of dirt. At Millstead, on the other hand, there was little attempt to enforce or reinstate spatial boundaries between different matter and the activities associated with them. This was the case even in instances where the physical layout of the home did not present an observable barrier to categorising work. In the fieldnote below, for example, I describe how one care worker, Mahesh, responded to an incident where a resident, Billy, defecated in a communal space at Millstead:

Billy, a resident with an intellectual disability, is being encouraged to stand from his seat in the dining room. This is often an arduous task, as Billy can be unresponsive to the care workers' requests. Today, Mahesh and I have been tasked with encouraging Billy to stand. As Billy rises from his chair, there is a loud rumble and squelch and a strong faecal smell disperses into the room. Mahesh, who is holding Billy by his belt, says bluntly 'he shit himself'. Though the smell is pungent and sounds continue to emanate from Billy as he walks, Mahesh guides him out into the corridor, past his bedroom – where another resident is using the commode – and into the lounge, where other residents are gathered for their afternoon tea. Mahesh tells me that Billy is not 'due' to be toileted for another thirty minutes and, so long as Billy is toileted at his designated time, Mrs G, the home's proprietor, will be happy.

Millstead Fieldnotes

As we saw in chapter four, the fitting of personal care activities into Millstead's strict routine, described above, was commonplace at Millstead. Though these activities took up a great deal of the care workers' time, they did not happen as and when the boundary from clean to dirty was broken and needed mending but, rather, when time was scheduled for it. The toileting of residents, for example, was scheduled after each meal time and would happen in a set order based on how long each resident was expected to spend on the commode or toilet. This routine ensured that those residents who took the greatest length of time to 'toilet' could be assisted first and left alone on the commode when other residents were assisted. Unlike personal care activities at Shorefield, the cleaning up of human waste at Millstead did not express a symbolic system. It did not take place when a resident's ability to project a viable, sacred self was threatened by their body's unboundedness but, instead, was ordered by practical concerns about time and efficiency.

When unexpected events occurred which made the cleaning up of bodily waste outside of Millstead's daily routine absolutely necessary, there was no hurry to reinstate a boundary between clean and dirty matter. This is made clear in the fieldnote below, which describes an instance where a resident, Joan, vomits whilst sat amongst other residents in Millstead's communal dining room:

I am in the dining room, stood at the table of 'early eaters' – those who require assistance at mealtimes – helping Joan to eat a yoghurt, when she unexpectedly begins to vomit. The vomit falls upon the table cloth and placemat in front of Joan. I call out to the other care workers – Mahesh and Agata – to ask for help. They do not approach the table to assist me nor recoil in disgust. Nobody leaves to gather cleaning products, approaches to reassure Joan, to move other residents away from the table, or to stop them from eating. Everybody carries on as though nothing out of the ordinary has happened. I leave the table to get cleaning products and am told to use an old soup container filled with soapy water. When I return to the dining room, Joan remains in her chair, salivating on the table. She does not appear to have been moved, spoken to, or washed and vomit is dripping from the edges of the tablecloth onto the floor. Agata, who does not appear to have moved either, continues to spoon dessert into other residents' mouths.

Millstead Fieldnotes

Whilst the event described above points towards minimal adherence to procedural rules regarding infection control, the care workers' lack of response to the incident is also indicative of a lack of symbolic boundary work in the home. When Joan vomited in an area where residents were eating, Millstead's care workers carried on as though nothing out of the ordinary had happened because there was no need for boundary maintenance; boundaries at Millstead were too unclear to invite or justify their protection. Matter which would have been considered 'unclean' or 'out of place' at Shorefield was quite acceptable in communal areas at Millstead. Millstead's care workers were not compelled by a need to undertake symbolic work – to clean, re-order, and eliminate dirt – when a resident's 'empty space' was breached. This lack of ritual care of the boundary protecting and sacralising residents suggests that, constrained by Millstead's strict daily routine, care workers at the home were unable to act in accordance with the principles of moral individualism. In short, Millstead's care workers did not have the time or materials required to uphold the dignity of residents like Joan.

Though members of Shorefield's kitchen staff played with boundaries surrounding 'clean' and 'dirty' food matter, the home's care workers maintained a clear spatial boundary between the two. At Millstead, on the other hand, both the consumption of food (by both residents and care workers) and the initial disposal of food waste took place within the dining room. In the following fieldnote, I explain the routinised task of clearing residents' plates in the dining room at Millstead:

When setting up the dining room for mealtimes, care workers find three empty plastic buckets in the kitchen (usually old powdered soup containers). One container is used to place dirty cutlery in, one to place liquids in, and one to place rubbish or solid food waste in. These are stacked on the sideboard in the dining room next to a tray which is used to stack dirty dishes. The process of sorting food waste into the containers takes place throughout mealtimes, as and when residents finish eating. The process is rather messy. Carers have been told by Mrs G and the seniors to drain gravy or other sauces off of a plate into the liquid container before scraping the solids into the second container. If a solid item falls into the liquid container, there is sometimes a splash of fluid – a mixture of drinks, soups, and sauces – and care workers are required to fish the solid item out of the liquid in order to place it into the correct container.

The categorising of waste described above occurred for two reasons. First, the lack of a food waste disposer in the kitchen meant that there was no means to dispose of solids and liquids together. The second was to save time in the kitchen. There was not a kitchen assistant at Millstead and, as such, it was the responsibility of an individual carer to wash, dry and tidy away thirty-three sets of dirtied dishes and cutlery after each meal, alongside emptying and washing the three waste containers. The task of cleaning up after mealtimes, often overseen by Mrs G, was a job which, amongst themselves, care workers greeted with dread. In chapter four, we saw how the boundaries between care work and other kinds of work – cleaning, cooking, and serving – were increasingly blurred at Millstead and how, for care workers in other homes, tasks such as cooking and cleaning were viewed with a similar disdain. Another upshot of this simple division of labour, however, is that it further disregarded the boundary between the handling of food and the management of bodily waste through necessitating that individual care workers did both.

Dirty Discourse

At Shorefield, it was not simply dirt in its material forms which was contained, categorised, and made the responsibility of particular groups of workers. The *discussion* of bodily waste was also confined to particular areas of the home and rarely took place amongst the home's kitchen or administrative staff. In the following fieldnote, I describe the care workers' silent response to an incident when Shorefield's valued classifications were temporarily negated by dirt, that is, when bodily waste traversed the boundary between private and communal spaces:

Maude urinates whilst at a cheese and wine event in the Café and she is not wearing an incontinence pad. The situation is handled so discreetly that no residents or visiting family members appear to notice. As soon as Maude stands up from her chair to ask for a second glass of wine, and Helena notices the wet mark on her skirt, she approaches Maude saying 'do you mind coming to help me with some paperwork for a minute?'. Meanwhile, Helena nods towards the chair that Maude has been sitting on and James approaches the chair mumbling about how it is 'due for

housekeeping'. James wheels the entire chair away from the Café and out of the coded door into the laundry room in the staff area. Within a minute of the incident, there is no visible trace of what has happened. Fifteen minutes later, Helena returns with Maude, dressed in a clean outfit, ready for her second helping of wine, and with a new chair to sit on.

Shorefield Fieldnotes

Throughout this incident, there had been no use of the words 'unclean', 'wet', 'soiled' or even any spoken acknowledgement that an incident had taken place – that Maude and the chair were required to be 'clean', 'dry' and 'unsoiled'. Instead, contaminating persons (Maude) and props (the chair) were quietly removed from the communal Café into the 'backstage' (Goffman 1959) of the staff area and Maude's private bedroom. The manner in which Maude's incontinence was dealt with was the usual approach to dealing with instances where matter was 'out of place' at Shorefield. When care workers were questioned by confused or angered (soiled) residents, who did not understand why they were being moved away from communal areas, they would not discuss what had happened until they were within the confines of the resident's room. Even within residents' rooms, dirt would rarely be explicitly referred to as dirt; for example, residents were told that they had had an 'accident' or that they simply required a change of clothes. Several other care workers in Esterton spoke of a similar need to 'be discreet' (Norma) or 'use a lot of distraction techniques' (Frankie) when they removed residents from communal areas following an 'accident'.

This practice of avoiding the discussion of dirt in communal areas was also observed in the communication between Shorefield's care workers. Each used subtle body language and facial expression to indicate, without publicity, when an incident had taken place. Some care workers were very aware of this unspoken communication. Within the walls of the care office, for example, one care worker was often teased for the wide-eyed, gawping face which she displayed to notify other care workers that a resident had inappropriately defecated or wet themselves. These silent ways of informing other care workers that matter had fallen out of place allowed Shorefield's care workers to go about the task of reinstating the boundary between clean and dirty without further polluting the communal space. By discursively avoiding dirt, Shorefield's care workers were able

to ensure that – despite the discernibility of the resident’s leaking body – their ‘ideal sphere’ was not intruded upon, particularly in front of other residents and visitors. In a Durkheimian sense, Shorefield’s care workers’ silence on bodily waste in communal spaces can be understood as a means to secure the honour of residents.

Outside of residents’ bedrooms, it was common practice that acts of personal caregiving were not discussed at Shorefield. The only exception to this spatial separation of ‘clean’ and ‘dirty’ dialogue was the care office, which was located in the centre of the building on the second floor. Though smaller than any of the residents’ bedrooms, it was the space in which all carers wrote their daily notes (twice during each shift) and where handovers took place. The care office was an area which was rarely entered by residents. Both during daily note-taking and handovers, ‘dirt’ was openly referred to and discussed. A Bristol Stool Chart⁵⁶ hung on the wall and it was not uncommon for care workers to debate which stool ranking a resident’s faecal matter should be categorised as. This discussion of ‘dirt’ often took a practical, if not professional, form. Bowel movements were discussed because they needed to be charted in a resident’s notes, or because those working on the following shift would be required to know if a resident had diarrhoea or constipation, for example. When particularly bad incidents of bowel leakage occurred, they would be openly discussed in the care office, often with a sympathetic tone. The following fieldnote documents one example of this:

Danika and I have been caring for Rose who has just returned to Shorefield after a stay in hospital and has a bad case of what the care workers call ‘overflow’: her bowels are leaking, but she is also painfully constipated. The shift is coming to an end, so a large number of care workers are sat in the care office writing their daily notes. Rachel, the lead for the shift, is preparing to hand over to the carers coming on shift. Danika and I enter the care office and Danika proceeds to tell Rachel what has happened. ‘It was just everywhere, bless her. All up her back, in her hair. Poor thing. We changed the sheets three times but it’s still coming’. The other carers look up from their notes and make sympathetic ‘ah’ noises. James and Lucy pull sad faces. Danika says, helplessly, ‘I just don’t know how to make her feel better. She’s all curled up in pain, bless her’. Rachel proceeds to write the information down in her handover notes, asking Danika about the

⁵⁶ A Bristol Stool Chart is a medical aid designed to classify human faeces into different groups.

consistency of the bowel leakage, the number of times it has occurred, and the severity and nature of pain that Rose appears to be in. Jenny, the 'med tech' on shift, leaves the care office saying that she'll get some Movicol [constipation relief] for Rose.

Shorefield Fieldnotes

Just as contact with dirty matter could not be avoided during the washing and toileting of Shorefield's residents, the discussion of bodily waste could not be avoided in the care office. Here, the recording and passing on of information concerning the porousness of residents' bodily boundaries – incontinence, bowel movements, vomiting – was a requirement of caring well.

Avoidance rituals, though useful in showing deference to Shorefield's residents in communal spaces, would prevent the provision of good care if adhered to in all spaces. Instead, within the confines of the care office, the home's care workers assigned those within their care a kind of sacredness by means of 'presentational rituals' (Goffman 1956). In the above account, for example, care workers conveyed positive regard for Rose by means of sympathetic utterances: 'bless her', 'poor thing', 'ah'. Such presentational rituals were complemented by care workers' demonstrations of demeanour (Goffman 1956). Demeanour, unlike presentational rituals, allowed Shorefield's care workers to talk about bodily waste and, themselves, maintain a credible front. This is most clear when, in the occurrence described above, care workers end their discussion about bodily waste in a professional and/or clinical manner: they focus on the frequency and consistency of bowel leakage, the condition of the resident, and the provision of medication.

In his account of interactions in an inflammatory bowel disease (IBD) support group, Thompson (2013: 31) noted how the presence of a medical professional allowed the support group setting to be framed as clinical, and, in response, 'members of the group were open about the ['dirty'] details of IBD that were otherwise unspeakable'. Thompson noted how this temporary clinical context, which was characterised by disclosure and detached objectification, prevented the open discussion of faecal matters from discrediting the group's members. For IBD sufferers in Thompson's study, this 'sterilization ... constituted a reprieve from

the moral necessity of avoiding soiled words and from acknowledging the body and self they implied' (2013: 31). For care workers at Shorefield, the materiality of the care office – medical charts, files, and equipment – had a similar sterilising effect. In this (clinical) space, care workers were able to discuss residents' bodily eliminations without rendering themselves or the residents undeserving of deference and respect. The materiality of the care office equipped the home's care workers with the appropriate material and discursive resources to come into contact with and talk about bodily waste, without doing away with the symbolic boundaries which protected and sacralised those in their care.

At Shorefield, there was a very clear demarcation of where it was appropriate to openly discuss bodily waste and where it was not. At Millstead, on the other hand, the discussion of faeces, urine, and residents' bodies in communal areas and in front of residents was commonplace. Care workers would often shout across the lounge to ask residents if they needed the toilet. Likewise, in communal spaces and in the presence of other residents or visitors, residents would sometimes be verbally 'reassured' that they were wearing an incontinence pad and, thus, that receiving assistance to a private space was not a prerequisite for relieving themselves.

Residents' speech and behaviour was also rarely policed in communal areas at Millstead. Billy would often masturbate without interruption in the lounge whilst catcalling the care workers, and another resident, Eileen, would often take off and display her soiled incontinence pad in the home's corridors. Millstead displayed many of the degrading characteristics that Goffman (1956: 483) observed to be typical of psychiatric wards, which were preoccupied with the 'substantive and instrumental requirements of the situation', but indifferent to the symbolic and the ceremonial:

Classic forms of "nonperson treatment" are found, with staff members so little observing referential avoidance that they discuss intimacies about a patient in his [*sic*] presence as if he were not there at all. There will be no door to the toilet, or one that the patient cannot lock. (1956: 483)

In the 'back' wards which Goffman found 'in typical mental hospitals':

Patients were denudative, incontinent, and they openly masturbate; they scratch themselves violently; drooling occurs and a nose may run unchecked; sudden hostilities may flare up and “paranoid” immodesties be projected; speech or motor activity may occur at a manic or depressed pace, either too fast or too slow for propriety ... Such wards are of course the classic settings of bad demeanor. (1956: 490-1)

In my year at Millstead, I did not observe an occasion where speech concerning the ‘dirty’ aspects of care was discouraged or halted either by the home’s management, care workers, or residents. This extended to those occasions in which, symbolically as well as practically, some degree of hygiene would normally be expected. This was most notable when the care workers themselves were eating. The fieldnote below, which was taken during a morning handover at Millstead, for example, tells of care workers simultaneously discussing residents’ bowel movements and eating:

Monica, a senior care worker, is outlining what happened on the night-shift. There are six other care workers present. Rosanna has just finished a packet of crisps and is now eating a Mars Bar and the other carers are drinking coffee and eating biscuits. Monica moves on from outlining which residents woke or wandered around the building in the night and begins to list who has had a bowel movement. Marta, Lidia and I note down the list of residents. When Monica gets to Oscar, she places her notebook on the table, raises her arm in the air, grabs her elbow and clenches her fist, exclaiming ‘Oscar’s stool was this big!’ Rosanna finishes her mouthful of Mars Bar before responding ‘you should have seen Joan’s the other day, I had to boil the kettle [to get the stool to flush down the toilet]!’ The other carers erupt in laughter before Monica continues to read out her list. The carers continue to eat.

