THE PRACTICAL ACCOMPLISHMENT OF CARE
IN TWO HOMES FOR THE ELDERLY

by

HARRIET HUDSON

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University of Edinburgh
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Acknowledgements

There are several people to whom I owe a debt of gratitude. My husband, Steve, who has had his own life disrupted considerably by the demands of this research, has given me love and support throughout. My friend and colleague May Ross has provided me with fresh ideas when mine dried up, and has acted as a 'trampoline' for discussion on many occasions. My supervisors Adrian Sinfield and Stewart Asquith have patiently listened, read papers and drafts and made helpful and positive comments. Wilma Butterworth, having taken on the Herculean task of typing a thesis has steadfastly produced good copy with an equally good grace.

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The residents and staff in the homes involved have not only provided me with the data for the research but have enriched and influenced my life with their warmth and friendship and views about the world. I think of them with great affection and hope that they will find some aspects of the study interesting and useful.
ABSTRACT

The research is a study of the role of care attendants in two old people's homes, one of which is a group living home.

Various propositions are developed following a review of the literature; firstly that what is official policy does not mirror everyday practice; secondly, that despite officially different policy and philosophies and apparently different settings and backgrounds the staff tend to accomplish care in similar ways.

The main method of participant observation is triangulated with survey, questionnaire and extended interviews. Analysis and data collection are informed by a social construction of reality perspective.

The collection and analysis of the data show that staff in both homes did not in fact accomplish care in the same way. Whereas an institution oriented model was recognisable in the traditional home this was not the case in the group living home. A model of care is developed which suggests that routines of work were organised differently and carried out by different types of people in each home, although the characteristics of the typical day involved similar types of work.

Much of the difference between the homes lay in the presence of a strong philosophy in the group living home supported by organisational and managerial structures that prevented staff from slipping into inappropriate 'institutionalised' practice. A clear induction course, supervised report writing and formal staff discussion were three such structures. Findings also suggested that the context of talk, as well as its content, was a major part of the practical accomplishment of care.

The thesis concludes that certain managerial and organisational changes in staff activity could affect real changes in routines and models of care practised by staff.
Declaration

I hereby declare that this thesis was composed by myself and that the work contained herein is my own, except where otherwise stated.

H.M. Hudson.
For my Mother and Father
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1. INTRODUCTION

This study considers the work of care staff in two Local Authority residential homes for the elderly.

Residential care for the elderly is both part of the problem of 'what we do with Granny', and part of the answer in so far as the quality of care provided in the homes and the quality of life experienced by the residents is a matter for concern, debate, and more often than not, criticism. The idea of 'going into a home' or being 'put into a home' is one that is not readily welcomed by elderly people or their relatives. The emotive public opinion of residential care is summed up by a comment in a Television Soap Opera 'Albion Road' where an elderly woman announces stentoriously:-

'I'm not going into one of those places - they put you there to die - human graveyards they are'.

As will be discussed in the literature review, more informed and research based opinion ranges from those who advocate 'gradual abandonment' of residential homes and a move towards sheltered housing and other community based provision, to those who are searching for more appropriate and acceptable styles of living within the homes themselves.
Along with a general agreement that there is room for improvement in homes and an increasing interest in 'professionalising' residential care work, evident particularly in the activities of the Residential Care Association, there are also the demographic implications of an ageing population and the decreasing availability of public resources for residential care. The combination of these factors makes a clear social policy about the place of old age homes in the welfare state an imperative of any 'caring' society. However, the aims and intentions of residential care are, as will be discussed, confused and ambiguous. Caring for residents is a less than satisfactory specific goal. Bolling noted the murkiness of goals in American old age institutions:-

>'In the absence of clearly defined goals and well understood means of achieving them, it is difficult for any organisation to improve or indeed accomplish very much at all'. (1977:81)

and points to three identifiable goals; health maintenance, tender loving care, and custodial. The latter was the most adhered to in daily life and most easily achieved but the least associated with official goals.

H.K. Evers (1981) has also noted the gap between the official activity theory based goals in geriatric
wards and the daily practice of staff. Since these goals proved inappropriate, staff developed their own styles of care which were based on a 'warehouse model'.

Roger Clough suggested, in his study of old age homes that:

"One of the first steps is to reconsider the tasks of staff and the purpose of the home". (1981b:204)

Linked with the need to define clearer goals and purposes is the discussion over the form the training of care attendants should take. Ann Davis (1981) noted the development and incorporation of residential 'Social Work' into the profession of Social Work. Residential work is seen as part of Social work.

Although there is largely agreement about the need for training to foster positive attitudes and improve caring there is discussion about the form of training this should take. Davies & Knapp for instance suggest that there is no actual empirical evidence that demonstrates the beneficial relationship between qualifications and quality of care. It may be that despite CCETSW recommendations, residential care for the elderly should aspire to goals not immediately connected to social work. Clough (1982a) for instance
suggested that the function of the old age home should be to provide a living base where physical needs are met. Residential homes should be seen as housing with services. This goal would obviously necessitate a particular role for staff.

In order to set out policy and launch feasible initiatives for residential homes there is a need for accurate and detailed information about the actual practices and experiences of those who work and live in the homes. This would provide a more suitable basis upon which to plan change and development rather than the 'folk devils and moral panics' at large in the public eye.

Institutional care for specific groups of people has been subject to criticism for almost as long as it has existed in the public sector. Focus on residential care for the elderly sharpened in the 1960's when Townsend pointed up the unnecessary incarceration of elderly people in homes and the advantages of sheltered and other forms of housing. Other writers drew attention to poor conditions in geriatric wards and nursing homes. A general consensus emerged which supported a policy of community care and domiciliary support and which criticised institutional care. However, residential homes for the elderly still exist and quality of life for residents still causes concern,
although there is a much greater variety of types of provision and quality of life enjoyed by residents.

Much of the explanation for the differences in the quality of life is made with reference to the quality of care given by the staff. This is known to vary between homes which ostensibly have similar resources. Inappropriate attitudes of the staff to their residents, and the quality of staff resident interactions are known to be crucial to the ease of daily living. In addition, short staffing, difficulties of shift work, lack of training of staff and lack of resources to facilitate more comfortable surroundings have all been pointed to as factors.

Residential care management has recognised the need for change and homes are becoming more 'home' like particularly with the adoption in some cases of a group living policy where residents' independence is encouraged and care staff role is 'enabler' rather than 'doer'. However, progress in care of the elderly in residential homes is put at a disadvantage by an overall policy which recommends community care.

Much has been noted in relation to the realities of community care policies where suitable community support is not forthcoming or provided by unpaid, mainly female, relatives. The increasingly elderly
and frail proportion of the population suggests that, for some, community care will not be feasible. A long term policy to wither away residential care for the elderly neither seems appropriate nor possible and such a policy relegates those who work and live in such homes to a second class status, as well as alarming those who see themselves as potential residents.

This study tackles the 'immediate' problem of achieving more appropriate life-styles for residents and considers the long term strategies that would give residential care for the elderly a full status as part of a package of social policies for care of the elderly rather than a dread alternative and sword of Damocles to those people whose frailty threatens their independence, and present housing arrangements.

It will suggest that changes to the role of staff can enhance the present residents' lives and the lives of the staff and set up the conditions for residential care of the elderly to re-examine and reorientate its long term policy, goals and purposes.

Lay Beginnings

The direction of the research was influenced by the 'lay' observations made by myself during periods working as a care attendant in old people's homes and
geriatric wards. These were firstly, that despite an initial disassociation from what seemed to be the dubious relationships between staff and residents, it took a very short time to engage in precisely the same relationships and practices and to learn and accept the tacit 'rules' of both the homes/wards and the staff. Behaviour that would have been on the margin of acceptability in another setting, was quickly absorbed as acceptable in these contexts. It was, for instance, common practice to leave toilet doors open when helping residents who were incapacitated to urinate, to dress residents in clothes other than their own and to fail to give them their false teeth in the morning.

The second observation was, that what was said to happen in the homes and wards in particular by senior and managerial staff, and what did happen 'on the floor' day to day were often quite distinct. This was particularly noticeable when showing round potential residents. Questions about home/ward practice were answered officially rather than 'for all practical purposes' which would have been a more accurate response. For instance on showing a man around one home the accompanying social worker told him that there were male staff who would help him bath. This was not strictly accurate although officially correct. A male member of staff would help him bath if he was on duty at a time deemed appropriate for bathing, otherwise the
man would be obliged to fit into the staff rota. Similarly it was officially recorded in one leaflet describing a home that breakfast started at 8.30 a.m. This implied that from 8.30 a.m. residents could go into the dining room. In practice the residents were expected in the dining room by 8.30 a.m. and were hurried out by 9.00 a.m. at the latest. This disparity between official policy and actual practice made a difference to the residents expectations and acceptance of the homes. It also pointed to a lack of official 'understanding' of what was going on, on the floor, regardless of whether or not it was deemed 'good' or 'bad'. The care staff had much control over the way in which the daily routines were carried out.

These observations combined with my overall belief that old people's homes can be much improved and have much to offer, formed the backdrop to the research proposal.

The research outline

The research examines the role of the care attendant in two residential homes for the elderly. In order to avoid some of the data collection problems of mismatches between speech and action, the method of participant observation was chosen and triangulated with other methods as appropriate. The participant
observation allowed the researcher to experience first hand the daily practice of staff. (This is discussed in Chapter Three).

Two homes were chosen for the research. The first

Both homes were selected partly as a result of the opportunity presenting itself, but in the main as a consequence of the survey carried out in November, 1980 (Appendix A, p.344). The findings of the survey confirmed that Fell View (the home in which I was already working) was not untypical of the authority homes and was therefore a suitable home for the main data collection. The survey data also made clear that Deer Park was quite distinct in terms of design, age and philosophy from any other home. This provided a good contrast to what was known as 'traditional care' and, since access was not a problem, Deer Park seemed a suitable choice of second home.

quality of life in residential care for the elderly. This was supported by a literature review (Chapter Two), where an examination of various models of care and research into their application suggests a tendency towards 'warehousing'. The literature suggests that a poor image of residential care and its workers does little to help development. This Chapter also locates the care workers as front liners with associated characteristics.

Chapter Three considers the advantages of using social construction theory as the theoretical basis for the data collection and analysis. It views policy as a process and care staff as the enactors of the process which reinforces the view of staff as front
liners. It points up three important elements of the theoretical position, "The Social Construction of Reality" that are particularly useful when considering care staff work, i.e. 'caring' in an old peoples' home that are:

a) that caring is a precarious phenomenon and therefore changeable and flexible.

b) there is therefore a need to have reality maintenance techniques that help stabilise definitions of caring situations.

c) caring is negotiable between participants although ability to negotiate depends on the structural and organisational position of participants.

Chapter Four considers the methods used to gather the data and to analyse them, and discusses the advantages of a social construction perspective for both.

Chapters Five to Nine are the analysis chapters. Chapter Five sets the scene and locates the staff and other participants in their setting and in their domestic lives. Chapter Six looks at how staff view their world and in particular compares how each group views the elderly with whom they work. The implications of these 'theories' are discussed in
Chapter Seven where the content of the staff's day is examined. A model of care is developed which suggests similar daily tasks occur in each home, but the degree of importance attached to each task and the participants involved in the task varies. It is suggested that the degree to which staff work involves 'essential maintenance' of residents' physical state is related to the degree to which residents are 'warehoused', and that residents' participation in their own maintenance changes the nature of staff role and therefore relationships with residents. A comparison with Deer Park is made in Chapter Eight.

Chapter Nine discusses the importance of some aspects of talk as part of the caring tasks and as part of the staff routine day. Style of conversation with residents and the way in which talk is used as an account to justify and explain practice are considered.

Chapter Ten summarises the findings and discusses their implications for both long term policy and immediate day to day care. Suggestions are made as to how homes might be organised to more effectively exploit care staff's abilities to act as advocates for residents and to maximise residents' opportunities for more independent living.
2. A REVIEW OF LITERATURE

Negative image

Even a brief survey of the major works produced on care of the elderly in institutions gives the reader the impression that a negative view of residential care predominates.

The general effects of institutional life upon inmates and staff alike have been well documented by Goffman in his study of a mental hospital (1974) and by Barton (1959) in his work on 'Institutional Neurosis'. Goffman's study suggested that the institution's goals become subverted and reworked by the staff who run the institution in favour of their own goals, so that means become ends. Barton showed that confinement to an institution in itself (whether a member of staff or inmate) induces a state of neurosis that becomes seen as part of the illness of the inmate and is expressed in forms of ritualised behaviour by staff. The residential care establishment is also still dogged by workhouse images. As Ann Davis has noted, the 1960's produced a number of works that demonstrated a workhouse model of care very much in operation (1981).

Townsend, Meacher and Morris, in various ways condemned the residential care establishment and
promoted a community based approach to caring for elderly people.

Townsend's (1963) arguments for the 'gradual abandonment of residential care' are based on the findings of 'The Last Refuge' a work that confirmed the high degree of institutionalisation (examined by Barton) experienced by staff and residents. He suggested that much of the admissions to residential homes could have been prevented by domiciliary support, and many residents were in homes unnecessarily.

Meacher (1972) in 'Taken for a Ride' examined the policy of separating severely confused elderly people from 'normal' residents and suggested that the very act of segregating elderly people from their wider community created a 'senile response'. He recommended community based care and integration rather than segregation.

Morris (1969) in 'Put Away' similarly condemned the care of mentally retarded in institutions and recommended a shift towards community care with half way hostels as a staging post to full integration. He also wanted to see a shift away from the 'custodial model of care' to a treatment oriented model.
It is not surprising given the negative backdrop to residential care of the elderly, that the specific treatment of staff in the literature is negative. A. Davis commented that:—

'The residential staff and residential homes generally have on their hands a 'battle with a past'. (1981:9)

that is, the workhouse legacy.

Staff - Legacy of the Pauper Nurse

The concerns about staff's lack of training, lack of numbers, high turnover, low status, poor attitudes and lack of commitment can in part be historically accounted for in the position of staff in the workhouse. (Longmate: 1974)

The poor law nurse or pauper nurse was the poor relation of the hospital nurse; the vast majority were female, low social class and often inmates themselves. Furthermore the people for whom they cared were incurable. Whilst curable patients and their carers gained higher status with the advance of medicine, those who were incurable and needed caring for, not curing, became second class 'patients' (White: 1978).
Curing and getting what is seen as 'positive' results from treatment has become a valued goal deeply embedded in our social life. As R. Wilkes noted in her sensitive study of social work with underprivileged groups (1981), those who do not cure but oversee and manage slow deterioration and eventual death are offending this value and so higher status and worth is given to those who 'cure' than those who 'care'.

Davis (1981) suggested that the pervasive 'pessimists' approach to residential care embodies a deep ambivalence of attitude on the part of society to the groups of people who work in institutions. These establishments remind us of our own vulnerability and, as R. Clough pointed out in his study of an old age home, give us a view of old age 'en masse', a sight that most members of society choose not to dwell on. (Clough: 1981b).

The attitude to the training of poor law nurses was associated with the status of simply caring. They did not need special skills since their charges were not sick or in need of 'curing'. The work they did was 'domestic' and, ipso-facto, needed no specialist knowledge since it was part of woman's natural work. Attitudes have not shifted dramatically. Caring is regarded as women's work and paid caring is the
imitation of domestic duty in the market place. The knowledge needed to care is fundamentally thought to be part of the natural knowledge given to women. (Note: Finch & Groves: 1983). And so the legacy of the pauper nurse lives on in the care attendant of today. Who, then, are the care staff of today?

Staff - Social outcasts?

Descriptions of care staff as in some way 'socially' disabled or outcast are not uncommon. Stannard (1971) studying the organisation of a nursing home in America, gave an account of his staff which suggested that:-

'Both patients and aides have in common the fact that they are likely to have discrediting characteristics which make them untrustworthy and unreliable. Furthermore both groups manifest these attributes daily'. (1971:184)

He typologised his care staff into five categories. Firstly the equivalent to Townsend's 'old reliables', a group of middle aged respectable unattached women; secondly the scapegoat who causes amusement or light relief as a result of some disability; thirdly, students doing a summer job with no long term commitment; fourthly a stigmatised group, for instance homosexuals; and finally the stop-gap worker who uses the job as a means to other ends, for instance a need for accommodation.
How appropriate is a social outcast image in British old ages homes?

Miller and Gwynne in their famous study "A Life Apart" looked at regimes of care in homes for the physically handicapped. They noted:-

'repeated evidence that staff vacancies in institutional homes attract candidates who, while not having a visible handicap, are in some measure socially handicapped. the institution is seen as providing a sheltered environment for them'. (1972:173).

They suggested that inadequate or weak members of society were attracted to working in institutions where their own failings could be hidden beneath the manifest 'failings' of the residents. This left staff vulnerable to the effects of 'institutionalisation' whereby they routinised and regimented their working lives irrespective of the needs of the residents. Institutional goals became subsumed to organisational needs and staff imperatives. This replacement of ends by means is discussed by Goffman (1974).

Robb's publication for Ageis 'Sans Everything' (1967) commented on this process. In her description of staff practice in a geriatric ward in 1967 she noted:-
"Staff in institutions develop neurotic self-propagating traditions such as misplaced loyalty of one staff member to another... institutions develop powerful instruments of defence for their protection and perpetuation... sometimes they lose sight of the primary purpose for which they were planned and their energies become deployed in ritual... the purpose being subordinate to the personnel". (1967:Introduction)

However, the nature and characteristics of staff in residential homes for the elderly in the 1980's must be a matter for empirical enquiry within homes.

With the concept and design of homes altering dramatically from the 'institution' to the residential home on the estate and with the characteristics of staff members altering to local married women and increasing numbers of younger people and male applicants coming into residential care* it is debatable whether the worst excesses of the outcast type are to be found amongst staff.

Staff - low status

If residential homes are vulnerable to inappropriate people seeking and gaining employment, a partial explanation could be the low status of residential workers. Low status is afforded from four main avenues: 1) educationally, 2) economically, 3) sexually and in the 4) nature of the work.

* Local Government Training Board (See page 20)
1) Economically, care staff are classed as manual workers; paid hourly rates; supported by a large union of all manual workers rather than a specialist union; given little opportunity for incremental pay rises or career advancement.

2) Educationally, care staff are not required to have qualifications of any kind. Townsend (1963) noted the lack of training amongst all grades of staff, and the predominance of nursing training where it did exist. Carstairs showed (1971) that out of the 358 care staff sample studied only 29 had attended any course at all. Williams (1967) noted that 82% of full time staff in his study had no qualifications. Recently, R. Walton (1982) noted in the introduction to his text book for residential care that only 4% of residential workers had a social work qualification and most of the 4% were trained in childcare. There is a lack of training and where training is evident it is often in nursing skills.

This means that the work is available to those who would have difficulty finding other forms of employment, whilst care work becomes less appealing to those who have qualifications and can work elsewhere earning more.
3) The work force is overwhelmingly made up of local, untrained, married women.

However, the Local Government Training Board noted in 1982 that:

'traditionally the workforce has been predominantly working wives and mothers, approximately half of whom are part time. However current employment situations mean that younger people, including school leavers are increasingly seeking work as care assistants'.

4) The nature of the care attendants' work also suggests a low status. As discussed, the work does not have the fillip of curing; a lack of training opportunities further implies that anybody could do it. The nature of the work is 'people' work as defined by Goffman (1974). This is a particularly ambiguous and emotionally laden task and treated, as noted, with ambivalence and pessemism by society. It is also imbued with notions of deterrent and control.

Patterson (1977) suggests the work that care staff actually do involves 'keeping old people clean, dressed, fed and properly medicated' and 'maintaining residents' well-being as far as possible. Defining and
perceiving people as 'work' sets up a complicated and sometimes damaging string of relationships and interactions between staff and elderly that are explored below.

Who are the staff?

Staff in Residential homes are, on the whole, local married women who have had little, if any, training and who have few formal qualifications. They are classed as manual workers and paid accordingly. Whilst gradual changes in the age and sometimes sex of care staff can be noted, the lack of training and low pay persists.

It will be seen that the two homes under study reflect this picture. Differences in perception of their work will be discussed in the analysis chapters.

The Importance of Staff

Models of care and staff role

Although the importance of staff to quality of life in homes is assumed, the degree of importance and
the precise relationship of care staff to the quality of life experienced by the residents is a matter for empirical investigation. This relationship and the role of staff in general has been approached in various ways. The development of "ideal types" of care from empirical research has been useful in looking at the role of staff. Most of this style of research has not been done in the field of residential care for the elderly specifically, but findings are still useful.

Three well-known models of care are presented by Miller and Gwynne (1972) in their study of homes for the physically disabled. Each model is an expression of a particular ideology or philosophy.

The warehousing model involved a process of care by which residents were maintained and 'stored' in the home awaiting physical death after a symbolic social death which took place on entry to the home. The role of the staff in this was to maintain physical life as long as possible. The emphasis was on postponing death rather than prolonging quality of life. They see this model as one in which humanitarian concerns underpin the practise and where genuine concern for residents encourages dependency on staff, by staff performing daily living tasks for residents.
By way of contrast (although all models could be in evidence in one home) the horticultural model, underpinned by what they called liberal values, was one in which residents were seen as intrinsically valuable and were nurtured, like plants, to help them maximise their individual potential. This model encouraged independence and the role of the care staff was to develop all capacities within the individual

'to give the inmates real choices and facilitate their ability to implement them' (89)

They suggested that the warehousing model tended to lead to the sort of institutional practices Goffman identified. For instance the obsession with fairness and equality to the detriment of quality of care; the stereo-typing of individuals, the scapegoating of those who do not fit into the dependent role; and the 'canonisation' by staff of some residents who presented themselves as perfect examples of 'good' residents.

The horticultural model, although treating the resident as a whole, tended to invite an over-reaction, and a pushing of independence and self help to the extent that physical care was played down to the detriment of the well being of the residents.
The third model that they discussed was the organisational model. Staff role was to support the individual in whatever life style she choose to lead and to be adaptable to the changing needs of individuals as they deteriorated or improved. The re-organisation of management to separate care from administration would aid this process of caring.

In each case care work in the homes was seen as the expression of particular 'theories' or philosophies about the world in general and caring in particular. How those putting into practice caring models (i.e. care staff) approach their social world, their attitudes and understanding of their role and their work were an important determinant in the emergent model of caring in operation in any one home.

Roger Clough (1981b) linked philosophical perceptions (what he calls models, but shall henceforth be ideologies to save confusion) and care work. He concentrated on old age institutions and suggested two criteria by which old age homes could be typologised. These were the ideology of ageing, that is the view held by participants about the process of ageing and the degree to which the resident did or did not have control over life style. So, for instance, when
activity theory, where satisfactory ageing is seen in terms of active participation combines with minimal control over life style by residents, the nursing home unit would emerge. Where disengagement ideology in which satisfactory ageing is a slow withdrawal from the main stream of social life, combines with minimal control of life style by residents, the institution emerges. Where there is a socio-environmental ideology where satisfactory ageing is seen as a match between needs, expectations and resources, Clough suggested hostels and supportive units were most likely.

Although his explanation as to why these particular units should emerge as a response to the particular configurations he suggests, is not clear, his typlogies reinforce the view that each type of old age institution depends for its characteristics (that is, the resultant form of care), to a large extent on the 'ideologies' of the staff and the degree to which they control residents' life styles.

Ann Davis (1981) adopted a slightly different approach to looking at models or styles of residential care, but also linked ideology to practice. She was concerned with all forms of residential care and
focused on child care. She identified three prevalent perceptions or approaches to residential care. These are connected to the relationship between family life and residential care. The 'optimists' anticipate a gradual improvement in residential care as the residential establishment takes on a more family-like environment and becomes a substitute for family life. The assumption here is that family life substitution is the aim of residential care. The 'pessimists' see residential care as a compromise between divided interest groups. They see it as inferior to family life and ipso-facto an inappropriate model of care. Similar assumptions underpin this model. The 'radical' approach sees residential care as a welcome alternative to family life, and states that some forms of family life are detrimental to an individual's development.

She then discusses three styles of care, that are associated with these views:-

a) family substitute care, where the institution emulates family life.

b) family supplement care, where the institution provides a go-between for family and individual in order to reintegrate individuals.
c) and family alternative care where the institution provides a different sort of living style to family life.

Whilst Davis and others have demonstrated the wide variety of models and roles available to residential care workers, it will be suggested that in practice the styles of care on offer in old age homes seem limited to group living with the emphasis on emulating some sort of "normal" family life or "warehousing". This suggestion is supported by a number of studies. Evers (1981) looked at work organisation in geriatric wards and suggested a mismatch between the activity theory ideology of the hospital, (therapeutic optimism, active intervention, independence and purposeful activity) and the long term care of geriatric patients which cannot aspire to these goals. She identified two styles of actual care available; minimal and personalised warehousing. The difference between these two styles depended largely on the 'strategies for accomplishing work with patients' of the nurses and the "scheduling behaviour" of ward sisters, in other words, ward organisation.

D. Baker (1978) looked at nurses perceptions of their work in five geriatric wards. She noted the 'getting through and getting done' approach to work of the nurses in her study who in effect "warehoused"
their patients. She called this a "routine geriatric style" and this persisted despite a particular ward sister's vociferous dislike of it. Two styles of care emerged in one particular ward although the routine geriatric was much stronger. Baker also noted that for organisational purposes, medical staff favoured a routine geriatric style where work and paper work took precedence so that alternative styles of care were administratively less acceptable.

Patterson's (1977) study of six old people's homes also found staff keen to publicly maintain standards of cleanliness and neatness. Physical maintenance superceded social welfare to a great extent, and in five out of the six homes studied residents were viewed as less than fully functioning adults.

These studies suggest that the day to day staff work should be regarded as the actual model of care in operation and that this is likely to be dominated by a form of warehousing. But it is only by detailed descriptive work of actual practice, based on observation and interview of front liners, that the myriad of involved and complicated practices that cut across and combine many of the models discussed above— not only at a general level but daily and even hourly— can be discovered. A small group home, with trained senior staff, an activity theory as philosophical
underpin and good support from a positive management should operate a less warehousing model of care than a large impersonal home, with untrained staff and senior staff and little support from central social services. The degree to which this is actually the case is a matter for empirical investigation.*

**Variations in Role**

The increasing variety of residential care for the elderly available today, suggests increasing roles available to and demanded of staff.

Short stay provision in long term homes, (see Isobel Allen's recent study (1983) ) is becoming a feature of residential establishments; day units attached to residential homes are not uncommon; but above all, group living or natural living is being introduced.

This emerged in the early 70's borrowed in part from the family unit model of care for children and the mentally ill and handicapped. Marston and Gupta (1977) summarised the objectives of the new style of care as:-

'delivery of service in a way that maximised personal independence, dignity and choice'.

* T. Booth, in a recently published work on the dependency of elderly and routines of care suggests that the question should be, why are apparently similar homes so different? Here the question is, are apparently different homes quite similar in day to day living?'(1985)
The right staff approach and winning staff over by convincing them of the benefits of a new system, and developing their understanding of it, are crucial to the success of any group living system. Indeed papers produced by social service departments on group living systems emphasise the importance of this aspect of change to group living.

A study carried out in Haringay by Peace (1980) into group living found very positive changes in terms of residents increased physical abilities, whereas staff reactions to changes were less encouraging:

"Unless staff fully understand the objectives behind the new philosophy of care they may find themselves running the old system but in a new setting with better facilities".

During an informal questionnaire survey of five group living homes in Kent made by myself in 1982 the understanding and acceptance of group living by the staff were said by the superintendents to be of great importance to the outcome of group living. The superintendent of the Stanley Morgan home in Dartford said the staff were very anxious about the change, and she put the eventual successful transition to group living down to slow informative introduction to changing practice. The other homes' senior staff said that time was still a problem because old jobs still
had to be done, staff were in short supply and still as busy with the old jobs; staff would have preferred more time with the residents. A clear opinion, voiced by most of the senior staff, was that shifting furniture, changing design and renaming practice was no guarantee that a change in actual practice would occur. Preparation of all participants, but particularly care staff was necessary to promote an actual qualitative change in practice.

A small report from Leicester C.C. echoed these sentiments. The difficulties experienced in a move to group living in the two homes commented upon were mainly related to 'staffing matters'. This highlighted the need for explanation about and agreement to change by staff. They noted that more pride was taken in the new work role but some staff felt threatened by the changes and they often found it easier and simpler to perform tasks for residents rather than allow them to do it on their own. So, much of the discussion of group living was about the new and difficult role of the care staff:-

'In many respects the process of preparation itself will go a long way towards releasing the energy, commitment and critical attitudes that are necessary if any change is to be successful. Once staff have accepted that there is a place for a more critical and positive approach
to their work the home should begin
to gain some benefits from that, even
before actual changes are introduced'
(1979:16).

A shift towards a group living style of care must,
it seems, be with the direct support and understanding
of care staff, otherwise the danger for social policy
is that group living ideals may flounder and change
may occur on paper only. Actual practice may remain as
before.

The present research compares two different
settings and the actual roles of the staff. One home
was a 'traditional' care home and the other a group
living home which was purpose built.

Group living and traditional care should
theoretically involve different attitudes and practice
by the staff. However research into group living noted
here suggests that without effective preparation and
change in attitudes, much of the group living practice
will, at 'floor' level, become similar to the practice
in 'traditional' care. The present research examines
a suggestion that although at a superficial level
traditional and group living care are different, at
'floor' level "in actual practice" the two outcomes may
be very similar. Is the 'warehousing' model of Miller
and Gwynne the dominant practical model of care despite
ideological and organisational goals that propose
quite different styles of care?
What factors help to determine the style of care, the views, perceptions and practice of staff in old people's homes? What are the variations?

**Explanations of Variations in Care**

Davies and Knapp noted the statement made by Kushlik that:

'It is the workers having the most direct and continual contact with residents whose quality of work is vital. The principal theoretical task is therefore to explain the variation of the quality of input of the direct care staff'.

(1981:79)

What are the influences upon care staff that may alter or vary the delivery of care?

Davies and Knapp (1981) suggested two main approaches for tackling an explanation of variation in quality of input. Organizational explanation and what amounts to 'perceptual' or socialisation explanations about effect on practice of different attitudes, training and experience. Although it seems unwise to list, and thereby limit, the possible influences on staff, their suggestion of four key and inter-related variables which shape the residential task are helpful.
These are:-

a) the philosophy of the establishment.
b) the structure of the unit.
c) the attitudes of the staff.
d) the response of the residents.

Organisational

They suggest four elements of organization, the presence of which indicates an institution oriented regime. This was drawn from Tizard's work which is based on children's homes.

The first is the extent to which the authority in the home is delegated to various participants or the extent to which it is centralised and protected by senior staff in a hierarchical model; the more centralised the management the more alienated and disaffected will those staff be who are at the bottom end of the hierarchy. These groups are the 'front line'. (See Page 45 for full discussion of the relationship of front liners to policy). Front liners are characteristically far removed from the authoritative decision making. This however allows them a degree of autonomy and flexibility as we shall see in Chapter Three.
In the case of the old people's home, the authority to make decisions and be part of the official policy making structure is, in most cases, in the hands of the management, not usually with care staff.

The second characteristic is formalisation; the extent to which rules and regulations constrain the manner in which tasks are carried out by the worker.

Care attendants on the whole, seem to operate rather regimented routines, having a tendency to routinise their work. Aitken and Hague in Davis B. & Knapp M. (1981) suggested that the presence of rules and regulations were associated with dissatisfaction with work. In the case of residential care workers staff tend to create their rules and regulations and are dissatisfied if these are not adhered to.

The third feature is communication. Perrow (in Davies and Knapp 1981) suggested that the way in which communication between personnel on the same level takes place is important to the way in which non-routine tasks are carried out. The better the communication the more effectively non-routine tasks are completed. As Davies and Knapp point out, the residential home is essentially a setting where much of the work is, by definition, non-routine since it is with elderly people
whose individual needs change with time. Hence a clear passage of information between staff and a co-operative co-ordination of tasks and skills is important to individualised caring. A home with good communication structures, such as regular staff meetings, careful file notes and reports should therefore operate a less institution-oriented style. Research has not yet shown how these structures operate in practice in old people's homes, although there is some suggestion which is explored in chapter seven, that informal networks of communication between staff can be damaging to quality care. Goffman (1974) looked at the 'staff culture' and the development and dissemination of fictitious accounts of resident activity and explanations for practice that reinforce staff culture ideology.

The role of the senior staff in controlling and guiding communication between staff is an important one and reinforces the importance of the senior staff.

The final organisational variable is that of specialisation. The degree to which tasks are divided into mini-tasks will affect the degree to which individual oriented care takes place. Division of tasks works against personal care. In a situation where care staff are responsible for an individual resident's total care, rather than the same aspects of many residents care, better, more personal attention
will/should follow. So an important factor in care work is the extent to which the care attendant is able to see through a whole range of activities with one individual. This will affect the degree to which residents are seen by attendants as people or work. The way in which work loads are organised, presence or absence of key worker systems, shift organisation, the relationship of senior staff to floor staff all become important factors in the resultant care.

Although the organisational features of a home are important in understanding the constraints upon care staff, Davies and Knapp (1981) point out the:-

'arguments about the influence of organizational characteristics is vague. No studies are about old people's home.. only by empirical investigation can these arguments be tested.. and the relative importance of these and other casual arguments be assessed'. (p.85)

However, there has been some work in this area. A study by Stannard (1971) examined the influences of the organization on care. Stannard was concerned with the structure of patient care in nursing homes and particularly interested in aide abuse of patients.

He identified certain factors that shaped the role and practice of the care attendant. The presence of which were more likely to encourage institution oriented practice.
1) Responsibility and discretion given to aides.
2) Aides physical and geographical isolation from management.
3) High turnover of staff.
4) Lack of staff support and mechanisms, lack of transmission of skills and knowledge.
5) Endemic lack of interest in job
6) The patients influence on organisation.

The lack of supervision and isolation of staff was partly a result of the administrative burden of senior staff (the nurses) and partly a result of the nature of the work which mostly took place in private between one aide and one resident. This allowed for abuse of patients to take place despite an abhorrence of abuse expressed by nurses and aides alike. The aide sub-culture then protected and excused the abuse via their talk and use of linguistic apparatus.

The ability of aides to use their discretion over the way they carried out care was increased as isolation increased. Discretion as a characteristic of the 'Front Liner' is discussed on page 45ff.

The organisational lack of control over aides practice was commented upon by Clough (1981b) in his participant observation study of old age homes. He made the point that it was disturbingly easy for staff,
especially senior staff, to translate their attitudes into actions. Advice to drink more, to drink less, to keep active, to get out more and so on is given and acted upon because it is seen to be 'good' for the old people by staff.

The lack of supervision led to particular styles of care which, in the case of Stannard's study, encouraged extremely negative attitudes and sometimes cruel behaviour on the part of the staff. The isolation and degree to which staff felt themselves to be isolated was an important determinant of care.

High turnover is a perennial cause for concern amongst residential care managers. This is attributed by such groups as the Residential Care Association to poor pay structure, no career prospects and little opportunity for training with a resultant lack of commitment. Another associated staffing difficulty that affects the organisation of the home is shortage of staff. Short staffing, it has been suggested, leads to more routinisation of work and less time spent with residents. However, as Goldberg (1981) noted, the assumption that more staff contact with residents would lead to enhanced quality of life for those residents should be examined. Although the importance of staff role is without doubt, appropriate staff role is a matter for discussion.
The organisational problems of high turnover and short staffing are linked to the way staff view their work. What Willcocks (1982) has called the 'manual worker mentality' of most care staff implies no intrinsic interest in the work, more an interest in earning a living. The mental and physical abilities of residents, particularly their approach to entry into residential care, (see Tobin and Lieberman: 1976) and their general perception of the home all affects care staff's attitude to them and behaviour towards them.

Willcocks noted for instance that:

'The presence of substantial numbers of very old women in a home may have a determining influence on the way in which members of staff perceive residents as a whole'. (1982:18).

Gubrium's Study of Residents and Staff at Murray Manor Nursing Home (1975) shows that the residents had great influence over the staff's attitudes and practice and did far more than was perceived by onlookers. Much "sitting doing nothing" was actually a series of skilled negotiations between staff and residents for privilege, attention, more privacy and so on.