Millstead Fieldnotes

As was the case in the handover described above, it was not uncommon for Millstead’s care workers to discuss the dirty nature of the job in a humorous manner. As we saw earlier, the temporal, material, and spatial constraints of care work at Millstead made it almost impossible to confine or eliminate dirt in a routine or ritualised way. The care workers’ solution to this appeared to be a trivialisation or normalisation of the dirty aspects of care – either through disregarding dirt or subjecting it to humour. In the following fieldnote, I describe an occasion where Millstead’s care workers joked about and taunted each other in relation to excrement:

I am walking around the building assisting 'early eaters' into the dining room for their lunch. I go to prompt Helga, a more mobile resident, down to lunch and find Pamela, another carer, crouched down on Helga's floor with disposable gloves on. On the floor, there are what look like chocolates. The chocolates are also squished onto the wheels of Helga's walking frame which she is attempting to wheel out of the door. 'Looks like truffle' Pamela says, laughing hysterically as she checks to see if any have rolled under Helga's bed. Both Pamela and I know that the 'truffles' are, in fact, dry stools. Pamela tells me to quickly get the faeces off of Helga's walking frame with a tissue and get her to the dining room. Mrs G, Millstead's proprietor, is in a particularly fiery mood this morning and Pamela knows that we will be in trouble if Helga is late to lunch. For the rest of the day, Pamela and I are asked to recount the 'truffles' story to the other care workers who giggle and tease us. Whilst eating my lunch, three carers jokingly ask if I would like truffles for dessert. Even Val, the cook, asks if we enjoyed our 'morning snack'.

Millstead Fieldnotes

Making bodily waste the subject of humour, teasing, and anecdotes was, perhaps, how Millstead's care workers prevented the dirty aspects of the job from polluting or spoiling their sense of self. In his work on IBD support groups, Thompson (2013) noted the utility of satire in relieving the tensions created by unbounded, leaking bodies. Here, satire protects the speaker from feelings of fault or shame. Much like the sterilising effect of clinical contexts (like Shorefield's care office), satire constitutes 'a reprieve from the moral necessity of avoiding soiled words and from acknowledging the body and the self they impl[y]' (2013: 31). Satire may have diminished the discrediting effect which contact with bodily waste had upon Millstead's care workers, yet making *residents'* bodies the subject of their humour did little to unsoil and show deference to those in their care. Below, I consider further the various ways in which care workers at Millstead and Shorefield sought material and symbolic protection against the polluting nature of 'dirty work' (Stacey 2005; Twigg 2000).

The Clean Self

Just as Shorefield's care workers carefully, and sometimes skilfully, policed the boundaries between bodily waste and clean communal spaces, they also worked to maintain boundaries between the bodily waste of residents and themselves. Though care workers at Shorefield understood that contact with residents' bodily

fluids was an inevitable part of the job, rituals were undertaken when this boundary was threatened or transgressed. In the following fieldnote, for example, I describe an instance where Lucy, a carer, comes into contact with a resident's bodily waste:

Lucy and I are working as a pair caring for a resident, Gloria. We are changing her soiled incontinence pad, which has leaked onto her white bed sheet. Whilst removing the sheet, there is a transfer of faeces onto Lucy's arm. Lucy screws up her face. Mid-task, we turn Gloria onto her back so that she is comfortable. Lucy leaves the bedroom and enters Gloria's *en suite* to change her gloves and wash her arm. She then puts new gloves on and re-enters the bedroom to assist me with dressing Gloria.

Shorefield Fieldnotes

This pausing of personal caregiving in order to reinstate a boundary between 'dirt' and 'self' was common practice at Shorefield. The rituals of hand-washing and glove-changing were, in fact, encouraged by the home's management, even though they took time. If there was a transfer of a resident's bodily fluids onto a care worker, so long as a resident was comfortable and safe, the worker would clean her/himself before returning to the task.

Several researchers have commented on the symbolic, as well as hygienic, functions which gloves can perform (Jackson *et al.*; Twigg 2000; Van Dongen 2001). In their interview-based study on the infection prevention behaviours of nurses, Jackson *et al.* (2014: 400) found that nurses were sometimes perceived by their colleagues to wear gloves as an attempt to 'protect self' or to 'put on a show' – to give an *impression* of thoroughness, knowledge, and taking seriously the issue of infection. For the care workers in Twigg's study, gloves were used both as a means to avoid direct contact with bodily waste and, more symbolically, to provide protection from the intimacy of care activities and to erect a barrier of professionalism between client and 'self'. This link between the use of personal protective equipment – gloves, aprons, masks – and professionalism was made clear in my interview with Kelly, who said:

I've said this so many times, they should get masks for the carer's face. Because we're in there wiping their bottoms and everything else and, you know, you go to a dentist and what does he [*sic*] do? He has that over his mouth so he doesn't have you breathing on him. So it should apply to a

carer as well I think ... when they've [resident] got a stomach bug and you need to clean them and they're really messy you really need something to put over your nose and mouth. Because changing a catheter or something, when you're flushing it down the toilet sometimes, all that splashes up in your face ... It's absolutely horrible isn't it? Absolutely horrible.

Kelly, Harkerfield Court

Both Twigg (2000) and Van Dongen (2001) have, however, identified that workers may even feel guilty about using protective clothing because of such connotations of contamination. Similarly, Jackson *et al.* (2014: 404) found that wearing gloves was sometimes perceived by nurses as offending patients who may feel 'dirty'. Care workers whom I interviewed expressed a similar concern with wearing gloves in a way which did not offend residents. Donna, for example, reaffirmed how spatial boundaries between 'clean' and 'dirty' spaces must be treated carefully, so as not to disrespect residents, when she said: 'I wouldn't sort of go into a room wearing them [gloves], because people get paranoid and they're like "oh, what's wrong with me?"'.

The important symbolic function of disposable gloves and aprons for Shorefield's care workers was made clear when it was gloves – rather than skin – which were dirtied. Just as Lucy did when bodily waste made direct contact with her skin, care workers whose gloves became visibly unclean would pause what they were doing in order to undertake the rituals of hand-washing and glove-changing. In instances of personal caregiving, the mid-task changing of dirty gloves was often a hygienic matter; it prevented bodily waste from further contaminating residents or materials. Interestingly, however, such glove-changing was also performed when visible dirt made contact with gloves during 'dirty' tasks which did not directly involve residents or 'clean' spaces – during the handling of soiled laundry or emptying of sanitary waste bins, for example. In these cases, gloves performed a symbolic function; they were treated as an extension of (the clean) 'self'. This frequent changing of gloves was encouraged both in Shorefield's induction training and in shadow shifts, and it was facilitated with the abundant supply of gloves in various sizes in each space where bodily waste was dealt with.

At Millstead, in contrast, it was not just time that prevented routine hand-washing and glove-changing but, also, the layout of the home and the facilities and materials made available to care workers. The number of gloves used by care workers, for example, was closely monitored by Brian and Mrs G, a practice I was warned about during my first (non-shadow) shift at Millstead:

As there are only three points at which to pick up gloves in the home, I decide to carry a few pairs of gloves on my person. When Sarah notices that I have gloves in my pockets, she immediately tells me to empty them 'because of Mrs G'. She tells me that, in the past, care workers have been accused of stealing gloves from the home when they have accidentally left the workplace with a pair in their pockets.

Millstead Fieldnotes

Brian and Mrs G made several attempts to monitor and, in turn, reduce the care workers' use of gloves and other material items – plastic bin liners, clinical waste bags, aprons, and incontinence pads. During my sixth month at the home, much to the frustration of care workers, Brian began sourcing gloves from a cheaper supplier. The new gloves sourced by Brian were of a poorer quality and dried out and damaged care workers' hands, particularly when changed regularly. In response, many care workers further restricted their use of gloves and two carers began purchasing their own alternatives.

Following this change in gloves, it became a more regular occurrence to see Millstead's care workers leaving residents' bedrooms wearing unclean gloves or, even, wearing the same pair of gloves to care for more than one resident. This meant that it was not only soiled incontinence products which were transferred across the building but, also, dirty hands and gloves. Though the practice of not removing gloves did away with infection control procedures and traversed boundaries between residents, it did maintain the, partly symbolic, barrier between others' bodily waste and 'self'. The practices of Millstead's care workers was, perhaps, not dissimilar to that of nurses in Jackson *et al.*'s (2014) study, whose wearing of gloves was perceived by their colleagues as increasing patient risk – due to a failure to change gloves between patients – and/or as a selfish and lazy alternative to hand washing.

In other instances at Millstead, however, a lack of resources – moral, material, and temporal – made the reaffirmation of boundaries between ‘clean’ and ‘dirty’, between ‘self’ and ‘role’, or between one’s own body and the bodily eliminations of residents near impossible. In the fieldnote below, taken during my first month at the home, I describe a care workers’ reaction to my own attempt to reinstate a boundary between ‘dirt’ and ‘self’:

There is a resident at Millstead, named Ruth, who tends to scratch, grab, and hit the care workers, leaving them unable to give her a thorough wash. Lidia says that, in the ten years since she started working at Millstead, Ruth has not been given a bath or shower⁵⁷. Ruth has long fingernails which are often filled with faeces as a result of putting her hands in her soiled incontinence pad. Today, I am assisting Lidia with changing Ruth. In the process, Ruth scratches my arm, causing it to bleed. I immediately step away and tell Lidia that I need to wash my arm. Lidia is quite annoyed. She tells me that I can wash my arm if I have a break later but, for now, we need to make Ruth’s bed and assist the next resident. When I refuse to continue working before disinfecting my arm, Lidia rolls her eyes and rebukes me for ‘not [being] very good at this’.

Millstead Fieldnotes

Learning to accept being dirty or soiled when working at Millstead – to further do away with preconceived ideas about what was ‘clean’ and what was ‘dirty’ – required guidance and instruction. At times, this guidance took the form of humour or light teasing; at others, it was achieved through discipline and control. The following fieldnote describes my own and another carer’s reaction to my coming into close contact with dirt:

It’s 1.45pm and time to assist Roger to the toilet for his daily bowel movement. Of all residents, it is Roger who fits himself into the daily routine of the home most precisely and this is welcomed by the carers. The routine is to walk with Roger to the toilet where he is left for twenty minutes whilst we help with other residents. Today, I go back to help Roger off of the toilet, and to clean and apply cream to his buttocks. Roger has made quite a mess of the toilet bowl, so as he walks to his bed, I begin to scrub the toilet. In the process of doing this, the tough bristles of the toilet brush flick the dirty water from the toilet bowl onto my face. As this is happening, Georgina enters the room to ask for my help. I wince and tell

⁵⁷ This seemed quite likely. In my year at Millstead, I saw just three residents being assisted with taking a bath or shower. This was due to poor accessibility to, and outdated facilities within, the home’s three bathrooms.

her that I need to wash my face. Georgina laughs loudly and says 'you'll get used to that. Now come on, diva!'

Millstead Fieldnotes

As the above account demonstrates, there was an absence of basic medical hygiene practices concerning sterility and infection control at Millstead. There was also, however, a lack of regard for the boundaries which protect and sacralise the individual – whether that individual was a care worker or a resident. During my time at Millstead, I did not see a carer or senior pause in their work to reaffirm any kind of boundary between 'clean' self and 'dirty' matter. Such boundary control was, however, carried out by Mrs G and Adelina (head carer) who, by means of allocating rather than carrying out personal care tasks, rarely (if ever) came into close contact with bodily fluids. Mrs G most often stayed in the kitchen (where residents were not allowed) and Adelina would always call out to a less senior care worker if physical contact with a resident was required to complete a task. As mentioned in chapter four, a separate staff toilet was available to care workers. Mrs G's use of a key for this toilet, however, appeared as a means to control the length of care workers' toilet breaks and, as a result, only Mrs G and Adelina refrained from using the home's communal toilet facilities.

Given the ubiquity of dirt and disorder at Millstead, it is hardly surprising that the boundary between 'dirty' work and care workers' own 'clean' homes was prominent in the consciousness of the workers. More surprising, perhaps, was that it was equally present in the accounts of care workers at Shorefield. In the fieldnote below, for example, I recount a conversation amongst Shorefield's care workers during a morning handover, where they discussed what time they awoke in the morning in order to get to work by 7am:

All but one of the ten care workers present says that they do not wash before work. Danni, the only care worker who says that she showers before working, and the most senior care worker on duty (who undertakes very little personal care) says 'don't you feel horrible all day?!' The other care workers respond saying that they do not have time to shower, they'd rather stay in bed, and they 'need to [shower] after work anyway'.

Shorefield Fieldnotes

Similarly, when discussing what they would do after work, care workers at Millstead would often state that they would go home to have a shower before meeting anyone or eating. This was despite the fact that all of the care workers would eat at work. It appeared that, though boundaries between 'clean' and 'dirty' were not present within the walls of the home, this did not have an effect on the care worker's boundary work outside of the home. This was reaffirmed in my interviews with care workers, several of whom said that the first thing that they would do upon arriving home after work was to wash themselves. Sally, for example, said:

I just get home. Have a bath. First thing when I get home, I have a bath. I change my uniform. Put it in the washing machine and have a bath... Because every time after work, I feel like I need to have a bath and if there's anything at work, I shouldn't give it to the people at home ... and for me to relax as well because a bath actually relaxes.

Sally, Stonecrofts Residential Home

Conclusion

Examining the differences between how care workers at Millstead and Shorefield carried out tasks concerning human waste reveals a startling contrast in the way that residents were treated in the two homes. Able to carry out their work in a manner which preserved and reaffirmed symbolic boundaries, Shorefield's care workers maintained both hygiene standards and more immeasurable qualities – dignity, respect, and privacy – which upheld the sacredness of residents in their care. At Millstead, on the other hand, little was done to establish boundaries between different areas, activities, or persons. The consequence of this was not simply an unsanitary working and living environment but a disregard, whether intentional or not, for the sacredness of residents.

Shorefield's market positioning and, in turn, high income ensured the provision of the spatial and material resources needed to implement boundaries concerning bodily waste: a purposefully designed building with large private spaces, *en suites*, and staff areas; a plentiful supply of gloves, aprons, and sanitary waste bins; and a well-equipped care office where care workers could professionally and privately discuss the dirty aspects of their work. Shorefield's care workers' own beliefs

about what constituted dirt, in turn, ensured that such boundaries were routinely established, maintained, and reinstated. Rituals concerning bodily waste – imparted in formal training and policed in everyday interactions – functioned to protect the resident’s ‘empty space’ from being traversed. Much like the contrast which Goffman (1961) drew between wards A and B in his study of deference and demeanour, however, the undertaking of personal care at Millstead was very different to that which I observed at Shorefield.

Millstead’s managers and staff’s disregard for symbolic boundaries can be viewed as indicative of a community in a state of what Durkheim called ‘anomie’. Residential homes, though staffed and run by paid workers, are, for the people who live there, a community. The explanation for the differences between Millstead and Shorefield must refer both to the material and temporal resources available to the care workers to do a humane and respectful job, and to the culture – the symbolic resources – of each community, which is transmitted both through formal training and on-the-job learning, and which outlasts the particular individuals who live and work there at any particular time. In the next chapter, I explore how care workers managed one event which can pose a threat to (even well-established) communities: the dying and death of one of its members.

Chapter 6: Caring for the Dying and the Deceased

In chapter five, I showed how boundaries were employed or disregarded during the carrying out of everyday care tasks at high-cost Shorefield and low-cost Millstead. At Shorefield, care workers' use of space and materials took a symbolic form; they enforced strict boundaries concerning the management and discussion of bodily waste. At Millstead, on the other hand, little was done to establish boundaries between 'clean' and 'dirty' matter. This disregard for symbolic boundary maintenance undercut both hygiene standards and less measurable virtues – dignity, privacy, and respect for the individual. Building upon the theoretical and empirical material presented in the previous chapter, in this chapter, I examine those events which, though somewhat less routine, demand more symbolic work on the part of care workers: namely, the dying and death of residents.

Residents in care homes are, arguably, living 'on the margin' (Nicholson *et al.* 2012: 1426). The state of being older and 'frail' is one of persistent liminality and imbalance, 'betwixt and between active living and clinically recognised dying' (Nicholson *et al.* 2012: 1426). Experiencing a 'precarious and often protracted dying trajectory', frail older people – with their finitude brought to the fore through 'functional limitations and the increasing social losses of old age' – may try to actively develop and sustain connections to their physical environment, routines, and social networks (Nicholson *et al.* 2012: 1426). This becomes harder, of course, when they live in residential homes.

Residential homes are commonly considered as places where older people go to die (Froggatt 2004). In 2008, 21 per cent of deaths of those aged over sixty-five in England and Wales occurred in nursing or residential homes, and a further 57 per cent occurred in hospitals (Broad *et al.* 2013). It is, perhaps, for this reason that providing a 'good death' for older people in institutional settings is now considered a key aspect of quality care (Ellershaw *et al.* 2003). Indeed, in 2014, the UK coalition Government announced 'new priorities' for end-of-life care which

called for the personalisation of caregiving to those at the end of life, and the promotion of a 'stronger culture of compassion' in health and social care institutions (Department of Health 2014: no page). Little has been done, however, to outline what a 'culture of compassion' might look like, or to establish how the accomplishment of such a culture might be made possible through particular forms of organising care work. With the intention of starting to fill this gap, this chapter considers what symbolic resources – beliefs, rituals, and vocabularies – were drawn upon by care workers when caring for dying and deceased residents at Shorefield and Millstead. For theoretical support I will, again, draw upon Durkheim, among others.

Theoretical Foundations: Durkheim, Weber, and Blauner

In order to consider how individuals might contend with dying and death in the present, it is useful to look to the past. It was, after all, the mourning rituals observed in pre-industrial societies that were a central focus of Durkheim's work on death. In *The Elementary Forms of Religious Life* (1912/2001), Durkheim described mourning as an example of a particular rite – a custom performed with the purpose of conveying and reaffirming the solidarity of the group in response to the loss of one of its members. Durkheim noted that pre-industrial mourning ceremonies always involved an effervescent communion of individuals, who actively demonstrated loss through displays of despondency, weeping and, even, the violent infliction of pain on oneself and others. For Durkheim, this frenzied grieving was not impulsive but, instead, was meticulously governed by etiquette; the lamenting individuals were obligated by custom. Durkheim concluded that mourning was:

not a natural impulse of the private sensibility, bruised by a cruel loss... [but] a duty imposed by the group. They lament, not simply because they are sad, but because they are obliged to lament. This is a ritual attitude they are compelled to adopt out of respect for custom, but which is in large measure independent of the affective state of individuals. (1912/2001: 295)

Rather than an individual expression of suffering, mourning was the realisation of the individual's duty to the group. In demonstrating this suffering – in reacting to the feeling of diminishment caused by the loss of an individual from the group –

the group assembled. For Durkheim, the role of mourning rituals was to 'gradually neutralise the very causes that engendered them' (1912/2001: 299). Originating in the group's sense of diminishment, mourning connected the group and, in turn, repaired and revitalised the collectivity since 'to commune in sadness is still to commune, and every communion of consciousness, of whatever kind, increases the social vitality' (1912/2001: 299). For Durkheim, the obligatory displays of communal pain observed in pre-industrial societies were demonstrative of the vitality of the collective life at that time.

Attitudes towards mortality have, of course, changed since pre-industrial times. As Weber (1922/1991) noted, increasing intellectualisation and rationalisation mean that, for the modern individual, death is robbed of the meaning that it might have had for 'some peasant of the past' who could die 'satiated with life', with no remaining puzzles left to solve:

for civilized man [*sic*] death has no meaning. It has none because the individual life of civilised man, placed into an infinite 'progress', according to its own imminent meaning should never come to an end; for there is always a further step ahead of one who stands in the march of progress. And no man who comes to die stands upon the peak which lies in infinity. (1922/1991: 139-140)

Weber describes not the meaning of death to the community that is bereaved, but the meaningfulness of death to the mortal person herself. Faced with a seemingly inexhaustible life, the modern individual is disenchanting and, in consequence, is unable to feel a sense of satiation or completeness when facing death. The price of freedom and the knowledge that there is more to come, or other ways one could have lived, is that death is always untimely or premature. It is always traumatic. How, then, do modern societies shape themselves in a way which manages and makes sense of the trauma of death?

Durkheim, like Weber, recognised that society's attitudes towards death were subject to historical change. Although Durkheim recognised that the strength of collective belief wanes as society develops, he also insisted that 'the whole common conscience does not, on this account, fall out of existence' (1933: 400). The ethos of moral individualism, he argued, grows stronger, not weaker. What this moral individualism implies for our understanding of mortality, the treatment

of the dying, and the rituals of mourning in modern societies, is something that Durkheim never spelled out. We can, however, make some tentative suggestions.

In his lecture 'The Spirit of Discipline', Durkheim pointed towards the important role which self-discipline plays in cultivating morally individualist behaviour. Durkheim considered the capacity for self-restraint – or what Goffman (1956) termed 'demeanour' – as the 'most essential element of character' because:

It is precisely in this development of self-mastery that we build up moral discipline ... It teaches us that conduct involves effort, that it is moral action only when we restrict some inclination, suppress some appetite, moderate some tendency. (Durkheim 1925/1961: 46)

For Durkheim, moral individualism requires that uncontrolled inclinations, instincts, and desires are contained and subjected to law. Unlike members of pre-industrial societies – who, following a death, were required to reaffirm the group by unrestrainedly inflicting suffering upon the self – modern individuals, one assumes, would be expected to show self-discipline, moderation, and respect for the individual. In mourning, the moral individualist must not violently inflict pain on herself, for the self is sacred. She must not erupt with emotion nor lament hysterically, for she must show demeanour and self-restraint. This is not to suggest that rituals and symbolism surrounding death have become dispensable or superfluous in the modern age. In fact, death, as outlined earlier in this chapter, is perhaps *more* traumatic for modern individuals and, in consequence, more symbolism must be required in order to manage it.

In chapters one and two, we saw that the pace of growth in the UK population aged over eighty has exceeded that of the broader 'old' section of the population (Myles 2002). This transformation has meant that individuals are increasingly experiencing an extended phase at the end of life. In contrast to the liminal phase which pre-industrial societies created between death and burial, modern day societies have, arguably, created a liminal phase *before* death (Holloway 2007). In this respect, we would expect the period *before* death to be strongly ritualised. Whilst Durkheim (1912/2001) noted that, in pre-industrial societies, the individual could only ever be viewed as sacred *after* death, moral individualism demands that the *living* individual (who is always dying) must be seen as sacred – it entails

concern for their suffering. The individual has become so important that pain to the individual causes injury to society (Durkheim 1897/2002). The character traits of restraint and respect for the individual must, thus, be employed in showing care and tenderness for those who are suffering or dying.

Against this trend towards moral individualism, however, there has been an increasing 'sequestration' of the dying from everyday life, expressing a kind of collective denial of the human condition of mortality (Blauner 1966; Mellor and Shilling 1993). In its worst cases, this amounts to the 'social death' (Sudnow 1967) of the older person – whose sacredness is devalued whilst she or he is living – in order to later reduce the disruptive consequences of the actual biological death. But the institutionalisation of care for older people also creates communities of residents and their care workers, and these communities are also symbolic systems.

Hospitals, hospices, and care homes – by facilitating the physical separation of ageing or dying persons from the rest of social life – can be understood as a means by which modern societies deal with the threat posed by death (Ariès 1981; Froggatt 2001; Hockey 1990; Mulkey and Ernst 1991). Whilst sequestering death in this way might minimise society's need for collective repair, however, another consequence is that death and dying become an increasing part of the day-to-day reality of residential care work (Holloway 2007; Smith 2013). In this respect, residential homes must not be left ritually void but, rather, must be symbolically well-resourced if they are to cope with the trauma of death both for the dying and the bereaved.

But what symbolic resources do those working in residential homes draw upon in order to tackle death's disruptive force? How do they mourn? And is this in accordance with the principles of moral individualism? How might the organisation of work prevent the carrying out of the ritualistic practices required to mourn the loss of the individual? It is to these questions that I will now turn, examining the treatment of individuals who were dying, and those who had died, at Millstead and Shorefield.

Dying: Sacredness, Sequestration, and Symbolic Systems

During the year which I spent at Millstead and the year which I spent at Shorefield, I observed and participated in the care of several dying residents. The number of Millstead's residents who died during my year of fieldwork at the home was around the same as that during my year at Shorefield, despite Shorefield having twice as many residents. The higher rate of mortality amongst Millstead's resident population, however, was most likely because this population had higher dependency levels (and, by association, morbidity levels) than Shorefield's residents. In addition, during my year at Millstead, the home took on a number of new residents who had been diagnosed (by a GP) as being in the final stages of their lives.

When a resident is in the final stages of a terminal illness, it is frequently not possible to transfer them into a wheelchair. The person's weakness and fatigue become so profound that they are unable to remain in a sitting position. The result is that, at both Millstead and Shorefield, residents most often spent the final stages of their lives within their own bedrooms and did not enter the communal areas of the homes. Despite this similarity, however, there were marked differences in the routines and rituals surrounding dying in the two homes.

Though, at Shorefield, a resident's condition in the final stages of life often meant that they would remain within their own bedrooms, this confinement to private space did not result in the person being left alone. In fact, there was a transformation in the care provided to a resident – both practically and symbolically – from the moment that they were deemed (normally by a GP) to require end-of-life care. In the following fieldnote, I describe the care provided to one dying resident, Jill, in the days preceding her death:

Over the past few weeks, Jill's condition has gradually deteriorated. She has stopped eating, has become very sleepy and we are unable to hoist her into a wheelchair. The GP has said that Jill is unlikely to survive into next week. In morning handover, Olivia, the lead carer on shift, tells us that Jill must receive one-to-one care for the remainder of her life. We will take it in turns to sit with Jill for two hours each and to note down anything that she says or any change in her condition. As I enter Jill's room, I notice that one of her CDs is playing. I take over from Fleur – another carer – who tells

me that she has massaged Jill's hands and painted her nails. There are fresh flowers on Jill's dressing table and her patio door – which looks out on to the garden – is open. In the two hours that I sit with Jill, I note down when she responds to me, sponge fruit juices into her mouth, and apply lip salve to her lips. When sleeping, Jill's chest rattles, her mouth falls open, and she breaths heavily, but she is spoken to as though she is able to engage in conversation. Another resident, Sylvia, comes to visit Jill to say goodbye, as does another carer who is on her break. Each sits and talks to Jill whilst holding her hand.

Shorefield Fieldnotes

The care of Jill in the days leading up to her death, described above, involved a series of rituals. The massaging of hands and the applying of lip salve, whilst a response to practical concerns about dying residents' chapped hands and lips, for example, also functioned to humanise and show deference to the dying resident. Other practices which moved beyond hygiene maintenance and pain reduction included the constant one-to-one care of the dying resident, the placement of fresh flowers in their bedroom, the use of a diary to mark (social rather than medical) events in the dying process, and the holding of hands. These practices, by symbolically attending to the residents' suffering, reaffirmed their sacredness as persons.

At Shorefield, staff, as well as residents' families, were informed when a resident was dying and were given regular updates on their condition. The resident's room was never empty; care workers would take it in turns to sit with the dying resident (if this was the resident's request) and would only leave their room when another worker was present to relieve them. Measures were taken by Shorefield's managers and care workers to ensure that dying residents remained integrated into the collective life of the home, even if they were physically separated in their bedrooms. With the dying resident's permission, for example, other residents would be updated on their condition if they requested information and, equally, dying residents would often be visited by friends whom they had made at Shorefield. Rather than being sequestered or subjected to a 'social death' (Blauener 1966; Sudnow 1967), Shorefield's residents remained part of the collective life of the home, even when their death was imminent.

Whilst some of the rituals undertaken when a resident was dying took place in all instances of end-of-life care at Shorefield, others were specific to individual residents. As part of the home's 'move-in procedure', residents and their family members were encouraged to disclose the nature of the end-of-life care they would like to receive. Shorefield's sales manager, Cliff, alongside the resident's designated carer would make note of the preferences in their Individualised Service Plan (ISP); for example: whether the resident would like to die at Shorefield or elsewhere; if they would like to listen to music; which family members or friends they would like to visit (and who they would not like to visit); and whether they would like to be given last rites or visited by a priest.

Shorefield's advanced care planning meant that the care of dying residents at the home was personalised; it was dictated by the individual resident and/or their family. In sticking to these plans in the event of a resident's dying, care workers were able to sustain the individual's identity as well their connections to others both at Shorefield and outside of the home. Residents often disclosed a preference to stay 'at home' (at Shorefield) when dying and, equally, several had requested not to be resuscitated in the event of their heart stopping. As such, the admission of dying residents to hospital was often actively discouraged at Shorefield. The fieldnote below documents how Shorefield's care workers responded to the news that a resident had died in hospital, against her own wishes:

Marilyn, a terminally ill resident who has lived at Shorefield for five years, had opted to stay at Shorefield in the final days of her life. Last night, Marilyn was struggling to breathe. An ambulance had been called to the home for another resident who had had a fall and the care workers on the night shift called the paramedics to Marilyn's room. The result was that Marilyn was taken to hospital where she died around two hours later. I'm now in handover and the night shift staff are informing us of what happened. Arlene, who is the lead on this morning's shift, is angered at the fact that Marilyn was admitted to hospital. 'She didn't want to die in hospital. She wanted to die in her home', she says. The other care workers interject 'why did they take her?'; 'we should have been with her'; 'she died alone'; 'what was the point in admitting her?'

Shorefield Fieldnotes

Though the care workers at Shorefield were upset at the loss of Marilyn, they were also angered by the circumstances of her death – both because of its location outside of the home (against Marilyn’s wishes) and because of its subjection to medical intervention. The day after Marilyn’s death, Shorefield’s management set up, what they called, an ‘inquiry’ to examine why Marilyn was admitted to hospital. As occurred in Marilyn’s case, Shorefield’s staff often framed the hospitalisation of dying persons as something which was harmful to those already suffering, and as something which prevented the ‘good death’ of a resident. Shorefield’s care workers perhaps disagreed with the hospitalisation of dying residents both because it went against the individual’s wishes – ‘she wanted to die in her home’ – and because it precluded their carrying out of the symbolic behaviours required by the residential community to uphold the dying person’s sacredness – ‘she died alone’.