E. Patterson's (1977) study of the interactive processes in six old age homes suggested that the organization of finance within a home affected staff
attitude and practice towards residents. Self paying residents received better, more positive care and staff held more positive attitudes about them, than those who were part of the state system. Care staff in a home where residents 'pay their way' were viewed and seemed to view themselves more as servants of the elderly than benificent carers, to whom residents should be grateful.

Patterson suggested that it was not so much the size or age or organisation of the homes that was a determinant of quality of care. It was more the views, perceptions and interactions of staff and residents that determined quality of care.

Clearly organizational factors and attitudes are inter-related and affect each other.

Staff Perceptions

On the whole it is assumed that staff are fairly negative about their work and residents, and that this is a reflection of their routinised work patterns and institution oriented approach. This begs the question of the actual relationship between care staff's views and their work.
Various studies have looked at the way staff develop and operationalise 'theories' about residents and their work generally.

Patterson (1977) Gilliland (1984) and Gubrium (1975) all use an interactional theoretical perspective where staff are seen as developing and using a set of "theories", or typologies about their work which are then reinforced and modified according to daily practice. (See Chapter Three for discussion on theorising).

Patterson (1977) suggested that staff saw residents as work objects and developed work routines accordingly. The 'work objects' were then theorised about in order to explain and rationalise practice. The theories about the residents were dominated by the view that the residents were in some way a different type of human being to other mortals - 'in a different category of human being'.

This idea, that adults in residential homes are less that fully functioning members of society is familiar in Goffman's work from which Patterson drew her observations.
Goffman pointed out that:–

'as material on which to work, people can take on somewhat the same characteristics as inanimate objects. Surgeons prefer to operate on slender patients rather than fat ones. People work is not quite like personnel work. The staff have objects and products to work upon, but these objects and products are people'. (1974:73)

Gillilands (1984) study of the attitudes of nursing home staff and their typifications of patients is interesting in that she started off with the suggestion that staff would view the patients as either good or bad, based on the review of the literature of good and bad patients by Kelly and May (in Gilliland), where "good" means little trouble to staff. However, she discovered that patients in long stay and permanent wards (i.e. in a state of incurable decline) were treated in a less judgemental way by nurses who tended to type patients in these wards in terms of their rewarding or unrewarding behaviour. Patients who were rewarding could also be 'bad' patients (demanding, fractious etc.) They concluded that the notion of favourite patient becomes an important concept to examine when discussing geriatric care. A point of interest was that, contrary to the theoretical view which suggests that as patients become more known the generalisations about them lessen and more individual and specialist theories emerge, she found that the nurses persisted with their general typifications
despite knowing their patients intimately for some time.

Gubrium (1975) also reported that his nursing aides developed views about residents which formed the basis of their action. The residents here were categorised according to the trouble they made for the aides in terms of completing work. Residents were seen as more or less trouble makers and were acted upon accordingly. The aides distinguished between complainers and non-complainers and their categories were related to the 'bed and body work' that is, making sure that all the tidying up and 'public order' jobs were completed. This is something of a contrast to Gilliland's study where nurses seemed to be able to make a distinction between their views about the person and the work that needed to be done with that person. Gubrium's aides were mainly concerned to get through the work and residents more or less hindered that process.

These studies suggest not only that care staff develop theories about their work which inform their day to day work but that theories can differ considerably whilst routines can be adhered to.

Since staff are so important to the outcome of care in an old people's home it is useful to have a
understanding of staff organisational position in old people's homes. Staff are viewed in this thesis as front liners.

**Front Line Workers**

A front liner is a policy implementer. Front liners have immediate and day to day contact with the work object of the organisation, be it the packaging of biscuits or nursing of patients. They are responsible for day to day translation and implementation of the intended goals of the organisation. What front liners do is policy outcome. Front liners are typically the lowest paid workers in the organisation, have the least education and the lowest status. The literature review has suggested that care staff fit into these categories.

Two specific characteristics that have been identified in research in this area have helped to guide data collection and analysis in the present research. The first is a tendency for front liners to be routine bound and pedantic and to resist change; the second is the power front liners have to assert their will over the day to day practice of the organisation.

That the front liner is commonly viewed as resistant to change, implies that new policy
statements of intent or schemes introduced from 'without' (that is from further up the organisational hierarchy), will be either rejected or in some way subverted. This characteristic was noted by Willett (ibid). He explained the existence of innate conservatism and resistance to change of his prison warders by the presence of a state of inertia amongst the staff which was brought on (somewhat paradoxically) by a genuine feeling of being unable to change things. Officers became alienated from the goals of the organization (in this case rehabilitation) since the daily situation made those goals inappropriate. Willett used Durkheim's concept of 'anomie' to describe this position. Then referring to Merton's 'modes of adaptation' which were developed to account for role response to organisational goals, he identified the most common response of the warders to change to be one of 'ritualism'. The prescribed goals were either not understood or understood but rejected and the front liners just 'went through the motions'. Rules became important for their own sake rather than as a vehicle to organisational goals. This was noticeable particularly in organisations where goals were vague and undefined and methods of achieving them unclear or unknown. Residential care for the elderly seems to fit this description (as discussed in Chapter One).
T. Scheff (1961) interested primarily in the ability of subordinate groups to exert control over organisation policy noted in a study of a mental hospitals that various blocking techniques used by ward staff to resist changes led to the central feature of the intended new programme, which was the ward meeting, becoming redefined as peripheral to it.

Resistance to change involves an internally created routine and sense of cohesion amongst front liners themselves, as Goffman (1974) pointed out the staff world is organised for the benefit and furtherance of staff comfort and ease of work. Gubrium (1975) noted, in the context of nursing home staff, that the aides considered changes in policy or 'edicts' from above as 'administrative annoyances' (p.142ff) and discussed the techniques used by aides to resist, routinise or incorporate these 'annoyances'. (See Chapter Eight for discussion of techniques). So front liners not only resist change, particularly if it comes from policy statements of intent, but may create their own internal routines and rules which become 'policy' (in terms of outcome) in themselves.

The second and associated characteristic is the power front liners have in converting their wishes, attitudes and beliefs into action.
In questioning the 'iron law of oligarchy' Smith (1965) suggested that in the case of the mental hospital, the isolated nature of the ward made it a discrete unit where the activities of the participants became largely independent of the wider organisation. When this situation occurred the participants, particularly the staff, were able to act as they wished using their own discretion, and in a way sometimes unconnected with wider organisational goals.

This suggests that front liniers are isolated not only from official policy statements but from daily supervision by those higher up the hierarchy. Stannard's (1977) study of nursing homes and his focus on acts of cruelty reiterates the point about the isolation of the ward orderly in terms of his physical and geographical place of work - often work with 'patients' takes place in bedrooms or bathrooms, and leaves orderlies unsupervised and vulnerable. Stannard suggested from his findings that isolation of this type allows malpractice to go undetected and unchecked and that acts of cruelty carried out by aides would have been seen as unacceptable by those same aides given different organisational features.

Residential homes require similar work in private and staff often work 'alone' with a resident. Roth (1972) was interested in the way in which front liniers,
the reception desk clerks, in a casualty department in an American hospital, controlled the flow and order of casualty patients and decided upon the seriousness of the complaint presented. He commented that:-

"Many of these matters require subtle judgements to be made concerning seriousness or urgency. For example how 'difficult' must breathing be before it is treated as something that should be taken care of right away". (50)

And he noted the ease with which clerks were able to re-organise lists and re-classify complaints to create what they saw as 'order'.

Smith (1965) noted that administrative (clerical) discretion was part of the procedure of becoming a social work client. Hall (1974) also found in a study of the gatekeepers in a social work department that secretaries were shown to filter clients. Young noted the:

"Propensity of subordinate or peripheral actors within the policy system to make choices which are incongruent with those of the formal policy makers....". (1981:1)

These studies question the view that menial workers have no power and are unimportant in terms of policy. Those who are not considered important by others may sometimes influence things more than is
thought. The front liner has power to enforce his/her particular interpretation of events upon the work object. A comparison of the actual operative policies of front liners and official goals of policy makers should be part of any policy analysis.

The front liners need to make daily decisions that affect the process or practical accomplishment of the job at hand and have obvious implications for the policy process.

The thesis takes the view that care staff in old people's homes are front liners, and postulates two characteristics that may then be present in an old people home:—

1) routine bound practice and resistance to change.
2) power to control day to day activities of the residents and therefore their quality of life.

These two characteristics are discussed during the text as part of the data analysis.

Care staff will in some way distort or divert official policy statements through their activities and will develop structures that are appropriate in helping them practically accomplish the daily task of working with the elderly. It should be expected that policy
outcome will not be the same as policy statements of intent and that a rich 'staff world' with routines, goals and techniques for survival will be in evidence.

Summary

In sum, the review of the literature suggests;

a) old people's homes and the staff who work in them suffer from a poor press and ambivalent feelings of society which hampers a clear policy over the development and direction of such establishments and has relegated residential care to the 4th division of social services.

b) much of the criticism centres on the regimes within the homes which is, in reality, uninspired routine caring which involves time based or shift based activity, despite theoretical availability of different models.

c) despite many variables being recognised as affecting care outcome such as size, environment, residents characteristics and resources, staff role seems to be the pivotal relationship and will be the focus of the study.

d) a growing movement towards group living as an alternative mode of care where staff role is intended to be qualitatively different is
discussed and it is suggested that comparison between two different models of care would help to address the suggestion that there is a marked tendency towards 'warehousing'.

e) there is a need for a clearer understanding of day to day work in old people's homes as a means of bridging the gap between policy maker and policy enactor, and the use of the concept of front liner aids this process.
3. PHENOMENOLOGICAL THEORY AND RESEARCH

Introduction

The thesis examines the work of staff as they 'care' for the elderly residents and considers this in the light of policy expectations and statements. This chapter outlines a conceptual framework for looking at policy implementation.

The chapter suggests a phenomenological definition of policy whereby policy is seen as an ongoing process rather than a predefined statement of intent.

The notion of participants in a social setting 'theorizing' about their situation as part of their practice and constantly defining and redefining their reality is discussed and some ramifications of a social construction theory of reality for the thesis are discussed. It is suggested that theorizing and defining reality are useful concepts when looking at policy as an on-going process.

The conceptual issues discussed in this chapter are referred to throughout the thesis as the data are analysed. This chapter helps to define terms and 'situate' some of the concepts used for data collection and analysis.
There is a tension between a view of the world as constructed by its participants which recognises the participants' definition of the situation as paramount and the assumption in policy studies that outcomes should and could be different. This tension, it is suggested, is not an obstacle to the type of research undertaken here but a means of highlighting and examining the problems of policy making.

The fact that care staff view their world in a particular way and act on it in a particular way has immediate and concrete consequences for the 'outcome' of care. 'Real' outcomes are directly connected to the constructions made by participants. An important element of the examination of policy outcome is the actual behaviour arising from 'constructed' realities. The task of the phenomenological researcher is therefore to attempt to understand the perspectives of the worker in the field, and the way these affect their behaviour towards residents and the effect this has on the experience of the care received by residents.

The more traditional emphasis of social policy evaluative research is of course over quality or effectiveness of services and the 'appropriateness' of staff behaviour to those needs. With its emphasis on the perspectives underlying the behaviour itself, phenomenological research obviously has somewhat different concerns. The two goals are not, however, seen as inconsistent.

Whether or not behaviour is 'appropriate' in a given situation is a matter for negotiation between participants, including policy makers and researchers. The criteria for what is 'appropriate' care are a matter for debate and negotiation between all the participants in the setting. The researcher should be viewed as part of the debate. And she/he negotiates 'inappropriate' care in much the same way as other participants.
Policy: A Process

Exactly what is meant by policy is not always clear. As A. Webb comments in Timothy Booth (1979)

"the word policy's ubiquity precisely requires some agreement about what it should be used to mean". (p.98)

He suggests two clearly differing usages of the word which are helpful in clarifying a definition for the present research although he talks about these two approaches as sharply differing where they could as well be seen as part of a continuum.

The first (and more usual) definition is that policy is an authoritative statement of intent...

"a centrally determined base for directing".

This emphasises the importance of the managerial policy makers, and the political and economic influences on policy making.

The second approach is to define policy as that which organisations do, thus emphasizing the importance of multiple and discretionary decisions made at various levels, peripheral actors and service delivery in policy outcome. Actual outputs become the focus of attention.
It is clearly important to establish the definition of policy since the decision to focus attention on particular actors depends on the definition used. If policy is seen as a statement of intent then those making the statements are of interest. If policy is seen as a process and an outcome then those involved in producing the outcome gain importance, as noted in the discussion about front liners.

Whilst the thesis uses the term policy to mean the outcome - that is 'residential care for the elderly' as it appears in a given home at floor level, an examination of the relationship between intention, that is, the 'authoritative statement of intent', what organisations do and what service results is seen as necessarily part of the analysis of policy outcome. Therefore there should be frequent reference to the relationship between intent which is called 'official policy' and outcome which is called 'daily practice of care'.

The bridge between intention and outcome is the front liner's relationship with the work objects - in the present case the care attendants relationship with the elderly.
A definition of policy in terms of outcome - what organisations do - can be viewed as part of a phenomenological perspective. This perspective sees the social world as subjectively 'constructed' by its participants and continuously changing as a result of participants negotiating with each other. The phenomenological task is to examine the practical accomplishment of social life; in this case the practical accomplishment of the care of the elderly.

The definition of policy as outcome re-focuses questions of how "official policy intentions" are arrived at. Young (1977) was interested in the importance of the part 'values' played in the official policy making process. Through using the notion of an 'assumptive world' which he called the framework through which actors interpret their world it would be possible to examine how policy making is achieved. The outcome definition of policy focuses more on the implementor of policy rather than the maker of policy so that the assumptive world of the implementor and how they come to act in one way rather than another is as important as the official policy maker's world.

A Social Construction of Reality

The perspective of the thesis is in the Berger and Luckmann tradition (1979) and focuses on the 'social construction of reality'.
It embraces the phenomenological assumptions of inter-subjectivity (the essential ability of human beings to communicate), subjectivity and objectivation (the process by which subjective man's realities become seen as objective realities with an existence apart from their creators) and language as topic and resource (where language is both the means by which we communicate and describe social life and part of social life itself).

This section will consider the aspects of social construction theory that help identify the practical accomplishment of caring and draw attention to some points in the theory that have been of importance to the research reported here. The structure of the thesis owes much to the various points raised below and each point raised is discussed during the course of the analysis chapters and is used as the basis for some of the analysis and data collection, as shown in the chapter layouts (page 10).

**Precarious reality and Reality Maintenance Techniques**

Social construction theory asserts that what is commonly understood by participants to be a 'given' objective situation, is in fact constructed subjectively by participants and then objectivated. This means that what is understood to be a fixed
'reality' is in fact a precarious and ever changing situation that is constantly in danger of being redefined and reconstructed. An example of a precarious reality is the gynaecological examination discussed by Joan Emmerson (1973). She indicates that

"apparently trivial features of the social scene such as details of the setting, persons appearance and demeanour and inconsequential talk". (358)

as well as the more important shared language and understanding of categories of participants, all go to ensure a particular situation or reality remains stable. She then notes that

"situations differ in how much effort it takes to sustain the current definition of situation". (359)

and that there are three types of events that can disrupt the reality:-

Firstly, where there are intrusions on the scene so that people or objects don't behave as was expected, thus shaking participants faith in the situation: Secondly, where participants are unfamiliar with the 'correct' procedures which will sustain the reality: Thirdly, where there are so many contradictory
definitions available that the original definition becomes less credible and defensible: The gynaecological examination produces all these situations.

An important part of her analysis was to illustrate the reality maintenance techniques that were employed by the participants in an effort to sustain the precarious reality. For instance, by talking in euphemistic terms about a patient's genitals, all participants could maintain a professional aura; by no eye contact between doctor and patient while the examination was being carried out to avoid inappropriate non-verbal communication; by the presence of a female nurse to underline the objective and medical nature of the examination. Thus the participants employed techniques to sustain a reality. These techniques had been learnt and were part of the social stock of knowledge.

Much of the reality maintenance 'work' is in the form of language. Berger and Luckmann talk about the legitimation and justification of one reality over another which takes place through talk. (1979:70-89).

Legitimation, as Berger and Luckmann see it, occurs according to the precariousness of the reality. Some situations are so 'obvious', and part of the
culture and tradition, that there is no need for further legitimisation. They call this 'naive acceptance'. There is a need for legitimisation to the extent that the reality has become a 'problem'. Most legitimisation takes place through socialisation of new members; this takes place in childhood and upon entry into a new social group as an adult. Secondary socialisation is therefore a very important legitimisation and maintenance technique. Another technique is the use of social control via 'therapy', by this they mean anything from exorcism to psycho-analysis: the proponent of the 'deviant' reality is restrained and reorientated and explanations given to explain the deviant's behaviour. The thesis data discover (p.295) that care staff demonstrated techniques for accounting for lack of agreement by suggesting some sort of mental or physical aberration. Another technique discussed is nihilation. This is the denial of the 'deviant' interpretations of reality either through assigning an inferior ontological status to the opposing definition of the situation, or reinterpreting deviant conceptions.

Negotiation

There is inevitably a degree of disagreement between participants in the same social setting about aspects of a "reality" and this is handled through a
process of negotiation of how a situation is defined. Negotiation is both a maintenance technique and contributes to a continuous process of change. Indeed negotiation facilitates change. Given the tendency for front-liner workers to resist change already identified, they would be expected to resist negotiating reality and be in a position where they had the power to do so. Negotiation is an important part of creating a social setting and, ipso facto, an important part of what is called caring.

**Lay Theories and Practice**

If care attendants are seen as front liners, with the associated implications for policy, a means of conceptualising and empirically examining the relationship between policy statements and intentions and the practical accomplishment of care is necessary. Work discussed in the literature review has used the idea of lay theories developed and used by participants as part of their every day understanding of their social world, (p42). Lay theories are part of the interpretative procedures used by participants to make sense of a situation and part of the process of social life. Schutz (Wagner:1970) called theories "recipes" of knowledge. By this he meant that actors hold in their heads a number of recipes which will help them interpret the world and act in it appropriately. The
recipes are not static or complete but are seen as 'doing for the purposes'. Recipes can be added to or abandoned after they have been proved unfit. 'Theory' gives the idea of an actor trying out various theories and testing and retesting them according to evidence presented during the course of his practice.

Kelly's work on personal construct theories (Fransella:1980) uses the image of man-as-scientist where, participants constantly engage in a process of hypothesising, observing, re-hypothesising and testing theories about the everyday world.

Theories, according to social construction, are developed from a social stock of knowledge which is a manifestation of biographical experience. All knowledge is ipso facto partial. The biographical experience is seen by Young as the assumptive world (1978). His work is useful since he is particularly concerned with policy making. He suggested that an examination of the values, beliefs and attitudes and perceptions of policy makers would reveal a tension between various elements in the conceptual framework particularly between the image of the world as it might be, compared to the world as it is. The tension between image and experience produces policy intention and policy statements. Thus particular policy statements of particular groups are clarified. He
suggested that values (of policy makers in this case) are of great importance in explaining policy initiatives and values, attitudes and beliefs are ranked in order of their 'embeddedness' with four conceptual properties making up the subjective understanding of the environment. Having stated his belief that the 'assumptive' world is of great importance he suggested that empirical examination of the assumptive world can take place through using Kelly's personal construct theory and in particular the repertory grid techniques where personal constructs of individual participants can be identified, charted and reduced to about ten major categories.

Although Young does not explore the possibility of examining the assumptive world of the policy implementor, his argument equally applies to policy implementors as to policy makers.

Implications of Young's work is that research should study the context and biography of participants in policy making. He draws attention to the significance of biography to the practice of individuals in the sense that the assumptive world is a manifestation of an actor's life experience to date. He also points up the need to make the context of activity clear, and therefore sees qualitative research where
actors are observed and described in situ, as essential.

Accordingly the thesis will look at the biography of the care attendants and the influences upon them in Chapter Five in order to put the theories into context.

However, it is not only important to understand where views, perception or 'theories' come from, (as Young seems to suggest) but to see how they are actually used in practice. It is arguably as important to know what the consequences of the interpretation are, as to know why an actor interprets in a certain way.

Theories are explanations, justifications and interpretations of action and part of action themselves. This is what gives them their depth as an analytical tool. They offer data on both why actors behave the way they do and how they behave in the way they do.

Patterson (1977) in her study of old people's homes, used the concept of theory to examine the care staff's interpretation of their situation, and work with the residents. She made clear the dual nature of theories as an account of caring and part of the practical accomplishment of caring.
"When people become routine work to others, sets of theories almost invariably develop about these objects of work... these theories serve not only as guides to management of routines... but as an explanation and justification of events". (p.121)

She also noted that there was a need for staff to hold general and specific theories about their work and the content of these two sometimes seemed contradictory. Indeed the contradictory nature of theories held by the same person about the same work object must be treated as part of the nature of theories. Part of the task is to point up contradictions and analyse them by looking at the context in which one theory is used in preference to another.

Patterson noted that theories held by staff about residents depend largely on the amount of work they made for the staff. This has been discussed in the literature review. This point is also made by Miller et al in "A Life Together" (1981) where they were interested in attitudes towards the disabled. They suggest that a potentially contradictory set of attitudes are available to an actor and, depending on the objectives of that actor and relationship to the disabled, attitudes are chosen accordingly.
Conclusions

This chapter has tried to 'situate' the analysis of the data in a social construction theoretical framework. Certain definitions and assumptions have been clarified about the process of social life in general and front-line participants in particular.

The present analysis of care staff work in two old peoples homes is structured by:-

a) a definition of policy as outcome and therefore a focus on 'the practical accomplishment of caring for the elderly'
b) certain theoretical assumptions, some of which are at the same time a matter for empirical debate; that language is both topic and resource, and that realities and definitions of situation are precarious and subject to constant change through negotiation. (In Chapter Eight the analysis explores the precarious nature of caring and the techniques available to staff in the homes to maintain a particular reality. It considers the 'conversational apparatus' that is available to staff and the structural features of the residential homes that promote or discourage particular styles of care).
c) the concept of 'lay theory' is used particularly in Chapter Six to observe and analyse the way in which staff account for and predict their caring role.

The advantages of this theoretical framework in helping to structure the data collection and analysis are also its disadvantages. The complex and lengthy data collection procedures needed to record the lay theories of participants and the use of conversational apparatus in 'caring' day to day are subject to the same "social construction" analysis as the data itself. A researcher uses lay theories about what she observes to hypothesize about meaning. Her very presence in the field involves her in negotiating and defining situations. The researcher must distance herself from the data whilst at the same time participate sufficiently to learn the theories. The researcher must bracket (epoche) a 'natural attitude', that is a fundamental belief and acceptance in the 'everyday' and question what seems obvious, whilst at the same time accepting the actor's definition of the situation.

The next chapter considers the role of the researcher as it affects data collection given this particular theoretical position, the actual role of the researcher in the present study and the nature of the analysis that was undertaken.
4. METHODS AND ANALYSIS

The main method used in the research was participant observation (P.O.), although this was by no means the only method.

Much of the positivist criticism of qualitative methods is based on the view that daily personal contact between researcher and researched renders the collected data 'subjective' and 'unscientific' since it cannot stand up well to tests of validity and reliability. Part of the response comes from the theoretical basis upon which qualitative methods in general and participant observation in particular rests. This suggests that all knowledge is partial and the purpose of social research is to examine the everyday activities of people in order to uncover the actor's own version of social reality. As Burgess (1984) and Cicourel (1964) both note the emphasis is on meanings that individuals give to a situation and how they construct and modify meaning. The qualitative task is different to the quantitative task and so the problems are different. The criteria of 'scientificness' is rendered less relevant than the way in which the theory and method unfold as the research develops. Methods are to be seen as part of the construction of the reality that is under examination.
The Relationship between Theory and Methods

As noted at the end of Chapter Three, social construction theory applies as much to the researcher as it does to the researched. The researcher is trying to 'account' for action from a detached position whilst at the same time learn what it is to be the actor in that setting. The relationship of researcher to her material is an uneasy one. The forerunners to participant observers - the anthropologists - saw themselves as strangers in a new group. This is examined by Schutz (1976). He illustrated the interpretive processes necessary to become part of a group and the way in which a stranger to the group is socialised. He made it clear, however, that the sociological researcher's relationship to her data should be different. The 'common sense' man, stranger or participant, experiences the social world

"as a field of his actual and possible acts and only secondarily as an object of this thinking.(91)

whereas the sociologist:-

"is disinterested, in that he intentionally refrains from participating in the network of plans, means and ends relations, motives and chances, hopes and fears which within the social world he uses for interpreting his experiences of it; as scientist he tries to observe,
describe and classify the social world
as clearly as possible in well ordered
terms in accordance with the scientific
ideals of coherance, consistency and
analytical consequence". (92)

Schutz offers an ideal type model for the
researcher to aspire to. However, Schutz did not seem
to acknowledge that a social construction theory
approach such as his, suggests that the researcher's
very presence is part of the field work data. In order
to be as 'disinterested' as possible the researcher
should therefore catalogue her research activities as
part of the data.

The researcher reconstructs the data observed as
notes are recorded. Observations are objectivatized as
notes are made. Indeed that is the purpose, to some
extent, of recording data.

There are two points to note about this process.
Firstly the researcher's attention will shift focus
many times (if not daily), through the observation
period as a result of recording observations. During
recording, a particular situation is brought to the
attention of the researcher and she develops a
hypotheses which is then tested during subsequent
observation periods. So hypothesis are developed and
tested continuously. This is discussed by Glaser and
Strauss (1967) in relation to the generation of
'grounded' theory during field work. They argued that comparative analysis produces conceptual categories which are disproved or otherwise during further observation. So a 'running theoretical discussion' takes place throughout the course of the research.

The second point, related to Glaser and Strauss' grounded theory is that the process of objectivation that takes place during recording sometimes masks the 'ongoing' or continuously developing nature of unfolding data. Once the data is in a readable form it may be filed away and there is a danger that the last observations of any research period are seen as the only 'true' or reliable ones. Vidich makes this point in Cicourel's chapter on theory and method in field research (1954):

'To refresh his memory, the participant observer can turn to his records, but if his perspective has changed with time he may disregard or discount earlier notes in favour of those taken later.... the field worker obscures change by treating his data as though everything happened at the same time. This results in a description from a single perspective, normally that held just before leaving the field, but redefined by rereading his notes". (1954:46)

The researcher must therefore acknowledge and document an ever shifting perspective that enriches but greatly complicates data analysis, and guard against a
static one-dimensional analysis of what will inevitably have been a changing social situation.

Given the researcher's activities of note taking and observing, there will certainly be a researcher effect on the situation. As Cicourel notes

'An immediate consequence of participating in the group's life is that the researcher inevitably is to help make policy decisions which will alter group's activities'.

(1968:41)

In following sections the difficulties of avoiding influential action are considered. Inevitable participation and influence on the research setting means that the researcher must be considered as part of the data. The recorded observations must note the researcher's role in an account of a situation, and role development and change are important to the data base.

Becker acknowledged this and suggested that a 'natural history' of methods be offered as part of the research (1971). The researcher would present the reader with an account of her own biases, (her starting positions, her assumptions etc.) and the development of her sociological research style and methodology over the research period. Becker wanted the researcher to record every stage of her actual activities in the field. Cicourel reinforced this (1964) pointing up the
difference between what is said to be done and what is done (that is between ideals and realities) in any research setting. Bell and Newby's edited book (1977) gives accounts of what happened in the field which differed markedly from the textbook accounts of methods. Cicourel encouraged a full documentation of methodological 'events' as part of the process of 'verification and replication', the lack of which is a major criticism of qualitative methods.

Frank Burtons's (1978) criticism of a documentation of method in the way Becker suggests was threefold. Firstly he called the 'bringing out of dirty linen' on the part of the researcher 'naive' since the decision about what is relevant or not is biased in itself and stating the assumptions only clarifies them, it does not eliminate them. Secondly, whilst the researcher will certainly affect the data and the interactions of the group he is studying by his very presence, the same would happen in any situation. People affect interactions. Indeed the researcher qua researcher is likely to be forgotten by the other participants as the length of research period increases, and the researcher becomes more and more incorporated and involved in the daily activities. Thirdly he criticised the idea that accounts in participant observation 'emerge'. He suggested that accounts of activities are "shaped" by partial
selectivity of events and partial retention by the researcher of events. Reality, he concluded cannot be reproduced. He saw the task of the methods, in his case a study looking at the Catholic population in Belfast, to document the passage of becoming an insider - that is to re-construct the socialization process of the researcher as part of the data.

The rest of this chapter is an account of becoming a researcher and discussion of the various methods adopted.

A Chronology of Methods

The choice of methods for the data collection was participant observation, extended interviews, survey, questionnaires, and file and report book analysis. Choice of methods must depend to some extent on the theoretical perspective of the research. Burgess (1984) noted that participant observation is a natural partner to the theoretical position of Schutz, Berger and Luckmann and others. However choice of methods is also a matter for personal preference, and is sometimes thrust upon the researcher. Joel Richeman (1983) used participant observation in his study of traffic wardens. He noted Kassebaum's three reasons for undertaking a sociological study. Firstly it is to study a theoretical problem, secondly to find practical
solutions to visible problems in society and thirdly the opportunity to make the study as it arises.

The present study and methodology developed out of a very clear desire to address the visible problems of care for the elderly and the opportunity to use

The two homes were selected as a result of the survey (Appendix A) which clearly demonstrated a distinction between the 'traditional' home and the 'group living' home. They were thought to provide a good contrast for comparison.

observer/researcher without too much personal upheaval or disruption to home life (see Chapter One). The transition from employee to researcher took place from one week to the next and to start with little change in the daily role occurred. Because of this particular entry into the field various problems occurred in recording my initial socialization as Burton (ibid) recommends, because I had long since 'become' a 'knowledgeable' care attendant. This is discussed in the next section.

As a participant observer, I continued working shifts (8a.m.-5p.m., 12.30p.m.-9p.m., 9p.m.-8a.m.) for several months. The nature of the participant observation gradually changed so that it went through various styles during the field work period (see below for full discussion).
The Fell View data collection period lasted eighteen months. During the participant observation various other methods were employed, to collect various types of data. A survey of all 28 homes in the Authority was carried out, partly to get details about numbers of elderly, admission paths, staff quotas and conditions to make comparison with the first home and to test some hunches, and partly as a public relations exercise. As a result of the survey (a report of which was submitted to the Local Authority and is found in Appendix Aii) I decided to make a comparison between Fell View and the only group living home in the Authority, Deer Park. Fell View staff also received a questionnaire about half way through the research period, which, combined with the survey, had the effect of distancing me from my previous role as care attendant. Indeed the process of participant observation over the eighteen months could be seen as a process of withdrawal from being a care worker.

I analysed files on the elderly residents, so that participants' 'theories' about the elderly could be compared to details in their files. The report books were also analysed. This took two forms; firstly the content and style of three months of reporting was looked at to examine home 'language' and to compare observations with reported accounts from staff.
Secondly, by following four residents' 'careers' through the report book, changes to and differences in theories were noted. The analysis of written documents also served as a means of distancing from the daily work, and provided an excuse to withdraw from compromising situations. As will be seen later, a problem of starting as an 'insider' was that the participants insisted on my participation. Often a whole shift would be taken up with routine daily tasks which made distant observation difficult. This emphasised the lack of staff and the way in which the demands of the routine day controlled actions.

Deer Park, the group living home, was entered in January (1982) and a questionnaire similar to the first home was administered immediately. A period of participant observation then followed, with quite a different mood and style since I was introduced as a researcher and had a shorter contact period. Extended in-depth interviews with 25 out of the 26 staff took place. These were tape recorded and lasted about three hours. Content analysis of report book and files took place concurrently with the participant observation. Overall contact with the home was about five months compared to nearly two years for the first home. The extended interviews completed the research contact with both homes apart from some 'feed back' from interviews.
Denzin and Zedditch (1970) have both contributed to the discussion over the merits of triangulation. This is a technique of research whereby the researcher uses more than one method both as a means of checking data and obtaining different kinds of data. Denzin itemises kinds of triangulation ranging from use of more than one theory (theory triangulation) on the same data, using the data for more than one purpose (data triangulation) and using more than one investigator.

The triangulation involved in this research meant that one researcher used more than one recognised method of data collection. This was used as a means of cross-checking participant observation; as a means of collecting fresh data difficult to obtain by observation; and as a means of shortening the research period at Deer Park.

Becoming a Researcher

The following section considers the way in which I became a researcher and, in line with the previous section's discussion, is presented as both the data collection technique and part of the data base itself. Text book accounts of qualitative methods are notorious for their understatement. Much of the process of becoming a researcher is through ad hoc responses to situations. However, the literature does show that
many of the problems associated with the method of participant observation concern the role and activities of the researcher as we have seen. The role adopted by the researcher will affect the data collected. Gold, Olesen and Whittaker (in Denzin 1970) have suggested that the researcher goes through various role stages which are progressive and associated with acceptance into the group and the final role is that which becomes established and accepted by all participants. However a more forthright analysis of role in Bell and Newby's collection (1977) suggests that role is by no means a matter for the researcher alone to decide upon. The participants have a relationship with the researcher and to a large extent dictate the roles adopted during the fieldwork period. The degree to which participants are aware of the research task will also affect the relationship between researcher and researched. The text book accounts of role technique in participant observation are not particularly relevant, appropriate or useful. Role is a matter for empirical investigation as part of the research data.

Similarly the problems of researcher bias and influence on the data are matters that are discussed in theory with little practical advice for the researcher. In this thesis bias in perception and influences on the care staff are dealt with as they appear in the data.
The ethics of the participant observation method, the way in which confidentiality is respected, and the way in which the researcher leaves the field is seen to be of particular concern and is considered in this section.

Entry and Access

As noted Frank Burton (1978) states that the research task is 'to document the passage of becoming an insider'. An aspect of the current research was that I had already become an insider, having worked for the Local Authority for several months, and gone through the socialization process prior to the research period commencing. The task was therefore to unravel the socialization process and regain status as an outsider once more. This led to particular role difficulties.

Firstly, I had learnt prior to the beginning of the research project to take for granted much of the day to day activities of the care staff and in particular had learnt and was using the home's language. The other care staff took for granted my care staff role. As a result asking questions as a researcher about why a particular situation occurred, or why particular rules were kept or broken, was seen as inappropriate by the staff. This led to the need to
reiterate role and task as researcher to explain why such questions were relevant, which in turn drew unwanted attention to the research. However this situation did not prevail for long. As I became more skilled in asking questions discreetly and my transition from care staff to researcher became accepted, an easier relationship developed.

Access to information and particular settings was never difficult. I was always invited to observe interviews and senior staff meetings; however, I was often drawn into the discussion as the care staff's spokesman. This required a reiteration of the confidential nature of my research, and the sensitive nature of my role in the organisation.

A deliberate clouding of the actual subject matter of the research helped me to be all things to all men and threaten no-one excessively. As far as the care staff were concerned the research was about old people in homes, and the senior staff understood it to be about care staff. Hence no group was particularly anxious. Indeed, in common with most participation observation studies, it was genuinely difficult to be exact about the precise nature of the research at any one time.
I had arranged access to the second home, Deer Park, during the survey and because of the "grapevine", knowledge about my research was well distributed in this home. This helped me gain the acceptance and confidence of the second group of staff. However access at Deer Park was more complicated on a day to day level for the participant observation since the design of the building (see Chapter Five) meant that I was usually excluded from the private areas of the residents' activity. At Fell View everybody sat in the same place and care work was carried out largely in the dining room, living room and hall toilets. I was able to observe and participate freely. Furthermore, my role as a member of the care staff remained intact as far as the residents were concerned. This meant that I had free access to bedrooms. At Deer Park, I never entered an elderly resident's bedroom, except by specific invitation of a resident, and then usually without other care staff. Some of the care staff activity was hidden to me at Deer Park. The interviews carried out at Deer Park were intended to compensate for this.

Interference and Influence on Data

As both part of the setting to be examined and the means by which the setting can be examined, the researcher's actions are an important part of the data.
These actions, called interferences and influences here, are discussed throughout the analysis chapters, as part of the data. There will obviously have been many occasions upon which influence has not been noted since it did not become apparent. Two examples of the researcher's interference and influence gives some indication of the range.

In an exchange with one of the male staff, taken from the participant observation files it was noted that:

'Chris was teasing Mary and asking her where her husband was - Mary is widowed and thinks her husband is another resident, Edward - Mary said he was "over there" pointing to Edward. I said to Chris that he was compounding her confusion and that he shouldn't do it. He told me not to be bossy... but he did stop'. (R2)

This was blatant and direct interference. However the ethical difficulties of not interfering were greater in some instances than the methodological problems of doing so. Less direct influence is illustrated by the following extract:-

'There was some talk about how women should stay at home or only have small part time domestic jobs at breaktime. Someone said not to say that in front of me since I was a "real feminist".(R3)
This particular influence was more insidious and probably didn't directly affect care practice. However this kind of personal influence on data may have affected staff's perception of myself and their relationship with me and reaction to my presence.

Another clear influence was the effect the extended interviews had on the staff at the group living home, Deer Park. Having got over initial anxiety about tape recording, discussions with staff opened up and digressed from the main questions, in some cases quite considerably, often disclosing personal details about their lives. (Almost all said they had enjoyed their interview). The following comments were noted at the time:-

The length, quality and truthfulness of the interviews will have varied of course. However, overall, I have been impressed by the apparent openness and sincerity and depth of the staff's comments. The value of having done some participant observation prior to the interviews should not be underestimated. Another factor I noted was that the interviewees tended to use the interview as a therapeutic exercise and would often say at the end that they'd really enjoyed the discussion - certainly whilst I was typing up I noted that the interviewees often 'got things off their chests' and focussed on particular incidents that had upset them in their work.... I began to feel that the presence alone of a researcher (or indeed an interested person) irrespective of findings is a shot in the arm for much neglected social service workers. A distinct Hawthorne effect!". (June 1982)
Previous participant observation meant that the supplementary questions in the interviews were prompted by prior observations of particular events. I was able to ask for an interpretation of an observed past event during the discussion which enhanced the value of the interview. It also meant however that I was always in danger of what Burgess (1984) described as 'trying to get the right answer'. He noted that researchers can be in danger of not accepting an unexpected answer. This was duly guarded against during the interviews.

A final point about the unconscious influence of researcher on subject is that the staff in Deer Park seemed more 'street wise' in their views generally than those at Fell View. Although this is discussed in later chapters, it is worth noting here that the role of researcher in Deer Park was much more explicit right from the beginning and this may have prompted staff consciously or unconsciously to give a more cunning account of themselves and their actions. At Fell View I noted many interactions between staff and residents that reflected poorly on the staff and felt the very fact that they acted in these ways in front of a 'researcher' demonstrated an acceptance of myself as part of the setting. At Deer Park there was less compromising behaviour and talk about residents in front of me. It may have been a result of the research project or a more appropriate code of conduct.
at large in the home or, most likely, a bit of both.

**Staff and residents’ reaction to methodology**

As already noted, the interviews provided a therapeutic forum for the staff at Deer Park. By way of contrast the reaction of Fell View staff to the questionnaire (Appendix B) which came during the participant observation period, was quite hostile and much of the detail asked in the form was not provided. There was some anxiety about what I was to use the information for, and speculation about my links with the 'Civic Centre' ("The bosses"). The questionnaire in fact sharply focussed my role as a researcher rather than care worker and since it was immediately followed by a group living project (see page 104) meant that my role as researcher was confirmed convincingly, to the detriment of a more relaxed previous relationship.

The precariousness of my role as researcher at Fell View was never so apparent as when I was asked in a morning shift if I'd come to work or to research! The shortage of staff and the needs of the residents meant that my own activities and role shifted according to the pressures upon the staff; at Fell View it would have been unacceptable to "observe" whilst staff felt particularly stretched and very 'busy'. Staff would
actually give me jobs if I did not pitch in uninvited. My field of study altered according to the staff and residents' needs. This was not the case at Deer Park where no previous care staff role had set a precedent. More peripheral members of staff tended to view me as a social worker. They described me to outsiders, after transition to research from care staff, as a 'sort of social worker'. This perception was not helped by the fact that I apparently dressed and spoke like a social worker!. Being a social worker was not a high status occupation in the eyes of the staff and I spent time during the months of research denying any social work connections.

The residents at Fell View, however, never really altered their perceptions of me as a member of staff and it was not an unusual situation to arrive at the home and immediately get involved with dressing, helping to the toilet, or washing urine stained floors and on one occasion 'laying-out' a dead resident. In fact, analysis of files and report book, was an essential device to help extract myself from the day to day activities of the home. This 'involvement' did not occur as much at the second home.
Leaving

Fell View had initially been my work place and consequently a place where deep feelings of anger, compassion, and resentment, to name a few, had been expressed. Intimate daily contact with staff and residents led to feelings of real friendship so it was hardly surprising that leaving the home was difficult. Unlike Joel Richmans's research (1983) about traffic wardens where he 'just faded out' I announced a date upon which I should leave the home. This date was for administrative convenience rather than because I had 'finished'. Participant observation is not so much finished as stopped. The date was around Christmas and leading up to my final departure I spent less time at the home. The staff gave me a Christmas present for which I was very touched.

When I reflected on the two 'field work' years, I realised that the staff population was virtually unchanged but the resident population had altered quite substantially. Recalling the residents who had died made me realise the transitory nature of the care staff work and admire the ability of the staff to constantly adapt to new circumstances and cope with loss. I was very sorry to say goodbye to the residents, particularly the ones with whom I had worked from the beginning, and who had, so trustingly,
confided in me their fears and disappointments and, less often, triumphs in their declining years.

My first return to the home six months after leaving, left me more distressed than I had imagined since more of "my" residents had died. I suppose I had assumed, somewhat pompously, that my presence and then lack of it would have left its mark on the home. Nothing of the sort had occurred. My lack of impact on the home and the souls within it was made all the more apparent by the fact that six months later very few residents knew who I was or remembered me.

At Deer Park my leaving was less traumatic since the role I had occupied had leaving built in to it. My relationship with the home was always a temporary one. Furthermore all the senior staff with whom I had become friendly and who were interested in the research had left and the new staff had less interest in a departing sociologist. Also, perhaps, the ending of a research period which had been relatively lengthy and certainly very intense, came as a relief since lurking in the back of my mind was the feeling that the more data collected, the more there was to analyse. The problem of analysis had begun to take on serious proportions.
Collecting Data

Having noted that there is a distinction between what is observed and what becomes the recorded data base for later analysis, the first stage of analysis is taken to be the initial recording where there is a reworking or reconstruction of observation into a coherent 'readable' form. An important element in the recording process is the time gap between observation and recording. The following section indicates the recording procedures used and notes some of the alterations to these procedures that took place as part of the 'unfolding of the data'.

The early participant observation at Fell View provided a chronological account of events in the home. The following extracts show the changing style of recording throughout the research period.

30.6.80 - First day. Staff infighting as usual. Everyone is angry with Chris today. 'Everyone' includes the residents; Flora called him fat and ungentlemanly this morning ...all the residents sit in the same chairs and only a few read but there is a television upstairs. There is very little resident contact or that's what it seems like. Some of them are capable of chatting although they almost seem to be resigned to behaving like senile stereotypes and completely unexpectant of any sensible conversation. A self fulfilling prophecy? No occupational therapy, no radio, no activity except eating. Rush meals. Typical nursing care, smell of pee. Bath only once a
week, very short staffed. I find it distressing and difficult talking to residents. I feel I'm on show. Presumably this will pass. (Rl)

This extract came from the very first day of contact with the home, when I was employed as a care attendant. The heavily laden judgements are apparent. By the end of the summer, when the research had been confirmed I wrote an account of 'some of my feelings having worked as a care attendant at Fell View for three months'. This was intended as a means by which I could exorcise some of those judgements:

'My first day was as expected a shock, and as far as I can remember I experienced the superior feeling that I would never behave like the other staff. I think I found them rather coarse and certainly felt they did not treat the residents with the dignity that I saw as being important... The onus for improvement fell very much with the care staff... I tended to see the elderly as helpless victims. I also felt that so much time had to be taken up with staff relationships, just the business of getting on with the staff is so personally essential, that it overrides, very often, any consideration for the residents. The work ethos for instance required that a care attendant was seen to be working and working was defined very much in terms of production. Therefore, to be seen sitting talking to a resident was seen as not productive and not work, whereas talking to another member of staff of similar rank was not seen negatively'. (Rl/10 August 1980)
Right from the start of the research the reported data notes contained categories ('the work ethos') and endless analytic comments about why situations were as they were. I also recorded the 'typical day' as I experienced it during the three months (see Chapter Six) and a small sketch of each of the residents as I had understood them as a care attendant.

The initial research period notes are organized in terms of incidents with sub-headings and researcher's comments about the typicality or otherwise of such incidents. This early period of note taking was both enhanced and dogged by a prior knowledge of the situation which means that much of the early analysis took place during the first few months.

As the research period lengthened and my role as researcher became more established, the notes became less anecdotal and of the 'typical incident' variety and more chronological and more "objective". For instance there is quite a difference in style between the 7th of July, 1981 and the end of the research period in December 1981. On 7th July 1981 the day's notes are sub-divided into complaint system, understanding of instructions, interaction with residents, conversations with officers in charge, and talking in the kitchen. In this session I had pre-headed the notes and drawn out events to slot into
the headings. By December 1981 there was a noticeable change in note taking. Firstly the notes were a record of the chronological order of events that occurred on the day. They were extremely lengthy and detailed compared with early notes and any 'inferences' or judgements made by myself - or at least those identified as such - were inset to distinguish it from the chronological account. For instance:

There followed an unfortunate incident with Tom. He was wandering about saying he needed to use the toilet. I led him to the bathroom. He said he was bursting. We got there. I told him he could go and he did, all over the floor. I was annoyed about it and grumbled at him. Put him into a chair and mopped up the mess. Tom kept trying to get out of the chair and I kept putting him back.

It is not particularly relevant that I was annoyed with him except that this indicates a mild form of what the staff have to put up with all the time:-

I took him upstairs in the little white chair which I never like because it's so unsafe. He made it difficult to wheel him. Absolutely incapable today of standing or following any instructions. Eventually I got him downstairs, clean, and appealed to M. for help. TT and PJ tried to get him to walk. They tried the 'Come on Tom you walked smashing for us last night' approach.
Two methods of encouragement could be used. The soft soap approach as above and the 'if you don't walk I'll bloody knock you' approach!
R3/220: December 1981

It is clear from the above that analysis of data took place simultaneously with recording.

By the time I reached the second home the note taking had a more established style and the detailed chronological style characterised the second Home's participant observation notes.

The other data came from a survey and questionnaire which was recorded on to standard forms (see Appendix A1,B). The interviews, which often lasted three hours or more, were guided by the schedule (Appendix C) and were tape recorded and later transcribed. This was very time consuming and sometimes quite a labour since regional dialect on tape is quite difficult to decipher. It also pointed up the ability of two people to talk about a particular subject without ever mentioning it. What from memory was perfectly coherant conversation looked quite ridiculous when transcribed. This also presented problems for feedback when the transcriptions were returned to their owners. Several of the staff denied having said half the things they did say, and all were appalled at their grammar and speech generally.
Adequate and Efficient Data?

The problems of inference and proof have been well considered by Becker (in Denzin 1977:398) particularly in relation to studies that seek to discover hypotheses as well as test them, of which this research is one. He distinguished three stages of analysis conducted in the field and the fourth stage that involved problems of presentation of evidence and proof. Based on a study of medical school students, it was suggested that the presentation of the characteristic forms data take at each stage of the research would help the reader to follow details of the analysis and see how conclusions were reached. However they also acknowledged that the use of qualitative data was in itself a problem for presenting findings. In the end the researcher must build up credibility to convince the reader that the account of events offered is an accurate one. This is to be distinguished from the analysis of events. There is a difference between disagreeing with the analysis and disagreeing with the description of events.

Zelditch (in Denzin:1977) notes two criteria of 'goodness' that he suggests are useful in judging the data collection techniques. They are informational adequacy and efficiency of collection. This seems to be a suitable criterion by which to measure participant
observation notes and techniques to ensure the highest standards in those respects can be identified and itemised.

Firstly it is possible to check accounts of situations that have been recorded by asking participants to recall those situations and their interpretation of them. This was done to some effect during the interviews at Deer Park, where past events were recalled for comment during the interview. At Fell View I would often recount a situation to invite comment from the staff. The institutional setting is particularly suited to inviting accounts of observed behaviour since much time is taken in accounting during a typical day. (Chapter Nine).

The multiple role of the researcher in this case also helped 'check' observation and data recorded. By wearing different hats at different times, I was able to view the same situation from various participant's standpoints. This also involved being both ignorant and knowledgeable about situations and playing wise man/fool described by Johnson (1975).

Finally the use of an 'informant' in both homes helped to broaden the researcher's perspective. In the first home, Fell View, a college friend got a summer job at the home during the early research period. Her
impressions and discussions with her about the home, helped to inform the data, and her presence at the home during my absence helped me 'fill in' incidents that had occurred during that time. A second woman, whom I had met originally on the deputies seminar courses held at Fell View, was appointed as Deputy at Deer Park. She and I developed a firm friendship which continues. She had also, a few years previously, worked at Fell View as a care attendant, and her comparisons and observations on both homes, guided some of my early analytic thought. Her own status in the home helped me gain access and confidence amongst the staff, who on the whole, respected her greatly. Our friendship may have alienated some care staff from me, although I have no evidence of this.

The criterion of accuracy of data is therefore one to which the thesis aspired. However, accuracy should not be understood to mean 'correct'. The constructionist standpoint suggests many different and equally correct views of reality and the task of research is to identify and explain actions and words using sociological imagination (Wright Mills ; 1970) and not just record them. Although constant checking of data is important, in the end disagreement over the meaning of particular events between researcher and participants does not necessarily discredit the research. The researcher must build up credibility
with the participants and readers as an accurate observer and using a sociological imagination analyse the data in whichever way she has chosen as fitting.

**Making Sense of Qualitative Data**

It is rare as Burgess notes (1984) to find accounts of analysis procedures in the literature despite a growing exhortation to do so. Blau noted in the preface to the second edition of the 'Dynamics of Bureaucracy' that the:

"Analysis of research findings never reaches a final state of completion. It is always possible to derive new inferences from the data, to carry the interpretation a step further, to make additional comparisons"...(1973:vii)

Whilst analysis is never complete it can and should be consistent with the data from which it comes.

Any reliable account of a piece of research should include an account of how the data was analysed. The final part of this chapter is a brief account of the way in which the analysis took place.

**Making sense of my data**

The initial lay observations made at Fell View guided the first part of the data collection. These
were that there was:–

a) a mismatch between what was said to be done by senior staff and what actually took place
b) as a care staff member I acted occasionally in ways that were inappropriate and in ways I would not have done in other settings. (See p7).

This prompted a gathering of data about what senior staff thought was happening and what was actually happening in particular situations. It quickly became clear that this needed a narrower focus so actual changes were analysed from the data. For instance an account of a change in the coffee and tea making and delivering procedure was withdrawn from the data and an 'analysis chart' was developed by which every change identified could be similarly analysed. These 'changes' generated various categories and grounded theories that were called Issues, and formed the basis of the interview schedule and observations made at the second home. For instance the coffee making analysis showed how sacro-sanct official or unofficial break times are for the staff. The issue of break time and work time distinctions formed the basis of questions at Deer Park about the work ethos and the distinction between work and non-work times for these staff.
The main analytic use of the survey and questionnaire were to:-

a) find out how typical the Fell View senior staff view of care staff and old people's homes in general was in the Authority and to choose a second home.
b) get some data about family background and commitments, job expectations and aspirations from staff.

The questionnaire came directly out of the analysis of the participant observation data which raised questions about staff's dependents, family background and domestic circumstances which were more conveniently answered through this method. Much of this data appears in Chapter Five.

The Fell View analysis formed the basis of observations at Deer Park. The extended interviews were the main data source, and participant observation provided a check and balance. All interviews were typed up in triplicate. Then they were divided into sections so that each question had twenty six answers to it, within a given category. This meant the sections were flexible and according to the question asked of the data, the data could be ordered and presented in various ways. The initial questions asked
of the data in this form, were:-

What theories do the staff have about

a) the homes?

b) the elderly, with whom they work?

c) about group living?

During the analysis of these questions other issues emerged.

Comparison between the two staff's theories and work practices then formed the final analysis of data.

The next problem was how to present the data. At first it was decided to present the analysis in terms of the issues identified and link them to the wider concerns about residential care, apparent from literature. So for instance, the issue of routinising work would be examined and discussed in relation to the wider problem of routine bound practice in old people's homes. In the end an alternative strategy was adopted which is presented here. This reflects the social construction framework discussed in Chapter Three.

This starts with an account of the staff's backgrounds and expectations and theories about the social world of the old people's homes. Then the typical day of the homes is described and tasks
identified. From this, two differing models of care emerged. The techniques the staff have to maintain the models they operate are then looked at in terms of how staff react to change either of an unintended or intended variety, and through conversational apparatus. Finally conclusions are drawn from the analysis and some discussion about the relationship between the findings of the two homes and the social policy implications is made.

**Fortunes and Misfortunes**

There were several changes within the homes during the research period which altered both the direction and pace of the data collection and analysis.

In both homes the superintendents left and were replaced whilst the research was taking place. In both cases these departures generated much comment about senior staff generally, and what was expected of the new superintendents in particular, which in turn delivered much spontaneous discussion and therefore data on the way care staff thought things should be. It also gave opportunities for genuine discussions with the incoming senior staff about their plans for the home. This set up some convenient links to observe intended policy, and actual practice outcome which are discussed.
The new superintendent at Fell View put into operation a group living 'project' whereby the staff were divided into four groups with about six residents in each group and were relocated with their group in a flat within the home for one week each. Although the project was not a success in terms of goals stated by the superintendent and only the groups operating this project gave the researcher the opportunity to look at a case study of change, the project itself generated much discussion about group living, about expectations of the elderly and about work expectations.

The final change was that at Deer Park, the new superintendent discontinued the old practice of staff writing daily accounts of their practice. These accounts had been very full and proved to be very useful, not only as data in their own right but as a means to discuss situations that had not been observed but read ex post facto. The lack of written reports also affected staff morale (as will be seen) and whereas at Fell View staff became more verbal, and willing to discuss practice and their lay theories, staff at Deer Park tended to become demoralised as the demands on them to examine their practice reduced.
Summary

The methods adopted in the thesis were closely linked to the theoretical position outlined in Chapter Three. They were also part of a natural unfolding of data which occurred as I "became" a researcher and adopted different roles accordingly. The methods have been described and the point was made that data collection is in itself part of the analysis.

Because of the criticism of these types of methods, it is important to clarify not only methods but analysis techniques. This is rarely forthcoming in research and this chapter has spent some pages demonstrating the analytic process as it unfolded, in order to expose the logic of the final analysis which is presented here. The next five chapters represent this final analysis.
5. PARTICIPANTS AND SETTING

Introduction

As discussed in Chapter Three, in order for care staff, in common with all social beings, to 'make sense' of their situation and operate within it, they must have a knowledge or understanding of their world. This has been called theorizing. Theories are influenced and shaped by the physical, educational, emotional and historical surroundings of the participants. In short, the biographical details of participants affect their theories and practice. These 'details' are what Young called the 'assumptive world' (Chapter Three).

The next two chapters consider the biographical details and the theories of a care attendant.

The physical and biographical details for the homes in which the care attendants work are called the setting.

Reputation and Official Philosophy

At the outset of the research period, Fell View was the newest home in the Local Authority and it had the reputation of being the 'best'. Consequently both
staff and residents enjoyed a high status in the context of residential care for the elderly. It was believed by the staff and management that their 'team work' was exemplary and that the residents would not find a better home in the Local Authority since the facilities were exceptional. The reputation of Fell View was reiterated by staff from other homes (see Survey, Appendix A(i)) who commented, somewhat enviously, on the high status and good facilities that Fell View enjoyed. Management brought visiting officials to see Fell View as the 'show piece' of the Authority and courses run by the local Authority were often situated at Fell View. The official philosophy and language of Fell View had loose associations with the group living style of care (p30) in that words such as 'freedon of choice', 'privacy', 'independence', 'activity stimulation' and 'motivation' were all part of the language. The official booklet described the home as a place:

'where within a warm caring environment residents can retain identity, dignity and independence, and where privacy and individuality are of prime concern'.

Often the official language created problems for staff. In using a "social work" language, they tended to reinterpret or give 'practical' meaning to the words. The same language was used to mean very different things by different groups. This meant that
the language sometimes hid difficulties in understanding concepts and poor practice.

The official Deer Park philosophy was also summed up in their official booklet:-

'when people come to live in Deer Park we want them to feel that it is a move from one home to another, but to where they will have company and the extra care that may be needed.....

The people who come to live in this home will receive accommodation and care from a dedicated team of staff and they will be encouraged to use their capabilities to the full. Although residents may be frail, they will be encouraged to live as independently as possible'.

Deer Park, as a 'group living home' enjoyed, and at the same time, was plagued by, a more clear cut and specific set of goals and aims. Both the physical/design aspects of the home and staff work were related to the achievement of group living. This allowed for a rare clarity of purpose and much discussion amongst floor staff and supervisory staff about their actions and roles. The dominance of the group living philosophy however, tended to lead to a rather inflexible approach to care work. Like Fell View, Deer Park was seen as a show piece and this was keenly felt by the staff and to a lesser extent by residents.
The number of visiting parties of social workers, potential residents, students, administrators etc., very soon became unmanageable and the superintendent put a stop to visits in order to preserve the privacy of the elderly.

**Design**

**Fell View** was a 'Part III' Local Authority Social Service establishment, opened in May 1967. It was situated in a northern city, within a council estate. It was purpose built and designed to accommodate forty elderly people providing 32 single bedrooms and four double bedrooms, reflecting the national trend towards smaller and more privacy oriented homes for the elderly.

The home was two-storied with a lift and two staircases. The building formed the shape of a figure Z. The communal rooms were situated at one end of the home, with the bedrooms stretching down corridors towards the other end.

Toilets were situated in groups of two at intervals down the corridors. The two floors were identical.

As a result of these arrangements residents whose bedrooms were situated at the far end of the two
corridors had a long walk to reach the dining and sitting areas. Staff were also often a long way from residents and public areas, whilst dealing with laundry and making beds for instance. Staff were able to find 'private' areas and escape routes from the residents although residents were not so easily able to escape staff, (see Chapter 9:304).

The communal rooms downstairs were used to the virtual exclusion of those upstairs, which were smaller and housed the television and library. Very few residents sat in these upstairs lounges. As a result the downstairs lounge became very full with few spare seats. Most of the day time movement amongst the residents took place between dining room and lounge and hall toilets.

The seats in the main lounge were arranged in circular groups although a centrifugal urge within the home meant that chairs often gravitated to walls and into straight lines. The carpet in the lounge had become soiled and smelly and the original water based paintwork on the walls was beginning to look shabby and chipped. The hall dining room, corridors and bedrooms were floored with vinyl tiles except in the case of two rooms where residents had brought in their own carpets.
The kitchen and dining room were situated parallel to each other beside the lounge and at the extreme end of the building. The office was beside the front door in the hall.

Efforts were made by the staff to brighten up the place with pot plants and hanging baskets. The home regularly received funeral flowers which were displayed in the communal rooms. The small grounds surrounding the home were well maintained by the gardener who was 'shared' with another home.

**Deer Park** was purpose built for group living, situated in the same northern city and opened in December 1980. It was built on one storey in a square around an open quad with a central corridor on either side of which were bedrooms and at each corner sitting rooms and kitchens. Three of these 'wings' housed a maximum of thirteen elderly people each and a fourth wing housed a group of 'younger physically handicapped' (over 50 years old). There was accommodation for 42 residents in all, 36 of whom were elderly. (See p.116 for discussion about handicapped residents).

Staff were attached to a particular wing and worked more or less exclusively with that wing. Being
a very new building the decor was in a better condition than at Fell View. There were carpets in the lounges and bedrooms and tiles in the corridors and the 'issue' furniture was punctuated by residents' own chairs, cupboards, ornaments and so on. The close proximity of the small kitchens to the lounges gave a cosy feeling to the communal areas, not least because cooking smells, like bacon, coffee and cakes were often apparent. The bedrooms had large windows which looked out either on the quad and flower bed or grass and shrubs that surrounded the home. Many of the residents had a television in their rooms and often furniture and belongings from their previous address. There was a television lounge at the entrance to the home and a main kitchen and office beside the entrance hall.

The design of the home gave a feeling of space as against the rather crowded feeling at Fell View. This was partly because residents at Deer Park rarely sat in the lounges together, as they did at Fell View. It was not unusual during non meal periods to find only five or six out of 42 residents in the communal areas; as noted, this design feature had implications for the participant observation method. (p.82)
Facilities and Activities

The only regular organised activity available to the Fell View residents was the 'Monday' club bingo game which was arranged and attended by an over 60's group in the community and held in the home. They also occasionally arranged day trips. This activity was attended by three or four residents on a regular basis.

The local Roman Catholic priest and Anglican vicar visited regularly to conduct services which were attended by four to five residents. The hairdresser visited every Tuesday and was used extensively by the female residents. This was a popular activity.

Entertainment was sporadically and seasonally provided by local school children (particularly at Christmas) and a local couple used to come in to sing and play the piano from time to time. On one occasion during the research period an amateur dramatics society did a show, following a music hall theme and ending up with a sing song. The home organised three fund raising functions, during the research period, taking the form of pie and pea suppers and bingo. These were well attended by locals and often there was only room for a few residents!
Other facilities available for the residents were a television, radio, record cassette player and library books. It tended to be the same small number of residents who participated in all the arranged activities in the home and who best utilised the facilities.

The home had saved for, and recently bought, a minibus. During the summer the bus was used for day trips and at Christmas time for shopping trips. There was always a problem of finding a driver which was partly met by the researcher driving. Staff could arrange specific trips in the bus. On one occasion they went to the theatre. This kind of outing took some organising and often residents cried off at the last minute. Specific events that needed long term planning were not common.

Independently organised activity by the residents was not very evident. The home was situated at the bottom of a hill in an estate and although shops and buses were reasonably near, they were difficult to reach for disabled or unsteady residents. Staff would often do shopping for residents on their way to and from work, particularly at lunch time. Relatives and one younger mobile resident also met shopping needs.
Deer Park owned a minibus and notwithstanding the perennial problem of drivers this facility was used regularly. The residents on the disabled wing and one or two other residents were members of the 'Quo Vadis' club for the disabled which had regular weekly meetings and organised activities. One or two residents organised outings either for themselves, often involving a taxi, or with friends. A public telephone in the home greatly facilitated contact with friends and relatives to arrange these outings and give independent contact.

The wings practised a form of separatism from each other which meant that at the start of the research period there had been no communal 'home' activity although sometimes a 'party' in one wing had spontaneously involved other residents.

The facilities and activities in the home were related to the philosophy of the home. There were, for instance, no hairdressing arrangements on the premises since it was felt residents should go out and that this would encourage them to do so. Shop facilities were a point of some contention. The Residents Committee wanted to start a shop but senior staff felt that this would discourage independence and visits to the shops in the community. There were no televisions in the
lounges since it was felt that they would be constantly switched on, and inhibit interaction.

**Summary of Setting**

The main differences in the settings that care staff worked in were:-

a) the physical layout of the homes.

b) the strong group living philosophy of Deer Park.

The physical design at Deer Park meant that the residents' areas of living, eating and sleeping were much more private than the open plan design of Fell View. As a result staff at Fell View were more "on show", in public areas but had more escape areas which were 'resident free'. At Deer Park staff were less "on show", but had less escape, 'staff only', or resident free areas. Later (Chapter Nine) this will be seen to be most important. Staff only areas gave opportunity to reinforce and legitimate particular versions of reality, and emphasised the division between staff world and resident world.

The care staff at Deer Park were based on the wings with no reason to leave them. They did not see a large group of elderly people or have the opportunity
to meet up spontaneously with other staff in a resident free zone. They did have the "official" staff room where they took their lunch, but this was not used at other times.

The strength of the group living ideal held by Deer Park staff gave them a clarity and unity of purpose not present at Fell View and, as we shall see (Chapter 6:170) guided theories about the elderly. This unified goal was not apparent at Fell View.

The Residents

Part of any explanation over differences in care staff practice must include residents themselves. The physical and mental abilities of the residents will affect both the staff's theories and daily routines. It will also affect the degree to which residents themselves can have control over their life style.

The handicapped residents - Deer Park

It was thought that the presence of a handicapped wing with younger residents might have had an effect on the theories and practices of the staff throughout the home. However observations in the home suggested that staff had a different approach to the handicapped residents and they clearly distinguished between
these groups, both in their theories and work routines.

Senior staff made a clear distinction in their report handovers between the elderly and handicapped wings and they did not seem to think that work with the elderly affected that with the handicapped or vice versa. They thought staff separated the two groups mainly because they were working exclusively on a particular wing and because the handicapped wing was the last wing to open:

'No I don't think there is.. all the wings were set up and routines established on other wings.. some care attendants haven't worked on wing one'. (B14/26)

The staff's own relationship with the younger handicapped wing and their view of the relationship between the practice on that wing and on the elderly wings was sought in the interviews. (Appendix C:B 13/15). The staff were asked whether they had ever worked on wing one and whether they enjoyed it. Follow up questions were about the differences they saw between the elderly and the handicapped and whether this affected their practice with either group. These questions revealed something of the staff's attitude to the elderly. (See later in Chapter Six).
Most of the staff's immediate response was that there was little difference between the elderly and the handicapped. Even staff who worked on the handicapped wing thought of the home as one for the elderly.

'See in my life, I work with the elderly not with the handicapped.. but 99% of it is with the handicapped.. that's strange that.. yet I haven't lost touch with the elderly, being so close'. (20.B14)

'I can't seen any difference because they are both handicapped.. the elderly and the physically'. (17.B14)

'You still have to do practically the same on both wings.. doesn't matter whether they are handicapped or not'. (11.B14)

The researcher asked, "Do you behave differently on the handicapped wing?".

'Oh no.. you look at Marylyn and you forget she's like that.. even they're just all people who you work with'. (23.B13)

"on wing 2? I never.. Frieda was 83 you don't think of them as old.. 'Not really.. they're all the same to me'. (4.B14)

However some differences were identified after more questioning. These seemed to be in the nature of the relationships that care staff had with the
handicapped and the elderly rather than the actual tasks done for them which were quite similar.

'Well they're different really because those are elderly and these are younger generation...routine wise there is no difference... I couldn't really help an old person, take Marylyn, I class Marylyn as a friend...I can talk to Marylyn and she can tell me her problems whereas an older person...I don't think why they'd tell you their problems but you couldn't really...well,tell her yours'. (14/B14)

The question seemed to be, how like a normal friendship can the relationship with the resident be? It was felt that the handicapped could be more like friends than the elderly and were treated as such. Age was an important factor:-

'I just treat them like I'm talking to one of my friends, but I'll go over there (to the elderly wings) and you've got to shout and be careful what you say...and watch the way you put it'. (21.B13/14)

It was possible to have a bit of a 'carry on' with the residents in the handicapped wings:-

'On the handicapped wing you have to be more positive.. and the residents are more positive with you'. (17.B14)
'You tend to carry on a bit more
act more funny..'. (4.B14)

'Entirely different.. they're younger
and you can carry on with them more..
you talk to them like friends.. but
the old people.. I treat them like
me Gran'. (25.B14)

'I don't know. Its just.. I mean
take wing one and wing four, the
difference. I mean they (wing 1)
are happy and lively, they crack
jokes.. you have a laugh up there'.
(8.B14)

In terms of affecting staff work with the elderly,
the presence or absence of a younger disabled element
seemed largely unimportant. What did show up from the
above (and is discussed in Chapter Six) was that care
staff wanted to, and liked, developing normal
friendships and having enjoyable relationships with
residents but, felt, on the whole, that this is not
possible with elderly residents.

The Elderly Residents

The elderly residents were the main object of work
for the staff.

The national picture suggests that the tiny
minority of people in care represent an increasingly
elderly population with disproportionate representation
of the very old, female, single and widowed, compared to the elderly population generally. There is evidence of increasing dependence in residents, although a substantial proportion can still cope with minimal help.* Reasons for admission are still complex and associated with breakdown in support systems. This national trend was reflected at local level.

In the Local Authority in which the homes were located, a survey of various aspects of the homes was conducted, the details of which are in appendix A. Various features common to both the Local Authority generally and the two study homes are worth noting.

Predominance of female residents: Both Fell View and Deer Park had more female than male residents. Deer Park had the largest proportion of women (83%). This was reflected in the layout of the three wings where one wing had no male residents and, another, only one. A dominant female presence amongst the residents might well have had some effect on the policy and practice in both homes. Willcocks et al (1982) comment on this in relation to the staff approach to residents:

'The presence of substantial numbers of very old women in a residential home, may have a determining influence on the way in which members of staff perceive and... relate to residents'.

(18)

* Although Booth (1985 Chapter 4 p.60) has recently suggested in work based on census material and 4 Local Authorities, that dependency levels are not increasing but staff perceive residents as having high levels of dependency.
It will be seen that group living and domestic chores were linked and this was thought to be appropriate in the context of few men and many women. At Deer Park the manifestation of a group living philosophy centered on washing up, cooking and laying tables all of which are seen as traditionally female tasks, particularly by the age group of residents in the homes.

The average age in both homes was over 80. The male residents were younger on average than their female counterparts. The age gap between the eldest and youngest resident was an astonishing 36 years at Fell View and 37 years at Deer Park. (This did not include the younger physically handicapped. With this group included the gap was 45 years). The two generational gap between some residents suggested an inappropriate 'looseness' of definition of 'elderly'.

The dominant group in terms of marital status in both homes was the female widowed residents who comprised of 52% and 57% of the population of Fell View and Deer Park. The total male and female widowed residents were 77% and 71% respectively. Three residents in each home were still married with spouses either living in the home or community. The single groups (10% at Fell View and 17% at Deer Park) were evenly divided amongst male and female at Fell View but
all the single residents at Deer Park were female. The male population at Deer Park were all widowed with one exception, where the wife lived in the family home.

It is likely that single residents will get on better than bereaved residents in adapting to residential life. A high proportion of recently widowed people suggests particular emotional difficulties which are perhaps understated and underplayed by society in general and old age homes in particular. Widowhood is seen as a natural part of ageing. However for the resident the traumatic and devastating change of marital situation must be an intolerable burden that has to be coped with in addition to a change in residence and status. It is hardly surprising that the burden, at times, is too great.

The physical and mental agility of residents was measured in terms of the amount of help staff needed to give residents. Estimates of a resident's ability to move around unaided by staff, confusion and incontinence were given by senior staff in the survey. A marked tendency to overestimate * confusion and incontinence was noted. (Survey: appendix A). It was notable that the Deer Park estimate of amounts of confusion and incontinence was very low by comparison. Fell View estimated a much higher amount of dependency,

* Which is in line with Booth's suggestions (1985)
in line with the Local Authority responses generally. Both homes had a higher than average number of residents who were permanently in wheel chairs.

The largest group of residents were admitted from the community, either living alone, or with relatives. This is in contrast to the national and local figures which recorded a 30% admission from hospital. As a result residents could have been less institutionalised prior to entry. 51% of Deer Park residents lived alone prior to admission and 11% with relatives. At Fell View a similar proportion of community admissions lived with relatives as lived alone. This might have indicatd a more independent spirit at Deer Park.

High turnover of residents, most of whom leave the home through death, might also influence the behaviour of participants. Willcocks suggests an abiding concern about death:

'The possibility of dying is a factor which underpins many of staff attitudes to residents and to every day tasks; thus anxiety and over protectiveness may characterise staff behaviour'. (20)

Menzies (1960) for instance found anxiety by staff over illness, pain and death in hospital, was dealt
with by developing organisational barriers to protect them.

Turnover, length of stay and deaths were not directly comparable between the two homes. Fell View had a higher than Local Authority average turnover at 50% (based on twenty admissions) with an average stay of $2^{3/4}$ years. 30% of the residents died in the survey year. The other discharges, either transferred to another home, returned to the community (but rarely), or most commonly were permanently admitted to a geriatric ward.

**Summary of residents**

The residents at both homes had, on the whole, similar characteristics to each other and to national trends. It has been suggested that an increasing elderly and predominantly female population could have affected staff perception and daily practice probably to the detriment of innovation and change. However, despite a similar resident picture, differences in theories and practice were apparent between the homes and it may be that apparently small differences in residents' characteristics had large consequences for perception and practice.
The Staff

As residents' characteristics will affect staff theories and practice, so will staff's background and experience. The Local Authority survey confirms the national picture of staff that was discussed in Chapter Two, that is, the high proportion of female employees which drops with the increasing seniority of position and the low numbers of any qualified staff. It was noted that the turnover in the study homes was low compared to the national picture. This was despite the view of most senior staff interviewed that turnover of staff was a real problem.