Given that the hospitalisation of dying individuals has been considered a common form of sequestering death (Blauner 1966; Clark 1993), Shorefield’s care workers’ distress at Marilyn’s admission to hospital could also be read as indicative of her continued engagement in the collective life of the home. Marilyn’s status as ‘resident’ – and, likewise, her status as ‘dying person’ – had not, by this account, led to a reduction in her social worth or sacredness. Instead, it was Marilyn’s admission to hospital that, by sequestering her from the home, caused her to die a ‘social death’.

Care workers at Shorefield were keen to reaffirm dying residents’ status as persons. However, at Millstead, a resident’s dying did not trigger a change in the activities of caregiving. There was no increase in the time spent caring for dying residents and, likewise, there was no visible carrying out of symbolic work. In the fieldnote below, for example, I describe how one resident at Millstead, Judith – who, according to the home’s care staff, had spent over two years at the ‘end of life’ – was treated by care workers:

Judith, a resident who doctors reportedly said was at the end of life over two years ago, is bed bound and remains in her room all day. Judith calls and shouts indiscernible phrases throughout the day but, despite this, the care workers do not engage with her. Aside from being washed, dressed,

changed, and fed, Judith's only contact with the rest of the home is through the steady stream of care workers entering her room to pick up or drop off the hoist, charge its batteries on racks in the corner of her room, or drop off and collect wheelchairs. This is all carried out as though Judith is not in the room. The care workers rarely look up to greet her, knock on the door, or appear to notice her hands raise from the bed as they enter.

Millstead Fieldnotes

As I mentioned in chapter five, Judith's room was also used by care workers to take a quick break, eat a snack, or chat amongst themselves, as it was one of the few spaces which they knew Mrs G would not enter. All these activities took place as though Judith was not present. The care which was provided to Judith – washing, dressing, changing, feeding – did not depart from the standard routine of personal caregiving at Millstead. Whilst care workers at Shorefield placed fresh flowers and played music in the rooms of dying residents, Judith's room was used as a storage space for large lifting equipment and spare wheelchairs. Millstead's care workers' disregard for Judith's private space, and her presence within it, though astonishing, mimicked the treatment of other, healthier residents. In chapter five, for example, I described how Pat's bedroom was freely used for its hot water supply and Billy's bedroom, situated in close proximity to the resident lounge, was used as a communal toilet during the day.

Millstead's care workers' lack of ritualistic behaviour surrounding the dying did not appear to disrupt the established social order within the home. In contrast to Shorefield's care workers, who carried out additional (and often time-consuming) symbolic work for dying residents, Millstead's care workers did not distinguish between 'end-of-life' care and regular caregiving activities. The mundaneness with which dying residents were treated at Millstead was unmistakable. Since the dying of Millstead's residents was not responded to with ritual work on the part of the home's care workers, we can assume that the anticipated death of residents and, likewise, their discernible suffering did not pose a threat to the home's social order. This lack of ritual work suggests that Millstead's residents were persons who, upon moving into the home, had already died a social death and who, in turn, approached their biological deaths with limited expectations (Sudnow 1967). That Millstead's residents had been 'sequestered' from society upon entry to the home

was discernible in a number of practices. In my year at the home, for example, I rarely saw a resident leave the building, outings were not organised, and several residents were not visited by family members or friends.

However, practices occurring *within* Millstead itself acted to further sequester certain residents. These practices – which placed a boundary between residents who were considered as ‘close to death’ and other residents – included the separation of ‘early eaters’ from ‘late eaters’, described in chapter four, and the confinement of certain residents, like Judith, to their bedrooms. Similar sequestration practices are discussed at length elsewhere, including Froggatt’s (2001) research on nursing homes and Hockey’s (1990) study on residential homes.

Millstead’s framing of residents as ‘non-persons’, as shown in the previous two chapters, allowed the home’s management and several care workers to view dying residents as inefficiencies which disrupted the usual pattern of work in the home. In chapter four, I described how, when Millstead’s residents asked for assistance outside of the home’s set routine, several care workers either refused to help or, alternatively, made clear to those residents that they were felt to be a burden. This meant that it was often when residents were at their most vulnerable – such as when they were dying – that they bore the brunt of ill-treatment and neglect. In the fieldnote below, for example, I describe how one senior carer at Millstead, Erica, responded to a dying resident, Alfred:

I am working with Erica as a double. Erica has a reputation, amongst both the carers and residents, for being unkind to the residents. We are looking after Alfred, a resident who has come to the home for (what are expected to be) the last few weeks of his life. He requires end-of-life care, but the care which we provide to him is exactly the same as that provided to other residents. Erica is in Alfred’s bedroom and has removed his bedclothes by the time I arrive to assist her. Alfred is lying naked and uncovered on his plastic-coated mattress as Erica dunks a flannel in a washing up bowl full of lukewarm soapy water and rubs it across his body. His curtains are open and you can see out into the garden. The room is rather cold. Erica does not talk to Alfred as I help her to dry his body (with a small hand towel) and dress him. Erica enters Alfred’s *en suite* to empty the bowl of soapy water. As I am pulling Alfred’s sheets back over him, Alfred says ‘I want to die’.

Erica walks back into the room towards Alfred and, looking into his eyes for the first time, says 'go on then please'.

Millstead Fieldnotes

Callous remarks like Erica's were not a common occurrence at Millstead, but there was an ugly undercurrent of irritation and disrespect that seemed to pervade the care workers' relationships with the residents. A characteristic trigger for expressions of resentment was residents' call bells. The limited time available to complete even the normal daily workload at Millstead meant that, when a resident's needs required a change in the schedule, the care workers became more strained. It appeared that one consequence of this was that several care workers had come to see the more intimate and unpredictable demands of end-of-life care as beyond their duties. The result was that, when a resident was dying, senior carers would frequently call-out the local GP whom they would, in turn, encourage to admit the dying or sick resident to hospital. The following fieldnote describes this practice in the case of one dying resident, Dulcie:

Dulcie has terminal lung cancer. Over the past few days, she has been ringing her call bell more frequently – around once an hour. Often, when we answer Dulcie's bell, she tells us that she would like someone to sit and talk to her or to offer her reassurance. There is so much work to do that, usually, care workers only have enough time to rush into Dulcie's room, reset the call bell and tell her that they are busy, before leaving. During a handover on Monday, Marta (carer) told Adelina (head carer) that she had 'had enough of cancelling Dulcie's bell' because Dulcie 'just wants to talk' and there was not time to do this. Adelina responded by saying that she would ring the GP again to see whether Dulcie could go to hospital. At Adelina's request, the GP has visited Dulcie three times in the past four days. Several carers have asked Adelina to arrange these appointments, in Marta's words, 'to send her in'. This morning, Dulcie was admitted to hospital. When we are informed in the afternoon's handover, Mahesh says 'that makes it [the shift] easier for me' as he teasingly grins at Rosanna, who must care for another dying resident.

Millstead Fieldnotes

This practice of encouraging, and sometimes celebrating, the hospitalisation of residents stands in contrast to the distress I observed among Shorefield's care workers when a dying resident was admitted to hospital. As indicated in chapter four, Millstead's care workers did not have the time required to meet both residents' physical and emotional needs – meeting the former was, thus, regularly

prioritised over the latter. Though care workers were often aware that a dying resident did not require or desire being admitted to hospital, hospitalisations functioned to eliminate any impact which their additional needs might have on the (already overworked) care workers. Here, residents' needs were experienced by the care workers as units of work. In her work on geriatric medicine, Latimer (2000) noted how, in medical settings, the constituting of an older person's needs as 'social' could lead to their exclusion from the medical domain. Unlike the medical practitioners in Latimer's study, who attempted to 'socialise' disease, however, Millstead's care workers made attempts to 'medicalise' dying residents, a process which functioned to exclude them from the residential home. These attempts were often successful. It was, as such, not uncommon for dying residents to be admitted to hospital, and not necessarily because of clear 'medical' needs. In fact, in the year I spent at Millstead, of the twelve residents who died, just two did so when present in the home.

What is clear when examining the treatment of the dying at Millstead is that, alongside the meeting of residents' emotional needs, symbolic work concerning dying was a casualty of work overload. Rituals take time and, given the lack of time available for care workers to carry out the symbolic work required to deal with death appropriately, it is perhaps unsurprising that alternative measures were taken to eliminate death's disruptive force. Admitting residents to hospital functioned to remove the visibility of death – to sequester and deny it. The call bell, a continual reminder of residents' dying, could not be dealt with through symbolic (nor practical) work, and hospitalising a resident was one way to remove this reminder. As Ariès (1981: 583) wrote in his eminent book on the history of death, the medicalisation of death is 'the final stage in the process of [death's] reversal' – from being normal and accepted to being banished.

The hospitalisation – or banishment – of those who were dying at Millstead acted not only to deny death, it also had both temporal and economic implications. Having one less (dying) resident to care for reduced the amount of work and, by extension, the number of care workers required on a shift. Furthermore, when a resident is admitted to hospital for a short amount of time, a residential home is

still able to charge for their care. It was, therefore, also in the proprietor's financial interest to admit dying residents to hospital.

But what happened when residents *did* die in the two homes? In the following section I examine how care workers at Shorefield dealt with the loss of a resident who was still a member of the group and how, in contrast, care workers at Millstead managed the visibility of death.

Caring for the Deceased: Honouring Individuals, Washing Bodies

The carrying out of personal care of the deceased is customary in all residential homes. The resident's body must be washed and dressed in preparation for their transfer to the mortuary or funeral home. This is to prevent the leakage of fluids from the deceased in line with infection control procedures. The manner in which these personal care tasks were undertaken was, nonetheless, distinct in the two homes I studied. Most notably, activities, often taking the form of rituals, which went beyond the physical preservation of the deceased's body, were carried out at Shorefield but not at Millstead.

When a resident died at Shorefield, care workers would usually be aware of the death before starting a shift – either by means of social media or text messages from care workers sent to colleagues when they were not at work. Handover would begin with the announcement that a resident had died and, if the deceased's body had not yet been removed from the home, care workers would pay visits to them. The following fieldnote describes events at Shorefield following the death of one resident, Norah:

At around 4am this morning, Norah died. We are informed of her death in the morning's handover which starts at 7am. Though her death was expected, the care workers appear shocked and upset. Karina asks 'who cared for her?' and Sara replies 'It was Sue and I. She looks nice and peaceful'. The carers who have just started their shift thank Sara and ask if she is okay. Norah's body is still in her bedroom as the funeral home cannot be called to collect her until a GP has confirmed her death. Before the GP arrives at 9.15am, several care workers and residents visit Norah's body to 'say goodbye'. Norah is lying on her back in bed. A single white sheet covers her. It is folded down beneath her arms and is tucked under the mattress. Her hands have been placed on top of one another and beneath them sits a small bunch of fresh lavender which is tied with a ribbon. Though her

mouth has fallen open, her eyes are closed and her hair has been brushed. The door to Norah's *en suite* has been closed, a bedroom window is ajar and net curtains are pulled over the patio doors. The breeze keeps catching the net curtains. The room is silent. I have entered Norah's bedroom with Hannah, another carer. She approaches Norah and kisses her forehead before stroking her hand. She sits on a chair alongside Norah's bed and remains silent with her head bowed for several minutes.

Shorefield Fieldnotes

As the description of events after Norah's death makes clear, the manner in which care of the deceased was undertaken at Shorefield went beyond the practical or hygienic requirement of the task. When a care worker asked 'who cared for her?' in the morning handover following Norah's death, they were asking who had been present at the moment of Norah's death and, by extension, who had undertaken this care. Sara and Sue had washed and dressed Norah in preparation for her departure from the home but, also, they had carried out several more symbolic activities: the brushing of Norah's hair, closing her eyes, placing fresh lavender in her hands, and opening a window. Similar death rituals were described in Adams' (1992) research on the role of the neighbourhood 'layer-out' in the 1920s and 1930s, a role which she contrasted with the 'casual and off-hand treatment' of the deceased by morticians:

The body [after being washed] was then left for an hour, with the window left open for the soul to escape along with any unpleasant odours of the sick room ... the tasks seems to have been performed with "a lot of compassion and care, making them nice for wherever they are going"... Friends and relatives would call to pay their last respects to the deceased. (1992: 159-160)

Deceased residents at Shorefield, like Norah, were also paid 'last respects' by the home's staff and, sometimes, by family members and other residents. Hannah's kissing of Norah's forehead, stroking of her hands, and head-bowing, for example, were respect-giving rituals which were repeated by other care workers who visited Norah. These death rituals, which displayed demeanour and self-restraint, preserved the dignity of the deceased individual in the eyes of the bereaved. Rather than an empty vessel to be disposed of, Norah's body was treated with a kind of sacredness.

As was the case for layer-outs in Adams' (1992) study, the details of the death rituals carried out at Shorefield were not formally codified in the form of induction training but, rather, they were passed on informally and somewhat sporadically between the care workers. We see here the importance of staff retention to the slower and more subtle transmission of moral norms. After I had worked at Shorefield for several months, I was present in the care office when Olivia, a lead carer, told Jess, a new recruit, what she should do if someone died on her shift:

Olivia asks if Jess is aware of what to do when a resident's family must be contacted. Jess says that, 'yes', she knows when to ring family members, but she's not 'one hundred per cent sure what to do when a resident passes away'. Olivia asks 'do you mean with ringing them [the family] or about the resident?' Jess responds saying that she thinks that she knows what happens after a resident's death, but that she has not directly dealt with the death of a resident before. Olivia reduces the volume of her voice and informs Jess that the care workers have to carry out personal care on the deceased – 'give them a wash, change their pad and put their best clothes on'. Jess seems surprised, exclaiming 'we have to do that?!' Olivia continues, explaining 'it's our job to make them look nice for the family'. She goes on to tell Jess that the deceased resident's room should be cleared of empty glasses, tissues, gloves, and laundry. The bedroom window should be opened slightly to keep the room cool. The resident's bed sheets must be changed, but Jess should make sure that the resident does not 'look trapped in the bed or covered up' and, if possible, she should find some fresh flowers to place in the resident's hands or on their pillow.

Shorefield Fieldnotes

When experienced care workers imparted the routine and series of rituals which care workers were to follow after a resident death, as Olivia did to Jess in the occurrence described above, much emphasis was placed on the appearance and imagined 'comfort' of the deceased resident. When Julie, a carer, outlined how I should undertake personal care of the deceased, for example, she encouraged me to treat the resident 'as though they're still alive'. Likewise, when Clarissa, a care worker in Esterton, was asked to describe the tasks she carried out after a resident death, she said:

We wash them. Because the body, when people die, the body usually leaks fluids ... we change the pads and give them a wash and make them straight and comfortable. We still care about them like they are alive ... we don't cover their face or something like that ... [Their room] stays the same until

the family comes to collect their things ... It's a different kind of work isn't it than office or (laughs)? It's with people.

Clarissa, Albany Lodge

In a curious inversion of how residents at Millstead were treated, one might say that the biological death of residents at Shorefield and homes like Clarissa's was considered to *precede* their social death. An element of the person was still viewed and, by extension, treated as though it was still present in the resident's room. This entailed talking to the deceased resident, dressing them in their preferred clothing, and ensuring their comfortable positioning. It was in these acts that the person's sacredness continued to be upheld.