The data is taken from the survey and questionnaire. The population called 'care staff' includes day care staff and domestics. Amelia Hunt (1978) and Valerie Imber (1977) suggested clear distinctions between domestic and care attendants by the nature of their work, and the homes under study tended to have a different hierarchy of tasks, as will be shown, (Chapter Seven & Eight). Both groups however spent similar amounts of time 'on the floor' and in discussion with each other as they theorized about residents. Domestic's theories were part of care work. In this section care staff and domestics are considered together unless otherwise stated.
In terms of actual employees the homes had similar numbers of 26 at Fell View and 28 at Deer Park. The total number of care staff was 15 and 17 respectively. However there were 12 full time day care attendants at Deer Park as against 6 full time and 3 part time at Fell View. This meant that Deer Park was on the whole better staffed. Of the 6 domestics at Fell View, 3 were part time and at Deer Park there was only one part time domestic. The Deer Park policy was to have no part time staff if possible.

Both homes had a shared gardener and one YOP worker each. Deer Park also had a secretary who acted as a clerical assistant and remained in the office.

Summary of Staff

<table>
<thead>
<tr>
<th>No.of Staff (Bodies)</th>
<th>Total Male Female</th>
<th>Total Male Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fell View</td>
<td>Deer Park</td>
</tr>
<tr>
<td>Superintendent......</td>
<td>1 1</td>
<td>1 1</td>
</tr>
<tr>
<td>Seniors....</td>
<td>2 1 1</td>
<td>2 1 1</td>
</tr>
<tr>
<td>Day Staff...</td>
<td>9 2 7</td>
<td>12 3 3</td>
</tr>
<tr>
<td>Night Staff</td>
<td>4 1 3</td>
<td>4 - 4</td>
</tr>
<tr>
<td>Domestic...</td>
<td>6 - 6</td>
<td>5 - 5</td>
</tr>
<tr>
<td>Cooks.....</td>
<td>2 - 2</td>
<td>2 - 2</td>
</tr>
<tr>
<td>Others(YOP)</td>
<td>2 1 1</td>
<td>2 1 1</td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td><strong>26 6 20</strong></td>
<td><strong>28 6 22</strong></td>
</tr>
</tbody>
</table>
Sex, Age, Marital Status

The majority of care staff in both homes were married and the majority were female. (2 male care attendants at Fell View, 3 male at Deer Park). The average age of the care staff was 38 at both homes. The age range was evenly spread although at Deer Park the largest group was 40-55. All male staff fell in the 19-29 group.

Age Breakdown of Day Care Staff and Domestics.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Fell View</th>
<th>Deer Park</th>
</tr>
</thead>
<tbody>
<tr>
<td>55+</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>40-55</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>30-39</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>19-29</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Total numbers of respondents</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Average Age</td>
<td>38</td>
<td>38</td>
</tr>
</tbody>
</table>

Turnover/length of service

Between January 1980 and January 1981 there was a 19% turnover of staff at Fell View; 5 out of 26 employees left. This comprised the departure of the superintendent, one deputy, two care staff and a domestic.
There were no figures available for the equivalent year at Deer Park, since the home opened in December 1980. Of the four who left during the first eighteen months, three were senior staff and one was a care attendant. Another care attendant transferred to domestic for family reasons.

As noted in the survey, the Local Authority homes' senior staff commented repeatedly on the chronic staff shortage, high turnover and absenteeism amongst care staff. In the study homes it was the senior staff themselves who represented the bulk of the turnover. Staff difficulties directly attributed to staff turnover, by senior staff, may in fact have been less to do with care staff mobility that was thought.

The two homes under study presented quite a stable picture of staff, despite changes in seniors and supported Goffman's view that:

'Lowest level of staff are likely to be the long term employees and hence the tradition carriers while higher staff and even inmates may have a high rate of turnover'.

(1974;107)

The care staff at Fell View averaged three years of service with the home, which had been open just five years. The Deer Park figures are not comparable. Here all staff had been at the home from its start, with one exception.
Domestic circumstances

None of the staff in either home 'lived in' although the superintendents could have done and the previous incumbents had done so. This non residential feature of staff is different to twenty years ago and reduces the 'side bets' attraction of the work noted by Stannard (1971).

At Fell View all but two of the twelve care staff were born in the same city. Most parents of staff were local to the city or area. The great majority of the care staff lived in the same vicinity of the city that they were born in; either in the same suburb or the adjoining areas. This corresponded to where the residents had lived prior to admission.

Only two residents at Fell View came from outside the area: one from the South who had married a local man, and moved up as a young girl and one from the Midlands who had also married a local man. The first world war meant that some of the men had travelled away from the area, but most residents were born and bred, and had stayed, in the immediate vicinity of the home.

This was also the case at Deer Park with only two non-locals amongst the residents.
All the care attendants at Fell View went to school in the area in which they were born.

At Deer Park six of the 16 care attendants were not born in the City and a corresponding number of parents were not local. For those born in the City there did seem to be slightly more mobility with people living further afield from their maternal home. There was one notable exception to the pattern that prevailed in both homes. At Deer Park one male care attendant's father was a lecturer in a southern university and his mother was a teacher. He had gone to public school in the south.

In terms of dependents and family commitments both homes were similar. Of the ten married care staff at Fell View, six had some or all of their children at home, dependent on them. At Deer Park nine respondents had some child dependents. One member of staff at Fell View had a father-in-law living with her. No other member of staff in either home had an elderly relative living in. Most spouses were in employment and the female staff had strong domestic commitments, fulfilling traditional sex roles. Spouses' attitude to care work (Appendix B) was one of not really knowing what they did but leaving them in peace over their job as long as domestic duties did not get neglected. The staff themselves felt that family commitment outweighed
their job commitment and participant observation bears this out. There was a rigid adherence to duty hours and a great reluctance to work over these hours. There was a lot of coming and going of staff, to and from their homes during the course of the day at break times. This was particularly so at Fell View. At Deer Park it was less convenient geographically to 'pop home'. Members of staff's families (in particular children) in either home, might well arrive to wait for their mothers, pick up a key, or just have a chat.

When the superintendent at Fell View suggested using a holiday cottage for a week, manned by the staff, most voices were raised in objection because it would be impossible to leave husbands and families for any length of time, let alone a week. One member of staff went home from Fell View each lunchtime to cook for her family.

Work done by care staff's partners was either skilled or manual rather than professional. Father's and husbands of staff often had similar jobs to those that had been held by residents. The old men in particular were sometimes already known to staff's family through work colleagues and neighbours. Whilst this is hardly surprising since most staff were born and bred in the area of the home as were the residents, it is worth reiterating the close community links between staff and residents and the similarity in their
backgrounds and domestic lives.

Often staff could remember the resident 'living up the street' and the participant observation notes included accounts of care staff recalling particular residents when they were living in the community. Explanations for behaviour were occasionally given based on community knowledge about residents. (Chapter Six).

Education

General level of education was predictably low. Fell View staff had two CSE and one 'O' level between them. All members of staff had left school at the earliest legal age. One staff member had a deep sea diving certificate. At Deer Park, apart from the mentioned 'exception' who had 'A' levels and 'O' levels, all staff had left school at the earliest legal age and had no school certificates. One care attendant was a qualified hairdresser and one had done the CA Civil Service exams. One male care attendant had attended a CoSIRO course.

Relevant training and qualifications for working with the elderly were also thin on the ground at both homes. At Fell View, two staff had home nursing and first aid, and five of the six full time staff had
attended one or more Local Authority run course, usually day seminars. No domestic had any qualifications or had attended any courses. No member of the care staff had any nursing qualification, although two had worked as auxiliaries. None of the senior staff had any qualifications (although the outgoing superintendent did have CSS as did the outgoing senior).

At Deer Park all three senior staff had CSS and the new superintendent had a CQSW. Two care staff had attended the TOPS care attendants course prior to commencing work. The cook had City and Guilds. All the staff had attended a two week induction course when the home opened and six said they had attended an 'admission process' day release course, although several of them could not readily remember what the course had been about. Only one care attendant had never been on any course. The Deer Park staff had received more 'training' in that they had the two week induction course prior to the opening of the home. This had made a deep impression and they referred to this period often, as will be seen. It also formed the basis of their understanding of group living.

Summary of Staff

The Fell View and Deer Park staff fitted into the national and local picture. However, they did not, on
the whole, present the social outcast typification that appears in the literature. (Chapter Two). They had strong domestic attachments and outside interests which, combined with a less institutionalised and more community based environment in the modern purpose built homes, meant they had easier access to their domestic lives.

It will be shown later that they viewed their time in the home as work time which had temporal limits and boundaries and to which they adhered more or less rigidly, and into which their domestic lives slotted. Their qualifications and training were minimal irrespective of age, marital status, or sex. Their biographies were similar to the residents for whom they cared.

The foregoing account of home environment, resident characteristics and staff characteristics has given an indication of framework within which staff operated. The development of theories and interpretation of situations cannot and should not be examined in isolation from the setting or context in which they are made.
6. A VIEW FROM THE STAFF WORLD

We now turn to how care staff view their work and their work objects, that is, the elderly residents.

The thesis' theoretical framework, as seen in Chapter Three, assumes that mankind is engaged in a constant process of constructive activity. The reality which a given set of participants identifies and operationalises is a matter for negotiation and reconstruction between participants. In order for members to participate in this activity they develop theories about their world which are flexible but which form the basis of their view of the world. The theories can be seen as part of a research endeavour the care staff are involved in such a process.

According to one member of staff at Deer Park:-

"All the staff have a picture of each resident which you communicate with each other and you say, well he's like that.. and he'll say that, but don't take any notice of that.. but I mean, you do see them like that.

You can have somebody going round and they are acting in some way and you say.. well you put them in a box and if they do anything different then you get a bit worried". (17.G)
Putting people into boxes, or everyday theorizing, is a process in which all participants in a social setting engage. Lay theories are furthermore of key importance in understanding the practical accomplishment of daily life. Oakeshott commented in the context of children's panel members, that:--

'lay theories of justice, equality, retribution, general and individual deterrence, have an important part to play in the practical accomplishment of decision making'. (1980)

Similarly care attendants' lay theories about elderly people, old people's homes and caring for the elderly have an important part to play in the practical and day to day accomplishment of care in an old people's home. Theory building is part of practice.

Care attending as work

One influence on the way staff work in the homes comes from the sort of training they receive, both formal or informal (i.e. from other staff). As we have seen there is a push towards more formal training and a 'professionalisation' of residential care work as part of a general trend in social work. Do care staff view their own work as in need of formal training, or as a professional job? Do care staff see their work in terms of career?
Training or Experience?

Fell View: Typical was the response to Jenny, the cook, who was sent on a day course about nutrition and the elderly. The two other cooks said they would 'knock it out of her in half an hour' when she got back. Two care attendants were accepted on the day release in service course. I noted that:--

'Maggie tells me that C is now being set apart from the others since she is doing the day release course'.(R2)

Another care attendant was roundly teased about needing a dictionary to understand what she was saying now she was doing a course

Training was viewed as an optional extra and a way to acquire posh but largely irrelevant, skills. Training was not seen as particularly relevant to practice.

At Deer Park the attitude to training was less antagonistic, although it was still seen as somewhat peripheral. Training was seen as a means of self-advancement rather than having some practical day to day use for working in the homes. The comment below was not untypical:--
Researcher: Are you going to apply for inservice training?

Care staff: I'll cross that bridge when I come to it. I'm content at the moment, doing my job'. (13.D1)

It seemed that training was not seen as particularly useful to 'doing my job'.

At Deer Park when there was interest in training it was for information rather than practical demonstration, particularly about the psychological aspect of ageing and developing relationships. This, it was felt, was not just common sense.

'I think in this job you find a lot of mental things - and individual personalities. Psychology isn't common sense is it?' (9.D3)

'I'd want to know a bit more about the medical aspect of the elderly.. like why this happens, why this bit drops off.. also learn a bit about mental welfare.. you see you cannot do a job unless you know what you are trying to do.. there's always a reason for what anybody does.. and people like myself who've come out of other trades, or been a housewife for twenty years, we're not qualified to see the way people tick'. (15.D3)

Some care staff at Deer Park viewed their role, as partly involved with 'psychological things'. 
The younger staff at Deer Park definitely wanted more knowledge to help their work and to 'get on'. The older staff, if they had to have anything, wanted practical information about lifting, first aid and medication.

In response to the same question (No. 37-39 Appendix B) the Fell View staff said they would like to learn more about senile dementia, nursing, medication and curiously, what social workers do. There is however, no record in the participant observation data of spontaneous comment about a need to know more about a particular area to help care work. The seminars arranged for care attendants to learn the new admission procedure were thought by staff to be telling them what they already knew and what they already did.

Fell View staff tended to be in agreement with each other about the dubious advantages of training. The Deer Park staff were divided in their opinions more or less along age lines.

Staff at Fell View and older staff at Deer Park thought experience of working with the elderly and of life generally was as good as, if not preferable to, training. Some of the older staff at Deer Park felt that the younger ones could benefit from training, although they themselves had experience, which far
exceeded any advantages of training.

'I wouldn't willingly put in for in service I'm not a scholar. I think 8½ year should stand for something.. because I think basically you've got to get in there with your hands and do it, it's not all writing, you've got to find out about a lot of things'. (20.D2)

'Well, you know if I had been a bit younger.. but from my personal view, I think.. I just try to get to know everybody in here.. well really I've done it all before this started.. I've been out and visited people in their own homes'. (12.D2)

'I think its useful.. not necessary but useful'. (14.D2)

At Deer Park and to a less extent at Fell View the young staff tended to be regarded suspiciously by the older, who felt that the younger girls could not 'understand' the elderly since they had no experience of life. The older staff at Deer Park were quite vociferous on the subject. They were aware that this view was not held by the senior staff who were known to believe that experienced staff from other homes had learned bad habits and that it was better to employ inexperienced staff and 'train then up'.

There was little encouragement at Fell View to translate learnt skills to everyday situations and therefore little motivation to learn. Senior staff at
Fell View tended to regard outside training with suspicion, although staff were encouraged to see themselves as people who were being 'trained up', through experience and guidance from more experienced staff. Whilst the seniors at Fell View saw the skills required as essentially stemming from common sense, they nevertheless saw themselves as skilled, which was called 'trained'; however, formal training was not seen as particularly appropriate. The Deputy indignantly told me that a relative had been rude enough to suggest that they were not trained people.

'I told her we weren't just dragged in off the street... that we were skilled, trained staff...'.(R2)

However on the face of it all the staff had been employed from 'the streets' with no experience. The word 'trained' meant one thing to outsiders and another to staff. The senior staff also talked in terms of providing regular in-service training to staff. The survey (appendix A(ii) ) showed that most senior staff thought they provided in-service training. However the participant observation did not note any "training" formal or otherwise or instruction taking place between seniors and staff, at Fell View.
Ambitions

One of the ways in which care attendants might have tacitly expressed their approach to their work was via their job commitment, ambition and reasons for leaving and joining.

For the research, ambition was defined in terms of what plans, if any, care staff had for their working lives and uptake of training. At both homes those staff who had considered their working lives at all tended to be the younger age group.

At Fell View one care attendant wanted to work with handicapped children and was trying to get transferred. One male care attendant was taking CSS and left as soon as he qualified. One care attendant applied for several senior posts but would not consider taking the CSS course. Two female staff were on the in-service day release course. None of the staff at Fell View expressed strong ambition. They were rarely prepared to use off-duty time on work matters so that various schemes the new superintendent introduced fell on stony ground since they required off-duty commitment.

Fell View staff seemed, not surprisingly, to be motivated mainly by financial need and expediency
although most felt when they applied for the job that it would be a bit better than 'just cleaning'. They had no qualifications and very limited opportunities for mobility. There was therefore a limit to the jobs open to them.

At Deer Park more staff were involved in some kind of work related learning exercise; the greatest proportion of whom were under 30 and included all the male staff. Two staff had applied to do O.U. training courses about the elderly. One was taking an 'A' level to prepare himself for CSS. Several older care staff would have liked to do some training, but felt too old or too stupid. This may have accounted for some of the defensive remarks made about 'experience'. One female care attendant wanted to be an assistant social worker and was actively making enquiries. One middle aged and very experienced care attendant acted as a relief deputy to other homes. One of the male members of staff wanted to move around social services to gain experience.

Despite an apparently more 'interested' attitude at Deer Park, most staff said that they did not know that the home was a group living establishment when they applied for their job and there seemed to be little conscious planning - circumstances merely presented themselves whereby work in a home 'came up'. 
Once employed as a care attendant however, a slightly more adventurous spirit prevailed at Deer Park. The staff had more confidence in themselves partly because they saw themselves as specially 'chosen' to work in this new and exciting home and partly as a result of having experienced an enjoyable induction course. Training and courses had become part of their 'realm of possibilities' in a way not apparent at Fell View.

Commitment to job

At Fell View one staff member left to have a baby, two retired at 60 and one left after an operation. The officer-in-charge also left. At Deer Park the one member of staff who left, did so because of managerial differences. He moved to another home which suited him better. All the Deer Park senior staff left, to other posts in the Local Authority.

Although the turnover of staff was small in both homes, threats to leave were often made by the staff. At Fell View they were mainly made because the staff were 'sick' of the elderly and of the the messy work. A completely new job was dreamed about but realistic opportunities were limited. At Deer Park threats to leave were mainly because of poor management and frustration over the blocking of new ideas and a
general disappointment with the progress for the group living ideal. Their threats to leave for other homes, contrasted with the Fell View threats to leave for other jobs.

**Professional social workers**

Although the senior staff and superintendents in both homes pushed the idea of care staff being professional social workers neither set of care staff talked about themselves in such terms and tended to rather disapprove of social workers.

Staff at Fell View talked about themselves as trained, in the sense of skilled as we have seen, but the new superintendent's views about them being professionals were dismissed by seniors and care staff as being part of his own wish to promote the home and his job.

Staff at both homes actively denied that they were social workers. When told by a Deputy that he was a residential social worker, a care assistant at Deer Park made much fun of the remark. Both sets of staff saw social workers as part of the 'them' management who did little work and got paid a great deal, without "getting their hands dirty".
They tend to try and get everything done for their dinner break kind of thing'. (CL/39)

At Fell View an irritated member of staff retorted to a sympathetic social worker that it was not surprising everybody looked tired in the home.

'I said we didn't drive round all day in our cars. we actually worked so no wonder we look done in'.(R3/5)

As noted in the Methods chapter (p.87) my own role was compromised when staff thought I was a social worker and I had to make my position quite distinct from that of social work.

Summary of Fell View

In sum, Fell View staffs' over-riding approach was that care work was just a job, that the skills required were common sense and could be learned best through experience and that training was a peripheral 'extra'. This was reinforced by senior staff. At Deer Park the over riding view was that training was an important part of the work especially for 'getting on' although not necessarily connected directly to day-to-day practice. This attitude was challenged by the older care staff who like Fell View staff emphasised experience over training but was supported by the
seniors, who promoted training as desirable and important. This created a potential climate for change and development, as against one of stagnation and rigidity.

However, the presence of a favourable opinion towards training may not in itself stimulate positive change and development. The way that opinions are exploited by staff in their daily practice is also crucial.

**Theories about the residents - Fell View**

Below are statements made by staff about the elderly who lived at Fell View. It has been noted elsewhere that a probable characteristic of theories is that they are at times contradictory and that members select an appropriate theory for the purpose of the moment. (p.64)

The Fell View statements were in some respects contradictory which was a recurrent feature of much of the 'Fell View talk' and were both general and specific. The general theories saw residents as too old and infirm to be expected to do anything on the one hand and as not trying hard enough to help themselves and could do a lot more if they did but try on the other. These two apparently contradictory notions of
inevitable decline and wilful inactivity underpinned much of the general theorizing about residents.

These theories are not dissimilar to those found by Patterson (1977). She found, with the exception of the private home, that general views ranged from the residents being untrustworthy, deteriorating, malingering and a noticeable moralising about the worthiness of the residents to be in the homes. Moral judgements are discussed below.

**Wilful inactivity**

This theory suggested that the residents were not trying to be co-operative and to behave as reasonable adults. They were believed to be able to do far more and, most importantly, it was believed that they should do far more to be less of a burden.

'M. came back from her holidays and said to the residents that she had been thinking about them. She was going to change her approach. When I asked her what to, she said 'they're not getting away with anything anymore'. (R2)

'They just sit there smelling all day and then go to be smelling at night. They don't like being out side, they do nothing'. (R2/30)
'Nobody was around to serve the coffee out. One care attendant remarked, 'I asked them to help themselves because we're short but nobody would'. (R2/56)

'Some of the residents could do a lot more than they do... just plain lazy'. (R1)

Much of the comment was negative in tone. Not untypical was a care attendant's comment that:--

'The residents were like animals. When the dishes were cleared away and the slops were put aside for the dogs, R said, "Yes, feed the animals, but these are worse than animals" '. (R3/208)

Inevitable decline

The theory of wilful inactivity was somewhat tempered by a theory of inevitable decline. A slow and inevitable physical and mental decline in the form of increasing incontinence, confusion and immobility were an expected part of a resident's career. This expectation meant that signs of decline were looked for, predicted and more often than not found. The 'career' ended in death. Any attempts to enliven or alter this process was seen as doomed:-

'It is not easy to teach this lot anything new. It's not possible to get them to do anything. Half of them
are daft. Mind you the other half shouldn't be here. This home is supposed to be for ambulant people not for the decrepit, and them that can't do for themselves at all (R2/50)

'Maryann said that the groups should really start with new residents but it's difficult to teach old dogs new tricks. The residents, she said, were too set in their ways'. (R2/46)

The declining career had a pattern and particular vocabulary. The stages were in the same order. Confusion about place, time and self which manifested in wandering around the building, talking to oneself and 'inappropriate behaviour'; this was described as 'being away with the mixer' or crackers. Incontinence of an increasingly regular nature which was called 'wetting'. Falls, leading ultimately to an inability to walk unaided and redefinition by staff of help needed for that individual.

These developments or stages were characterised by particular staff responses. Since decline meant more staff 'input' or care work, there was a struggle to maintain a resident in the earlier stages as long as possible. (See example of Jack p.161)

The theory of decline excused or explained inactivity on the part of the elderly. It also excused lack of innovative care from staff. Resistance to
decline was based on a resistance to additional work, rather than helping residents maintain themselves at a more independent stage.

'When I asked if the groups had met today J. said, why not give them a rest... all this group activity is too much for the residents' (R2/87)

'Overall I think things are getting serious; more and more can't manage for theirselves'.

**Negative theories of elderly**

The third general theory was embodied in an essentially negative approach to the elderly, which focussed on how the elderly should be.

'Mrs Spencer was just like Daisy when she died, said J. 'She sort of gave up and stopped eating and started being sick. Although at least Daisy was cheerful with it'. (R3/249)

Dying was no excuse for lack of cheerfulness.

Strauss and Glaser's account of expectations of dying behaviour by nurses in 'Anguish' (1970), demonstrated similar attitudes.

The residents were seen as, on the whole, unreasonably cheerless and ungrateful. A similar view
was championed by the seniors at Fell View and echoed by the care staff. Christmas was a time when it was very apparent. A senior staff member was speaking to the residents:-

'Do you think the staff are paid overtime to get your presents... you think all extras are part of our job: you can't even be bothered to get up and pour your coffee'. (R3/253)

I also noted a care attendant admonishing a few residents at the end of a tiring day:-

"She also told them that it might help if once in a while they thanked the staff, since its (the jobs's) rewards were cleaning up shit and vomit". (R2/97)

Care attendants often complained about unreasonable demands of residents:-

'Mrs Daws is a real workie ticket, she's so demanding, getting people up in the middle of the night, and asking for paracetemol'. (R2)

Mrs Daws was seen as being unreasonable; her need for paracetemol was automatically or routinely denied. Her act therefore became one of being a nuisance and she quickly became characteristed as a gloomy and demanding resident.

'When I arrived I asked about the new admission, J., The staff told me to go and talk to her. She was a real 'ray of sunshine' they said sarcastically'. (R3/134)
'for some reason they took against J. She wanted to bring furniture into her bedroom which was inconvenient'.

Janet was also given negative characterisation:-

'I was told to watch Mrs B cos she was a right old cow.. Peggy told me that she was a trouble maker.. and Elizabeth said she was two faced (sic) about her diabetic diet...'.(RL/45)

Comments about particular residents made by different staff tended to follow patterns and it was rare to find the staff producing entirely different theories or assessments of particular residents' activities.

**Importance of Experience in Theory Building**

The basis for these general theories was predominately experience. Past experience was the main credible source used to support the theories and practice. These theories and their justification were built up by the way of comparison, anecdote or hearsay.

There could be an appeal to the specific past where similar circumstances involving a different resident had occurred. The two situations were then compared and the present situation analysed in terms of
past experience. There could also be an appeal to the general experience of others in the same situation, which I have called hearsay, or the experience of a similar but not quite identical situation which is here called anecdote.

Care staff said, for instance, that they could 'tell' if somebody was going to die or if they were going senile, by referring to past general experience of self and others who worked in either Fell View or other homes. Commenting on some strange behaviour exhibited by a resident, one care attendant said, "Janet is going senile I've seen it all before". Janet's behaviour is boxed into the 'going senile bracket'. The expected careers of residents are reinforced by care staff's experience.

Residents were compared to each other, either in the present or past. Mary for instance, reminded the care staff of Florrie who by all accounts ended her days quite demented. They predicted and therefore worked towards a similar decline for Mary.

There was often reference to specific past experience:--

"Mr. Brown's incontinence has been looked at by the Doctor. We have tried toilet programmes with him, but they don't work". (R2)
Comparison was sometimes used for diagnosis of other residents illnesses:

'Lily is behaving just like Louise and she had Parkinsons'. (R2)

Ipso facto Lily must have Parkinsons and be treated accordingly. One night care attendant suggested that Lily had an over active thyroid condition based on her experience of another resident's nocturnal behaviour.

The result of using experience as the basis for the general theories had the effect of deterring innovation or new practice since 'it had all been tried before' and the patterns of resident and staff career and behaviour were laid down by past events and, in some mysterious way, unchangeable.

The use of experience as the main credible explanatory and predictive basis meant that inexperienced new members had to bow to the greater authority of their elders. We shall see later the Deer Park staff used training as their knowledge base far more. At Fell View, training was not particularly valued as a knowledge base, or as a basis for theorizing.
The general theories and their basis had consequences for the process of care in practice.

**Consequences for Practice**

**Moralistic overtones**

The notion of wilfulness or 'doing things on purpose' had certain moral or judgemental overtones. The talk about the elderly tended to mix how the residents were with how they might or should have been. D implied that Mrs Moat should not have relied on her niece:-

'D said she thought Mrs Moat was guilty about what she'd done to other people and that was why she was so withdrawn. She'd relied on her nieces and another relation to care for her to the point that relatives felt under a great deal of strain'.(R2/15)

The judgements about how residents should behave were apparent in specific theories about individual residents.

The theory that the elderly were wilfully inactive encouraged the view that they were shamming or feigning physical difficulties and inabilities. A care attendant's 'explanation' of a particular resident's sickness shows this:-
'Mrs W didn't want to walk so she made herself sick. However she is rarely more than spit sick. Each mealtime she says she feels sick'.

(R3/130)

One resident who said he was coughing up blood from an ulcer, produced a blood stained handkerchief and asked for attention. He was said to be 'trying it on' by staff, because his daughter was going on holiday, and he didn't want her to go. The cessation of the bleeding was seen as proof that he had been shamming in the first place.

This feeling that the elderly were shamming was reflected in the vocabulary used in the report book. Words like 'appears to be', 'says he is', 'seems to be', 'complaining of' which offer room for doubt accompanied complaints of illness reported by the elderly and recorded by staff. For instance a complaint of constipation was given short shrift.

'Complained of not being able to move his bowels. Sat on the toilet for a good hour and does not seem very happy with what seems to be a very good movement'.

(R2)

These theories meant that, at the very least, care staff were tacitly encouraged to routinely disbelieve and reinterpret the residents' actions and words.
'This morning I watched Tom constantly doing up and undoing his flies. The care staff call this wanking. I said to Andrew that he wasn't really wanking as far as I could see, just obsessively opening and shutting his flies. I wondered why. Andrew said, 'Oh yes he is. He's got his hand right in and when I said to him to stop playing with himself, he said I'm not'. (R2)

Here not only did the care attendant see the same set of actions entirely differently to myself but used the denial of the resident that he was wanking as proof that he must have been!

A similar situation prevailed with Mrs Spencer. She was a very frail 'new admission'. Over a period of time she started to complain of sickness and inability to walk. Walking was a very important part of being a good resident and failure to walk made more work, so Mrs Spencer's complaints tended to be ignored.

Care staff successfully insisted that residents followed certain set routines like walking to bedrooms, going to the toilet unaided and at specific times eating only in the dining room and so on. The fact that residents did these things was used by them as evidence for their theories. By insisting on residents performing these activities they 'proved' the actual capabilities of recalcitrant residents. A
resident who said he couldn't walk to the toilet and then did so after staff 'encouragement' (which took various forms) proved to the staff that residents did sham.

Mrs Spencer however, continued to complain of increasing difficulties in walking and to be sick at the dining table. Her sickness was called 'spit sick only' and she was said to be 'attention seeking' and 'making herself do it', despite the fact that she regularly vomitted at the table. A care attendant remarked that she had:-

'stopped at every room on her way to the dining room to sit on a chair and rest.. trying to get a wheel chair you see'. (R3/165)

Mrs Spencer was seen as 'trying to get a wheel chair' under false pretences, rather than an equally valid explanation that she was exhausted and needed a chair.

Jack was also seen as a faker and someone who 'tried it on'. He was said to pretend to be unable to walk as a form of attention seeking. Some entries about him in the report book bear this out:-

'Encouraged to walk but lowered himself to the floor on two occasions' .(RP)
The difference between slipping to the floor, falling and lowering oneself to the floor is one of perception.:-

'Complaining loudly when requested to walk with a zimmer. Will not try to help himself'.(RP)

'asking staff for a wheel chair. Does not like to walk. Could do more'.(RP)

One of the care attendants re-translated my account of the interaction described below, to fit into her existing theory of Jack specifically, and elderly residents generally:-

'I watched Jack and M discuss their outing. Jack was teasing M. for not buying him an ice cream and she responded so there developed some rather light hearted fliriting, enjoyed as far as I could tell, by both participants and the other residents, who were in earshot. Later I recalled this conversation to a care attendant and she said that Jack 'was always being horrible' to M. Furthermore on the trip his catheter bag had come off. She and two other members of staff present agreed that this was impossible.. so Jack must have worked it loose on purpose'. (R3)

In one sense the accuracy of either account (mine or the care staff's) concerning the interaction between M and Jack is not as important as the practical implications of such negative perceptions.
Even tangible signs of physical need were reinterpreted. Miss Hughes was often 'refused' permission to go to the toilet because she couldn't want to go as often as she said she did despite the fact that when she did go she produced copious amounts of urine, which was charted routinely by staff. On one occasion, when she had been taken to the toilet and then left, she complained:

'that she had been left in the lavatory from 10.50 - 11.29. Peggy said it was rubbish and then, that it just proved she clock watched all day'. (R2/72)

So, as far as Peggy was concerned, even if Miss Hughes complaint was true (and this was routinely denied) Miss Hughes was still judged to be in the wrong, since clock watching was a clear example of her own inactivity and small mindedness.

Self Fullfilling Phrophecy

The negative comments set up a process of self fulfilling prophecy. The care staff's actions reinforced the theories:

'Lois was left 'stranded' on a chair in the dining room, too far away from the table to reach it and unable to pull herself in. She grabbed at the table cloth and shouted, disturbing the crockery and other residents at
the table. MD looking on, said she was a stupid, senile old woman and left her to struggle'. (R2)

Tommy became virtually blind and deaf during the research period. Never very bright, this left him quite bemused and unable to orient himself. Tommy's eating habits became more and more distasteful.

'Tommy was got up late and wheeled hurriedly into the dining room, then left with an egg sandwich. Almost totally blind and fairly dim, Tommy finds it difficult to eat and spends most meals with his mouth open, some food inside, shouting inarticulately for help. Often he has a coughing fit which expels all the food, back on to the table' (R3)

The difficulties that Tommy experienced were avoidable, but their presence confirmed the staff's view that he was a 'disgusting' old man and prompted the comment, already quoted, about the residents being like animals.

Whilst comments about residents' tended to err on the negative side, the residents' behaviour could of course have been translated or interpreted differently. The particular interpretations reflected the dominant modes of the theories, i.e. those of inactivity and decline and there were indications that wilful inactivity took precedence over inevitable decline. For instance, it was felt that two of the residents
'taking the staff for a ride...
they used to dress themselves'.
(R2)

It was assumed that they could have dressed themselves still but for their own bloody mindedness, not that increasing arthritis and decline in physical abilities prevented them.

Again, a particular interpretation is given by a member of staff who:-

'said that M was vain, she was always talking about her legs and saying how lovely and slim they used to be'. (R2/23)

This resident could equally well have been seen as 'interested in herself still' in a positive way.

**Alternative Theories**

Although the overriding trend in the home was to be negative about the residents in the ways described, and to have rigid general theories which informed the specific theories, the care staff did make some positive comments about the elderly and were able to change their theories about individual residents.
These flexible and positive comments were in the minority.

It is worth noting that in both these cases the residents were considered to be 'characters' for very different reasons. It may have been the case that some residents were more able to re-negotiate the staff theories about them than others. Patterson (1977) found this to be the case with the more alert and physically able residents.*

Beth, characterized initially as being 'away with the mixer' (daft) became something of a favourite and seen as a bit of a snob, but quite right in the head. A combination of circumstances which consisted of

a) comment by her daughter that she had been a bit of a snob as a younger woman and would not mix with neighbours for various social reasons.
b) she was found in bed with one of the male residents.
c) that her ECG test proved negative (no evidence of senile plague) conspired to rework her original characterization of daft to one of snobby and choosy.

This was despite increasingly inappropriate behaviour.

* As did Gilliland (1984) who concluded that the 'favoured' patient could be as much of a nuisance as the 'bad' patient, but perceived quite differently.
'At Christmas Marie, who was to buy Beth her present, asked her what she'd like. Beth said she'd like something expensive. Everyone laughed. 'I'm not daft' said Beth. 'You're not and all' Marie said. 'You're just choosy'. (R2)

Jack also became redefined as someone who always had a wheel chair, after a great struggle between himself and the staff. Eventually entries in the report book ceased to mention any attempts to get him to walk. At the end of the research period Jack was defined as 'a wheelchair' and he was incorporated into the wheel chair routine. The report book documents this redefinition over a period of three months:-

'-Encouraged to walk but lowered himself to the floor on two occasions'.(June 1981)

'-Complaining loudly when requested to walk with zimmer. Will not try to help himself'.

'-Walked to bedroom this evening with firm encouragement'.

'-Still needs a great deal of encouragement to walk'.(July 1981)

'-Went down on dining room floor Will not walk or help himself. C/o of weakness in left leg'.
'Asking staff for a wheelchair all the time. Does not like to walk. Could do more'.

'Rather upset at having to walk and not given a chair'.

There then followed a series of entries about his depression, which also recorded his need for help. The final mention of his failing mobility appeared two weeks later.

'Finds great difficulty moving from a wheelchair to a lounge chair, even with the aid of staff'.

(August 1981)

Evidently the shift to a wheelchair had been made and was no longer a point of negotiation. This was confirmed by the participant observation notes.

It was however the care staff rather then seniors who 'offered' the alternative perspective or theory when it did occur, since they were in the best position to observe and process the evidence. This is important for later discussion of the relationship between staff and senior. Two examples of redefinition of resident demonstrate the ability to be positive and flexible.

Specific theories varied of course, as did practice, depending on who was theorizing and at what period the theorizing took place, in terms of day or shift.
'I asked Da if she found any major changes in residents now she was working on days instead of nights. She said the main one was Arthur. I asked in what way. Well on nights, you go in, give him a cup of tea and then collect the cup. He's no bother at all. On days he's so demanding'. (R3/104)

**Summary of Fell View**

The dominant general theories about the residents at Fell View suggested that the elderly residents were in some way different to "normal" old people who lived in the community. This difference, according to staff theories, manifested itself in the way in which the residents "gave up", and became inactive when they could have done more for themselves; the way they exaggerated their physical ailments and emotional distress, and their unreliability in their own assessments of their health and abilities. By way of contrast the care staff also thought that the residents would inevitably decline in abilities in a particular way which was defined and "known". Both these theories were negative in mood and supported by a Fell View vocabulary and an emphasis on experience as the basis for theorizing. The dominance of the general theories of decline and inactivity was part of the interpretive framework available to the care staff. At Fell View the general theories guided the development of specific
theories about individuals.

It was possible for specific theories to either deviate from that or change over a period. A number of factors influenced the development. Notably the theorist and situation in which they developed. It will be shown that (Chapter Nine:309) the care staff on occasion 'represented' an individual residents' case for changing a specific theory to senior staff after empirical evidence had suggested overwhelmingly that an alternative theory or explanation might be more appropriate. It was commonly the senior staff who promoted the general rigid theories and the care staff who mediated them as a result of their observations. Seniors at Fell View were in a position to dominate the theoretical perspective, partly because of the reliance on experience rather than training and new information as the basis of knowledge, and partly, as will be discussed, because of the mechanisms in the home that enabled them to transmit these theories freely and with little challenge. (Chapter Nine)

Deer Park Theories of the Elderly

Like Fell View care staff, Deer Park staff had at their disposal "theories" about the elderly that helped to explain, predict and prescribe the process of care. The two homes' theories differed substantially. Part
of this difference can be explained by the particular interpretive framework available to Deer Park staff. It has been noted that during the course of the interviews at Deer Park it became apparent that not only did the staff have a very clear idea of group living, but that they had a clear set of theories to account for and describe the elderly residents. These theories were on the whole positive, and distinguished the residents at the home from other "traditional" residents. However, through prolonged questioning and the participant observation it was apparent that negative sets of theories about the residents also existed. Care staff knew what they should have thought and said about the elderly residents, and this was offset to some extent by what they did say about the residents on a daily and spontaneous level.

Interview Responses - "The Deer Park Resident"

As already seen in their comments about the handicapped (p.116) the staff felt that there was less chance of having a 'normal' relationship with elderly residents. Not withstanding this, staff distinguished between types of elderly residents. Questions A2-A5 (Appendix C) asked the staff how Deer Park differed to other homes. During the course of these questions staff mentioned the difference between Deer Park residents and those in "traditional" care (i.e.
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non-group living). On the whole staff felt that in a traditional home residents slept all day and did nothing but sit around. (This was blamed on the rigid routines). But at Deer Park:–

- "They're fighting...They're still alive, they're not sitting like cabbages in a corner".

-"The residents seem more with it than other residents do from other homes.. more talkative".

-"The residents are happier, they've got more choice.. they're not just waiting for someone to take them to bed".

-"Much more lively residents.. able to make up their own minds.. individual people you know". (A2-A5).

These comments were very closely linked with the aspirations of group living which was to encourage the elderly to be more lively, give them more choice, to retain their individuality. A Deer Park "vocabulary" was evident in these comments.

Other comments on the same questions were less positive, although these were less in number. These comments noted a 'decline' in the residents and offered an explanation of any failure in the group living style of care in terms of unsuitable elderly.
"The old persons we've got mostly aren't interested - very old and infirm, there's a lot of mentally infirm here".

"They don't seem to be as interested... the old folks are... there's a lot of deteriorating... not a dramatic change just a few old people don't seem to be as eager to do anything... they don't seem to have as much interest...". (A2-A5)

There was a general theory about who was suitable and who was not suitable for Deer Park. This was addressed in questions 10, 11, A6, A9, whereby staff were asked what sort of person would be suited to living in a residential home and who really suited it at Deer Park. They were also asked who would have difficulties living in residential care. A minority view was that any elderly person was, and should be, suited to Deer Park. This view felt that it was the home's responsibility to accommodate the resident.

The dominant view however was that there were residents who were "suited to group living" and there were those who were not. Those who were suited, were like Nell:-

"A person who actually utilises the things that are here... i.e. trips out and clubs. Nell is an exceptional lady. She doesn't come in and do things just like that because she has to... she has her bits of grumbles and her bits of happiness and she's loving". (All)
"Anybody who is not willing to do small activities and work in a group is not suitable here". (A12)

This meant that those who were very confused or very frail were less suitable.

"The confused don't understand what other people are doing... they tend to get frightened". (A10)

"The groups are all getting towards their 90s... their tempers are... their tolerance is bound to be getting low... they tend to blow up". (A12)

From the interviews there emerged a definite picture of a "Deer Park resident" which was resisted by only a small group of staff who felt that all potential "Clients" were Deer Park clients. The onus, nevertheless, was placed on the residents to fit in with the group living model.

Question A12 and F5 asked the care attendants to consider whether the elderly liked residential care and whether they (the care staff) would want to live in residential care. In contrast to the "never had it so good" attitude of the Fell View where, as shown, gratefulness and cheerfulness were thought to be appropriate responses to care, Deer Park staff were more circumspect seeing as realistic the elderly's response to care as something that they were
obliged to accept and make the best of.

"I think quite a few are happy here because they can't live by themselves or their families can't look after them... they do find some satisfaction... but I'm not saying that it suits them". (A12)

"I think its difficult for them to give up their homes 'cos obviously that's what they've been working for all their lives. I think most of them now realise that there is no alternative".(A12)

In response to the question about themselves going into homes in old age the replies were almost uniformly negative, and showed a faintly pejorative edge towards those who do "end up" in care.

(F5)
"I would want a livelier life when I get old than what they're getting".

"Never unless it was um... some calamity. Because I like my privacy.. I like to be independent".

"I damn well hope not".

"I never want to live in a home and I would never put my mother in a home".

"Only if I'm severely disabled".
-"You lose so much, you're not free. You are in a system".

-"I won't live that long. If I can't care for myself I should be dead".

It was noted that at Fell View there was a feeling that old people in care were somehow less capable than their community counterparts and similar feelings about not ending up in care themselves were evident amongst Fell View staff.

The Residents Career - Theory of "Joining In"

As shown, at Fell View the residents were seen as inevitably in a state of physical and mental decline and their career was marked by increasing levels of confusion and incontinence and immobility. Question B3-B6 asked Deer Park staff about changes in residents and the responses suggested that the dominant theory was that residents would improve within their own limits, as social beings. The improvements were expressed in terms of becoming part of the group and starting to do group tasks:-

-"I think that it's natural and it does happen that people who come in and don't want to do anything gradually after they've got grounded in the home.. feel more inclined, especially when they get to know people round them.. some are very resistant.."
it might take six months with some... you're going to get a desire from them to work in with the group... as time goes on they object less and less as they work in with each other... so you do see improvement as time goes on, except with the odd one...

"Yes I've noticed a lot of them, when they first come in although they knew that the home was like, they still used to come in and just sit and hope that someone else would do something for them... since they've been in they've picked up the routine and that and I think they're maybe beginning to look in a bit more..."

Decline in physical abilities was recognised as inevitable.

"Well of course they are another year older like, but they're not as quick as they used to be... some erm... of them don't walk as good as they used to... we've got one now whose on a zimmer frame who wasn't when she came in".

"Naturally as they get older they are going to deteriorate... because that's just with old age... you can't expect any other... you can't expect to make wonder women out of them".

Although improvement in physical abilities was by no means seen as impossible:-

"We've got one or two who've improved since they've come in... like Mrs Daws... she used to walk with a stick... and she walks smashing by
herself now... she also does things for herself, like makes her bed".

"Tom, well he's just fantastic for a fellow with one leg... one day I said that I'd bath Tom and I thought 'eeh I've taken on a job here but I didn't do a blessed thing for him. All I did was wind up the chair. He even wound himself down... and got the towels that he had used and took them to the wash".

**Theory of Slipping Back**

As shown, the feeling at Fell View was that residents were "naturally" disposed to doing as little as possible for themselves, with the consequence that care staff tended to disbelieve their complaints of frailty and difficulty. At Deer Park the emphasis on residents as unreliable sources of information was not present to such an extent. There was however the feeling that residents could easily "slip back" to traditional resident behaviour and become inactive without stimulation from staff members. This is discussed in Chapter Eight (p.251).

**Summary of Deer Park**

The general theory of the elderly was marked by a view that Deer Park elderly were different to other elderly people in other homes. There was a positive view of the residents and high expectations, in the
sense of what could be achieved, in group living. Care attendants felt that the elderly had resigned themselves to coming into a residential home and understood and accepted that, although they were basically quite relieved to be there, it could never be quite like home.

The staff said that they would dislike living in any sort of home (even group living) and would make serious attempts to avoid it. They said they understood the difficulties and negative feelings of those entering residential care and when asked what they would most dislike about residential care, most answers focused on the lack of privacy and loss of independence.

There were alternative, less positive, and more traditional based views that the elderly would "try it on" and were in some way failures in that they had "ended up" in a residential home. However the group living principle promoted the view that elderly people were potentially more active, lively and happy than was usually thought to be the case. They were thought to want to be independent, private and self-caring and even if they didn't want to be they should be!

The implication of these theories for practice of care was that the care staff treated the elderly people
as relatively normal and tended to take their views into account. This practice was aided by structural features discussed below (Chapter Nine).

Staff views at Deer Park were dominated by a guiding principle, in this case group living. This concept allowed more specific and individual theories to emerge since individuality was part of the group living ethos. These more specific and individual theories were more open to negotiation and reform. Care attendants had a degree of control over the individual theories not available to the staff at Fell View. This reflected the nature of the interpretive framework and the basis of the data source for the theories.

At Fell View experience was the main source of data. This effectively placed the theory building ability in the hands of seniors and long term staff members. At Deer Park training and the group living model was used as the basis of theorizing and this was available to all members and adherence to it encouraged by senior staff.

The senior staff were initially very active in promoting the group living associated theories about the elderly. Their influence on the staff as the home was setting up was acknowledged by staff members. It
was noticeable that senior staff influence decreased over the period of research, and various changes in routine and contact between members, along with a change in superintendent meant that staff were required to sustain theories without senior staff re-inforcement. It was during this period that most members of staff noticed "traditional" care creeping in and remarks were made about the residents being unsuitable for group living or declining too much to be able to be active in group living. As senior staff support lapsed and group living dogma became less strident so theories became less uniform and stable and more traditional, as did the process of care.

Comparison of Homes

Part of the difference between the two homes theories can be explained by the source of the data used to form the theories. At Fell View the theories were based on the experience of life and the elderly usually handed down to the staff from the senior staff (as the most experienced members). There was little credence given to training knowledge; experience was seen as the key to being a care attendant and "knowing" about care. This gave power to those longest serving members of the staff who were, in the case of Fell View, the senior staff.
At Deer Park there was much less reliance on experience as the basis for theory formulation. Expertise and skill acquired from formal training was given a high status. Those with the most training had the greatest influence on the theories. Again this was the senior staff. The emphasis on training encouraged Deer Park staff to use daily observable and empirical evidence to inform their theories, in a way that was not apparent at Fell View. Fell View staff interpreted the empirical situation before them in the light of experience. Deer Park staff noted and reformulated theory in the light of evidence from various sources. Staff at Deer Park generalised less about the elderly and focussed more on residents as individuals.

The moralistic undertones noted at Fell View were less dominant at Deer Park. This allowed both residents and staff more freedom to act, react and interpret without constraint.

The Fell View staff did not enjoy such a cohesive and strong, unifying philosophy. Expectations and theories fitted less well together and were often openly contradictory. Each home had a vocabulary of care; that is, typical words and phrases used to describe residents and situations and both homes used their particular vocabulary to aid their theory formulation.
The relationship between theories and process of care

As will be shown the Fell View manifestation of care was one where elderly people were 'worked upon' and maintained in an agreed publicly acceptable state. (Chapter Seven). The residents were seen as work objects and accepted, on the whole, a passive form of care where staff did things for them and to them. The theories the staff had about the residents mirror to a great extent the 'care' evident in the home. The important element of wilful inactivity present in the Fell View theories meant that the staff practised routine disbelief. This encouraged a lack of faith between the two groups and a division between staff and residents. In the case of Fell View, the theories about the elderly rendered change very difficult. Experience taught staff that altering styles of care was useless since there would be no response from the elderly.

At Deer Park the contrasting automatic belief in the residents' abilities to improve was very much linked to the group living philosophy. Whilst at Fell View there was a pessimism over possibilities of improvement and change either in the style of care of the residents, at Deer Park there was a superficial optimism which sometimes blinded care staff to the realities of the residents' abilities, and of the model
of care in operation. A question addressed in Chapter Eight is how much did the process of group living and self care actually take place. Did the theories and philosophy of the home tend to paper over the cracks in a system that was inherently flawed?

In both homes the theories of the staff about the residents indicated that the onus was on the residents to change or fit in to the model of care in the home. This was very apparent at Deer Park where the philosophy and practice was so clear. So, whilst, at a superficial level, Fell View seemed the less flexible of the two homes, in practice the domination of the group living principle tended to make Deer Park theories quite rigid.

In the next chapter the relationship between the above theories to day-to-day practice is examined by looking at typical days at the homes and the models of care that predominated.
7. THE DAILY ROUND, THE COMMON TASK

Introduction

It was noted in the literature review (Chapter Two) that regimes or models of care were related to the orientation of tasks, as institution or individual centre, and the perception of staff of their "work". Furthermore the official account of regime and the daily practice were often divergent. This chapter considers what tasks care staff actually do as recorded through observation, how they do them and the focus of the tasks as routine, time or resident orientated. A model of care at Fell View will be described and Deer Park compared with it. It will be suggested that whilst similar tasks were carried out at both homes the style and order of carrying out these tasks differed as did the participants. The frameworks for care regimes in each home had similar components but different configurations. This produced different outcomes. In addition the presence of a clear philosophy at Deer Park gave staff a role as mediator between philosophy and actual practice of both staff and residents.

It will be suggested that the relationship between routine and spontaneity partly determined the care styles of the two institutions under study. The greater the spontaneity the more individual-orientated
the practice.

The chapter will start by describing the typical day of both homes. The data for this section was taken from accounts written as part of the participant observations data during observation periods. The Fell View account was written after the summer working as a care attendant (see Chapter Four) in October 1980 and the Deer Park account was written after three months observation. (July 1982). These accounts should be considered as 'raw' data and are presented as being consistent with the views considered in Chapters Three and Four - that all data should be part of the final data analysed and that it is a mistake to ignore early participant observation data.

The analysis of the tasks itemised in a typical day has suggested that at Fell View the dominant tasks were those concerned with maintenance of the "public" appearance of both the home and the residents and that these were highly "routinised" tasks which were supported by 'repair' work. Other work either related to that or fitted into the regime dictated by it. Fell View seemed to have little room for spontaneity. The comparison with Deer Park suggested that although tasks are similar the obvious presence of spontaneity and innovation as part of the "repair" work re-shuffled the process and the result was two different types or
styles of caring and being a care attendant.

**A Typical Day - Fell View (October 1980)**

It is part of the night staff's job to "assist the residents up" and this is recorded in the nightly report book. The night staff usually "get started" about 5.30 a.m. Some residents also start ringing their room bells about the same time. A number of residents dislike lying in bed since they get very stiff. Several go to bed so early that they wake, after eight hours sleep, in the small hours.

The night staff get as many residents as possible up in the morning. They go off duty at 8.00 a.m. and most residents are dressed by then. Between them the two night staff dodge about the rooms, sitting one person on a commode, helping another with a vest and so on. Dependent residents have to wait for the night staff to move them on to each progressive stage of getting up and occasionally staff forget a resident altogether. These residents are "rescued" by day staff. The staff do not concentrate on one person at a time, but treat dressing as a series of stages although each staff member will concentrate on one floor. Everybody who needs help should be ready by 6.50 a.m. This allows time for a cup of tea for the residents (some of whom are already in the lounge) and
a break for the night staff. Working without stopping it takes about 1½ hours to get all those who need it, dressed and ready for the day. By 7.00 a.m. most residents are in the lounge.

The day staff, domestics and care staff arrive at 8.00 a.m. or just before. Before they "start" they have a cup of tea and a chat with the night staff who finish their jobs, particularly washing the tea cups which is an important "clearing up" task. Night staff complete their hourly report and recount problems to the day staff that have occurred, particularly any unusual incidents, during the night. There is no formal report or handover. Tasks are informally allocated amongst the staff members. Sometimes no arrangements are made. Sometimes staff repeat tasks although usually the work organisation is completed with the help of tacit knowledge over who generally does what.

Shift changeover takes place very promptly at eight o'clock. Once the night staff have left, the day staff go along to each bedroom to check on the progress of any 'slow' resident. Breakfast is served at 8.30 a.m. so that aim is to get the residents into the dining room by that time. Many of the residents who have got up about 6.00 a.m. will be asleep in their chairs. The staff direct the residents towards the dining room. "Stragglers" who arrive late, have some
difficulty negotiating the zimmers and wheelchairs which clutter the floor space and occasionally seats get changed as difficulties become great. As a general rule however, residents sit in a regular place in the dining room and the sitting room. Some residents have to be helped into the dining room. Domestics and care staff tend to interchange jobs around meal times. However domestics have their own jobs during the day.

Breakfast rarely takes longer than half an hour and care staff start to clear tables as individual residents finish their meal. The clearing of the tables enables order to be regained and allows the next stage of the daily routine to proceed. Clearing the tables supersedes all other work at this point. After this the major morning tasks are to take the residents to the toilet, make the beds, clean the bed-pans, do any dressings or medical treatment required, prepare the coffee and lay the dining room for lunch. There may also be residents to escort to hospital or day centres.

The first mass toileting takes place after breakfast, and then after each meal. Commonly requests for help to the toilet at a "non-toilet" time are greeted with disbelief, refusal or delaying tactics by the staff.
Prescribed medicines are given out either during or just after each meal. After breakfast any dressing needing attention might be looked at. There is no clear system for dispensing and checking medication. The senior staff "put up" the tablets into individual containers and any care attendant can distribute them. The elderly sometimes point out errors.

Residents are discouraged from returning to bedrooms after breakfast since this impedes the progress of bed-making and very few residents make their own beds. Bed-making is seen as an essential task and always takes place directly after residents' breakfast.

Staff breakfast is "called" by the kitchen staff when all the breakfast dishes have been washed and dried and the kitchen cleaned for preparation of lunch. Usually there is an immediate response to staff breakfast.

Staff have several official breaks throughout the 24 hour day. The formal meals consist of "breakfast" where any leftovers from residents' breakfast can be eaten and tea and toast is made. Staff on the day shift have a one hour lunch break which involves a meal that they pay for, and which starts after residents' lunch has been cleared.
There is tea for the "backshift" at 4 o'clock which also has to be paid for and night staff have an hour during the night in which to eat and rest. There are also less official breaks which will be discussed.

The care staff are responsible for making the coffee and tea for the residents and washing up the equipment afterwards. Coffee and tea are served mid-morning, mid-afternoon, supper time (7 p.m.) and bedtime 9 p.m. when cocoa and Horlicks are included. There is a great reluctance on the part of the care staff to take tea/coffee to the residents not sitting in the central sitting room. There is a similar reluctance to give meals outside the dining area.

A care attendant prepares a trolley and takes it into the lounge. The rattle of the trolley is one of the familiar noises in the home and prompts residents to organise themselves for coffee. Care staff dispense coffee with minimal participation from residents. Residents' preferences become quickly known and thereafter care attendants do not consult residents about their daily preferences. Tables are laid for lunch which is at 12.30 p.m.

The "backshift" staff come on duty for 12.30 p.m. and there is an informal coffee break with the two shifts, where information is passed on. Staff can
also call in at the office and talk to the seniors and read the report book. All staff are supposed to read the report as they come on duty. Often word of mouth is preferred and reports are read later in the day. Residents' lunch is served with a similar process of the residents slowly making way into the dining room, toileting and clearing tables afterwards.

In the afternoon the pace drops, partly because all the cleaning and "getting tidy" work has been done and partly because there are double the number of staff on duty. The backshift might do some bathing or dispensing the laundry. The staff enjoy bathing. They say the residents tend to "open up" in the bathroom and have a good chat. The care staff feel the residents can "get things off their chests" in this situation. Bath times are determined by how busy the staff are. Each staff member has a certain number of "baths" (residents) on a list which she must complete every week.

Bathing usually takes place during the day and rarely upon rising or retiring. Staff are keen to get their baths "done" for the week. Bathing is felt to be an extremely important part of the care attendants' work. When one staff member was rumoured to have just "ticked" her bath list without actually doing them,
there was considerable discontent and the member of staff concerned was seen as behaving unfairly. However it was seen as unfair, not so much to the residents who had missed out on the bath, but to the other staff who were actually doing baths.

Dispensing the laundry can be carried out at any time during the day, but it is usually done when there is less rush, in the afternoon. Once the clothes have been dried they go into a pile for ironing (which is done by the night staff) or they go to the laundry room ready for dispensing. Clothes are badly marked on the whole and there is no clear system for distribution. As a result clothes often "go missing" which is often a euphemism for getting into somebody else's drawer. It is far from uncommon to find one person wearing another's pants or vests. (Particularly these items since they are all quite similar). Distributing the clothes usually relies upon the knowledge of the care staff who recognise unnamed garments. Only care staff who have been at the home a reasonable time can be expected to recognise clothes. This means that the new care staff and more especially the temporaries (or "outsiders") spend more time in the residents' company since they do not have sufficient knowledge to attend to the laundry and they have no bath list.
The afternoon is also the time when most visitors arrive.

High tea is served at 4.30p.m. and this is the last cooked meal of the day, although there is a "supper" of sandwiches and left-overs at 7.00p.m. The day shift leaves at 5 o'clock having filled in the day report. After this there is a "quiet" period until supper at 7.00p.m. Staff either find a job and chat amongst themselves or less commonly to the residents.

The "back shift" help the residents to bed and they try to get as many people as they can into bed before the night staff come on duty at 9.00p.m. They should also lay out clean clothes to be worn the next morning.

The night shift arrives for 9.00p.m. and the back shift leave promptly at 9.00p.m. after a final cup of tea. There are usually very few residents still up, certainly amongst those who need any help getting to bed. Night shift take round hot drinks and medication to the residents and lights are switched off at about 10 o'clock. The night shift are expected to clean up the communal rooms, iron the clothes and make hourly "rounds" to each room, to check on the well being of the residents.
The daily round is over and ready to restart at 5.30a.m.

A very apparent overall feature of a typical day is the amount of talk that takes place particularly between staff.

A Typical Day - Deer Park July 1982

Observing and describing a typical day is not so straightforward at Deer Park. This is partly because Deer Park's four wing groups each operate their daily activities somewhat differently, and partly because the residents are more in control of their own daily self-care routines of eating, bathing, dressing and so on, much of which took place in private. Whilst similar activities take place during the day, the order, timing and participants varied.

The hours of work are the same for Deer Park staff. Night staff start getting some residents up about the same time. However fewer residents need help to get up and dressed and fewer get up at that early hour. This, combined with the home's policy which emphasises choice for the residents, conspires against the night staff getting all those who need help up before the day shift arrive.
Each shift starts with a "talk-in", an official or formal activity, which is a discussion between senior staff and care staff as they come on duty. This talk-in involves passing on information about residents' health, emotional state and activities and interaction in the group.

It is used by staff to air views, discuss problems and to arrange daily work patterns.

After the morning "talk-in" which lasts about half an hour, the care attendants give what help is needed by the residents to have breakfast. On most wings residents will have laid the tables for breakfast the previous evening. Few residents want a cooked breakfast (those who do are supposed to cook it themselves) and porridge is sent down from the central kitchen to the wings. The staff make the toast and tea. Resident participation varies. Wing D are entirely self-sufficient and responsible for the whole process of a meal whereas Wing B get far more staff help. The amount of help depends on the varying abilities of residents and the approach of staff. Domestics, who do not attend the staff talk-ins, also help at breakfast time.

The residents are encouraged to help themselves as much as possible and the morning tasks, similar to
those at Fell View in character, tend to be carried out by different participants. Because of the design of the home the residents have less distance (and therefore difficulty) getting to their dining chairs, toilets, and bedroom. The residents can wash up the breakfast dishes at their wing kitchen sink, which is a few yards from the dining area. The toilet is a few yards from their sitting rooms.

Breakfast may take up to 10 o'clock and since the care staff are not expected to clear up, there is little pressure on residents to complete breakfast. Lunch is made in the central kitchen, so preparation of it is not impaired by slow breakfast clearing.

Bed-making is bound to the home 'rule' that residents' rooms are private areas. Bed-making is often done by the residents - or with the residents present since many residents will go to their rooms after breakfast. The domestics give each room a clean once a week otherwise doors to bedrooms are kept shut. There are exceptions to this, amongst a few residents described as "confused". Bed-making by residents is further encouraged by the beds having duvets rather than heavy blankets that need tucking in.

During the morning, domestic staff attend to various cleaning chores, according to a self-devised
rota and care staff attend to residents. Much of this work involves observing activities or promoting activities rather than actively taking part. These can be described as quality of life tasks. Quality of life tasks are those where, for instance, care staff "remind" residents who may need it to go to the toilet; suggest a resident might like a bath or a hair set; staff and residents doing the crossword; or simply have a conversation. These tasks can be seen as life enhancing not simply essential to daily living.

'Daily living' tasks are where staff actually do the tasks rather than encourage them in the residents, like taking residents to the toilet, feeding residents, bathing and so on.

Lunch takes place very promptly. The cook likes to "get straight" after the meal which involves clearing up work in the central kitchen. The staff lunch takes place from 12 - 1.00 and 1.00 - 2.00 p.m. in the staff room and these times are very exactly observed. Staff breaks never involve all the staff since a home rule is that there should always be a member of staff on each wing.

There are bath lists and staff work their way through their bath list during the week. However, completing bath lists does not have the priority it
does at Fell View. Sitting talking to residents is officially seen as a work activity and is not, openly at least, condemned as non-work. Often the back-shift will spend one or two hours sitting with the residents.

Residents lay the tables for tea and sometimes a resident or staff member will make a cup of tea at about 3.00p.m. for the group. Most group members disappear in the afternoon either to sleep or go out with relatives or friends. The public areas of the wings are often nearly empty at this time.

Day staff go off duty at 5.00p.m. and back shift finish their tea break then. Some residents might go to the communal television room after tea. A number of residents retire to their room at that point. Staff spend some time sitting with residents and each other chatting. Various residents need help going to bed and others need "checking".

By the time night staff come on duty at 9.00p.m. there are few, if any, residents left in the wing lounges.

Task Analysis

The following section looks in detail at the tasks performed by care staff as indicated by the account of
the typical day. Particular attention is paid to any change or attempted change to the nature of tasks or their priority and staff reaction to it. This points up the "objectivated" nature of tasks that are perceived as inflexible and routine bound with a meaning of their own over and above their relationship to residents needs.

It will be suggested that three associated organisational factors have emerged from the data of Fell View:

1) work was attached to shift
2) work was attached to time
3) the jobs were hierarchically ranked both officially and unofficially

These factors characterised the style of care at Fell View. This style is presented and discussed and used as a means of comparing Fell View with Deer Park.

Fell View - Maintenance and Repair Work

The above account of a typical day showed that care attendants mainly performed daily living tasks which involved keeping both the residents and home running smoothly by dressing, feeding, bathing, making beds, clearing tables, report writing, doing laundry, and dispensing medication. It will be
suggested in the following analysis that these tasks had the over-riding purpose of maintaining an acceptable degree of order, cleanliness and routine. What is henceforth called "maintenance" work was that which routinely maintained the equilibrium of the home and "repair" work made good any gaps in the maintenance work. All the tasks geared towards that aim were seen as essential. Maintenance work was routine but repair work was carried out in passing. 'In passing' meant it occurred when necessary rather than as a matter of daily routine. Both care attendants and domestics were involved in these two types of activity although each had different areas of responsibility. The care attendants primarily maintained and repaired the residents and the domestics maintained and repaired the home. However both groups overlapped in their tasks and both groups tended to repair each other's work. The way in which essential maintenance tasks were carried out was both the confirmation of and breeding ground of the general theories about the elderly discussed in Chapter Six. Theories of inevitable decline and wilful inactivity influenced much of the practice and were in turn reinforced.

**Rising and Going to Bed**

An essential task at Fell View was to make sure that residents were up and dressed in the morning and
safely in bed at night. This activity ensured the continuity and smooth running of the days. Residents were required to get up in time for breakfast and as we have seen, there was pressure on staff (and therefore on residents) to get residents to bed at a time convenient to staff shift requirements. A resident who failed to comply with this routine created problems for the staff. Other routine tasks were disrupted by, for instance, the late arrival of a resident to breakfast. As a result unofficial "rules" were made about when breakfast should be completed and about the dispensing of food anywhere but in the dining room. These rules facilitated a smoother running of the routine.

The new officer-in-charge tried to introduce flexible bed and rising times. The following account of the progress of this demonstrates the "embedded" nature of the care staff's maintenance routines, and their adherence to time and shift requirements.

The officer-in-charge instructed the care staff at a staff meeting that from that date:-

"no one gets up before 7.00a.m. and no one goes to bed before 8.00p.m.". (R2/71)
The immediate response at the staff meeting was fairly positive. Only one care attendant had reservations saying that he thought:-

"the residents should be free to decide when they want to go to bed". (R2/71)

There was also discussion about particular residents who, it was thought, would be difficult to persuade to stay up and not get up early. The officer-in-charge said that the care staff should try to motivate the residents to stay up longer, but gave no practical advice on 'motivation'.

A few days later I asked staff how they were managing the new system. They thought another staff meeting was necessary since some staff were getting much heavier work loads than others. They said that the back shift of one day (who were usually the day shift of the next day) were having to put people to bed on one shift and get them up on the next. This was seen as unfair distribution of tasks. There was a lot of tension between the night staff and day staff and the domestics were having to serve breakfast since the care staff were still helping residents. This held up domestics' kitchen and cleaning work.
The back shift clearly saw it as their "job" to get their residents to bed. The officer-in-charge's alteration to their routine involved getting residents to bed between 8 and 9.00 p.m. rather than 6 and 8.00 p.m. They had translated the instruction in terms of their existing perceptions of what it was to be a back shift worker.

The tensions between the staff came to a head when the night staff complained to the officer-in-charge that they were being 'victimized' by the day staff who said they were not doing their bit. The officer-in-charge asked them to continue the new method. The situation was actually resolved in the following way. Firstly collusion with residents by the night staff meant that some residents still got up much earlier than 7.00a.m. These residents were several women with painful arthritis who found lying in bed for too long extremely uncomfortable and another woman who had no legs who could not drink her tea in bed. Thus several residents were made into "special cases" (R2/80). A back shift device to make residents special cases for going to bed before 8.00p.m. was for staff to agree that they looked ill or tired and so could retire for humanitarian reasons. On the back shift it was soon discovered that residents could be bathed and got ready for bed before 8.00p.m. and then sat in the lounge until 8.00p.m.
There was a feeling of embarrassment when the night shift came on duty if residents were still up - this uncomfortable feeling was a powerful inducement to ignore the new instructions. Another device used to not obey the instruction was to agree that the officer-in-charge* was not a reliable or credible giver of instruction. This is discussed elsewhere. (Page 294).

As a result of the reworking of a new instruction into the old shift/work pattern, bed and rising times were more rushed (in order to complete same work in less time) and the intended aim of a more "normal and peaceful" rising and retiring was defeated. The care attendants apparently found it difficult or inconvenient to alter their perception of the work allocation of each shift.

Similar numbers after the new instruction suggested that the effect of flexible bed times and rising times was not very great. So the attempts by the officer-in-charge to de-routinise and de-shift the bed and rising times was reworked by the care staff.

Coffee making

Feeding and drinking times were essential but potentially disordered events that had to be got

* The Authority changed Head of Homes' Title from Superintendent to Officer-in-Charge half way through the research.
through and completed before other essential tasks could proceed.

Coffee making in particular was generally an unpopular job and low in preference hierarchy for the care staff. Ann (care attendant) said she quite disliked coffee making and would avoid it if possible. This task required long exposure to the residents and therefore potentially to requests for "extra" work. The coffee sessions were one of the rare "routine" points of contact in the day between staff and residents. Each resident's particular wishes were known, so that for instance, Mr. Brown and John were given a lot of sugar because they like their tea sweet, Mrs. Chapel got a bit of cold milk in her coffee because she liked it a "bit cool". Bunty had a cup of cold milk, although sometimes if she was sleeping, she was missed out. Charlotte liked her coffee made with water and cold milk and Mary Daws had tomato juice and toast.

Staff "knowing" residents' choices restricted the potential for residents' participation in their "break times". Resident participation in all feeding and drinking events was minimal and so was staff's expectations that residents would participate, although occasionally there was an effort to make those who were able to, do a little bit more.
Once coffee and tea were dispensed the staff might have a cup themselves and sit with the residents for a while before collecting the cups. One or two residents might collect their immediate neighbour's cups (Edward used to do this). One or two might hand the staff their cup as the care attendant went round. The rest would leave their cups for collection.

During the day the cups were used for other purposes, particularly meal times, and were therefore in constant demand. A tight schedule needed to be followed so that laying the tables for lunch or tea was not held up by lack of cups. Resident participation slowed up this event. The goal of tidying up and getting straight ran throughout the whole process of coffee making and drinking and militated against chats, second cups and long drawn out coffee sessions. The purchase of another set of cups might have substantially altered the process.

The officer-in-charge's plan to reorganise coffee time so that the residents might participate more, resulted in a reshuffle in the hierarchy of tasks. It illustrated the strength of the routine bound system, where the meaning of the task was isolated from the task itself. (R1/60)
The officer-in-charge informally suggested to the staff soon after his arrival that they might like to get more residents to help themselves to coffee. He then reinforced this in his first staff meeting. This was part of a general plan which he discussed at length with myself to get residents "going" or "motivate" them. Asked about the content of the staff meeting, the staff reported this suggestion to me as:

"The residents have got to help themselves to coffee now".
(Rl/68)

At this stage staff were generally welcoming any suggestions from the officer-in-charge and saw this as a good idea. They liked the idea that the residents would have to do more for themselves, particularly since this reinforced their own idea that residents could do more for themselves.

The residents reaction was quite strongly negative. There was a lot of grumbling particularly from the older men. There was a feeling that the staff were paid to care for them and giving coffee was part of the caring. The staff on the other hand did not see themselves as "servants".

The new method of delivery was that the staff made the coffee and tea, wheeled the trolley in and then withdrew, inviting the residents to help themselves to
coffee. The staff saw this change in routine as a great release giving them more time, whilst the officer-in-charge saw it as more work helping residents to help themselves.

Initial annoyance from the residents was not helped by the staff who delivered the "having to help yourself" message as a sort of punishment or threat. The trolley was wheeled in and someone shouted 'coffee time'. One or two of the able-bodied would get up and help themselves and perhaps their neighbour. The staff knew who to ask to help themselves. A further group was too much trouble to argue with. The immediate result was that some residents got no coffee or tea, some drinks were spilt and there were resident complaints. However coffee making was unpopular and the care attendants gave this task over to non-care attendants wherever possible. This meant that coffee making was regularly done by people who had not been instructed about the new method and who were not socialized care staff. These non care attendants tended to operate the old system giving out a cup to each resident and "repairing" the care staff's new system. This non care attendants' "over help" acted against the instruction to self help but ensured each resident received a coffee, and modified residents' complaints.
Short staffing meant that relatives were on occasion asked to make the coffee or volunteered their services. (R2/56,R2/72). They dispensed to every resident, all of whom remained seated, reverting to the old system.

At this point the introduction of the group project (p.103) helped confirm staff suspicions about the hidden ability of residents. The aim of the project was to uncover these abilities and stimulate more activity. The project meant that less staff were on the floor and there was less time to get the jobs done. Therefore it became a matter of some necessity that the residents should help themselves to coffee. This meant increasing pressure on residents to help, and particularly to wash up cups.

More people were getting up to get their coffee and as a result the area around the coffee trolley became rather congested with zimmers and walking sticks. One or two spillages occurred which began to agitate the residents. One member of staff suggested to Mrs. Ermine (a "capable" resident) that she might like to take over the coffee dispensing herself in order to alleviate this rather fraught advance to the trolley. She agreed and confirmed her role later that day by saying to Katherine (care attendant) and myself that she thought it was much better with just herself
dispensing coffee.