This practice of treating deceased residents 'as though' they were still alive was observed in many of the activities which Shorefield's care workers undertook between a resident's biological death and their physical departure from the home. The following fieldnote, for example, describes the activities which were undertaken by staff and residents at Shorefield during the removal of a deceased resident, Agnes's, body:

Martin, a carer, comes upstairs to the care office to inform the other care workers that the funeral director [mortician] has arrived. We immediately head downstairs to the lobby. We inform residents who are in the communal Café that Agnes is going to be taken by the funeral director and that, if they wish, they can stand with us in the lobby. Residents and members of staff form two lines [a guard of honour] leading to the front door of the home. Agnes is wheeled out of her bedroom and down the corridor. She has been placed in a red velvet body bag with gold tassels and is lying upon a gold stretcher gurney. As she approaches, the lobby falls silent and, as her body passes, residents and staff bow their heads. She is preceded by two members of staff who open the double entrance doors. For a moment, the lobby remains quiet and heads remain bowed. When the two members of staff who have been assisting the funeral director re-enter the building, everyone quietly returns to their previous activities.

Shorefield Fieldnotes

The heavily ritualised practices which marked the removal of Agnes' body from Shorefield following her death, described above, were undertaken in the same way each time that a deceased resident's body was removed from the home. Moreover, these ceremonial displays of deference and self-restraint were performed in communal areas of the home. Residents and members of staff would

silently form a guard of honour in the home's reception area and bow their heads as the deceased's body was wheeled out of the front doors of the home. Since Shorefield's residents were still treated 'as though' they were alive following their biological deaths, it was perhaps in the event of their physical removal from the building that their 'social death' occurred. This occurrence signalled the loss of the deceased individual from the collective life of the home and, as such, it is perhaps unsurprising that it was marked by further symbolic work; work which functioned to convey and reaffirm the solidarity of the group.

At Shorefield, I was able to observe the activities and interactions of care workers following a resident death. At Millstead, in contrast, I was not present at the time of either of the two resident deaths which occurred within the home during my year there. In consequence, I asked several care workers about what normally happened when a resident died in the home. Their accounts did not depart far from that given to me by Marlene, a senior carer at Millstead, whose account I have paraphrased below:

Marlene: You come and tell us about it and we ring the GP to come and see them. You've got to wash the body. Make it clean and put the clothes on it. Two of us do that because you've got to roll it and it's really heavy. It's not a nice job.

Me: What about when they come to collect the resident? What do we do?

Marlene: Oh, you've got to go and help them lift it [the body] on the trolley. Make sure nobody [the residents] sees... so close the doors when you take it out.

Me: How do we leave the building?

Marlene: You just go the quickest way – so maybe patio door, maybe by the cleaning trolley [the door which we use to access the external clinical waste bin], then they [the residents] won't see it.

Millstead Fieldnotes

In Marlene's account of the routines expected to take place following the death of a resident at Millstead, presented above, there was a notable lack of sentimentality and minimal use of personal pronouns. The care of deceased residents at Millstead, described by Marlene, did not appear to extend beyond

standard infection control procedures. The care workers would carry out basic personal care on the deceased (washing and dressing) before leaving the resident in their bedroom until the funeral director's arrival. Staff did not visit the deceased resident other than to carry out these tasks. At Millstead, personal care of the dying was a practical, rather than symbolic, undertaking for, having died a social death, it was only the biological death of the resident which had to be dealt with. The deceased resident, who was not treated as sacred prior to death, did not become sacred after death either. This lack of care was clear in the manner in which Marlene referred to the deceased's body as 'it': the body was not afforded any kind of personhood.

When a resident's attachment to the collective (both outside of the home and within it) has been severed prior to death, mourning rituals (as a way to reaffirm the collective) are not required, for any loss to the group has already occurred. Something notable, however, was the importance which Millstead's care workers placed upon being discreet when moving the bodies of deceased residents. In fact, *every* care worker in Esterton whom I spoke to about the practices occurring in their places of work after a resident death described a similar emphasis on removing the bodies of deceased residents 'very discreetly out the door so that nobody knows' (Angela). In practice, this required that 'all the doors [to communal areas or other residents' bedrooms] were closed' and that care workers removed bodies via 'the nearest exit' (Donna). Often this exit would be a side or back entrance, since 'if you went out the front door, you'd have to go past the public lounges' which would result in 'everyone chatting ... and be[ing] like "oh God, there's a dead person"' (Grace).

At Millstead, moving the bodies of deceased residents discreetly was far from the day-to-day practice of personal care at the home which, as discussed in chapter five, did not involve any notable boundary work. This suggests that, after death, boundaries were not placed around the deceased's body in order to establish or reaffirm the individual's sacredness. Instead, Marlene's emphasis on the need to conceal the deceased's body from other residents was, more likely, due to the cadaver serving as a reminder of death; a reminder that Millstead's residents were

dying. Since the residential home lacked the symbolic resources required to deal with death's threat to the group, it became necessary to sequester the bodies of deceased residents.

Making Sense of Death: Collective Repair and Continuation

Up until now, my focus has been on the events leading up to residents' biological deaths at Millstead and Shorefield, as well as those activities which immediately followed death. Differences in the availability of material and moral resources to care workers, as well as differences in how (or if) residents were integrated into collective life in the homes, meant that the dying and death of residents signified different things for Millstead and Shorefield's care workers. For care workers at Shorefield, death wounded the group and, in consequence, it required activities of collective repair work. For Millstead's care workers, on the other hand, death did not signify more than the biological termination of life and, so, was met with practical (and financial) concerns about workload and the reoccupation of resident bedrooms. Below, I explore the activities which followed residents' deaths in the two homes further.

Since Shorefield's residents often chose to die at the home rather than in hospital, the home's care workers were frequently required to deal with and make sense of death. In what follows, I describe how the home's staff sought to find meaning in the timing and circumstance of the death of one resident, Hettie, to whom they were very close:

Hettie was admitted to hospital last week, following a stroke, but has not recovered her capacity to swallow. Hettie's family have decided to have her transferred back to Shorefield so that she can die at the home, rather than in hospital. Despite Hettie's age [95], her sudden decline was unexpected. The care workers have said this several times – 'it's too soon', 'she had so much life left in her', 'she wasn't ready for this' – and they seem rather shocked. One of the housekeepers, Emma, was informed by a senior carer that Hettie's breathing had deteriorated and she came to Shorefield on her day off to sit at Hettie's bedside. It was whilst Emma was at her bedside that Hettie died. Later in the day, Emma comes to the care office and relays the story of Hettie's death to the care workers. Hettie loved to watch Jeremy Kyle so, at 11am, Emma made sure to switch on the television since she had missed a whole week of the programme, having been in hospital. Eleven minutes later, as Hettie's daughter, Lizzy, entered

the building, Hettie took her last breath. A strong breeze swept through the room 'out of nowhere' and Emma knew that this was 'her going'. Emma waited for a moment before standing from her chair to inform a senior carer of Hettie's death. As Emma entered the corridor, Hettie's daughter, Lizzy, was walking towards Hettie's bedroom. Emma stopped and looked up at Lizzy and shook her head to signal that Hettie had died. Lizzy approached Emma and hugged her. As Emma relays the story of Hettie's death to us, she and the other care workers speculate that Hettie 'must have not wanted her daughter to see her go' or 'she must have been waiting for Lizzy to get here' and 'sensed that she was here'.

Shorefield Fieldnotes

Viewing death as something which is, in part, controlled by the dying individual was common at Shorefield, and it was interesting to hear how the care workers used sentimental and imaginative stories to integrate the resident's death into his or her personal life-narrative. Care workers would often remark that a resident 'was holding on to say goodbye' – be it to a relative who had not yet visited or to another resident. Likewise, when residents did die, the care workers would often comment that 'he chose for X not to see them like that' or 'she wouldn't have wanted to upset X on that particular day'. Similar stories were relayed to me by some of the care workers whom I interviewed. Kelly, for example, described an instance where she visited a dying resident on her day off, saying 'I sat in that room just holding her hand, talking to her, and about half an hour after I left her she dies... it was like she was waiting to say goodbye to me'.

At Shorefield, though care workers would often remark that residents were 'ready to go' or 'ready to die', this readiness was not framed in terms of the increased burden which the resident's needs might have on the care workers but, rather, in terms of the resident's prolonged suffering. The care workers would often discuss the 'unfairness' and 'cruelty' of this suffering and disclose that they hoped for its conclusion. Death, as the only solution to such suffering, was presented by the care workers as both a welcome relief and a dreaded fate.

Care workers' descriptions of resident deaths at Shorefield were full of symbolism. There was a clear distinction between the accounts of dying written in residents' 'daily notes' (which would indicate what personal care was provided to a resident) and the notebooks kept in a dying residents' bedrooms (where inferences would

be made about the resident's mood or thoughts). Following a resident's death, this bedroom notebook would often be passed on to the deceased resident's family. Residents were also involved in collective efforts to mourn the individual. A memorial card and photograph of the resident would be placed in the communal Café after each death, regardless of whether this had occurred at the home or in hospital, as documented in the following fieldnote taken on the day of Hettie's death:

This morning, a memorial card reading 'with sympathy' was placed on the counter in the communal Café. The card stands next to a large picture of Hettie, which was taken when she moved into the home⁵⁸. The card has already been signed by several members of staff and residents. The messages are personal, using nicknames, terms of endearment, and offering anecdotes and remembrances.

Shorefield Fieldnotes

These messages, displayed alongside a photograph of the deceased resident, were a way to mourn the loss of a group member *and* the loss of the individual. Likewise, staff and residents would openly discuss the deceased individual, commenting upon their character traits and friendships with other residents. These stories often took the form of eulogies, honouring and paying tribute to the individual who had died but, also, presenting the deceased's life as a journey which had come to its natural end. Here, drawing upon the linguistic and symbolic resources available to them, residents and care workers at Shorefield were able to talk about and deal with death in a meaningful way: by honouring the individual. At the same time, the rituals carried out by the home's staff and residents allowed the group to come together and reaffirm itself.

Following the removal of a deceased resident at Shorefield, their room would be cleaned and emptied of personal care materials – incontinence pads, toothbrushes, gloves – the door would be locked and would not be entered by

⁵⁸ These photographs were routinely taken as part of Shorefield's move-in procedure and were displayed on resident's ISP to assist new recruits in identifying residents. Residents would only ever see these pictures when they were re-printed and displayed following a resident's death. The display of these pictures was such a clear part of the home's mourning ritual that, when I was tasked with taking updated photographs of the residents, one resident said 'oh is this the one you're going to put up when I die? Let me get my lipstick!'

members of staff or other residents. Deceased residents' families were charged for the occupation of their bedroom until it was cleared of possessions and, often, bereaved families would visit Shorefield to carry out this task during the week following their relative's death. Since delaying or halting the payment for deceased residents' rooms would have aligned more closely with the moral ethos of the care workers – providing the community with more time to mourn – it is unsurprising that Shorefield's care workers frequently expressed their disagreement with this practice.

It was only when a deceased resident's family came to collect their possessions that the room would be unlocked and entered⁵⁹. It was also on this occasion that the care workers would usually be informed of (and often invited to) a resident's funeral. Residents' funerals, if held locally, were always attended by at least one care worker and attendance was, most often, organised by the care workers themselves. On other occasions, several members of staff would attend a resident's funeral. In the following fieldnote, I describe the events which took place before, during, and just after a resident, Bill's, funeral, which was attended by several care workers:

Last week, Bill, a resident who lived at Shorefield with his wife Teresa, died. The couple's family requested that as many of us [care workers] as possible attend the funeral. Bill and Teresa's family organised the funeral for 3pm so that those who had worked the morning shift can attend. Bill's funeral is today and eight care workers are driven to the funeral in the company minibus by Tim, Shorefield's minibus driver. Amanda, Shorefield's general manager, also attends the funeral but drives there in her own car. Fleur, a carer, is unable to attend as she is working the afternoon shift, but she gives Jade, another carer, a single red rose to place on Bill's grave. Bill has been cremated prior to the ceremony and his urn sits on a table at the front of the room. The funeral ceremony is notably composed. Bill's eulogy, read by his son, outlines his various occupations, where he has lived and lists his family members. A poem is read by Bill's daughter before the family forms a procession, followed by the rest of the mourners, to Bill's burial site. Though there is no crying in the service – from Bill's family or otherwise – there is one clear display of sadness by the care workers at Bill's burial

⁵⁹ If a resident's family came to collect their possessions 'too soon', they would be criticised by the care workers for being 'uncaring' or 'money-grabbing'. This was particularly the case if they also enquired about the payment of care fees and/or if they had not frequently visited their relative prior to their death.

place. June leans down to place Fleur's rose on his urn. As she does this, she catches a glimpse of a flower placed on the urn with a note from Bill's wife, Teresa. The note reads 'wait for me Bill, I won't be long'. Fleur moves away from the urn and approaches the other care workers, informing them of the note. The other care workers do not cry but look upset and hug each other. Shortly afterwards, we are back on the minibus. We sit silently waiting for Tim to drive us back to Shorefield. Several care workers have glazed eyes but nobody makes a sound. As we wait, Amanda, Shorefield's general manager, steps onto the minibus and says 'thank you all for coming today. You did a great job. You've really done Shorefield proud'. The care workers do not respond, other than to glance in Amanda's direction to acknowledge that she has spoken. As the minibus leaves the burial ground, the atmosphere in the minibus is notably tense. Jess pipes up, angrily, 'I can't believe she just said that!' The other care workers nod and mutter in agreement. 'She doesn't have a clue does she?! She thinks we came here for her. I came here for Bill. To support Teresa... not because it's my job'. June tries to pacify Jess 'I think she meant it in a nice way...like we've made an effort kind of thing'. Ada chips in, 'who even says thank you to someone for going to a funeral? Like we were paid to come here or something'.

Shorefield Fieldnotes

For Jess, attending Bill's funeral may well have been for the purposes of collective repair as well as to honour Bill (the individual). Nonetheless, this 'collective' was not that specified by the company but by the care workers themselves – it was *their* moral community, and their attempts to re-establish it were done out of a sense of duty to the residents and, perhaps, each other, not out of a sense of duty deriving from their contract of employment.

Although Amanda expressed 'pride' in her workforce for their presence at Bill's funeral, care workers' attendance at residents' funerals was often a source of tension between the management and the care workers at Shorefield. Though families often requested that care workers attend their relative's funeral, workers were not permitted to do this when 'on duty' unless they could swap shifts with a colleague. When particular residents died – those whom the care workers had developed close relationships with, or those who had lived at the home for several years – there would often be care workers who wanted to attend the funeral but were unable to. There was a conflict here between the duty of care arising from the care worker's contract and a more personal sense of duty which went beyond this contract – the duty to mourn and honour the individual. It was not uncommon

for care workers, such as Fleur, to try and resolve this tension by sending notes or flowers to the deceased or their family via those who were attending a funeral. On other occasions, residents' funerals were followed by wakes – attended by resident's families and friends – which took place at Shorefield.

In contrast to the collective repair work which took place following a death at Shorefield, a resident death at Millstead caused minimal disruption to the care workers' daily routine. In fact, it was not uncommon for care workers who had not been present at the time of a resident's death to be unaware of the occurrence until hours after their shift had started. In the fieldnote below, I document how both care workers and residents were informed (or not) of the death of one resident, Eileen:

Tola, after being off sick for a few days, has been assigned 'singles' on the left hand side of the building and has started working in the usual manner – assisting Rosa onto the commode before washing and dressing her. At around 9.30am (almost 2 hours after commencing work), Tola enters the communal lounge, looks around at the residents, and asks 'where's Eileen? She's not in bed'. Occasionally, the night staff will assist Eileen into her day clothes and it appears that Tola is expecting to find Eileen dressed and sat in the lounge. Marlene, a senior carer, turns to Tola and says 'she's dead', before continuing to place side tables next to residents' armchairs ready for morning coffee. Tola looks shocked. She mumbles something sarcastic like 'thanks for telling me' before leaving the lounge. Later, I find another care worker, Elizabeth, in the laundry room. She is angry that she was not informed of Eileen's death either because 'my job is to help the residents ... how can I do it if I don't know if they're alive?' Later in the day, another resident, Betty, asks after Eileen and is told that Eileen 'isn't here today'.