Mrs. Ermine took over and some "outsiders" lent a hand. Mrs. Ermine operated a similar system to the old one in that she dispensed known orders to all residents. Things continued like this for some time, until a male resident "threw" a cup of coffee at her and although the details of this episode are rather contradictory, (R2/93 and 96), the upshot was that she refused to do the coffee any longer.

The care attendants then had to return to the scene. However, a break in this task had changed their perceptions. Help for coffee was now given "in passing" by a care attendant. Coffee making was no longer seen as a complete task of making, serving, and washing, but was divided into small tasks.

Coffee making visibly altered its place in the home's hierarchy of essential jobs although it still retained its essentialness. The system for coffee making broke down and more and more "repair work" was needed to patch up the system and ensure a cup of coffee to all. Relatives, friends and outsiders as well as the residents were required to take over the 'repair' work to some extent.
Unlike the new bed rising times that were unacceptable and re-interpreted by the care staff, coffee making was reorganised in the hierarchy, though the officer-in-charge had intended a qualitative rather than organizational change. Care staff used the instruction to reduce their work load rather than redefining the nature and style of this task. Washing up the cups was no longer directly connected to the making of the coffee (which was still done by the care attendants). Therefore it was more difficult to know whose job it was and staff became less accountable for completing the task. As a result it was often left and done at the last minute. Coffee times also became flexible. Instead of promptly arriving at three o'clock, coffee was served at 2.30 to 3.30 p.m. Coffee making could be done by domestics since it no longer required contact with the residents and it became more of a kitchen job.

Mealtimes

Meals, as seen, had to be finished and cleared away before other work could continue or start. The priority was to get the tables cleared and get residents back to their seats, via the toilet if necessary. Residents were fed as quickly as possible - plates were removed from tables before all members of the table had finished; puddings were placed beside
residents who had not finished their main course. This meant that washing up could begin before the meal ended thus speeding the completion of the meal associated tasks. Residents who needed help to walk usually had to wait to leave the dining room until dishes were stacked and tables cleared.

Since care attendants and domestics wanted to clear tables quickly, they tended to be laid sparsely. This "short cutting" as part of the daily routine of getting through is noted by Baker (1978:p.212). Shortcuts became part of the unofficial rules followed by staff. For instance, water glasses and jugs might be left off tables and water given only to those who ask for it. This saved time at the clearing end of the meal. Similarly, milk jugs were collected and left in the fridge for the next meal rather than emptied and washed. Toast racks were not laid since they needed washing afterwards. Tablecloths were left on tables. Salt and pepper pots were also left so that the next laying could be speeded up. As a result the dining room tended to remain in a half laid/cleared state most of the day. On several occasions I was told to leave the tablecloths on the table that I was about to clear, or to top up milk jugs and leave them.

It was however known that these practices were officially unacceptable. A domestic told me that one
day when the tables had been relaid directly after lunch for tea, the officer-in-charge had arrived unexpectedly and insisted that all tables were stripped until 4 o'clock, and tables were more appropriately laid and cleared when the officer-in-charge was on duty. A convention or "rule" in the home was that meals and food generally were served in the one place. Staff were usually very reluctant to allow meals in other places, for instance take trays to rooms. Residents were expected to go to the dining room for "their own good". It was usually seen as good for them to mix with others, to get exercise and to eat a proper meal. Those who chose to ignore this good advice went without food. Several rather frail and weak old ladies tended to forego tea in order not to have to walk into the dining area, which they found difficult. A senior member of staff once "caught" Mrs. Foat being given some tea by her friend who had saved her a bit of pie and brought it out to her. There were strong words exchanged, the senior insisting that Mrs. Foat go into the dining room and not be "fed" by her friends. She was seen as cheating the system.

The "rule" about attending meals in the dining room was occasionally carried to extreme lengths and sometimes worked against the smooth running of the home. When a senior insisted that Mr. Atkinson had his breakfast in the dining room despite the fact that he
was to have a bath (therefore get undressed and go upstairs again) directly afterwards, the care staff pointed out how illogical this was and grumbled considerably about the extra work.

As the residents sat down the care staff and domestics distributed the food. As with the coffee dispensing staff usually knew what residents preferred. Both domestics and care attendants knew exactly who had what in the way of cereals and grapefruit, hard eggs, soft eggs, no bacon and so on and were able to place the food at the appropriate seat prior to the residents' arrival. Only a few residents had to be asked, either because they were known to change their minds or they were new to the home. Often "special combinations" like a lot of potato, a bacon sandwich, fried bread and so on were prepared at the hatch without the resident's specific request. "Everyone knew" that this resident liked potato, that that resident liked her fried bread only done on one side and so on.

This extra knowledge could be used against as well as for the resident:-

"Ann (care assistant) said that Mrs. Hughes liked a lot of chips and held out her plate to the cook for extra chips. The cook said that everyone got the same and wouldn't give her extra". (R2)
This was certainly not always the case, since personal variations were catered for. On this occasion Mrs. Hughes' preferences were used against her.

Domestics played a large part in helping at meal times. They carried out much of the repair work at meals, producing forgotten egg cups, or milk jugs and speeding up the process of eating so that dishes could be sent into the kitchen.

All staff were expected to be present and this mealtime activity was very much a team effort to get through and get done. Meals never lasted longer than half an hour.

There was little logic to the seating in the dining room (or lounge) and it was more a question of "first in" occupying last out seats. A fastidious woman sat with a dribbling and incontinent man simply because that was the only place available. There was a fairly rigid adherence to seats. This suited both residents and staff. Residents seemed to need the security of a permanent familiar place to sit and complained if they were moved and staff were able to routinise their actions since they could predict where elderly residents would be sitting.
The official home philosophy was that nobody owned a seat. Care staff did capitalise on the official philosophy from time to time, insisting that an old woman who was "sitting in the wrong seat" according to some residents, could sit anywhere she liked. However the normal situation was that the residents had "their seats" unless the care staff chose to override this convention. There were some "floaters", that is, people who varied their requirements from day to day. In this case the residents became a "known" or "fixed" floater. It was quite inappropriate for a floater resident to say "you know I'll have what I had yesterday" or to insist she always sat in a particular chair.

When an attempt was made during the group living project to make less fixed the seating arrangements in both dining room and lounges, the residents, particularly, expressed their dissatisfaction. Staff also said they disliked this impromptu seating since they never knew where anyone was and meals and pills could not be set at known places in advance. They did however use the new "no-one has a fixed seat" rule when they were irritated with residents and wanted to disrupt and upset the routines.
Bedmaking was an essential maintenance task. The care attendants always made the beds but the quality of bedmaking depended on the exigencies of the shifts time schedule.

Beds were not always made carefully and if a resident had attempted to make the bed by just pulling up the covers this was said to be "made". However residents as a rule did not make their beds, partly because they were not expected to and partly because their particular physical problems made stretching, bending and tucking in difficult. No instruction was given to new staff about how to make a bed properly (unlike S.R.N. trainee who spends a great deal of time on learning how to make beds quickly and efficiently). However the same goals of quickness and efficiency were aspired to by the staff. Staff aimed to finish bedmaking by staff breakfast which started about 10.00 a.m.

Since the quality of bedmaking deferred to speed, repair work was carried out by the backshift as residents prepared for bed. Residents had some implicit control over how their beds were made. Some residents were known to make a fuss if their beds were not made to their satisfaction. Depending on the power
of the resident to complain the bed would be made more or less well.

Staff often took a radio round the rooms as they made the beds and enjoyed a good chat to another member of staff. Bedmaking was quite a social event and it removed staff from the main lounge where residents might make requests.

Bedmaking also "opened up" the bedrooms and made them public. Because of bedmaking and domestic work (bedroom cleaning) that took place after breakfast, it was not practically possible for residents to use their bedrooms and was discouraged by both care staff and domestics who wanted to "get on".

Bathing

"Andrew (care attendant) showed me his bath list, complaining that he had eight baths and Chris (care attendant) only had six. When someone said that Chris (care attendant) had done two of Andrews (care attendant) baths, Andrew (care attendant) said that they were the easy ones". (R3/168)

Baths were considered to be real work and staff complained if they felt their list was disproportionately heavy, either in terms of numbers or in terms of individuals who were "difficult" to bath.
There was an understanding of what was an easy and difficult bath; having completed the list was a demonstration of hard work. Real indignation was expressed when a member of staff was thought to be shirking this "real" work as noted (pl92).

There was a "rule" that all residents had a bath at least once a week. Sometimes residents got an extra bath mainly as a result of an "accident" where it was quicker to bath. There were occasions where people who were known to enjoy a bath, would have more than one a week. No resident bathed independently and alone.

Bath times were determined by work routine. It would have been inappropriate to give a resident a bath at 8.15 a.m. when breakfast work was beginning, or at 8.45 p.m. when night duty was about to start. As a result baths took place often in the afternoon, or between 6.00 and 8.00 p.m.

Repair work for bathing was done by care staff rather than domestics. Repair work usually involved cutting finger nails or toe nails which had been missed from the list and re-bathing because of an accident. This work could be done by any care attendant, not just the list holder. Repair work concerned with washing residents and keeping them tidy was also carried out by relatives. They would wash dirty clothes and replace
residents' clothes if needed. They attended to nails and hair. They would also take residents to the toilet.

Toileting

Care staff took residents who needed help to the toilet as part of the maintenance process. Mass toileting tended to take place at prescribed times associated with mealtimes, rather than on request from the resident. 'Toileting' was seen as part of the routine and fitted into a time and work orientated pattern. Excessive visits to the toilet were seen as inappropriate. This was partly because care attendants, not surprisingly, disliked toileting and made it into a routine as a way of containing a disliked task within time boundaries. Toileting was high on the hierarchy of jobs that were essential maintenance although low on the staff's hierarchy of preference and dodged where at all possible.

Toileting was also an area in which staff theories of residents as wilfully inactive and indolent were very apparent.

Jane Hughes was a resident who was seen as asking for the toilet excessively, and as "working herself" (being a nuisance on purpose). She needed a lot of work to take her to the toilet. Two care staff had to
help her to walk and wait for her. The process could last half an hour. This could take up the whole complement of staff on a shift. There were numerous occasions when Jane would ask to be taken to the toilet and staff would try to thwart these attempts. Senior staff supported the view that Jane was "pretending". One senior staff member of staff encouraged listening at the door to see if "anything happened".

Staff tended to feel on the whole that demands to go to the toilet outside the prescribed times were unreasonable.

"Chris (CA) said he'd also "Had a time" with Jane. They'd had no one on back shift and Jane wanted to go to the loo although it was Chris' (CA) lunch hour. Chris (CA) had then been asked by Mrs. Foat to take her to the toilet and Chris(CA) said that if he took her she would have to walk back or wait until he's finished his dinner hour". (R3/148)

The domestics were responsible for cleaning the toilets. This task was linked to time not demand. They were cleaned at 8.30a.m. when the residents were having breakfast because domestics could "get on" without being interrupted by shuffling residents and bustling care staff, who did not usually start making the beds until after breakfast. Sometimes, therefore, routine worked against efficiency. The greatest demand for
toilets was inevitably after each meal due to the care staff's mass toilet routines and so the clean toilets were very soon made dirty. This created a new need for cleaning which was not met since other tasks had to be completed, by a certain time. Cleaning toilets was seen as a task that had an end. It was a maintenance task. As a result emergency repair work had to be carried out on the toilets during the day. This was done by the care attendants "in passing" as they took "errant" residents on unscheduled visits to the toilet. The need for more paper, clean towels or mopping up "accidents" at points during the day was met by care attendants. Domestics were carrying out other tasks in the dining area or in "their bedrooms" and would not necessarily notice these slips in the decor.

The repair work to the toilets hid the flaws in the routine maintenance and masked any need for change to the system. Similarly the care attendants routinisation of toileting and its inherent failure to provide an adequate service was masked by repair work carried out by domestics who helped people to the toilet at non-routine times, and relatives who gave their relations a hand. The system self-perpetuated since the contradictions were hidden by repair work. Repair work was only carried out when the need for repair became public. When a slip in the maintenance was not obvious or public that is, available for all members to
see, repair work was not seen as necessary.

An example of repair work not taking place was the case of a doubly incontinent immobile man. Because Mr. Brown could not walk, the fact that he was incontinent was not obvious. (Wet trousers were hidden under blankets) As a result he was not changed when he became wet but when the staff were free. This tended to be once a day, routinely. It was only when Mr. Brown shouted out or actually urinated on the floor in the dining room (which was tiled and tended to show up "spills" more than carpet) or when he started to smell, that repair work was carried out.

Occasional Work

In addition to the essential daily tasks there were tasks that cropped up from time to time. This "occasional work" was not part of the regular routine, but was sufficiently common for staff to have a pattern to each task. It usually involved contact with outsiders, that is, not residents or staff. Most commonly this was in connection with some part of the admission process, either to show a social worker and potential client around the home, to help to admit a resident or to discuss some point with a relative.
Doctors' visits involved care staff in occasional work. Rooms and residents were given special attention in anticipation of these events. Flossie was in bed when her Doctor was due to visit and she was given a wash, clean nightie and generally tidied up. Her room tended to smell of urine and efforts were made to get rid of the smell. The District Nurses did not get the same preparation perhaps because they visited so regularly they became part of the routine and they also had less status.

Occasional work included laying out after death, attendance at funerals and visits out of the home. Funerals were usually attended by a deputation from the home of both staff and residents. Mixed with genuine sadness at the death of a familiar person, there was a feeling of escape from the home for both staff and residents and on the occasions that I attended the funerals there was much pressure from staff on the driver (myself on most occasions) to "go back the long way" or "drive slowly" via the pub or coast. Other trips out involved going in the ambulance to escort residents to out-patients appointments and arranged trips in the mini-bus with the residents.

Occasionally entertainment was brought in to the home. School children (especially around Christmas) prepared plays and concerts for the residents and one
or two groups of local singers came in from time to time to entertain the residents which involved staff in arranging seating and food. Fund raising by the home itself usually involved variations on "pie and peas" suppers which brought people from the community and again involved care staff in preparation work.

A characteristic of this occasional work was that it involved a more direct social contact with the elderly than the essential maintenance and repair work. Both occasional work and innovative work (see over) helped generate the less rigid specific theories about individual residents. However occasional work was fitted in to the routine of the home and usually scheduled for a time when essential work had been completed wherever possible. It was most unusual for instance to have a morning ride in the mini-bus and often morning funerals were less well attended since staff felt they were "too busy" to attend. Doctors' visits could not of course be controlled in such a way.

As a result of its non-routine and non-daily characteristics occasional work gave staff the opportunity to move away from time and shift-work constraints. Occasional work, particularly visits out of the home often cut across the home's daily markers. However at Fell View routine daily work took precedence
over any occasional work. Occasional work was anticipated and "known" in the sense that it could be worked into the routine to some extent and that it took on familiar patterns.

**Innovative Work**

From time to time staff were involved in unexpected, un-anticipated and innovative tasks. This was an 'un-rehearsed' type of work. Innovative work was that which altered or enhanced the daily round of the home and residents, as opposed to simply maintaining and repairing it. Unlike essential tasks that tended to be attached to shifts and occasional tasks that were fitted more or less into shift routine, these tasks tended to be anarchic in the sense that anybody could do them, at any time. However afternoons tended to be the time when innovative work occurred when the maintenance tasks had been completed and staff were "at a loose end" or "bored". This meant that backshift did more innovative and repair work. It was no suprise that the backshift (although disliked for its social implications of ruined evenings) was the preferred shift in terms of spending more time with the "residents". It was also seen as the "boring" shift because there was "nothing to do". Since innovation largely depended on the individual's ability to use imagination, be creative and enthuse the residents and
staff, the less imaginative staff tended to be those who found the backshift boring.

Observed examples of innovative work were activities like, watering pot plants and re-arranging flowers, spring-cleaning residents' bedrooms with residents, sorting out drawers, going through family albums with residents, taking a resident shopping, playing a game of cards, suggesting television programmes they might like to watch.

Innovative work was work that was not and did not become routine. This spontaneous work has a certain quality to it because of its very spontaneity.

If spontaneity was routinised it lost its vitality and its innovative character. For instance it was a "routine" to make a birthday cake for residents and sing happy birthday to them although it was offered as a spontaneous gesture. Birthdays were marked in the diary so as to enable staff to remember. Everybody got exactly the same treatment. When Jack's birthday was forgotten, a cake was made the next day and happy birthday sung to him. One of the domestics said to Jack "There are you happy now Jack?". The whole process was over in a matter of minutes and Jack could not have eaten a piece of cake in any case due to dietary problems.
The innovative work that I particularly noted at Fell View was celebrations for the Royal Wedding of 1982; a trip to a neighbouring town to have a drink in a new pub; a resident playing the piano one evening and staff encouraging residents to dance and sing and the whole evening turned into a cabaret show. There were also individual staff and residents who between them carried out innovative work. However innovative work was not very apparent. When it did occur, there was no doubt that both staff and residents benefited from it and talked about it for some considerable time. Innovative work became part of Fell View history and was recalled as evidence of good caring. Recounting innovative work helped disseminate specific "theories" about residents.

The Characteristics of Fell View Style and the Model of Care

Below is a discussion of the aspects of staff practice that characterised Fell View care. The maintenance model of care is used to compare the two homes under study. Three characteristics of the typical day at Fell View have been identified and it is suggested that the degree to which these are found to be present, acts as a guide to the style of care dominant in the home.
Work was attached to shift.

At Fell View patterns of work for both shift and individual care attendant, once established, became fixed and expected. The relationship between the care staff and work carried out on each shift was based on the understanding that each shift had tasks attached to it, and that these tasks would be completed by the staff on duty for the shift. A breakdown in this task completion process created difficulties in staff relationships.

As seen, each of the three shifts at Fell View typically had particular tasks attached to them. For instance day shift (8.00a.m. to 5.00p.m.) were expected to help residents get dressed, make beds, serve and clear up breakfast, make mid-morning coffee, clean the commode bowls, and lay the tables for lunch. The back shift were expected to do some bathing, distribute laundry, lay tables for tea, clear up after tea, and help residents to bed. The night staff were expected to get as many residents as possible up, clean the lounges, lay the breakfast tables and do the ironing.

There was some flexibility, particularly between night and day staff. It was commonly "known" through the theories exchanged between staff that one or two of the residents were rather difficult to coax into bed
before 9.00 p.m. and others difficult to get up before 8.00 a.m. As long as an attempt was seen to be made a degree of give and take was evident - but this only stretched so far. There would be grumbles if too many residents were still in bed in the morning when the day shift arrived, often despite rational and valid explanations for it, there were reciprocal "go slows" in the evening to demonstrate disenchantment. Fewer residents would be in bed before 9.00 p.m. until equilibrium was restored. Similarly a spurt of good will meant that more residents than usual were in bed by 9.00 p.m. and the following morning most residents up by 8.00 a.m.

The work-shift pattern was complicated by the fact that some care staff were known to do particular jobs. When the day shift came on at 8.00 a.m. they "knew" to some extent which residents would be up and dressed and what night work would remain. For instance, one member of the night staff always made the beds on the ground floor (although this was accepted as a day staff job); another male member of the night staff would never help any of the women on his floor to get up although it was a night staff job. These personal idiosyncrasies and work variations seemed to be acceptable if they were well known. Tensions arose when expected practice did not occur.
Work was attached to time

An associated characteristic of the work-shift relationship was the degree to which work was attached to time and derived its meaning from it. At Fell View time was the criteria by which jobs were completed in the first instance and a sense of work being seen to be completed pervaded the care attendants' approach to tasks.

Being seen to be working and completing agreed tasks was extremely important. Work was defined primarily in terms of doing tangible, concrete jobs that had an end, in other words "productive" work; for instance, bed-making, cleaning, washing, commode washing and so on. Work that was non-productive in the sense that it did not produce tangible results and have an end (like talking to residents) was considered less important, and was conspicuous by its absence.

The bath list was a good example of this. Care staff, as we have seen, were allocated a certain number of baths. Pride was taken in the number of baths that could be completed in an afternoon or a bath list being completed or "done" early in the week. Similarly bed-making was approached in terms of how quickly all the beds could be made, not how well they were made. Speed was of the essence. Quality of bed-making was
less important.

The Hierarchy of Jobs: Official and Individual

The nature of these two hierarchies determined both the order in which tasks were completed and the way in which tasks were completed.

For instance, the "official" hierarchy at Fell View determined the priority of tasks. Bed making at Fell View was seen as more important than flower arranging. So beds were to be made first thing in the morning after breakfast whereas flower arranging was something to do when "the jobs" were done. However the order in which the beds were made was a matter for the care staff's individual hierarchies, as was the way individual beds were made. It was known, for instance that Bunty liked her pillows placed in a particular way and Jack liked his bed clothes left loose. Although it was almost certain that these beds would be made it was by no means certain that they would be made to the residents' preference.
Similarly getting residents up and putting them to bed was at the top of the hierarchy of jobs, but who got up and when, and how they were got up was a matter for individual staff hierarchies, discretion and negotiation between resident and staff. For instance a high priority routine for Mr. Atkinson was to give him a salt bath in the morning, he had little say in this. He could express opinions about the temperature of the water but not about the time of the bath or the length of it, since this was part of a set routine, and was determined by factors outside his control since he was unable to bath himself.

The staff adhered to a priority or hierarchy of tasks which was basic "home" knowledge and at the same time operated an individual list of priorities or
hierarchies which determined the order and way in which the tasks were carried out.

Care staff therefore regularly used their discretion over how tasks were carried out, although which tasks were carried out was pre-ordained by the official hierarchy.

The three characteristics underpinned the model of care at Fell View.

**Summary**

The central tasks with which the care staff were involved at Fell View, refer to the maintenance of a smooth running day where both the residents and the home are kept publicly neat and tidy.
The operation of this central purpose involved routinising the daily living tasks of bathing, toileting, dressing, eating and so on, so that they could be accomplished at an appropriate time and place in keeping with the shift day staff requirements.

Sometimes maintenance and routine broke down. At this point a back-up system of repair tasks done by various participants shored up the gaps and helped to regain order. The balance between maintenance and repair depended amongst other factors on the relationship between the task and its place in the hierarchy referred to at the home. The lower the position of the task, the greater the amount of repair work undertaken. Repair work took place when gaps in the maintenance work were in danger of being publicly exposed. Repair work focussed on public messes.

Those who carried out repair work varied according to the nature of the task. Often relatives and outsiders repaired the appearance of the residents by finding hearing aids, changing soiled clothes and so on. Domestics also repaired some care attendants' work and vice versa.

At Fell View the three factors encouraged a maintenance model of care which supported general and derogatory theories. The residents were seen as work
objects". The shifts had work attached to them, the work was time-based and there was a hierarchy of jobs known within the home. These three factors, all of which were organisational in the first instance, conspired to prevent or inhibit the other types of work carried out in the home, that is occasional and innovative work. Occasional work took place according to the demands of routine maintenance work and was not given priority. Spontaneous work was stultified by the over-riding needs of the time-bound routine. Tangible, "productive" work was seen as the real work of the home and this took priority. Less tangible or less obvious work was relegated to a lowly position.

Implications

There were various implications of this model of care for the residents and staff at Fell View.

Firstly, routinisation of the essential maintenance tasks limited the scope for resident participation; secondly, it contributed to the publicising of private areas of care; thirdly, it encouraged the development of 'rules', all of which worked against the official aims of the home.

Residents at Fell View participated very little in their own daily living. The residents tended to have
things done to them, rather than get help with things or do things themselves. As a result not only did they become seen as "objects" on whom work was done, but their participation in these events was actively discouraged since this would interfere with the routine. This situation resulted in a Catch 22 for all concerned. As seen in Chapter Six, the staff tended to see the elderly as lazy and unwilling to participate but at the same time they prevented participation by operation of the maintenance model.

Lack of resident participation indirectly encouraged the making public of essentially private areas of care, for instance bathing, bedrooms (tidying rooms and making beds) and toileting. The routine excluded the active presence of the elderly who could have personalised such activities of bed making and clothes washing by their very presence which would remind the care staff of the personal nature of such tasks.

Various "rules" emerged, as we have seen, to support the smooth running of the routine. These hidden rules, such as fixed seating, fixed choice, eating only in the appropriate place, bathing once a week and so on, limited resident participation, residents' privacy and reinforced routines. Indeed on occasion rules developed to help the routine actually
The purpose of the tasks that the staff carried out was all too often lost in the dominance of the routine. The routine tasks have their meaning located in the routineness and the completion of a task rather than in the task itself.

By way of contrast the "in-passing" repair tasks were prompted by observation and had their meaning located more in the task itself rather than the routine it represented. Making coffee was a task that had to be got through before other tasks could be started. It was part of the routine day; whereas making coffee for an old lady who says "she's gasping" and who had missed the official coffee time for some reason, was a direct contract between staff and resident. The onus was on the staff to make a good cup of coffee. They became directly accountable to the resident.

The repair work, involved straightening petticoats, mopping up spilt coffee, producing new batteries for hearing aids and so on. Although repair work mostly took place when "messes" were in danger of being publicly noted, repair work did involve some kind of non-routine contact with the elderly. Care staff carried out some repair tasks and this helped to mitigate or relieve their own dilemmas and tensions.
between residents' personal needs and the routine demands.

The role of the outsiders, that is the non-care staff, in repair work was quite an important one. The "outsider", be she relative, researcher, temporary or voluntary worker, could alleviate but at the same time mask the impersonal nature of the routine work thus helping to prolong and tacitly endorse it.

Occasional and spontaneous work also helped to relieve tension between these needs and routine demands. However at Fell View there was little spontaneous work. This was both a result of a lack of a resident/staff relationship and a cause of it. As noted there was no doubt that spontaneous action, when it did occur, was a cause of considerable uplifting for most participants and reinforces R. Wilkes' comments that:

"the need for spontaneous action as an expression of concern is paramount". (1981:65)

It is suggested that spontaneity only appeared at Fell View as and when the routine allowed, which was on very limited occasions. As will be seen at Deer Park spontaneity takes a much more central role and is officially sanctioned in the sense that it has a
dominant position in the hierarchy of tasks. The presence of active spontaneous action is stimulated by and alters the nature of, the relationship between staff and residents which affects the overall model of care. It also encourages specific and individual theories about residents which have more positive underpinnings. The Deer Park model of care indicates this tendency.
8. THE DEER PARK MODEL OF CARE

The Group Living Philosophy

It has already been noted (Chapter Six) that a strong group living philosophy underpinned staff practice at Deer Park and that their theories about the elderly were more positive and specific with a "normalising" effect despite a tendency to make negative generalisations about the residents on occasions. The strong philosophy and accompanying guide lines for practice influenced the priority of tasks and the nature of those tasks carried out in the home, both at an "official" level (that is, what was said should be done) and what was done in actual daily practice.

At Deer Park the raison d'etre was that the residents should do as much as they could for themselves. As a result an essential component of each of the daily tasks was a negotiation between staff and residents as to how much each should contribute to daily tasks. The outgoing officer-in-charge noted in discussion with myself.

"that now she was helping in ways unthinkable at the start. She gave an example of that morning when she had been sitting with an old lady struggling on with a sweater. If it
had been outside the home she would have lent over and given a hand with the sleeve... but it was difficult to make those kind of rules. You had to make a balance between not helping too much but being normally considerate and helpful". (CL/1.3)

There was a fine balance between doing too much and not doing enough.

"Susan (CA) said that one of the most difficult things was the balance between feeling that you were being cruel by not offering help and being kind in not offering help. She said it was very difficult to tell sometimes. Each resident, Susan (CA) said, had different levels of ability and it was difficult to remember what not to do for people. For instance, one lady would have her tea poured but could butter her own bread, another couldn't manage the sugar but could do the milk and so on". (CL/35 para 2)

As a result staff were not so clear about what was and what was not their job, and they tended to "help where needed" as the "negotiated" need arose. A consequence of this was that care attendants and domestics were more closely associated in terms of their actual work roles. It also meant that staff work was less definable and more individual.

That the staff found this a dilemma was quite clear in what they said, particularly in connection with the problem of "standing back" which was seen
again and again as one of the most fundamental but difficult "jobs" of a care attendant. A dilemma not particularly apparent at Fell View:-

"Mary (CA) said that they, care attendants, would love instinctively to help the elderly and make them tea, etc. but they had been told to stand back and stifle their instincts". (CL/47, para 1)

In reply to an interview question about difficulties in work, a care attendant replied:-

"Standing back and knowing you're quicker to do it, but they've got to keep independence.. see how far they can do it for themselves.. and yet you feel that you're hard and it upsets you". (B9/13)

and a similar response from another care attendant:-

"When I started here because um... they kept mentioning stand back.. you know. I was sort of saying right I'll do this for you and that, just, you're all right now, I'll manage that... and I realised that I'm not supposed to do this, they're supposed to do it for themselves... I've found the hardest part is standing back... but when you see somebody who's really poorly but you know you've got to... course I mean you know how far to push them, but you still feel awful having to say well try and do that when you know they're really bad". (B9/16)
This continuous dilemma over what to do and what not to do underpinned the care attendants' day and required a constant process of discretionary decision making as to the needs of particular residents in particular situations. However, there were still areas where "typifications" could be made, and depending on staff's commitment to and understanding of group living, roles were more or less fluid.

Often different staff did different things for the same resident which confused issues and prompted care staff to call for more liaison and discussion between staff and more senior staff guidance. Discussions and consultations between staff over tasks both at formal and informal levels was part of daily practice in the home, being particularly obvious at the "talk-ins".

As noted, daily practice in both homes was to engage in constant discussion, recount stories, gossip and chatter. That is given the general heading of "talk". The astonishing amounts of talk (noted by Strauss (1964) in the context of mental hospital staff) and its characteristics and purpose are fully discussed in Chapter Nine. Here it should be noted that the content and structure of the talk in each home varied.
There was quite a divergence of opinion as to appropriate practice:

"She felt quite strongly that sometimes we push them too far and that some of the residents are too old to be bothered with group tasks. They may just want a rest. The older care attendants she felt understood this feeling". (CL/100, para 6)

Care staff were aware of a tendency for some staff to disregard the philosophy and inter-staff problems consequently arose:

"But I'm sometimes disappointed... sometimes I think things tend to slide back... and I've maybe been on a wing when it was started... and I can see it backsliding... You see you get a lot of, some staff saying, don't tell anybody I did... it means the other poor soul that comes on gets themselves disliked because they're saying... come on now I know you can do it... I've stood back and I've seen this, it didn't actually happen to me... and I've thought how unfair, you've got one motivating and the other one undoing it.". (B8/10)

Some staff openly acknowledge a lack of commitment to "standing back":

"You see if I think like the residents need me I would go to them... I would help them... I would do something for them... I would help them... and this is why I used to get wrong for before... because you can only take it so far... if you meet them half way... I don't
think they should be made to do everything for themselves... cos because you know you can... be cruel to be kind... but I think they could do with a bit of gentle... well I was always told to STAND BACK but I didn't... I used to say if I start off like this, helping them and encouraging them... then stand back a bit more and a bit more... (B9/21)

Evidence of differing interpretations of "standing back" and divergent practices resulting, is that care staff feel a need for more discussion about group living and care attending and generally more staff communication.

"I think there should be more discussion amongst staff about each resident, more staff meetings, and getting what other staff feel about residents. You can find out much more about the residents as well. You get a clearer idea of how to approach them". (B10/6)

"I think the staff should work more together, this could make it a lot easier... they're pulling apart". (B10/23)

Much of the important work, according to care staff, was emotional support of one form or another, as well as a strong feeling that staff should maintain basic care standards of keeping residents clean and dry. One member of staff distinguished between the "physical" side and the "mental" side. As far as the mental aspect went she said:-
"That means making their life as comfortable and easy as possible without cossetting them". (B10)

Other staff said:--

"You've got to get to know them properly - gain their respect... they've got to trust you...". (B10)

"It's all about giving a little bit extra care and love, trying to make them happy". (B10)

"Caring for them when they're sick". (B10)

"Keeping their identity".

Some staff focussed on the physical aspect:--

"I think hygiene is of great importance and yet some people say its nothing. If an old lady was sitting untidy they'd say - well she's happy like that so just leave her - There's certain things that have to be done for all its a group living home. I don't mean a resident has to be dragged along to the bathroom to be bathed because that care attendant says she's got to be bathed... It's up to the staff to keep an eye on her". (B3-B10)

"Toilet definitely. If they don't have toilet... are not kept happy with their toilet... I thing it's the biggest hazard for old people". (B3-B10)
Domestics also agreed with the care staff, that work with the residents was the most important aspect. One domestic said the most important part of her job was:—

"Well... to see that the residents are all right... I mean if you're in the middle of doing a job and they ask you to do anything I would just leave it (the job) that was the first thing that was drilled into us when we started... that the residents are more important than work". (CL/1)

There was clearly a focus on the residents as the most important part of both the care staff and domestics' day and a recognition that needs changed. This meant that "work" was less tangible and visible without such clear boundaries and similarly "non-work" less definable. The group living philosophy meant that staff engaged in two activities, "standing back" and "discussion and consultation" that marked a difference between their daily practice and that at Fell View.

The Traditional "Pull"

Despite this quite marked difference in the philosophy of the homes and the amount of resident participation and involvement in the work day, there was still a tendency to attach work to shift, and time, although to a lesser extent than at Fell View.
This may have been a reaction to the more ambiguous nature of "work" at Deer Park and the need amongst staff to identify some areas that could be agreed upon as "work". The policy of wing autonomy meant there was no overall routine for the home. However the general aim of the day to day running of the home was to complete the self-care tasks and daily living tasks, which have been called maintenance work at Fell View.

As shown there was evidence of a pull or "slipping back" towards the routine-bound day which the care staff at Deer Park called "traditional care". This was felt both by the seniors and by the staff and often remarked upon. The pull towards traditional care manifested itself in some adherence to routine, time and shift based practice and in doing too much of the basic daily living tasks.

A senior staff member was very conscious of the pull towards traditional care.

"She felt as though things were slipping back to traditional care but she doesn't know what to do". (CL/46 para.4)

and

"She felt that the principles of group living which were so strongly adhered to in the past had started
to slip. She felt as though she was out of control, she didn't know what to do next, there seemed to be no direction. All the good "standing back" and "motivation" type training had seemed to disappear.

(CL/38, para.2)

This pull was also confirmed by staff:-

"Susan (CA) expressed the belief that once you had let them go it was so difficult to pull them back to previous levels of self-care".

(CL/35, para 5)

Some staff felt there was a pressure upon them to conform to time and shift requirements.:-

"Basical physical things, are always highly regarded. Food and health, clean clothes, toileting, always found really that those are basic kind of priorities. Set times for meals, a very kind of regular routine I find myself doing it here. I should be doing something at a certain time because it is expected from me to do that. I mean I feel worried if I don't get Martha to bed before 9 o'clock, because the night shift... but even if Martha doesn't want to go to bed at 9 o'clock I feel I should be putting her to bed even if she doesn't want to... I'll be sitting there persuading her, and I know I shouldn't...".

(A5/6)

Another care attendant recognised this pressure but knew it was quite unacceptable and unsupported by the official doctrine:-
"Well here you know... like Fred the other day, he didn't get up till 10.45 and that's quite acceptable and you know he came along and was able to have his breakfast... well I made it for him at 11 o'clock... er... they're encouraged to wash dishes, if they can't get up and go to the kitchen the cutlery's taken to them... you know it gives them something to do... something to occupy their mind... and there's no way that they get their nighties put on at three... Well sometimes you find, say if Beth is not up, some staff get a bit annoyed... but they wouldn't dare go to the office... because they would get... well that's the policy of the home you know.... let them stay if they want a lie in...". (A5/21)

It was recognised that there should be no routine that over-rides the residents' wishes, and there was no official support for the routine.

Notwithstanding this, care attendants and domestics have quite clear ideas about what back shift, day shift and night shift means. In question 11 (Appendix C) they were asked which shift they preferred and why. Most respondents preferred back shift because it was more relaxed and there was more of a chance to talk to the elderly. The routine work tended to go on, as at Fell View, in the morning. Those who preferred the day shift seemed to prefer it better because it was more routine and they felt they were getting more done. They felt they were more involved.
"I prefer day shift... I've got my evenings free".

"Back shift... I can get more baths done... it's a lot more relaxed... you have more time".

"Back shift is just the relatives and the residents".

"Day shift... I can get into a better routine".

Each shift was given characteristics by staff which were not dissimilar to those at Fell View.

**Maintenance Work**

As at Fell View the primary activities of the day at Deer Park revolved around self-care and daily living tasks. The major difference between the two homes was that there was more resident involvement in these activities, to the extent that a noticeable amount of maintenance work was carried out by the residents themselves. The care attendants and domestics at Deer Park were engaged much more in various forms of repair work, both of maintenance tasks and of the group living philosophy.

In the morning it was the non-elderly wing, (the physically handicapped residents) that required the
most maintenance work in getting up. However often their day did not start until 8.30 a.m. Some more able residents breakfasted much earlier whilst other residents did not finish their breakfast until after 10.00 a.m.

The elderly residents tended to rise by themselves, and although breakfast appeared to be a straggling affair on all wings, the vast majority of elderly tended to complete breakfast by 9.00 a.m.

The domestic work of cleaning rooms, changing sheets etc. involved the elderly since they often went to their rooms after breakfast. Domestic work took on the characteristic of "housework".

Whilst the elderly residents controlled their daily routines this did not mean that they themselves did not try to routinise activity. In fact the battle between residents over when jobs should be done was a regular occurrence. The residents overwhelmingly preferred time-orientated activity. This varied from wing to wing but routine daily patterns on each wing were quite evident.

On wing four for instance a great commotion was caused when a resident whose duty it was to lay the lunch table, returned from shopping at 11.45 a.m. and
found her job had been done. She was indignant, saying that there had been plenty of time before lunch. But the rest of the group were adamant that she was late. Similarly an evening drink on wing two was always produced by a resident at a particular time, irrespective of demand, or season. The residents due to wash up and clear the table grumbled when other residents were slow. Residents it seemed also liked to "get on".

Aspects of staff activity in the morning, during and after breakfast are recorded in the participation observation notes:--

"Breakfast may be long over on wing three and hardly started on wing one. However each wing tends to stick to its own time".(CL/80)

"During breakfast, staff help get up anybody who is struggling and make the beds of those who need to be helped. On wing three this involves two beds to be made, one on wing four and several on wing three". (CL/95,para 3)

"Breakfast is made on the wings and tables are usually laid the night before. Sometimes places are kept for late arrivals and breakfast is officially over by 10 o'clock. Porridge is made in the kitchen". "The fridges are kept stocked by the staff and the residents. How much the residents actually control this is a debatable point. I know that wing four collect their own bread and milk".(CL/95,para 2)
"The breakfast dishes are washed by the residents who work out their own rota". (CL/94, para 3 to 5)

Unlike staff at Fell View, Deer Park care attendants were not constrained in their daily tasks by the fact that breakfast was not finished. There were no dishes to wash, so central kitchen was not held up in preparing for lunch since dishes were cleared and washed in the wing kitchens. There were no tables to clear for staff breakfast since this took place in the staffroom and at a set time. In this sense there was nothing to be held up by a protracted breakfast and there was no pressure on staff to get breakfast out of the way.

The care staffs' role was to make sure that the breakfast associated tasks did get carried out at some stage and to make sure that work was fairly distributed amongst residents. There was a difference of opinion as to how this should be done. Some staff organised rotas and instructed residents, whilst other wings/staff left it entirely to the residents.

Bed-making was a very minor task. Residents made their beds and often domestics helped them, or "repaired" their work. On each wing about three beds actually needed making.
The Fell View post-prandial mass toileting was not apparent at Deer Park. Residents either dealt with this themselves or were given necessary help as they requested it. Since groups were small, breakfast was taken at staggered intervals and since toilets were close at hand, toileting was a much more discreet and personal affair. Not once did I observe aggravation between staff about toilet arrangements.

Not all the wings had coffee or tea mid-morning or mid-afternoon. This depended largely on the residents who were present in the communal areas at the time. Often residents would have a cup of tea after their lunch rather than mid-afternoon. Relatives were often involved in coffee-making activities.

Lunch took place fairly routinely. The cook explained that she liked to "get on" and so trolleys were ready for collection at about mid-day. Trolleys were collected by the staff or residents. Apart from wing four the groups needed some assistance. There were serving dishes so that residents helped themselves to vegetables and potatoes. When the care staff were involved in giving the meals there was no evidence of slips into the mass treatment which was a feature of Fell View.

"Pete (Care attendant) was on duty for wing three and I asked if I
could help at dinner time. You go
to the kitchen to get the trolley
which the cook has filled with the
appropriate amount of food in
containers. The trolleys then are
taken to the wings. The wing
residents have already laid the tables
and the trolleys are plugged in to
wall sockets. The plates and crockery
are waiting and are not pre-heated".

"Pete (CA) dishes out the soup and I
handed it round to all those residents
who wanted it. Then, before the
residents had finished the soup the main
course was served and vegetables put
separately on the table for self service,
except on Rose's table when Pete(CA)
pre-served the vegetables. The staff
then wash up the kitchen utensils and
the serving dishes that are going back
to the kitchen. Pete (CA) then served
the pudding and placed that beside each
resident whether or not they had
finished their first course. Once the
trolley is returned to the main kitchen
with the appropriate kitchen utensils the
care staff have completed their part in
the meal. Thereafter residents complete
their meals and start to clear away the
dishes. Rose and Violet did the washing
up". (CL/17, paras 3 and 4)

But other staff were not quick enough for the
residents!

"Susan (Care attendant) delivered
lunch to wing three in quite a
different way. In fact she waited
so long in between courses that the
elderly got impatient. She washed
the kitchen dishes and offered
second helpings. Pete (Care
attendant) tends to put all the
courses in front of the person
together. Susan (CA) waits a long
time". (CL/65 para 5)
Baths, as at Fell View, were seen as important and there were lists attached to care staff. Care staff did bath in the afternoon, but more often as the residents went to bed. Several residents bathed alone or needed minimal assistance to get in and out.

Lost laundry was as common as it was at Fell View and one of the main areas in need of change was the whole system of marking and distributing clothes. However Deer Park staff saw lost laundry as a problem rather than an irritation.

Tea was a very moveable feast both in terms of its time and contents. Each wing decided what they wanted and often left-over from previous day, or relatives' baking, was distributed. The central kitchen did provide a tea which was ordered during the afternoon. Often, especially in the summer, wings had strawberries and ice-cream, rather than a cooked meal.

After tea, as noted, residents tended to disperse and this was generally a quiet period. One or two residents watched the television and care staff often had group discussions with residents at this time.

Residents tended to go to bed very early, similar to Fell View so that by the time night staff came on duty most residents had retired to their rooms if not
their beds.

"I commented to Linda (CA) about how early they tended to go to bed. Linda (CA) said that they were used to industrial lives where they got up really early and so they were "used to it". Like they were used to going to bed early. Most wings were empty by 9 o'clock".
(CL/11, para 3)

In sum, much of the daily activity was done by the residents themselves with help from the care attendants. The nature of this help was negotiated between care attendants and residents in the light of the circumstances that prevailed so there was a different emphasis for the staff role.

Repair and Innovative Work

As a result of the noticeable resident participation in maintenance work, much of the care attendants' daily work focussed on repair work, both to the maintenance work carried out by the residents and to group living practice when it was seen to slip. These activities involved two major components,

a) that of dealing with immediate "on the floor problems" of group living as they occurred.

b) representation to senior staff on behalf of a resident regarding a particular
situation via either the report book or the talk in.

The Deer Park repair work was in some respects quite distinct from that at Fell View. Fell View staff focussed on the physical maintenance of the elderly, whereas the Deer Park staff had the additional task of "representing" the group living philosophy. They were in the unenviable position of having to promote group living and at the same time reconciling the consequences of it to the residents. Much of the Deer Park repair work was innovative in character.

Repair of Maintenance Work

As seen there was some ambivalence as to how far care attendants should repair maintenance work done by the elderly, and how far they should leave the elderly to cope alone. This was part of the general ambivalence and dilemma of operating a group living home.

The relatives' contribution and attitudes to it of the care staff demonstrated the feeling that there could be too much repairing to maintenance work which defeated the object of group living. The main comments about relatives are centred around them "undoing" care attendants' work by interfering too much.
"Mary (CA) said that relatives were a bit of a problem. They tended to over do the help and misunderstand the notion of group living".

"Terribly interfering in every way".

"You find relatives just come in and kind of take over the laying of tables...".

"Actually they interfere too much... after you have been trying to motivate the residents".

"Relatives do come in, for all they know this is a group living home they still come along and say, I think my mother should be having help". (E1-E3)

**Arbitrators and Advocates**

As noted there were two main components to the Deer Park repair work. Firstly the staff acted as mediators between participants "on the floor" in order to maintain a group living style. Extracts from the participant observation notes indicate this negotiatory or conciliatory role. At Fell View residents tended to argue, if at all, with staff. At Deer Park much of the disagreement took place between residents. Care attendants were the referees and their judgments were based on a group living philosophy.
"An argument in wing one about the lights. In the end Winifred asks Linda (CA) to arbitrate (she wants the light on). Linda (CA) takes a vote and the light goes on contrary to Samuel's wishes".

"Linda (CA) says that sometimes she doesn't know how to handle arguments and sometimes when she gets home she wonders where she could have managed better". (CLll/para 6 - 8)

Susan (CA) was required to intervene in two difficult situations and she was obliged to use her discretion as to the nature of her intervention. Other care staff acted differently. Hence the discretionary and innovative nature of much repair work.

"Tom shouted at her, and Ruth lay in her chair as usual saying her usual things, "pigs, the lot of you. Pigs and nouts, I'd be far better dead, etc.". Tom wheeled off to the office despite Susan's (CA) intervention - where she told him he shouldn't shout like that. This all happened in the middle of their lunch". (CL/65 paras 3 and 4)

"Sometimes the residents would refuse to wash up and it was important not to give way. Susan (CA) said she'd had to explain on occasions that if they didn't wash up there would be no clean dishes at lunch time. They would sit and worry about it all morning and eventually they would wash up. Susan (CA) said she found it very worrying and threatening. She said the residents thought she didn't do anything. Like us sitting here, she said, (we were sitting at a dining room table) they
Staff discussed residents and difficulties with them at the talk-ins and through the report books where they had been recording most daily events, their response to them and receiving feedback from senior staff.

"This wing was left to prepare breakfast this morning without help of any kind. Quite a few residents sat around the table complaining about having nothing to eat with Teresa being the ringleader and Albert saying he was just a pensioner (I took this to mean he should have his breakfast made for him). However I did a lot of explaining about the group situation once again as Teresa was talking about reporting the situation to the Civic Centre. I also showed her the booklet which explains to the residents what is expected of them but also what is done for them—resulting in Teresa apologising and laying the blame on the residents for getting her to speak on their behalf when they knew they had to help and she didn't (she says). In the end she went into the kitchen and was shown how to use the toaster again so she had a couple of slices and appeared content".

"I feel as if I get a bit sick and tired of explaining the situation to the residents so am trying this method of galvanising them into action subject to officer-in-charge's and the deputies' approval".

This practice tailed off when new senior staff and officer-in-charge showed little interest in the
report writing.

The report books were used initially as a means of communication between staff and senior staff and the staff felt they acted as a means of getting things off their chests. The use of report book and their place in the "accounting" procedures of the staff is discussed in Chapter Nine. The extract from one report showed both the mediator role of staff, their frustrations over it and senior staff response. It will also be noted what a rich source of data there was in the report books and the similarity of style with participant observation notes. The contrast between report books at Fell View and Deer Park was marked. The cathartic function of this style of "reporting" is discussed in Chapter Ten.

Writing the reports was initially very much part of the care staff's work as well as an account of it.

The talk-ins were a more direct form of representation, particularly during the research period when the report writing tailed off considerably and talk-ins became the main form of communication. The talk-ins were an opportunity for care staff to justify and legitimate their practice and definitions of reality. They also used them to "negotiate" an agreement between official philosophy and daily
problems. The following are records of talk-in discussions. Both extracts are discussions concerning the increasing frequency of "accidents" and growing problems of incontinence in two residents.

"Betty (CA) says that Beth has taken a turn for the worse since she's been away. Now she doesn't bother to put her hand up when she's waiting to go to the toilet she just sits there and does it. Violet wonders whether she's dopey with the Melloril. Susan (CA) and Ann (CA) said that even at nights she wasn't ringing. Violet said she thought lying in bed didn't encourage continence and said she thought Beth should be got up at least by 10.00a.m. Her toe also needs a dry dressing". (C/44 para 4)

Here Betty (CA) suggested that Beth's incontinence troubles were self-inflicted whereas the senior and other care staff suggested that her drugs might affect her alertness and the senior staff offered a practical strategy to help care staff cope. The next extract showed the negotiation between staff about definitions (is Diana to be "incontinent") and advocacy on Diana's part by some staff who encouraged a toilet programme rather than incontinence pads on the grounds that pads were undignified.

"Diana is beginning to be wet. Ann (CA) and Susan (CA) brought this up. They felt that Diana needed some sort of assistance going to the toilet. Betty (CA) who is attached to wing two resisted this, saying that once you gave assistance "they" always expect
it. They start slipping back. Susan (CA) says that surely Betty (CA) could meet her half way". (C/61, para 7)

"Betty (CA) asks about the possibility of using Inco pads to keep her walking. So that if she had an accident it wouldn't matter. Susan (CA) says that all that means is that she sits in her wet. It doesn't help. Betty (CA) asks if this new instruction about Diana has come from the office. Betty (CA) says she will wait for instruction from the office. Susan (CA) says she should be able to use her own judgement, but Betty (CA) says she could be wrong. She is expected, she feels, to go to the boss".

"However she sees no reason why they can't put her on a toilet programme".

"Susan (CA) says that Inco pads take away your dignity and also make you lazy. You can't just leave her sitting and smelling. She should be reminded every two hours to go. Susan (CA) points out that Diana is getting old, she is not going to get any better". (C/362 paras 1 - 3)

In sum, much of the main care attendant work was not directly involved with the routine maintenance work as at Fell View but with repair work and arbitration between group living philosophy and floor situations. At Deer Park the repair work looked more like innovative work since each situation was new and required a new response.
Occasional Work

The occasional work with which staff were involved was similar in style to occasional work at Fell View but outings, particularly, were a much more predominant feature of Deer Park. This type of work often involved the relatives and friends more obviously. All staff said they would have liked to have seen more outings and non-routine activities. The philosophy of the home however, implied through its policy of choice, that ideas for outings and non-routine non-daily activities should come from the residents. Staff were to be "enablers". Staff expressed disappointment at the lack of ideas that came from the elderly. These comments were recorded in the minutes of a staff meeting:-

"Staff felt that even after the three month "settling period" the residents were not putting forward any suggestions of their own on what they would like to do in their spare time. It was generally felt that staff did all the suggesting. The residents did not seem to have many ideas of their own, but that the residents did not seem to want our suggestions anyway. One idea was an expert on Arts and Crafts to come and give our residents some help, but although this could be possible, it was again inflicting our views on to the residents. This has to come from them". (C/69)

This view was also expressed in the interviews. For example:-
"You see the horrible thing is if you ask a resident what they want they don't answer... what would you like to do and they'll say well I don't know... you tell me... I don't know... does everybody get like that when they get old? I mean you may be dogmatic when you get old but they'll just sit there... and you know 'I'm happy'...".
(B10/17)

Discussion of the Deer Park Model

Resident Participation

The implications of this style of care for resident participation were extensive.

Firstly it offered or reinforced a perspective on elderly residents that meant less "objectification" of the elderly by staff members into work objects. Elderly residents were perceived more as individuals in their own right, as has been shown (Chapter Six), and this had repercussions for interaction and staff–resident relationships.

Secondly, resident participation in daily living maintenance tasks freed care attendants from the constraints of the routine day and the completion of essential tasks. The onus for completion of tasks was much more shared, if not dominated, by the residents. This freedom gave staff more time to engage in
discussion, reflection and planning either between themselves, at talk-ins, through the report books, staff meetings or with the residents during the course of the day.

Thirdly resident participation meant that staff were far more engaged in repair work than maintenance work.

**Repair Work as Social Work**

Repair work had two components. First, as at Fell View, to repair gaps in the maintenance work. This, as has been shown, was done with some discretion and staff tended to vary on the amount of repair work maintenance they carried out.

The second type of repair work and the dominant type was the repairing of precarious social situations brought about by the group living philosophy. This did not involve physical "tending" in Parker's sense (1981) but was rather more in line with what might be called "social" work and a main characteristic was its innovative nature.

An interesting feature of the difference between the two homes is that at Fell View repair work was valuable service in making residents' lives more
personal and acceptable. At Deer Park repair work of the physical and social type done by relatives and outsiders was seen to cloud the purpose of the home since relatives were not familiar with and/or disapproved of the group living principles.

Less Routine – Less Rules

At Fell View adherence to a rigid daily routine involved a need for unofficial rules, hidden rules and shortcuts. At Deer Park less rigid routines meant less need for short cuts and hidden rules. There were rules, but often these were developed by the initiators of the routine - the elderly. Where rules did emerge, in order to promote a routine, staff knew they got no official support for them (such as bed times) either from senior or other staff. At Fell View official rules and hidden rules were supported by senior staff.

This chapter has looked at what care staff in both homes did during their daily work. A framework has been developed from the Fell View data to examine practice and it has been suggested that the components of work in each home were similar whilst the configuration of these components differed markedly. This was paticularly apparent in the role of staff at
Deer Park who acted as mediators for the philosophy of the home, thus "repairing" the "slips" in daily living and interaction. The Fell View staff had no such philosophy to protect and/or transmit, and repaired largely physical maintenance slips.

The next and final analysis chapter considers aspects of the phenomena that underpin both homes' daily practice - that is, the talk and conversation of staff, how did aspects of talk aid or hinder particular styles of care?
9. TALKING ABOUT CARE: CARING ABOUT TALK

Introduction

The importance of language in the maintenance of a stable reality has already been noted in Chapter Three. Language or what Berger and Luckmann have called 'conversational apparatus' (1979) includes all aspects of communication, both verbal and non-verbal. Ethnomethodologists particularly have emphasised the dual nature of language as both a description of and a part of action or practice.

This chapter continues to look at what care staff do, by looking at their talk. The chapter explores and compares the particular styles of talk (rather than content, which has been discussed throughout the thesis) and organisational factors within the homes called the "context" that influence these styles. It will be suggested that the theories of the staff and the models of care found in the homes are intimately linked to the style of talk predominantly practised in the homes. It points up the way in which style of talk informs the practice of care staff and the affect of style of talk on quality of life in residential homes. It begs the question, to be addressed in Chapter Ten, that adjustments to organisational and structural factors might stimulate particular styles of talk that
in turn might promote changes in theories and practice.

There are some methodological and interpretative issues to be addressed, when discussing talk and styles of talk. Understanding what people say involves an interpretation of not only words but tone and non-verbal messages that accompany words. In everyday life the lay actor trusts to her own learnt social skills to interpret messages. However, the researcher, as we have seen in Chapter Four, is to suspend her lay actor's assumption that cues are being given and received correctly and question the 'taken for granted' everyday world. D. Baker's study of the attitudes of nurses to geriatric patients (1978) points up this dilemma.

Baker suggested that auxiliaries saw patients as less than whole and usual adults - as people apart. To come to this conclusion she used material from participant observation notes demonstrating what staff said about the patients. She gave an example of a comment made by a nurse:-

'In the past geriatrics wore uniforms so they could be distinguished and nowadays they don't so you can't tell them apart' (102)
Baker interpreted this comment as meaning the auxiliary thought geriatric patients should wear identifying clothes to tell them apart and therefore they were seen as less than 'normal adults'. However, the extract given, in itself, does not necessarily suggest this. The nurse could equally well have meant that it was a good thing they didn't wear distinguishing clothes. It was therefore the tone and non-verbal messages that accompanied the words and their context that indicated the meaning to Baker. The reader is to rely on the researcher to interpret tone and style correctly and give information about context.

The way in which words are said and the context in which they are said are as important as the words themselves. The way in which members of staff talk to a resident while helping with incontinence or talks about the incident afterwards is part of care work. In survey and questionnaire work context and style are effectively ignored. However in qualitative data it is ignored at the peril of the research, whilst acknowledging it creates presentation difficulties.

This chapter concentrates on two particular types of talk whose context and style give them meaning. These have already been noted in the homes and are judged to be fundamental to, and part of, the routine and typical day. The first is the talk that justifies
and explains actions which will be called 'accounting' and the second is the style of conversation engaged upon with residents.

It is suggested by the social constructionists that whilst talk exists in all social settings, the more 'precarious' the situation in terms of agreed definitions of reality, the more talk there will be to bridge the gaps between the realities. Strauss (1964) has noted the great amount of talk that took place in the institutional setting of the mental hospital and this has been noted by others in other institutional contexts. This thesis has already noted the constant and high level of talk during a typical day. It has discussed the way in which theories about residents were developed and disseminated and how staff at both homes spent time discussing and (sometimes) appraising their past or future practice. It is suggested that the two homes operated in an environment of 'precarious reality' where talk was used to bridge gaps. However each home had quite different styles of talk and context was often very different.

The first part of the chapter looks at how staff are 'socialized' and become care staff and it is suggested that the organisational factors involved in becoming a member of the care staff maximise the possibility that new staff will learn the 'appropriate
styles' of talk. Socialisation is an essential part of reality and order maintenance. Roles have to be learnt by the acquisition of knowledge, language and tacit understandings, i.e., conversational apparatus. Successful socialisation is more likely where there is a similarity between the significant others (the established members) and the new staff and where similar and homogenous objective realities are being offered. That is, where new staff already agree with the significant others' world view. Unsuccessful socialisation is more likely to occur where significant others and new staff are at odds.

**Becoming a Care Attendant - Fell View**

In becoming a care attendant a transition is made both in terms of role and perceptions:—

'I used to go home and tell the family funny stories about the residents - what they had done or said, but now it all seems quite normal. You get complacent don't you. (R2)

Becoming a care attendant meant learning the general and specific theories about the residents and the implications of these in terms of routine and behavioural requirements of staff and residents. This meant learning both the style and content of language used in the home as well as the routine. A great part
of the language was accounting and conversing.

At Fell View new members learnt the official rules and 'short cut' rules of the home by osmosis, that is, with no official or formal guidance from other members. Socialization of new members was largely a common sense process of copying others actions.

'Belinda (YOP) arrived today. She received no instruction from anyone, just hung about and watched'. (R2)

'Caroline (YOP) learnt quickly what the nasty jobs were and how to avoid them. She said she was going to 'help wash up' to avoid the ritual post-prandial toileting which she didn't like doing'. (R1)

Giving direct guidance and instruction was seen as inappropriate work by care staff:-

"Care staff openly instructing each other is discouraged. However Chris (CA) gave me instructions. I was to do the coffee and Mona the beds. Mona (CA) said Chris (CA) did the same to her the day before (i.e. he instructed her) and Andrew (CA) was dumbfounded that he had done so. 'It's not his place'. said Mona (CA)". (R2)

When a new care attendant arrived, the cook asked me to tell her what to do, since she was wandering about the place. The cook said:-
"It isn't my place to instruct a new member of staff". (R2)

As noted socialization proceeds smoothly if conditions are suitable. That is, if the primary and secondary socialization are congruent with each other (i.e. meanings and interpretations do not contradict each other) and if the 'significant others' and new members share meaning structures and are seen as plausible by each other.

The noticeably successful and speedy socialization of new members noted in Chapter One was likely therefore to be due in part to the congruence between outsiders and insiders. The similar domestic and educational backgrounds has been noted. Although other factors discussed below conspired to control all staff despite backgrounds. The organizational and structural features of entry into the residential home also aided successful socialization of staff by ensuring as much "congruence" as possible between new staff and older staff.

Entry

Application for entry was indirectly controlled by "market forces", via the status given to care work in general and care attendants in residential homes in particular so a limited group applied for work in the first instance. This has been discussed in Chapter Five.
Secondly entry of staff was controlled at interview by senior staff who favoured particular types of people. These were individuals who would 'fit in' to a team in the case of Fell View, and 'be willing to operate group living' at Deer Park. In both cases interview and pre-interview choice weeded out individuals who tended not to fit the prevailing characteristics of care staff.

It was said at Fell View that interviews were 'rigged' in the sense that the successful candidate was decided upon before interviews took place. Andrew, for example, was "sponsored" by the line manager who had suggested that he should apply and at interview, compared other candidates to him. The criterion for this comparison was whether the candidate would 'fit in' as well as Andrew would.

Teamwork and 'being able to fit in' (i.e. to be like the others) was seen as extremely important at Fell View.

A candidate with competent and unusual handicraft and physiotherapy skills was deemed to be 'over qualified' for working in residential care. Another long experienced woman with some firm and fresh ideas was said to be too pushy and criticized for not putting her family first.
At another set of interviews for a night staff post a similar set of circumstances occurred. The new officer-in-charge who as seen was in the process of disrupting the established order wanted to appoint a former colleague who had experience in group living care. He had plans to get her on the staff and then move her to days in order to gain some ground in his plans to move to a group living mode. He set about canvassing his senior staff who were to be at the interview in his place, since he was going on holiday. His seniors could not see what good a night care attendant with group living experience was, since he did not tell them of his plans for switching staff around and promoting group living practice. Fuelled by a growing general criticism of him, the seniors refused to co-operate and supported another candidate, Rosemary, who was already working at Fell View as a temporary care attendant and who was said to 'be getting along smashing, 'really part of the team'. All these negotiations were carried out prior to the interviews.

Entry to Deer Park

At Deer Park all care staff were involved in a two week training project before the home opened. This formal socialization involved them in role play, group discussion, instruction on aspects of ageing and
reading the files of the residents about to be admitted. Most of the staff in the study underwent this induction course since most staff remained in the home throughout the period of research. It made a deep impression on them and this was reflected in the interviews where time and again mention was made of the induction course and facts learnt during that period.

New staff members who had not attended the training were not given any instruction or supervised on a daily basis. The main factor affecting their orientation was the strength of the group living philosophy itself. A more 'experienced' wing member tended to informally 'keep an eye' on the new member of staff. This appeared to be acceptable since, as has been discussed, it was recognised by all members that the group living style of care required different behaviour from other homes which was a complex task and therefore had to be learnt. The overall emphasis on the importance of training as against experience as a proper basis for knowledge and practice aided this view.

Deer Park seniors were able to control entry of staff through interview in the same way as Fell View although they were looking for different qualities in their staff. Responses to question A8 (Appendix C) by seniors indicated the sort of person they saw as suited
to working in the home:-

'Reasonable intelligence and a good attitude to understanding the elderly or learning about the elderly. Must have a commitment to the elderly. Looking after an old mother is not good enough these days...'.

'A caring nature. Someone who does the job and can say at the end that's the way I'd like it done to me'.

'A secure sort of person. Someone who is not looking for power. Someone with commitment'. (A8/5)

The focus was more on how they would be with the elderly residents rather than with the other staff.

Whilst there were clearly differences in 'entry requirements', a similar staff profile in both homes in terms of background and experience was evident (Chapter Five) and this suggests that 'market force' played a not insignificant part in recruitment, in the "suitable" candidates as far as seniors at Deer Park were concerned did not necessarily apply.

It was in this context that staff learnt how to appropriately account and converse and become care staff.
At both homes there were occasionally 'outsiders' who did not pass through the controlling mechanisms either of 'market forces' or interview although interviewing for permanent posts was mandatory in the Authority. These mavericks were usually students, YOP scheme youngsters, transfers or reliefs and volunteers. Priests, social workers, hairdressers and of course, relatives also had regular contact with the home. Deer Park seniors however, resisted using 'un-trained' reliefs or temporaries on the grounds that knowledge or training about group living practice was essential.

The people who had not gone through the weeding out process were potentially more likely to provide the alternative definitions of the situation, resist the socialization process, and challenge the accounts. The presence of an unsocialized worker or visitor prompted vigorous accounting work and very often discrediting accounts when all else failed. These are discussed below. Methodologically speaking, accounting was at its most prominent when 'outsiders' were present. As a result, my own experience of accounting was marked particularly since I also asked more questions of staff than was usual. It is possible, therefore, although this was not the impression given by informers, that the intense accounting observed and experienced in both homes was less apparent during
shifts where all staff were old hands and in congruence with each other.

**Accounting**

Scott and Lyman (1968) have suggested that one feature of talk is accounting which they describe as:-

>'the ability to shore up the timbers of fractured sociation... to repair the broken and restore the estranged'. (46)

The account they suggest, is a linguistic device:-

>'employed whenever an action is subjected to valuative inquiry'. (47)

Characteristically, accounts

a) prevent conflict by verbal bridging of gaps between action and expectation.

b) are linked to the status of individuals giving them; accounts can be appropriate or inappropriate according to the status of the accounter.

c) are 'standardised' in any particular setting and so can be learnt and delivered as part of the accepted social practice.

d) are given particularly when untoward action takes place.
This notion of 'accounting' is similar as they have noted, to C. Wright Mills' (1940) vocabulary of motives whereby actors in particular settings learn the vocabulary of explanation and justification appropriate to those settings. In both cases the importance of learning particular 'forms of speech' that are part of the everyday practice of the particular situation are highlighted. In both cases also, the actors are learning to 'repair' possible gaps in practice.

Fell View Accounting

A great deal of the talk that took place at Fell View was of an accounting nature and formed much of the repair work. However accounts at Fell View seemed to be offered without an obvious stimulus of demand. Accounting could therefore be seen as an 'institutionalized' part of the routine day, and if, as Scott & Lyman suggested accounts occur when untoward action takes place, it is assumed that there was a chronic mismatch between action and expectation.

The context and situation in which accounts were presented was as important as the content of the accounts. At Fell View anecdotal story telling and 'instant replay' characterized most of the accounting, and took place at any time irrespective of the
activities of others and taking priority over other work.

Anecdotal accounting was very much dominated by the senior staff and relied heavily on experience. In effect senior staff held court over care staff and told 'stories' about past situations which confirmed and reinforced the general theories which were part of the Fell View ideology, but which often referred to specific incidents.

Accounting also took the form of an action replay, which was very much a process of justification and exoneration. This process repaired the care attendants' self image as well as the maintenance of essential tasks. It also emphasised staff separateness from the elderly.

This was fairly typical:-

"Mona (CA) stopped me 'en route' to the office and told me that Mrs. Chapel had been crying. "She thought she would get a chair 'cos her legs are bad" said Mona (CA), who had denied her the chair. I said I was going to write up the report book and Mona (CA) told me to write up that Mrs. Chapel was 'upset and depressed this a.m'. (R3/150)

In effect Mona (CA) had exonerated herself from being the cause of making somebody cry through
accounting for it to me and by recording a 'justification' -"upset and depressed"- in the official report book. Mona (CA) accounted for Mrs. Chapel's crying as a result of being upset and depressed, rather than getting no chair when she wanted it. This was a situation of routine disbelieving of a resident by staff.

Sometimes instant replay accounts were 'performed' in the hearing of a resident or participant involved. In the following lengthy extract from the participant observation notes a senior gave an involved account explaining why she wasn't prepared to help a resident in a voice loud enough for the resident to hear. It includes the researcher's comments.

"I helped them both into the lift and downstairs. As I was helping them out a senior walked by. I said that Helen wasn't feeling too good and that she wanted a pill. The senior said 'I'm sorry Harriet, but she's not getting anything I've had enough of her and her husband. I had a right to do with them over the weekend'. Helen was looking at me and I had no idea what the 'do' was. In the end I said to Helen 'you go into the dining room and the senior will bring your pills'".

"A common dilemma - getting stuck between Resident and Senior, one playing me off against the other. Usually I try to transfer
"We stood in the dining room. A senior was behind the serving hatch in the kitchen facing outwards. I was facing towards the kitchen. She explained loudly in earshot of residents that on Thursday Ma Seed had complained of feeling unwell, and, giving her the benefit of the doubt, she called the Doctor. When she told Ma Seed which Doctor it was, Helen said she 'wanted the other one.' The Doctor arrived and in conversation with Enid Taylor asked if they were still fighting. The Doctor had then told her that they had been fighting for years and whoever lost the fight then had a heart attack. He said that they could call the Doctor three or four times a week. However the Doctor changed the prescription and left. Enid Taylor said that Helen should get up, and that one day she or Frank would cry wolf once too often. She said that she had strong words with Helen. Enid Taylor felt she had been made a fool of. However the next thing that happened was that on the Saturday Helen had been staggering along the corridor saying she was going to fall.

Shelia (CA) interjected here, saying she did that when she had an audience.

In fact she'd walked perfectly o.k. until she got into the lounge when she staggered from chair back to chair back. Sandra (CA) had given her a zimmer, saying it would steady her. Later on that day she had a phone call, a friend who was crippled with arthritis calling to speak to Helen to wish her a Happy Christmas. Enid Taylor called Helen to the phone, giving her a zimmer. Helen staggered into the office and in speaking told her friend how ill she was and how no one believed her. When she had finished the call she said she couldn't walk back. Enid
Taylor said she could and said it was worth remembering that there were others worse off than herself. Helen walked out of the office and sat on the chair in the hall. When Enid Taylor told her to walk into the lounge she threw the zimmer away from her and shouted that she couldn't walk. Enid Taylor insisted that she walk. Enid Taylor likened Helen and Frank to Jane Hughes, 'can turn on or off her paddies at will'.

(R3/175)

Various features stand out about the above action replay accounting which were typical of such accounts and common in a routine day. Firstly the dubious practice of the senior in insisting on Mrs. Seed walking is justified in terms of the deviousness and shamming of the resident and outside evidence is brought in to support this. Secondly the other staff serving at the meal were obliged to act as audience to the accouter but critical assessment of the reported situation was not offered. Thirdly other staff found themselves in the uncomfortable position of having to mediate between accouter and participant or more often were left to resolve the situation. Accounts, as well as being linguistic devices to 'repair' action, also created the need for repair.

As noted at Fell View accounting was the strongest amongst the most experienced staff, (i.e. the seniors) and as a result the consequences of much of the seniors' accounting had to be dealt with by the floor staff.
'Work' was therefore created by senior staff. The front line characteristic of staff did not apply so aptly to the seniors, who were able to 'account', issue instructions to staff (as in the case of Mrs. Seed getting no pills), and disappear to the 'office'. Staff themselves had to deal with the fractured social relations at floor level. Senior staff were in a position to, and did, abdicate this responsibility.

This situation repeated itself amongst the floor staff where the most confident and experienced staff would 'account' for their actions with the elderly (usually to withdraw a service) and leave less experienced, more junior staff to deal with the resultant situation. Therefore it was not uncommon to find the least experienced staff (YOPS, reliefs etc.) coping with the complex social situations in the aftermath of an account.

At Fell View most accounting took precedence over other work being carried out. This was particularly noticeable when the elderly were 'the work' of the moment. Extreme examples of this feature of accounting were where it actually superseded work, and prevented it, rather than held it up.

'Enid Taylor told various stories and we sat for 2½ hours (sic) - found it difficult to get away. Even Sandra (CA) remarked on it'.

(R3/109)
Mostly however this kind of interruption held up work rather than actually stopped it; most importantly it reduced the quality of work.

"Chris (CA) left Lois stranded on her chair, too far away from the table, while he stood gossiping". (R3/149)

"I was taking Lily into the dining room which involved her putting her hands on my waist and me walking backwards. A slow laborious operation. A care attendant stopped me, and physically prevented me from continuing, while he told me all about an incident that morning with Tom. Meanwhile Lily is still holding my waist". (R3/162)

Deer Park - Accounting

It will be remembered that at Deer Park accounts of action were part of the routine official day in that they took place at set times (talk-ins) and in set forms (the Report Book). They were not however accepted so readily by other staff members and tended to be asked for and challenged, both at official and unofficial times.

Because of the designated place for accounts in the day, accounting tended not to take precedence over other activities. This meant that additional
accounting was interrupted by work with the elderly rather than vice versa.

The style of most accounting took the form of a specific description of present behaviour rather than a general analogy with the past. The accounting was, in this sense, more pragmatic and descriptive, meant to inform the immediate situation than interpretive and part of a staff support system. To be sure care staff did indulge in anecdotal story telling and instant replay but the appeal to experience was less valued than empirical evidence. It was perhaps no coincidence that a large number of staff had no previous experience of this type of work (Chapter Five). Furthermore staff and seniors' relationship was less casual so that informal staff/senior accounting sessions did not take place to the degree that they did at Fell View.