Millstead Fieldnotes

Tola and Elizabeth's disgruntlement at not being informed of Eileen's death perhaps indicates that, whilst resident deaths at Millstead did not have a collective impact, they did result in some sense of loss for individual care workers. More cynically, however, their disgruntlement might be read as something more pragmatic – failing to inform care workers of a resident's death left them unsure of the size and content of their workload and (as was the case for Tola) meant time wasted looking for deceased residents. However Tola and Elizabeth's irritations are read, what is clear is that an absence of symbolic resources which care workers could have confidence in meant that death was largely ignored. In order to

sacralise death and dying, Millstead's care workers would have had to acknowledge death and, without the symbols needed to appropriately talk about and deal with death, they were unable to do this. Other care workers in Esterton similarly spoke about their discursive avoidance of death, particularly in the presence of residents. Whilst this silence was framed by some care workers in terms of the need to 'maintain confidentiality' (e.g. not revealing information about residents to other residents), the goal of maintaining confidentiality appeared to be to 'avoid upsetting residents' (Donna) rather than maintaining the privacy of the deceased. Sally, for example, described this practice by saying:

When they [residents] pass, we are not allowed to tell the other residents because it would upset them as well ... There were two ladies and they were very close and they lived in the room next to each other. And even when they were in the rooms, they would shout to each other and communicate like that all the time ... So when one passed away, the other really, really got into a depression. They didn't want to eat. They didn't want to talk. They were always emotional. Crying. For about a week or so. She realised because some of the carers were not confidential.

Sally, Stonecrofts Residential Home

Other care workers, in contrast, described how the practice of not being able to inform residents of the deaths of other residents could sometimes be upsetting in itself. Joanne, for example, said that she felt 'really bad' when she was not permitted to tell a resident that their partner, who lived in the same residential home, had died. Joanne said: 'She kept asking me about her partner. "Oh where is he? has he come to see me yet?" ... he has died but you can't really tell her that. It's just sad'. At Millstead, there were, however, occasions where death was discussed by care workers. This discussion often took the form of humour, as I document in the following fieldnote which relays the account of a caregiving interaction given by one carer, Agata:

Jack is a new resident who has come to Millstead from hospital and is likely to die within the next few weeks. He remains in bed but can communicate. Jack is alone in his room for most of the day, except when being fed, turned, or washed and dressed. His bedroom door remains open and looks onto the corridor which the care workers walk up and down to access each of side of the building. Often, you can hear Jack shouting from his bed 'I'm dying', 'let me die', 'I'm going to die', 'help me die'. Unless a care worker needs to carry out the above duties, Jack is mostly ignored. In handover,

when discussing Jack, Agata tells a story of a discussion she had with Jack where he said 'please kill me' to which Agata responded 'ok then'. Jack then said 'not now, maybe tomorrow?' The care workers present in handover appear to find this very amusing and laugh along with Agata.

Millstead Fieldnotes

It appeared that, though Millstead's care workers did not want to deny the existence of death, they were unable to discuss human mortality with good demeanour because they lacked the ritualistic vocabulary required to do this. Humour was one resource which the care workers could draw upon but, in doing this, death was made profane. A great deal has been said over the decades about humour in forms of worker resistance (Beynon 1973; Cavendish 1982), but less has been written about humour in relation to feelings. In the case of residential care, feelings are important, not least because to care well for someone is to feel for them, and to feel for them is to anticipate the misery of them dying. This anticipation is an imaginative exercise, facilitated by moral and intellectual resources by which, as Adam Smith described it, we find ourselves 'changing places in fancy with the sufferer' (1759/1976: 10). Smith's theory of moral sentiments argued, however, that this sympathy meets an obstacle and limit in a person's bodily sensations; 'a disappointment, or ambition, will', he wrote, 'call forth more sympathy than the greatest bodily evil' (1759/1976: 29). We sympathise more for an individual's loss of dignity or experience of moral distress, 'because our imaginations can more easily mould themselves upon [his/her] imagination, than our bodies can mould themselves upon [his/her] body' (1759/1976: 29). Bodies – particularly soiled, deceased or dying bodies – can often shock or repulse us with ugly sights or smells, and jokes may be a legitimate, if unedifying, way of displacing or repressing feelings of disgust.

Fevre's (2000) distinction between sentiment – which is the foundation for feelings – and common sense – which is increasingly used in sentiment's place – is useful here. For Fevre, jokes are the triumph of common sense over sentiment:

It is common sense and not love you will need to care for your elderly parents when they become incontinent ... Common sense prevents us from being transported by joy, but also keeps us from giving way to despair. It is where resilience comes from and it keeps us alive, gives us the ability to

look after ourselves and each other, keeps us whistling in the dark ... It cuts our fears down to size ... it keeps a sense of proportion in all sorts of ways but most famously by making us laugh – it is where *all* humour comes from. (2000: 80)

It is perhaps through the use of humour that care workers at Millstead made death manageable. One side effect, however, was that any ardent desire to minimise residents' suffering was diminished and such suffering was, instead, trivialised. This was particularly the case when residents who were suffering called out in pain, pressed their call bells more frequently, or expressed a fear that they would soon die. Much like Goffman's (1961) account of the depersonalising practices witnessed in asylums, Millstead's care workers often made sarcastic remarks about these residents, labelling them 'overdramatic' or 'crazy'. This, in turn, led to both practical and emotional care for these individuals being further withdrawn.

Whilst Millstead's care workers made attempts to manage death's force through the use of humour, the home's manager, Brian, responded to resident deaths by focusing on re-occupying deceased residents' bedrooms. In fact, the fieldnote below makes evident that, on some occasions, Brian pursued this endeavour prior to a dying resident's departure from the home:

Winston, who appears to be in the final weeks of his life, no longer attends lunch in the dining room and spends most of his time in bed. Brian has been talking to a middle-aged couple in his office. Prior to their arrival, he told Marta to vacuum and spray air freshener in the downstairs corridor. Brian walks the couple around the home, and around the garden (despite the garden not being used by residents). He proceeds to enter Winston's bedroom with the couple. I can hear him discussing the 'benefits' of the room – a window which looks out onto the garden and a hand basin. Winston remains in bed and does not appear to have been acknowledged by Brian or the couple.

Millstead Fieldnotes

Brian's attempts to recruit a new resident to occupy Winston's bedroom, described above, were mentioned later in the day by a (at the time, relatively new and often candid) care worker, Sorin, who said 'that man's going to hell, the greedy lying bastard'. At the time, it appeared that, for Sorin, Brian's sales pitch

overstated the qualities of the home⁶⁰ but, also, that entering a dying resident's bedroom to 'make the sale' constituted sacrilege. Other care workers in Esterton expressed frustration at the behaviour of their managers following resident deaths. Grace, for example, described the home where she worked as 'all about the money' because 'if someone is ill or if someone passes away, they'll say "oh, we've got to make sure we get our last cheque"'. Two months after expressing his anger at Brian's behaviour, however, it was Sorin who suggested that a deceased resident's bedroom – still full of her personal belongings, unwashed sheets and other personal items – be used to house another challenging resident. This suggests that the anomic culture of care at Millstead would eventually demoralise even the most conscientious of care workers.

Conclusion

I started this research expecting to find that – whilst higher cost care might offer more lavish accommodation, meals, and entertainment – there were important aspects of care that could not be bought without cheapening and degrading them. What I found, however, was an alarming gulf in the quality of care between a high-cost and a low-cost residential home, and this gulf was probably at its greatest in the way that care workers treated the dead and the dying. Douglas (1966) described the distinction between dirt and cleanliness not as a hygiene barrier but as a way of organising social experience in a collectively meaningful fashion. The boundary between life and death is rather different, however, because no matter how hard we try to sequester death and dying, the inescapable mortality of human existence haunts our experience of living, and death itself remains a living reality. It is the very porousness of the boundary between life and death that leads the treatment of the living to bleed into the treatment of the dead and vice versa.

At Millstead, where many of the residents appeared to have been condemned to a social and moral death, it was no surprise that the dying and the dead were often

⁶⁰ Similar claims of false advertising were made by other care workers in Esterton. When asked about how the residential home where he worked recruited residents, Mark said 'everyone will be put on high alert when we do have visitors ... we have to make sure that we're constantly smiling and keeping ourselves busy. Not that we're ever not busy ... they [the home] over-exaggerate some stuff'.

treated with disregard and indifference. At Shorefield, in stark contrast, care of the living was extended beyond the biological termination of life. Shorefield, of course, is part of a large corporation, which sells 'high quality' care because there is a profitable market for it. Shorefield's care workers and residents, on the other hand, were members of a community who, in their gestures and rituals of honouring, remembering and mourning the dead, made this high quality care possible. In the final chapter, I consider in more detail what the worlds of Millstead and Shorefield can tell us about the commodification of social care provision for older people in general.

Chapter 7: Discussion

The major impulse behind this research project was a concern that care in later life is subject to wide variations in quality, and that older people who are reliant on the public funding or subsidising of their care are at a much greater risk of receiving poor quality care. It was with this concern in mind that, in the preceding chapters, I explored how care was organised and delivered in a low-cost and a high-cost residential home. By examining the day-to-day work practices of care workers at low-cost Millstead and high-cost Shorefield, my intention was to consider what residents in each home were receiving in terms of the quantity and quality of their care. Moreover, I wanted to establish what such care – whether good, bad, or unexceptional – rested upon. What roles were played, for example, by management, training, material resources, and the normative and symbolic culture of work? Since previous research has indicated that the quality of care is linked to the quality of work conditions in residential homes, my pursuit of answers to these questions required that I examine the moral, emotional, and material stresses which are experienced and managed by care workers. Finally, taking into account the problematic divide between empirical and conceptual accounts of care, I drew upon sociological theory in order to explain and understand the drivers and consequences of the everyday practices and experiences of care workers.

In this final chapter, I consider, in light of my study, how we might think about ‘good quality care’ and what is essential for its accomplishment. I reflect on how the availability of the material and symbolic resources required for good care – language, space and materiality, time, collegiality, and a sense of community – have become increasingly entwined with its funding and costing. To conclude, I consider how we might manage the impact which the commodification of care, in shaping the availability of these resources within residential homes, has upon the equity of service provision for older people.

What is Good Care?

In chapter two, I considered how various scholars have conceptualised paid care work. A central argument within this literature is that good care is that which leaves the recipient feeling 'authentically' cared for, 'recognised and valued as an individual, emotionally supported, emphatically connected, or in shorthand, loved' (Folbre and Nelson 2000: 129). Stacey (2005) claimed that care of this nature was also good for care workers. She suggested that, in a society where caregiving is perceived by outsiders as unskilled and menial, care workers can craft a sense of dignity and self-respect by developing 'unique bonds' with their clients. By emphasising the personal relationship between care workers and those they care for, however, some scholars have been criticised for evaluating paid caregiving in terms of its likeness to, often idealised, family caregiving (Meagher 2006). Researchers have shown how, in a privatised care sector, the promotion of 'family-like' care can 'institutionalize an expectation of self-sacrifice' which creates a 'workplace culture ripe for the exploitation of ... care workers' (Dodson and Zinavage 2007: 922; Johnson 2015).

It was with the shortfalls of the 'family model' in mind that Meagher (2006) proposed the development of a more appropriate range of normative resources which paid care workers, their managers, care recipients, and society more broadly might draw upon when evaluating the quality of care. Meagher's suggestion was that paid care relationships *can* have a strong moral component, *without* being simultaneously harmful to care workers. This argument led her to propose three 'moral bonds' – contract, professional duty, and compassion – which might aid the development of ideals and practices of good care, yet she did not test the availability or appropriateness of these normative resources empirically.

By subjecting residential care work in Esterton to in-depth empirical analysis, my study provides the raw materials required to examine what normative resources – other than familial love – might underpin good quality care. Examining the contrasting forms of care work at Millstead and Shorefield, whilst also drawing upon the theoretical literature on care, morality, and interaction, I was able to

identify 'moral individualism' as an alternative normative resource which we might use both to promote and to evaluate good quality care. Unlike familial love, moral individualism does not rely on the presence of a pre-existing relationship between the provider and recipient of care. Moral individualism also departs from Meagher's concept of compassion in two critical ways, which I outline below.

First, although Meagher framed 'compassion' as a potential alternative to 'familial love', empirical research has shown that those working in the care sector commonly express compassionate care in the language of a family model of caring (Dodson and Zinavage 2007). This has resulted in compassion being framed as a natural female trait, the expression of which need not be required in care workers' pay packets (Ball *et al.* 2010; Johnson 2015; Kolb 2014). This is not to say that care recipients do not have a need for dignity and compassion. Indeed, this study has provided empirical evidence that a 'stronger culture of compassion' *is* required in residential homes (The Department of Health 2014: no page). Drawing upon Durkheim (1899/1978), however, we learn that respect, compassion, and care for actual persons can only be a by-product of the collective belief in the sacredness of *all* individuals. By shifting our focus from personal compassion to the ethos of moral individualism, we are able to reconceptualise compassionate care not as derivative of the natural traits of individual care workers but as a by-product of the collective beliefs of the environments in which they work.

Second, in Meagher's (2006: 41) account, compassion is described as a moral bond 'to which recognizing the human dignity and individuality of the care recipient is integral'. By broadening our focus from compassion to moral individualism, we are able to consider how such recognition might be extended beyond judgements about the needs or deservingness of individual care recipients. Compassion calls for moral regard and respect to be shown towards those regarded as having a need for care. Moral individualism, on the other hand, promotes *equal*

opportunities for this kind of treatment⁶¹. In this way, conceptualising good care as that which is aligned with the principles of moral individualism has allowed me to examine the quality of care provided to individual residents *and* to consider whether this care is extended to others.

In short, the concept of moral individualism offers us the tools with which to talk about, promote, and evaluate ‘good care’ – that is, care which makes the recipient feel ‘valued as an individual’ (Folbre and Nelson 2000) – in a way which does not ignore or sacrifice the humanity of care workers. Since moral individualism’s motive force is sympathy for all that is human, care workers are, by this account, the focus of the same morality as those in their care. Therefore, it is with the notion of moral individualism in mind that I dedicate the next section to discussing what is needed for care workers – accounting for the emotional, interpersonal, social, physical, and ‘dirty’ aspects of their labour – to care well.

What is Needed for Good Care?

By examining the activities, routines and rituals of residential care work – in light of the theoretical literature on morality, beliefs, and interaction – my study has revealed that good quality care is rooted in symbolic systems. Moreover, my analysis of Millstead and Shorefield makes clear that these symbolic systems do not emerge in a vacuum. This reaffirms Goffman’s (1956) argument that ‘well suited’ institutional environments are essential for the preservation of the sacred treatment of persons. Developing and sustaining a ‘well suited’ culture, which allows and encourages care workers to convey moral regard and respect for individual residents and each other, requires the presence of certain resources. Below, I outline what these resources are – language, space and materiality, time, collegiality, and a sense of community – what role they play in the provision of

⁶¹ To reiterate, this is not to say that Meagher’s suggested moral bonds – compassion, professional duty, contract – do not have a role to play in paid care relationships. In particular, and as Meagher anticipated, professional duty certainly encouraged some care workers in this study to feel a shared sense of responsibility towards residents. On the other hand, there was not much evidence that care workers’ employment contracts provided normative underpinnings for their relationships with residents. This was perhaps because of the specific context in which this research took place. Unlike home care workers, who sometimes enter into a direct contractual relationship with individual care recipients, in the case of residential care, care workers are employed by the residential homes where they work.

good quality care, and, critically, how their presence or absence has become closely tied up with the funding and cost of care. This list does not account for *all* kinds of care, but it does provide a sense – in a context where care is difficult to theoretically or empirically pinpoint (Thomas 1993; Twigg 2000) – of what resources are fundamental to the provision of care for older people

Language

The pervasiveness of the family model in valuations of ‘good care’ becomes apparent when we examine the language used by academics, care providers, older people, and care workers. Academics have claimed that care recipients should ideally feel ‘loved’ (Folbre and Nelson 2000: 129), and some care home providers promote the ‘adoption’ of residents as ‘family’ or ‘grandparents’ (Dodson and Zinckage 2007). Meanwhile older people have stressed the need for care workers to be ‘genuinely caring’ (Meagher 2006: 35), and care workers have been shown to evaluate their work in terms of the presence of a ‘natural’ ability to care (Ball *et al.* 2010; Folbre 2008; Johnson 2015). Twigg (2000, 2006) notes how the semantics of the term ‘care’ – connoting tenderness, warmth, and love – have compounded misunderstandings of paid care work, which overemphasise its emotional elements at the expense of its physical aspects.

My own study reaffirms the importance of both researchers and practitioners having an appropriate language with which to talk about, promote, and evaluate ‘good care’. For care workers working in residential homes, the language used and the forms of interaction displayed by managers and co-workers are symbolic resources; they impart to the care worker how her/his work is to be carried out. At Shorefield, for example, there was a readily available supply of verbal and non-verbal interactional resources which care workers drew upon to act with ‘demeanour’ and to communicate and symbolise ‘deference’ to residents (Goffman 1956). The language of the family model did creep into Shorefield’s discourse of ‘good care’, but care workers also had access to a clinical lexicon to talk about the ‘unspeakable’ aspects of their work (‘bowel leakage’, ‘overflow’) (Thompson 2013), facial expressions to silence dirt, tones and utterances to convey sympathy towards individual residents, and sentimental and imaginative

stories with which to make sense of dying and death. Language, therefore, is an essential symbolic system for guiding care workers in how to talk about, behave towards, and ultimately respect those in their care.

Within residential homes, semantic and interactional resources are transmitted to newly recruited care workers both via formal training and on-the-job learning. At Shorefield, for example, I was taught about the home's pollution beliefs during a shadow shift when another care worker spoke of 'crossover', and my induction training involved overt learning in communicative styles⁶². At Millstead, on the other hand, it was the language of humour and satire that was passed on informally between care workers, so that they could deal with difficult or 'dirty' elements of the job (Thompson 2013; Twigg 2000).

The importance of induction training for teaching care workers how to behave and communicate in ways which respect and promote the dignity of the individual has been recognised by policymakers and inspectors. At the time that fieldwork for this study was undertaken, for example, 'person-centred support' was one of Skills for Care's eight Common Induction Standards (Skills for Care 2010). In April 2015, Skills for Care launched the 'Care Certificate', which was more explicit about what language and communicative styles were required for care workers to work in a 'person-centred' way. Outcomes of the Certificate's, now fifteen, Minimum Induction Standards included: care workers being able to demonstrate 'use of appropriate verbal and non-verbal communication'; use of 'appropriate volume to discuss care and support of an individual'; and the ability to 'describe the importance of finding out the history, preferences, wishes and needs of the individual' (Skills for Care 2015a: 8-12). Skills for Care provides a range of free training materials related to the Care Certificate to care providers and, since 2016, CQC inspectors have looked for evidence that the Certificate forms part of care workers' induction training (CQC 2017a). There is evidence, then, that the linguistic and communicative resources required to carry out and evaluate care in

⁶² For example, incontinence pads were never to be referred to as 'nappies', and each resident was to be addressed by their preferred name

a way which promotes respect for the individual are readily available to managers of residential homes to pass on to their staff.

In the context of a commodified care sector, however, the semantics of 'person-centred care' and terms associated with it, are somewhat blurred and distorted. Beresford (2009), for example, has drawn attention to how the language of 'personalisation' used in policy documents might represent an extension of the privatising and consumerist agenda for public policy which began in the 1970s (Andrews and Phillips 2000; Drakeford 2006; Scourfield 2012). Beresford (2007: 79) notes that, though often incorporating the rhetoric of service user movements, government policies for social care have 'tended to reflect more closely the managerialist/consumerist agenda, with its emphasis on market "choice" and ongoing commitment to outsourcing'. There are clear parallels between the language used to describe and promote person-centred care in training guidelines and policy documents for the social care sector, and the language used by those promoting the expansion of markets and the sovereignty of the consumer. Their common use of the terms 'choice', 'preferences', and 'wishes' are just a few examples. This language is also used ubiquitously in both political and public accounts of 'good care' and in the mission statements, service principles, and marketing of high-end residential care homes like Shorefield (Johnson 2015).

The language of person-centred or individualised care can be a useful symbolic resource for promoting 'good care', because it provides care workers with the linguistic tools with which to convey moral regard towards residents. However, in considering what beliefs and values underpin this symbolic system, we must take heed of Durkheim's (1898/1969) warning that a concern for persons *in general* is not to be confused with more egoistic concerns for the individual *per se*. In its commodified form, the language of individualised care is better understood as a symbolic system underpinned not by *moral* individualism, but by *egoistic* individualism. Viewed against this backdrop, the fact that this language was audible at high-cost Shorefield, where residents were fee-paying customers, but

not at low-cost Millstead, where residents' care was chosen and purchased by the local authority, is perhaps unsurprising.

Space and Materiality

A second resource which underpins good quality care, and which has often been overlooked within the literature, is the physical environment in which it takes place. Walls, doors, furniture, and other material items create and order space and, in so doing, they shape how residential care work and, in turn, care is experienced. Adding to the growing literature on the materiality of care (Hout *et al.* 2015; Martin 2016; Martin *et al.* 2015), I demonstrated how the provision of space and materials has implications not just for residents' measurable health outcomes – pressure sores, falls, mobility – but, also, for more symbolic elements of good care. Drawing upon social theory, I was able to show how architectural design and materiality play a role in allowing care workers to 'order' and 'classify' matter through symbolic performances (Douglas 1966; Goffman 1956). Whether care workers are able to mark out boundaries between the private and the public, the dirty and the clean, the frontstage and backstage of a care home, and the profane and the sacred, has implications for how those in their care are treated.

To some extent, this connection between space and symbolic systems concerns how buildings and the materials within them are organised and used. Routine acts – knocking on doors before entering them, drawing curtains, and bringing our talk into line with our location – can help to mark out and reaffirm sacralising boundaries; such as the 'ideal sphere' around persons (Simmel 1950). These symbolic activities, which utilise space and materials in particular ways, are encouraged and sustained by patterns of work organisation and training that are mindful of their significance. Since the introduction of the Care Certificate, for example, it has become a requirement that care workers are trained to 'demonstrate that the privacy and dignity of the individual is maintained', such as: by 'making sure doors, screens or curtains are in the correct position'; 'getting permission before entering someone's personal space'; and/ or 'knocking before entering the room' (Skills for Care 2015a: 12).

Whilst care workers' sensitive use of space is partly an outcome of training and the organisation of work, my study makes clear, however, that it also relies on an adequate provision of material items and, to a degree, on the quantity and quality of space which is available. It was Shorefield's large private *en suites* equipped with sanitary waste bins, for example, which allowed care workers to act in accordance with their training, which instructed them to maintain boundaries between bodily waste and communal areas. Millstead's care workers, on the other hand, were able to knock on and close the doors of residents' bedrooms, but a lack of washing facilities, sanitary waste bins, and gloves would have rendered such boundary maintenance futile. If the material and built environment of a residential home makes the avoidance of profaning activities impossible, no amount of training or guidance will rectify this.

By considering the role played by space and materiality in the provision of good care, we are able to recognise that the poor quality care offered in residential homes like Millstead is not symptomatic of ethically deficient workforces who are not committed to broader societal principles of moral individualism. Indeed, several care workers whom I interviewed were clearly demoralised by their inability to carry out care in ways which aligned with their own principles. This is not a story of irresponsible and morally-void 'monsters' (Foner 1994: 245) who often become scapegoats in panicked and scathing media accounts (Lloyd *et al.* 2014). Instead, what my study has made clear is that, if care work is to be underpinned by a concern for the dignity of the individual, care workers need access to adequate space and material resources.

Those operating at the high-end of the residential care market are well attuned to the importance of space and materials for facilitating 'good care'. Large-scale corporate providers like Shorefield, for example, employ architects and interior design teams to plan and arrange the layout, style, furnishings, and decorations of their residential homes (Martin *et al.* 2015). In chapter two, I showed that there has been a history of aspiring towards, if not always offering, 'hotel-like' residential places, where older people will be treated as 'guests' (Bland 1999; Johnson *et al.* 2010b) and can preserve their privacy and lifestyle. In the 1960s,

Townsend (1962) questioned whether these high expectations could be realised in the private sector. My study has shown that hotel-like residential care *is* available in the private sector, in some residential homes at least. That the materialities of care were so different at low-cost Millstead and high-cost Shorefield is both a reflection of how residential homes at different ends of the market come into being and how their services are costed and paid for.

Millstead, ironically, operated as a hotel in the 1930s, yet it was a run-down building with inadequate facilities, a layout which was not well-suited to the use of wheelchairs or mobility aids, and small and poorly-positioned communal spaces. Furthermore, at the low-end of the market, residential homes rely more heavily on funding from local authorities, whose decisions about the care placements of older people are ordinarily based on cost (Forder and Allan 2011). Since ownership of space, design, and the provision of materials require expenditure, we would expect that, in the low-cost homes chosen by local authorities, these resources are of a poorer quantity and quality than in high-cost homes, which have a larger number of private paying residents.

At the high-end of the market, where residential homes accommodate a higher number of private payers, the cost of care is sometimes directly related to the quantity of space occupied by a resident and the materials which will be required to undertake their care. This was the case at Shorefield, where residents who chose to occupy a larger room, with their own *en suite*, paid more for their placement. Since space, facilities, and materials are marketable and profitable products at the high-end of the market, private care providers often opt to boost profits by purpose-building luxury, 'hotel-like' alternatives to 'traditional', low-cost care homes like Millstead.

In sum, at the low-end of the market, cost-oriented decisions about care placements do not ordinarily relate to the provision of space. At the high end of the market, on the other hand, the amount paid for care is sometimes directly related to the quantity and quality of the space provided to fee-paying residents. My study has drawn attention to the implications which these differences in funding and costing have for the equity of older people's care provision. If the

space, facilities, and materials required for symbolic work are more likely to be found in highly-priced residential homes, 'good care' becomes something which can be chosen and purchased, or not, by older people.

That there is a link between the availability of space and the quality of caregiving is not revelatory to those researching residential care. In chapter two, for example, I showed that one of Townsend's (1962: 433) principal concerns about the residential care sector in the early 1960s was that an immoral 'form of discrimination between human beings' had been perpetuated by government failures to replace 'old stocks' of communal residential homes with purpose-built homes, which had private living quarters. What my study shows is that this spatial and material discrimination between individuals has been further perpetuated by the increasing privatisation, commodification, and market polarisation of care provision.

Time

A further resource which underpins good quality care, reaffirmed in this study, is time. Those who have expressed concerns about the quality of residential care in the past have recognised the impact which time pressures have upon care workers' ability to do a good job (Kemper *et al.* 2008; Lee-Treweek 1997). The amount of time which care workers are able to spend undertaking care activities is directly linked to staffing levels. Researchers have long stressed how low staffing levels, by reducing the quantity of caregiving time, can lead to poor health outcomes for residents (Eaton 2000; Mt. St. Vincent Providence 1994). My study reveals two further casualties of the lack of time caused by short staffing: care workers' sensitivity to interpersonal communication and their capacity for symbolic work. Forced to complete many physical tasks within a tight schedule, care workers in short-staffed homes have little time for the luxury of acting with 'demeanour' or communicating and symbolising 'deference' to those in their care (Goffman 1956).

When care workers are pushed for time, they are left with little option but to prioritise certain aspects of their work and eliminate others. My observations of care work at Millstead, as well as the accounts of other care workers in Esterton,

made clear that it is the emotional, 'invisible', and/or less measurable aspects of care which are first to be relinquished by care workers when time is scarce. This reaffirms the findings of ethnographic studies of care work in both the UK and the US undertaken in the 1990s, which indicated that work 'speed up' leads care workers to focus on the 'hands on' tasks required to produce 'clean, orderly, quiet resident[s]' (Diamond 1992; Foner 1994; Lee-Treweek 1997: 54).

My study also revealed that, when time is in short supply, the 'hands on' tasks of care – toileting, washing, dressing – are undertaken in the quickest time possible. This speed-up results in a routinised, factory-line form of care-giving, where residents are treated not as sacred individuals but as dehumanised products on an assembly line. My ethnographic observations of the backstages of care at Millstead revealed that the type of care work observed by Lee-Treweek (1997: 57) – which 'consisted, in effect, of acts performed on objects in the swiftest way possible' – is still taking place in residential homes in England today.

We know that 'providing care for *people* takes time but the ordering of *objects* can be undertaken more rapidly' (Lee-Treweek 1997:57, my emphasis). What my study adds to this knowledge is an understanding of how, in a commodified care sector, the relationship between individualised care and time plays out in different ways at different ends of the care market. Since short staffing is a common and well-known strategy to reduce costs (Dodson and Zincaavage 2007; Lloyd *et al.* 2014), the degree to which it is adopted by care providers will depend on their corporate goals, budget, and marketing strategy. At the high-end of the market, residential homes like Shorefield often calculate part of a resident's fees in terms of how long, at least according to managerial calculations, it takes to meet their needs. When formalised in care plans (or, in Shorefield's case, in ISPs), these calculations can be used to determine staffing levels. If fee calculations appropriately account for residents' needs – that is, physical needs, emotional needs, and the need to be treated in a dignified and individualised way – then they can function to ensure that care workers have the time required to carry out 'good care'. This is not dissimilar to Meagher's (2006) argument that contracts of employment can promote positive caring relationships because they spell out the

characteristics of the service which is being paid for. Though it was not Shorefield's care workers who entered into contracts with residents, the formalised way in which Shorefield determined its staffing levels based on its contractual agreements with residents and their families did ensure that care workers could care in accordance with the principles of moral individualism.

At low-cost homes like Millstead, on the other hand, care placements are more likely to be arranged via contractual agreements with local authorities, rather than with individual private paying residents (Forder and Allan 2011). In the case of block contracts⁶³ – which appeared to be the preferred contract type of Esterton local authority at the time of my fieldwork – there is not always a clear link between a resident's care needs, the cost of their placement, and, in turn, the amount of time spent undertaking their care. Since contractual agreements between local authorities and care home providers do not always specify how much time is to be spent caring for individual residents, they provide little buffer against time-saving and, by extension, cost-saving decisions made by care providers.

Forder and Allan (2011: 15) suggest that, 'public purchasers are more interested in purchasing from the lowest cost bidder', but that this is only the case 'once homes have attained minimum quality levels'. We would hope, then, that CQC inspections safeguard against providers' desacralising time-saving strategies, even if local authority contracts do not. One issue faced by care inspectors is, perhaps, that the relationship between staffing and the time available for care workers to provide care is not easily measured or assessed in terms of care worker/ resident ratios. Both Millstead and Shorefield, for example, were regarded by the CQC as complying with their regulation of deploying 'sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs' (CQC 2015: 70). The care worker/ resident ratio in both homes during the daytime was, in fact, fairly similar and,

⁶³ 'Block contract' or 'block purchasing' refers to a contractual agreement whereby the purchaser (in this case the local authority) makes a commitment to purchase a pre-determined number of beds from a care provider. 'Spot contracts' or 'spot purchasing', on the other hand, refers to the purchase of a one-off placement and/ or services from a provider.

indeed, during the night, Millstead's ratio of care workers to residents (1:17) was higher than that at Shorefield (1:22). My study, thus, makes clear that inspectors need to examine and regulate for other factors which have implications for how much time is available for care workers to undertake care activities: the quantity and quality of residents' care needs; the complexity of a care home's division of labour (e.g. if care workers are also required to cook and/or clean); and how time is allocated to individual residents.

In short, my study draws attention to the knock-on effects which financial decisions about staffing, when left to the market, have on the quality and equity of care. This thesis also highlights the impact which a lack of time has upon care workers, not just in terms of what work they are able to carry out but in terms of how they experience their labour. It is towards reflecting on the importance of care workers' relationships and experiences that I now turn.

Collegiality and Identity

We know from quantitative research on the reasons for high turnover in the social care sector that the temporal demands placed on care workers can result in stress, exhaustion, and burnout (Dodson and Zincaavage 2007; Simonazzi 2008). We are also aware that a key element of employee burnout is cynical depersonalisation, described elsewhere as the 'development of indifferent and negative attitudes towards others', such as an 'impersonal and dehumanised perception of (service) recipients' (Maslach *et al.* 2001; Van Droogenbroeck *et al.* 2014: 101). Since there is an absence of qualitative research on burnout amongst care workers, however, little is known about the nature of the relationship between work conditions and cynical depersonalisation, and what effects this can have on the quality of care.

By exploring care work in an ethnographic way, and by becoming a care worker myself, I was able to see how cynicism and indifference can result from a workplace's shortage of symbolic, as well as temporal and physical, resources. Without access to collective beliefs and values about the importance of the individual, or the symbolic and material resources required to put these beliefs into practice, care workers find themselves unable to show moral regard for residents. Working in an environment which makes it difficult, if not impossible,

to treat others in a dignified and respectful way is, on the evidence presented in this thesis, morally degrading and damaging to care workers.

Previous research suggests that care workers' motivation to care well stems, in part, from the intrinsic rewards to be found in doing so (Stacey 2005). This aligns with Sandel's (2012) argument that, like a muscle, our capacity for ethical behaviour grows strong with exercise but shrivels when neglected. Thinking of morality in this Aristotelian way, we can see how the caring virtues of those working in residential homes like Millstead, which lack the resources required to care well, might languish. Unable to provide good care, and without a potent narrative of caring well – which might encourage them to perceive their labour through a lens of esteem, dignity, and gratitude – care workers will struggle to find satisfaction, meaning, and dignity in their labour.

Cynical depersonalisation, then, not only results from overwork and physical exhaustion, but from anomic workplace cultures which make it difficult, if not impossible, to respect others. Without a shared purpose, values, or beliefs, and with few avenues for exercising their 'moral muscles', there is a risk that care workers will perceive their labour as nothing more than 'dirty work' (Hughes 1971) which is devoid of intrinsic meaning. If it is the rewards of caring well which motivate care workers to continue to provide good care, those working in poorly resourced residential homes may become indifferent towards individuals in their care, even on occasions when they *do* have the temporal and physical resources required to show deference and demeanour. Locked in a cycle of poor care and cynicism, then, it is unsurprising that, when free time was available to them, Millstead's care workers snatched this time for themselves rather than spending it with residents.

But how might this cycle be broken? Given that collegial relationships can serve as a buffer against burnout and cynical depersonalisation within the workplace (Van Droogenbroeck *et al.* 2014), it is concerning that there is evidence of poor work relationships in residential care homes (Kemper *et al.* 2008). My observations at Shorefield, however, captured how a sense of collegiality and collective identity *can* be cultivated among care workers. Those working at Shorefield demonstrated

a clear affiliation to the residential home and conveyed their pride in and devotion to their work by openly referring to themselves as 'Shorefielders'. As members of Shorefield, workers embodied a common commitment towards the home's ethos of care, which was characterised by a belief in the value of those being cared for.

Collegiality amongst care workers does not just prevent poor working conditions from leading to burnout, for it is, in itself, a crucial resource for the promotion of good care. At Shorefield, for example, it was care workers' collective identity which encouraged mutual learning, facilitated a shared sense of responsibility for the home's residents, and gave them a clear understanding of what their role was and how it should be undertaken. Employers can strengthen care workers' sense of collective identity in a number of ways, such as: clearly marking out what *is* and *is not* part of the care worker role; training care workers to understand and work in accordance with the goals and duties of their profession; and setting an appropriate moral ethos of care.

Whilst at Millstead, Brian, Mrs G, and Adelina tended to focus on the *appearance* of care rather than the *substance* of care, Shorefield's managers emphasised team work and a familial caregiving environment. Shorefield's ethos was successful in encouraging care workers to share a moral commitment to residents and, in turn, to perceive their labour as dignifying and as a source of pride (Stacey 2005). We must not forget, however, that the promotion of family-like caregiving can lead care-workers to over-extend their moral commitment towards residents (Dodson and Zinavage 2007: 922; Johnson 2015). That Shorefield's care workers sometimes visited and cared for residents outside of their formal working hours makes evident that a strong collective identity, when underpinned by familial ideals of 'good care', can lead to exploitative forms of self-sacrifice. A balance needs to be found, then, between encouraging care workers to exercise their right to find dignity and honour in their work and, at the same time, ensuring that this commitment to care is not exploited in the name of profit.

Community

The collective identity of those *working* in residential homes is a critical resource for good care, but my observations made clear that the sense of community

shared by those *living* in residential homes also plays a role in shaping the treatment and experiences of individual residents. Previous research has told us that most older people, given a choice, prefer to spend their final years of life at 'home' and that this preference is, in part, because the presence of family, friends, and/or neighbours is regarded as crucial to both an individual's quality of life and the quality of their death (Gott *et al.* 2004; Leathard 2000).

My study has reaffirmed how an individual's integration into communal life can ensure that they experience both 'good care' and a 'good death'. At Shorefield, for example, it was a resident's membership of the group which prevented them from dying a 'social death', and which prompted their suffering and biological death to be marked with symbolic work on the part of care workers and other residents. Whilst feelings of belonging and 'personal relatedness' are key aspects of a sense of community (McMillan and Chavis 1986: 9), few empirical studies have examined how these feelings can be established within care homes. Below, I draw on my research to consider how residential homes might foster a sense of community.

Though not a completely homogenous group, Shorefield's residents shared many similarities: they were all wealthy enough to afford a place at Shorefield; their care needs were often minimal and, moreover, were rarely visible or audible; and they were mostly able and willing to engage with others. In its marketing to potential residents and their families, Shorefield drew attention to this like-mindedness; portraying itself as a community of active, sociable, and civilised older people. Membership of the Shorefield community was part of what the home sold to residents; residents who themselves matched the community's membership criteria; what the home's marketing manager, Cliff, referred to informally as 'the Shorefield type'.

Shorefield's marketing and admissions practices draw attention to what McMillan and Chavis (1986: 9) have called, the 'most troublesome feature' of community membership: boundaries. That is, the boundaries which a community, in order to establish and sustain itself, must erect between its members and others. Since Shorefield's residents were characterised by their low care needs, wealth, and civility, those not fitting this description would be regarded as a threat to the

home's sense of community. This 'other' might include: older people living with dementia⁶⁴, those whose incontinence could not be brought into line with the home's classificatory systems, those who could not engage in conversation or activities, and those who could not afford a place at the home⁶⁵. Shorefield's admissions process⁶⁶ was, then, a form of boundary work which facilitated a sense of community by categorising prospective residents into 'Shorefield types' and 'others' and accepting them based on these criteria.

Whilst residential homes at the high-end of the market are often able to pick and choose who they sell their services to, providers at the low-end of the market have less of a say in who becomes a member of their communities. Not least, this is due to increased reliance on local authority purchasers of care, whose level of funding for an older person's care placement is based on the extent and type of their care needs. In this context, older people who exhibit challenging behaviour, or who have complex care needs, offer the best opportunity for low-end care homes to profit financially (Scourfield 2007). One possible implication of these factors is that care homes like Millstead will be more likely to accommodate residents with more complex and diverse needs, of multiple ages and who, in consequence, have few commonalities⁶⁷.

In chapter five, I described the parallels between Millstead and Goffman's (1956) description of the back wards of psychiatric hospitals, which were filled with patients who scratched themselves violently, were incontinent, and openly masturbated. Since these patients' attributes inhibited propriety, such wards were characterised by indifference to the symbolic and the ceremonial and by classic forms of 'non-person treatment' (Goffman's 1956: 483). Unlike Shorefield, which was able to sustain the feeling that it was a civilised space in which to live and work by excluding 'unpropitious' residents, Millstead's market positioning made

⁶⁴ Who could become Shorefield residents, but resided in a separate, secured part of the building where fieldwork did not take place.

⁶⁵ Including older people whose care was publicly funded.

⁶⁶ And its practice of moving residents who developed signs of dementia to its separate part of the building.

⁶⁷ In addition, older people of lower socio-economic groups have a higher prevalence of multimorbidities (Marengoni *et al.* 2011).

institutionalising the deference and demeanour practices required for civility might be impossible.

Throughout this thesis I have highlighted the important role which classificatory systems and boundaries can play in giving meaning to everyday experiences (Douglas 1986). What the boundary work of Shorefield's management and marketing team makes clear is that the ideas expressed in symbolic systems are not always concerned with conveying moral respect for human beings in general. Whilst the day-to-day boundary work of Shorefield's care workers appeared to align with the principles of moral individualism, the home's classificatory systems concerning resident admissions did not.

The boundary work of Shorefield's marketing team did foster a sense of community amongst the home's staff and residents, but a further result of this classificatory work was that the object of the care workers' moral conduct was not persons in general, but 'Shorefield type' individuals. In short, Shorefield's high quality of care was underpinned by a sense of community but, paradoxically, this sense of community was reliant on the disregard and exclusion of others. One potential problem of establishing a sense of community, then, is the possible neglect and subsequent dismissal, both metaphorically and literally, of certain populations – that is, those whose attributes fall outside of what an institution deems acceptable for, and worthy of, membership. That Shorefield did not extend the individualism which it promised to residents to *all* older persons calls into question the authenticity of its commitment to the dignified treatment of the individual according to his/her needs.

Conclusion

As highlighted throughout this thesis, the residential care sector for older people in England is under heavy strain, and this looks likely to intensify over the coming decades. A shortfall of workers, anticipated funding gaps, and increasing demand for residential care places will inevitably impact upon the capacity to secure the future quality and equity of service provision. To put it bluntly, residential care is a service in crisis, reflected perfectly by the situation of Millstead, one of the two homes where fieldwork was carried out for this study.

Since fieldwork ended, Millstead has ceased all operations. This closure took place following a series of inspections by the CQC from late 2016 to late 2017⁶⁸. Without providing too many details – with the intention of preserving anonymity – the overall rating for the home was ‘inadequate’, and the standard measures of safety, effectiveness, care, responsiveness, and being well-led were all rated as either ‘inadequate’ or ‘requiring improvement’. More specifically, the CQC documented breaches related to care, safety, treatment, governance, and staffing (e.g. recruitment; incomplete training, supervision, and induction).

Millstead closed prior to the publication of the CQC’s report on its most recent inspection, but it does not appear that the CQC enforced this closure. Likewise, when Millstead announced that it was closing with ‘immediate effect’, the home had increased its number of residents from thirty-three to thirty-five, many of whom were funded by Esterton local authority. It does not appear, then, that Esterton local authority had ceased placing residents at Millstead, or that they anticipated having to relocate its thirty-five residents within forty-eight hours of the home announcing its closure. The fact that Millstead was able to stay open for so long, and close of its own accord, indicates, in conjunction with other concerns outlined throughout this thesis, that the current funding and regulation of residential care is not working to ensure good quality care for all older individuals.

The sharpness of the contrast between the care provided to residents at low-cost Millstead and high-cost Shorefield is, partly, a result of the fact that working and living conditions at Millstead were so abysmal. Indeed, when contrasted with Millstead, any satisfactory residential home is likely to appear paradisaical. Just like Esterton’s care workers, who were keen to call attention to the atypicality of media portrayals of residential care, we must be wary of labelling all care homes or all care workers either as wholly terrible or as completely perfect. Though there was certainly an ethical dimension to the care which was provided at Shorefield, for example, this is not to say that all practices at the home were ideal or virtuous.

⁶⁸ The closure of Millstead is not a standalone case. Of the thirty-eight residential homes for older people in Esterton which formed my initial sample in January 2013, seven had ceased operating by December 2017.

The emotional and temporal demands which the home placed upon its staff, for instance, were sometimes unreasonable and exploitative.

There is, equally, a danger that, by focusing on the most shocking or dreadful cases, we forget the importance of subjecting the mundane and the mediocre to proper critique. I expect, and hope, that Millstead is an outlier in terms of care quality, but the day-to-day routines and rituals which I observed at the home were not dissimilar to those described in some of my interviews with other care workers in Esterton. Whilst, in some ways, Millstead is a deviant case, then, this is not to say that there is little to be learnt from a thorough examination of the routines and rituals of care at the home.

My contrasting accounts of care at Millstead and Shorefield do evidence that the ‘two-tier’ system of care which academics and policy analysts have warned of is well-entrenched (Forder and Allan 2011; Humphries *et al.* 2016). One obvious way to rebalance this system, which has been repeated time and time again in the literature (e.g. Age UK 2017a, Cottell 2017, Humphries *et al.* 2016.), is to increase the money going into residential care, particularly at the low-end of the market, where a larger proportion of care placements are funded by local authorities. This, of course, requires increased taxation or a redistribution of funds from the public purse. Whether this is achievable or politically acceptable – particularly in a context of austerity, increasing demand for services, and a rising complexity of older people’s needs – remains to be seen.

At a deeper level, this thesis suggests that in order to make sense of what is going on in the residential care sector, there is a need for more comprehensive academic and empirical research. More needs to be done to establish how particular conditions and resources impact upon the quality of care and care work, in both measurable ways (dissatisfaction, staff turnover, medical outcomes) and more immeasurable ways, such as in terms of the moral and emotional stresses experienced by care workers and the moral regard and respect shown towards residents. This should be done in conjunction with policymakers and other stakeholders to establish workable solutions for ensuring that older people are treated with respect, dignity, and compassion.

Other than this, it is difficult to make recommendations and identify solutions for the problems which I, and others, have identified with residential care, when so many have defined the state and future of the sector as bleak and unsustainable. Nonetheless, my study has offered some food for thought in moving forward. By exploring the everyday routines and rituals of care work in two differently priced residential homes for older people, I have pinpointed how current practices of funding and pricing social care have implications which seep beyond the practical and measurable, and into the realm of the symbolic. It is only by taking the normative and symbolic culture of work in residential homes seriously that we can fully recognise and work towards establishing a care sector which is equitable, both for older people and for those who take care of them.

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