Whilst Deer Park accounting was built into the routine day, it was treated critically and subject to constant alteration. Part of accounting was to defend the agreed definition of group living. Staff perceived 'outsiders' as interfering in group living, tending to undo good work by 'doing too much'. This particularly applied to relatives. They also saw other staff as a threat in using 'traditional' care practices inappropriately.
At Fell View staff were defending their routine and the theories that supported that routine. Outsiders performed useful 'repair' work as shown but they also pointed up faults in the care work routines. Both sets of staff therefore resented and resisted challenges to their routines and theories. This was expressed through accounting.

**Discrediting Accounts**

An important way of dealing with challenges, or threats to the smooth running of both homes was to discredit the sources of the challenge and thus reduce their validity.

As noted the main challenges came from unsocialized participants who were in front line positions in that they had direct contact with the residents; in particular new and temporary staff. It also came from the residents. At Fell View in particular criticism of staff practice from the residents was explained away in terms of their inevitable decline and ever encroaching senility: Whereas at Deer Park residents criticism was explained as a lack of commitment to group living.

The power of the discrediting accounting to resist ostensibly authoritative 'challenges' is clear from the
notes in the participant observation concerning Fell View's officer-in-charge. It has been noted that after receiving the new officer-in-charge warmly as someone with enthusiasm, good ideas, a lively style of management and a real "caring person", the staff rapidly and to be quite fair, not surprisingly, became confused about his objectives and methods of achieving them and found him difficult to understand. They felt that his ideas were going wrong, despite all their efforts to put them into practice and they slowly reverted to their former practices, blaming the officer-in-charge for the failure. Their justification of this rejection of the officer-in-charge's plans and instructions rested on the belief that he was no longer able to make rational decisions. Firstly it was suggested that he was a homosexual since he had affected mannerisms and wanted to paint the men's bedrooms pink. In terms of the care staff's cultural value he lost status and credibility. Secondly, he was said to display manic depressive symptoms and was therefore unreliable.

"They (care staff) had been reading an article about manic depression in 'Doctors Answers' and felt the officer-in-charge fitted the symptoms exactly. The seniors were present and discussion centred on the officer-in-charges's possible illness. Thereafter the officer-in-charge was seen as a manic depressive". (R3)
and his actions were therefore translated accordingly.

Outsiders and Challengers

Relatives, social workers and "outsiders" generally, tended to be critical in some way of the home and the care provided. Staff accounted for this by the general theories that all "outsiders" were ignorant of the facts having had no experience of the daily reality of care; that relatives were money grabbing and only visited on pocket money day; that doctors weren't interested in the elderly and made fleeting and inadequate visits; that social workers just sat in offices and found fault.

It was felt that none of these groups of outsiders had any practical experience of "real life" in the homes, and as a result they had no right, and were in no position, to challenge the order of things.

At Fell View there was very little internal challenge to the routine day from 'credible' sources (i.e. accepted staff members) and much reinforcing of the routines and attached theories from the 'experienced' and esteemed staff. In this respect Deer Park was very different. Here staff who were credible were the main source of challenge to slipping back and stimulus for constant discussion and manipulation to
maintain group living.

As at Fell View, there were methods of discrediting potential sources of challenge or threats to the established group-living order. The main potential threats were again outsiders, although "outsiders" was more narrowly defined as those coming from outside the wing. This usually included other staff seniors, as well as relatives, social workers and so on. Relatives particularly were on the whole viewed with mistrust as they were generally thought to do too much for the residents and thereby misuse the notion of group living, and undo all the work of the care staff.

Several explanations were given for this:

a) that they didn't understand group living concepts.

b) that they felt guilty about their relatives being in care in the first place.

c) that they could not bear to watch their relatives struggle.

d) they could not come to terms with the improvements the residents often made since it reflected badly on their decisions about suggesting residential care in the first place.
Relatives were nevertheless seen as an important feature of the resident's life.

Senior staff and other staff were considered a threat to order since they could interfere in the wing plans and practices either by insisting on "too much" group living, or not standing back enough, i.e. giving too much support. The balance was very fine between these two stands and wing harmony could easily be upset. Wing staff developed and operated wing theories which were not common knowledge to other wings and which were specific to individuals.

Conversational Styles

A second aspect of the conversational apparatus that new staff had to learn was the appropriate style of conversation to use with the residents. The general theories disseminated about the residents anticipated and invited a particular style of conversation.

At Fell View style of talk with the elderly was characterised by jokes or banter, sometimes with a faintly sexual innuendo, usually based on the assumption that the elderly people were not "credible" conversees, i.e. they were not able, for various reasons, to hold a conversation.
"Mark had come into the office to say that he couldn't see (sic). Enid Taylor showed him five fingers and asked him how many she held up. When he answered he said, 'you're testing me aren't you?'. She pointed to the Fell View Plaque on the wall 'What does that say?' Mark said 'Fell View'. Enid Taylor said 'are you sure it doesn't say Lourdes - I've just worked a bloody miracle, you can see'. She also told me that she's told Mark to move his feet if he wanted to walk". (Ref. 2/33)

"Ann gave Lois (resident) an empty cotton reel and said, 'Now Lois guard that - don't tell everyone I've given it to you, otherwise they'll all want one". (Ref. 2/82)

"Tom said he thought he was falling in love with me (Harriet). Peggy (a care attendant) said, 'Well I'm giving you your ring back, you told me you loved me'. Tom laughed". (Ref. 3/142)

This sub-adult talk had the effect of denying the adult status of the resident and thereby trivialising the residents lifestyle, needs, fears and demands, which in turn allowed the elderly person to be seen and treated as a work object, (Chapter Two). This style of talk helped to 'objectivate' the elderly.

Circumstances and location of talk as well as style contributed to the tendency for conversations between staff and residents to be trivial and minimal. Most conversations between elderly people and care staff took place "in-passing" as care staff moved
from one area to another, or as a result of some routine maintenance activity like bathing or toileting. Conversation as the main purpose of contact (rather than a side-effect of some other activity) was less common since, as seen in Chapter Seven/Eight conversation per se was not considered to be part of the essential routine maintenance work.

"On arrival at 8 a.m. it was asked if I was going to work or "talk to the residents that shift!". (R2)

This comment already noted views epitomised on conversation.

Most of the communication between staff and residents took place not only in passing, but in public, and tended to publicise conventionally "private" areas of an individual's life.

"Chris (CA) was helping John along the corridor, Susie was behind him in her wheelchair. He said loudly to me 'Eh Harriet, John's penis is raw, and went on to describe it loudly so that all around could hear". (R3/112)

There was a tendency to use endearments and pet names inappropriately. For instance calling the residents for lunch by shouting "come along boys and girls", or referring to residents by surnames only,
when they were out of favour.

As at Fell View there was a style of talk peculiar to Deer Park. However unlike Fell View where sub-adult interactions were common place, Deer Park staff actively tried to normalise interactions, sometimes against considerable odds. A stroke victim who had lost her speech and could only say 'good' and 'If I can' had been extremely agitated one evening. The staff made genuine and eventually fruitful efforts to establish from her the source of her agitation and discussed it at the talk-in the next day:-

"Susan (CA) asked Gwenn if she had established what the matter had been with Julia last night. They explained to me that Julia had appeared quite upset and got out her handbag and pointed to her purse then pointed at Maud. They wondered whether she had had something taken and had gone into her room to check. She didn't appear to have lost anything. Then they discussed the pocket money and it turns out that Julia is now receiving less than her £5.55 for some reason and Susan(CA) wondered whether it may have been that which was worrying Julia. Gwenn asked Susan (CA) to have a word with Julia about it and they all agreed that it should be explained to her. Gwenn said she'd just put the money up, she hadn't handed it out and it may not have been explained to Julia".(CL)

Newer staff, and particularly younger staff who spoke to the elderly 'like babies' were reprimanded.
Residents' views and opinions were, on the whole, taken seriously. The care staff and domestics tended to know a lot about residents' lives and encouraged them to talk about their past homes and present outside contacts, which added to their 'normal' status.

Content of conversation was helped considerably by the fact that the care attendants and elderly did more together, so had more to talk about of common interest and more important, conversation was as has been shown part of the routine work day. Conversation was accepted as a bona fide activity rather than 'in passing' or a side effect— as an end in itself. Both the content of the conversation and the style tended to maintain the integrity of the residents.

Organisational & Structural Factors

Both accounting and conversation styles in the two homes seemed to be aided or fostered by particular structural and organisational factors, that created the conditions for particular patterns of conversational apparatus. The control of entry by market forces and interview has already been noted. Other factors will now be considered.
Staff Tea Breaks

These periods were the main vehicle for Fell View talk. At the morning break all the staff including the seniors had coffee together and exchanged information about the residents in the form of stories. Here also new members of staff and temporary staff were informally socialized. As we have seen, (Chapter Six), official breaks were sacrosanct. It was important that everyone attended these "rituals" and working during breaks was frowned upon and actively discouraged. This confirmed not only the routine of a Fell View day but gathered together all staff and seniors. Often "instructions" about daily tasks would be passed at these break times. However it was anecdotal talk, which reinforced the Fell View ideology which dominated these discussions.

Breaks at shift changeover also gave staff a chance to communicate with each other. This was supplemented by the reading of the report book. I noted at the 8.00a.m. changeover from night to day shift:

"The report book is read by incoming staff. There is a very informal verbal report given, by staff to day staff in the form of anecdotes. Each resident had their known idiosyncracies and if they trangressed acceptable levels, the incoming staff heard about it". (R1/15)
The shift changeover helped to reinforce and confirm views about residents. It also acted as a control for the night staff who tended to see the residents more positively and who were less susceptible to accounting since they worked at night. These latter images were sometimes not in tune with the days staff's experience. The common belief was that "things were different at night", and, by implication, unreal.

At Deer Park the rule that a member of staff from each wing had to be on the wing all the time, meant that even at official breaks wing staff members were not all together - and, as shown, other wing staff were potential threats, and therefore not so readily confided in. At lunch time when all the staff on one shift were together there was little staff group activity, different members would disappear to do different things. Senior staff were not present at these breaks.

The other main official accounting place was the "talk-in" before the shift (similar to a hospital report) where seniors led a handover session based on the report book and previous shift activities. The system was however becoming less detailed and staff said they were relying more on word of mouth as time went by.
Design for Escape

The design of Fell View seemed to lend itself to a sub-culture of care staff and particular types of talk. This was mainly because staff were able to "escape" resident contact. The kitchen was very much the "haven" for the home, a legitimate area for working care staff but out of bounds to residents, protecting the staff from contact with the elderly and providing a sanctuary for care staff from their demands. The kitchen was the scene of much staff talk, and the cook provided general support for care staff's views.

The office was also a non-resident place and a lot of accounting and story telling took place there. Use of the office often coincided with report writing which was a stylised and ritualised process. Since the office also housed the seniors, accounting as described predominated.

The design of Deer Park was such that care staff areas, that is areas where residents were not allowed, were officially non-existant but in practice limited to the staff room. Areas where care staff were not allowed were officially, residents' bedrooms but in practice they went everywhere given the residents' permission. The kitchen was not central to the home. Each wing had its own kitchen which was in full view of
the residents and was used continuously by members of the resident group. Thus a "sanctuary" did not exist at Deer Park in the Fell View sense. On the wings care staff could only escape resident areas by going into the toilets, which they sometimes did to discuss problems.

Since each wing was autonomous, ritual collective activity, (Goffman's 'Institutional Ceremonies 1974') rarely took place. This reduced the scope for seeing the elderly en masse and stereotyping them. As Clough points out:-

"Old age homes present society with the apathy or handicap of residents en masse". (1981b:5)

The design and organisation of the home also helped the care attendants escape the senior staff (whereas at Fell View the seniors were present at breaks and constantly around). It has been suggested that the Deer Park care staff felt the seniors represented a threat to the order by applying general principles inappropriately to specific interests, about which they knew less than the care staff. "The office" was used only as an information centre, not as a story telling centre. Report book and talk-ins were held in the television room. Furthermore the seniors were inhibited from getting round the home, by administrative demands and telephone work.
The philosophy of the home promoted the privacy of the wings and there was certainly an awkwardness about "strangers" (i.e. not wing members or workers) entering each group space. As a consequence of these factors the seniors tended to stay in the office.

Isolation

Access to alternative views at Fell View was restricted partly by the controlled entry and partly by the generally isolated position of the home - both in the sense of being in an institution with all that implies and in the sense of being part of a wider community which itself overlapped with the ideology and general theories of the home in some significant respects (Chapter Five).

The care staff did not have easy access, through training, files, outside views and presence of outside people, to alternative disconfirmatory evidence against which to balance and modify the Fell View theories. As a result myths about residents were allowed to develop and go unchallenged, indeed they were the only source of knowledge. An example of this process was the "theory" of Jane Hughes.

Jane Hughes was an unpopular resident who was seen as a 'workie ticket' (trouble maker). It was 'known' and passed on to myself that she'd had an accident
(been electrocuted) which had caused the physical disability from which she suffered and the mental degeneration which she was seen to display. When I read the files I could find no mention of this accident but that Jane had a degenerative illness which caused her increasing difficulties in walking and which accounted for her increasingly 'demanding' requests for a chair. My comments to staff, when the "electrocution" story was retold at a later date, that I could not find evidence of her accident, were remarked upon with surprise, but effectively ignored.

Contact with outsiders was much greater at Deer Park. Although few care staff had actually attended reviews, contacted social workers or carried out the admission procedure, they were at least aware of the possibility that they might do so at some point. Also the ideal of group living promoted in the home was in vogue amongst other agencies. Greater contact with outsiders reinforced the group living ideals and practices.

Outings also re-affirmed the normality of the residents and it gave them something to talk about:--

"You see the residents talk to their relations and they think, fancy them going to a pub... they've got something to talk about in the outside world which makes them more interesting people". (C6/9)
Deer Park staff engaged in quite a lot of activities that took residents out of the home, which promoted individual theories and produced new credible evidence with which to mediate theories. One resident diagnosed as having "mirror-de-signs" went to see her sister with Lucy (CA).* When Lucy (CA) came back she was full of what Diana had talked about and impressed by her sensible behaviour. Visits out also gave the care staff a lift.

Complaint Mechanisms

There was no satisfactory formal system for complaints to be lodged either by care staff or residents at Fell View. 'The office' (meaning the senior staff) ultimately dealt with complaints and care attendants would refer residents to the senior staff. Both residents and staff seemed to feel that 'telling the office' (the only realistic option open to them) was a fruitless exercise.

"Mrs. Hughes told me there was no point in complaining - nothing ever got done" (1/43)

"Linda (CA) hoped that I'd write in my book that they tried to care, but they felt stupid going into the office about residents, since they were treated as tho' it was just them being silly. 'You don't like to say anything!'". (2/25).

* CA = Care Attendant
It was felt that Mrs. Chapel's bedsores could have been prevented if a care attendant's early suggestion for treatment had been followed. But the "office" had taken no notice. One care attendant said she felt stupid going into the office to report things. Helen who was 'known' to be a good actress and caused some considerable trouble with the seniors 'really did seem poorly' said a care attendant 'but they don't listen', so there seemed little point in reporting it.

One member of staff spoke about Mrs. Poat's legs, and how ridiculous it was that she still had to be kept walking. She complained to me:-

"I know they don't want the place full of wheelchairs, Harriet, but have they seen her legs?". (R3)

No formal means of expressing dissatisfaction encouraged gossip and tacit dissent with rumour and counter rumour running riot.

If the office were told they responded in various ways. The request/complaint could be 'forgotten' and then an account produced to rationalise this. Towards the latter part of the study the senior staff used the officer-in-charge's perceived inefficiency and forgetfulnessness as an excuse for lack of action, or forgotten tasks. Requests could be blocked by
fabrication. This was used particularly when staff complained or made requests on behalf of the residents. They were told that something was being done or had been done when it had not. Jack was told, after continual representation to the office by himself and staff that a conference was being held about his physical complaints at the hospital. This was done to 'keep him quiet'. Fabrications took on various forms, from humouring a confused old lady:—

"Mrs. Baker came into the office wanting to phone her mother. A senior said he assumed it would be long distance. Then he picked up the phone and dialled a few numbers and said it was engaged". (R3)

to actual lies:—

"Jane Hughes said she didn't want to take two pills as they made her sleepy. I reported this to the office who said 'tell her it is for the pains in her legs (in fact it was leflunomide). They said when I asked them to tell her, that this was 'good practice for me'". (R1/39A)

Despite official policy that had instigated the key worker system staff did not attend reviews where opinion might have been legitimately aired. Staff had little access to 'authority' that would be in a position to promote effective change in daily care work.
This was not the position at Deer Park. Staff routinely wrote "accounts" in the report books and used the talk-ins as a means to voice complaints and act as advocates for residents. This arrangement allowed staff to modify and elaborate their theories and practice in accordance with presenting circumstances and to formally express opinions. They also operated the key worker system and attended reviews.

**Shift Work/Short Staffing**

A factor that militated against development and change in both homes was the shift work system and the perceived short staffing, both of which were linked to the routine. I noted that:

"I should not forget how tiring the job is. It would be easy to feel that the care staff were being irrationally hard when I'm not working there day in and day out". (R1/29)

Shift work and the tiredness that it induced did not encourage innovative practice. It made staff tired and grumpy. It made them less alert to, and concerned about, contradictory or plain bad practice. When tired both shifts were more inclined to see the elderly as obstacles to their work, rather than the purpose of it. I noted:
"The tiredness that night duty brings is very conducive to moaning about anything you can". (R/13)

"She, (a care attendant who had transferred from nights to days) said that the first week she was very very tired. She went for a drink and felt sick and ill". (R3/104)

Short staffing also created problems of simply getting through the routine and did not help a climate of reflective change.

At Fell View the structure of the shifts and routine meant that the tired out-going back shift put the elderly to bed and the tired out-going night shift got them up. This important task of ending and starting the day, which made so much difference to the outlook of the individuals concerned, was performed by staff who just wanted their beds and who were clock watching rather than resident tending.

At Deer Park staff were more numerous and under less pressure to fit into a routine and had been specifically instructed through training to "stand back". These three factors meant that the effects of shift work were not so dramatic.
Summary of Chapter

The chapter has looked at the way in which two aspects of the conversational apparatus underpinned the routine typical days in the homes and has compared organisational and structural context of these.

Both homes were constantly engaged in 'accounting' for care work and 'conversing' with the residents. The nature of these two activities it is suggested, characterized the type of care available in the homes. That is, the way in which conversations were conducted and care work talked about influenced the conduct of the routine day.

At Fell View accounting was a dominant but random activity that superseded other activities and that was dominated by experienced staff. The consequence of accounting at Fell View often fell upon the junior, less experienced, staff to resolve. Accounting was the main form of socialization in the home and also to be learnt as part of socialization. Unsocialized members posed potential threats to the order and stability of the home. The conversational style at Fell View was described as 'sub-adult' and took place in-passing. Conversation for its own sake was not a valued part of the work day.
At Deer Park accounting took place routinely and as a recognised means of negotiating routines and theories. Conversation with the elderly was 'normal' and part of the daily work tasks, valued in itself as work.

Various structural and organisational factors seemed to help maintain these two different types of accounting and conversation. The staff breaks at Fell View encouraged staff to 'account' and the design of the building meant staff could 'escape' residents, spending considerable time during the day out of resident sight. At Deer Park breaks were monitored and residents were free to go where they liked in the home. Staff were less able to escape residents.

Formal complaint systems and communication links at Deer Park helped staff to express their views openly and discouraged the gossip and rumour which was a feature of the Fell View staff's routine day. It also gave them access to authority which could effectively alter their routine days.

Both homes suffered in degrees from short staffing and working long and tiring shifts, although this was far more marked at Fell View. In short, staff at Deer Park, who had developed more positive theories about the residents, who were less routine bound, who talked
about the residents in a more controlled way, and who
talked to the residents as part of their working day,
were also working in an environment where:-

a) they could not escape contact with residents
b) they could escape seniors
c) they did not have staff breaks where all staff
gathered together away from the residents
d) they had access to accurate information
about their residents and group living
generally
e) they were able to take residents out of the
home situation
f) they had more chance to complain effectively
on the residents' behalf.
g) they were less oppressed by short staffing and
the shift work arrangements.

Various inferences can now be drawn from the data
presented. The final chapter will summarize the
conclusions drawn throughout the thesis and discuss the
implications of some of them for long term policy
strategy and short term alterations to practice that
could enhance the daily lives of those living and
working in residential homes.
10. SUMMARY AND CONCLUSIONS

The purpose of the research was to look at the work of care attendants in two different settings, both of which aimed to care for the elderly. This was undertaken by using participant observation and other qualitative methods and a theoretical perspective of social construction of reality that shaped both data collection and analysis. Various suggestions or propositions were made in the first four chapters.

The Research Propositions

The thesis started with two personal observations;

a) that staff behaved in ways that in other circumstances would have seemed quite inappropriate.

b) staff work differed markedly in daily practice to what was intended to happen.

A review of the literature followed up these themes by examining previous studies into aspects of care attending. Firstly it was noted that the poor image of homes is reflected in the inadequate staff and resources although staff relationship to quality of care and life in the homes is recognised. An examination of models of care that have been identified in different residential settings demonstrated a potential variation in styles of care available, but the
specific studies on care of the elderly in institutions suggested a more or less warehousing style (following Miller and Gwynne 1972) was often the actual style practised. It was therefore suggested that warehousing type care was likely despite ostensibly different policies in homes. The importance of staff was further reinforced by examining changes introduced to regimes. It was clear that staff approach to change was as important a factor in introducing change as any careful planning and organisation. Staff perceptions of their work therefore were central in planning any change in practice, and a matter for empirical examination.

Whilst staff perceptions of role and work were fundamental to any explanation of differences in quality of care, organisational factors were recognised to contribute to particular practices and foster particular perceptions. For instance the staff position in the hierarchy of the organisation was typically, isolated in terms of communication links to higher management, in terms of access to information and access to training. On the other hand staff were in a position to use their discretion over their work and the way they carried it out to a large degree.
It was suggested that care staff were usefully seen as front liners. This concept was looked at and two major characteristics identified:

a) the tendency to resist change;
b) the power to assert their will over their work.

It was suggested that a useful way of looking at care attendants work was to adopt a social construction framework whereby man is, to some extent, seen as a scientist 'theorizing' about his world and social reality is seen as a precarious and negotiable phenomenon. Care staff are said therefore to have 'theories' about their work that both describe and are part of what care staff do, and that their 'talk' was to be treated as both topic and resource. The most appropriate methods for this approach were suggested as participant observation and interviews.

The propositions set up for examination in the analysis chapters were therefore that:

a) staff are fundamental to the quality of life of residents;
b) warehousing styles of care would be dominant despite differing intentions.
c) care staff are front liners and as such resist change and have power to assert will.

d) staff develop theories about their work that both inform and are part of their practice of caring.

e) therefore talk is an important part of what it is to care both in its content and the way it is carried out.

All these propositions are a means of addressing the main question of the study - what is the role of care attendants?

Summary of Findings

In Chapter Five the setting in which the research took place and the characteristics and background of the staff was examined. It was found that both sets of staff had parallel domestic experience and biographies in that they were more or less local to the area, were in the vast majority women, had had little school education, with very few school certificates and had chosen the job for domestic, or geographical convenience and financial necessity rather than commitment to the elderly. These characteristics were similar to the national picture.
The residents in both homes were in the majority women and widowed and came from the immediate locality. They had a mixture of ailments and problems that made daily living difficult.

The designs of the buildings were different and were a reflection of the different philosophies. One home was built to maximise small group living, with discrete living areas and small group kitchens with no mass communal rooms. The other was a more 'traditional design' with communal living and eating areas.

The group living home promoted a very clear and strong philosophy that had been transmitted to staff at two week induction training sessions. The traditional home had a much more diffuse and vague philosophy.

In Chapter Six staff theories of work and residents were looked at. Staff at the homes had different perceptions of the usefulness of training and courses and this was particularly marked in the area of whether or not experience of training should be the basis for action. The emphasis on experience at Fell View encouraged a reliance on senior staff views (as the most experienced staff). Senior staff interpretations of situations were not always informed by actual and specific theories. Since care attendants
did most of the daily work they were able to develop more individual theories, but general theories were favoured. Reliance on experience at Fell View encouraged a rather negative approach to change since 'it had all been tried before' and it also encouraged negative theories about the residents whose careers were compared to previous residents who had, in the course of time, died. This led to the assumption of inevitable decline of all residents through "typical" stages of senility and incontinence alongside a theory that residents were wilfully inactive and could do more for themselves. The implications for these dominant general theories at Fell View were that staff tended to moralize about residents' behaviour and routinely disbelieve and reinterpret events and behaviour of residents to fit in with the 'experience' of staff.

At Deer Park, with its emphasis of group living and training, residents were believed to be credible and their careers were seen in terms of how residents joined in and improved in the context of becoming part of a group. Where residents were seen as 'in decline' it was in relation to their group living abilities and to what extent they were slipping back.

The theories of staff at Deer Park were as a result more individually based and specific than those at Fell View.
Chapter Seven and Eight looked in detail at the typical day of each home and suggested that whilst actual tasks were similar in the sense that bathing, toileting, eating, washing up and so on took place, it was the participants involved and the way in which tasks were carried out that made the daily routines different in each home. An analysis of the tasks that were identified in the typical day led to the development of a Fell View model of care. This was called a "maintenance" model of care and had as its characteristics a situation where:

a) work was attached to shift;

b) work was attached to time;

c) and jobs were hierarchically ranked.

The maintenance model of care had four types of task called maintenance work, repair work, occasional work and innovative work. The main work was maintenance and repair work where staff carried out certain essential tasks and other staff repaired the parts of this work that were not carried out adequately. The priority work was maintenance of residents' daily living tasks. The occasional and innovative work was more concerned with quality of life tasks and it was this work that added a 'caring' dimension to the day, although these two types of tasks were not very common. The implication of this model was that it offered
limited scope for residents' participation, it publicized private aspects of daily living by making it routine, and it encouraged the development of rules for residents and staff. Repair work also masked poor care work and therefore hid a need for change in management. The purpose of care became to maintain a routine rather than care for the individual.

This model was considered in relation to Deer Park in Chapter Eight. It was found that similar types of task featured during the day but different participants carried them out. In particular, residents' activity was far more apparent. This release from maintenance work on the part of staff meant that staff role was less clear cut and open to negotiation. Negotiation of what group living meant became a central part of the staff role. This manifested itself in 'standing back' and 'discussions'. Staff's main work was to repair the 'slipping' group living. Their repair work had two characteristics. Firstly they acted as advocate on behalf of the wing residents to senior staff via the talk-in and the report book and secondly they acted as arbitrator between the group living philosophy and the residents. This role was accompanied by a noteable degree of residents' participation in their daily lives and meant in turn that staff did not view residents as work objects to the degree the Fell View staff did. Staff were also
free from routine daily tasks and this made time for innovatory practice and life enhancing as well as maintaining work. It also meant that outsiders were seen as a nuisance, rather than part of the repair system since outsiders, particularly relatives, tended to thwart the group living principles with too much help and 'traditional' care.

Chapter Nine considered the way in which talk took place during the routine day. Talk to the residents and talk about residents was part of the daily routine and central to the work of the staff. Theories that staff held about residents and the model of care were operated intimately linked to and part of the style of talk in homes.

Two particular aspects of talk were identified. Firstly the way work was talked about and secondly the way conversations were conducted between staff and residents. The process of becoming a care attendant in both homes was similar in that entry was controlled both by types of applications to the job and the wishes of the senior staff to have new staff who would 'fit in'. This meant staff who would adopt the theories of the home without difficulties.

The theories were developed and disseminated through accounting. At Fell View anecdote and instant
replay were both style of accounts that occurred daily and helped to legitimate practice; they also acted as a means of instruction to new staff. The senior staff were very particularly involved in accounting. Accounting took place and precedence over other tasks.

At Deer Park, accounting although very much in evidence was part of a specific routine "voice". Accounting was formally recognised as part of the talk-in, and work of staff was far more specific than anecdotal. Accounts were challenged by other members of staff whereas at Fell View accounts were seen as the property of the deliverers and were rarely challenged.

Conversational styles were also very different in each home and were associated with the theories staff had about residents' abilities to communicate. At Fell View conversation was carried out in passing as a result of some other main task, whereas at Deer Park conversation was seen as a legitimate task in itself.

The chapter then considered the organisational and structural factors that helped to promote particular styles of talk in the homes. At Fell View the staff were isolated in terms of their ability to legitimately discuss work with seniors or complain or make suggestions. Staff breaks were used to reinforce
existing views and encourage particular accounting styles. At Deer Park talk-ins enabled staff to discuss practice and the report books system gave staff a chance to air views and question practice. It also gave them formal access to seniors.

Staff at Fell View were helped by the design of the building, to escape from the residents to staff only areas where they could talk about residents free from constraints. This encouraged gossip and talk that Deer Park staff could not indulge in since the residents were likely to be in sight or earshot.

Discussion of Propositions

**Warehousing tendencies**

The previous sections make it clear that the statement that warehousing is most likely to be the actual model of care in the two homes is not substantiated. The styles of care in each home were quite different although similar tasks or activities took place in each home. The distinct division of labour meant that the two sets of staff had different roles although routine tasks in the home were similar. The role of advocate and enabler at Deer Park was a precarious one and its persistence depended to a large extent on certain structures available to the staff.
which involved encouragement to discuss role and tasks through the report book and talk-in sessions.

This finding highlighted the influence of the strong clear philosophy which had an associated code of practice. At Deer Park staff knew that the home's goals were and had been given a vehicle by which they could be achieved. They knew the home's intention or aspiration was to promote an independent living where attention was paid to individual residents and their quality of life. They also knew the means of achieving this was to stand back and encourage group help and independent daily living. Although there was much discussion and negotiation of what 'standing back' meant it was 'known' to be an important part of the role of the staff. So although warehousing styles were not apparent at Deer Park, the staff recognised an ever present danger of slipping back which was escalated by the discontinuation of the use of the report book as a means of staff discussion and the change in nature of the talk-ins. Both these developments were attributed to changes in senior staff personnel.

Theories and Talk

An important suggestion at the beginning of the thesis was that staff developed theories about their
work which were associated with the outcome of care, and linked to this that talk in the homes should be seen as part of the care work. It was shown that staff theories about the residents informed their work with the residents but were also part of the daily routine in the homes. Both homes, but particularly Fell View, spent much of their day formulating and transmitting theories about residents by 'accounting' for a situation that had occurred. The marked difference in the two homes was that one accounting process was informal and the other was partly catered for in the home's organisational structures. Accounting in both homes was part of the daily caring role. It could be seen at Deer Park as a useful and positive method of discussing practices and negotiating situations whereas at Fell View it tended to be part of a staff culture that encouraged idle gossip and the view that impromptu staff discussion was as important as contact with the elderly.

If accounting was performed as part of the routine day at Fell View, talk with the residents was not. Again it was clear that talk of all kinds was an important, if not central activity in the homes. The lack of emphasis on talking to residents at Fell View was therefore notable. Talk was not seen as work. When talk to residents did take place it tended to be characterised by functional or instrumental discussion.
or sub-adult banter which took place in-passing. As an activity alone it rarely featured. At Deer Park talk to residents was viewed as part of legitimate work and part of the daily caring. Positive theories dictated positive talk. It was clear in both homes that talk by staff both in terms of content and style was part of caring and extremely important. It will be suggested below that structures to aid more appropriate talk might well be developed.

**Front line staff and Talk**

The thesis also suggested that staff as front liners would be resistant to change and have the power to assert their will over their work, largely through using their discretion, unfettered by supervision, over how they practically accomplished care. It was suggested that receptiveness to change was $\frac{9}{10}$ths of change itself, therefore change would be an unlikely feature of staff work.

Theories of both sets of staff showed distinct differences in perception of the elderly residents and leads to a suggestion that a strong philosophy encourages specific and individual based theories which are often more positive perceptions of residents and are more receptive to development and change.
The staff at Fell View tended to react against change or formal discussion of purpose as we have seen, and they were able to confidently predict the failure of new strategies from their experience, either personal, direct, or vicarious from others. The staff at Deer Park tended to accept change and discussion of purpose and strategy as part of their role. The importance of the senior staff in reinforcing theories and transmitting goals and codes of practice was also highlighted in the study. Senior staff at Fell View encouraged generalization by an appeal to experience which negated the usefulness of training and change whereas senior staff at Deer Park encouraged specific and positive theories and structured the transmission of them to encourage development.

Staff in both homes were able to and did use their discretion in deciding how to perform their daily tasks. This manifested itself in different ways in each home. At Fell View this was used largely in order to maintain the job hierarchy and routine. Intended changes to routines were resisted tacitly. However at Deer Park where discretion was used equally frequently for accomplishing daily tasks, there was a constant recognition of the need to reassess and change routines and work practices.
The strength of the philosophy which took change to be axiomatic influenced care staff's daily work. It seemed particularly that at Deer Park discretion was at a group level, whereas at Fell View individual staff made ad hoc decisions about daily routines without reference to a peer group or a central guiding philosophy.

It is suggested that the reason for this was that various structures, along with a strong philosophy, aided and abetted certain staff practices and similarly discouraged others. Organisational factors were found to influence staff theories and work but not necessarily those that are commonly understood to do so, for instance short staffing and poor resources.

The analysis suggested that talk was a part of caring and that particular styles of talk characterized the two homes. It was found in Deer Park where more 'organised' talk took place that there was less gossip and rumour and negative talk about residents than at Fell View where talk took place randomly and in an unstructured way. Furthermore the design of the building helped limit gossip and random talk at Deer Park whereas it was encouraged by design, particularly the central kitchen and out of bounds to resident rules at Fell View. Shift work and staff rotas and short staffing hindered organised group discussion since all
staff were never present together but did not seem sufficient to assume that short staffing, lack of resources and 'difficult' residents were primarily the cause of routine maintenance care.

It is the view of this research that careless and uncontrolled talk in the shape of theories and accounts plays a large part in encouraging routinized regimes and that despite the limited resources available to residential care, attention to the style, content and organisation of talk would do much to foster more positive caring.

Differences in the homes

There were three major differences in the two homes which led to two different models of care.

a) clear philosophy - clear goals;
b) different theories;
c) organisation of talk.

a) Firstly, the Deer Park staff had a strong philosophy with clear guidelines for practice transmitted at an induction course where all staff were present. Whether or not the philosophy of group living is an appropriate one for the elderly is a matter for separate discussion and there have been a number of comments made on its disadvantages previously. The
emphasis on self help for instance was sometimes over played to the detriment of general welfare (Miller and Gwynne (1972) note this tendency in their description of the horticultural model). The emphasis on group domestic tasks could be viewed as exploiting the female residents by 'assuming' roles to the advantage of the male residents who do not see it as their 'place' to wash and dry dishes. However, despite reservations about the appropriateness of group living, the advantages of a clear philosophy in giving direction and purpose to staff were evident.

b) Secondly, and associated, staff in the home held different views about residents. More positive and individual theories at Deer Park, encouraged a more positive and individual approach to care work. Views were reinforced by senior staff.

c) Thirdly, at Deer Park the organisation of talk in talk-ins and report books for accounting for practice predicting situations and discussing future practice encouraged discussion as part of work. At Fell View although talk took precedence over other work, it was not officially endorsed as part of work and tended to express itself in terms of a staff culture rather than a means of doing caring.
Some Comments

In this final section the findings of the research are used to support general comments about the role of the care attendant. These are offered in the knowledge that such a limited sample must constrain generalization and extravagant claims. However, it will be suggested that organisational and managerial changes to staff role, which might be implemented relatively easily, could produce qualitative changes in theories and practice of staff.

The thesis has noted that:-

a) a strong and clearly understood home philosophy helped staff individually orient their practice;

b) positive and specific theories about residents rather than general typifications helped individualise and humanise care;

c) the report book and staff discussion was a means of communication between staff and management and a means of disseminating and encouraging both a) and b);

d) talk was part of caring and could be organised to promote more communication and conversation with residents which in turn helped staff to see residents as individuals and discourage idle "staff only" chat about residents;
e) relatives and outsiders provided an alternative or fresh view of the daily routine that could usefully challenge routine practices.

In view of these findings the thesis will end by offering suggestions that might go some way to helping participants in residential care to rethink their individual homes' practice and offers tentative guide lines for different approaches. A future research project might monitor such changes to role.

Revise Job Description

In line with the assertion that staff see their work as people work and have a clear idea of what their work is and is not, it would be helpful to adapt the job description to include different activities that are seen now as non-work and could be seen as work. Particularly appropriate would be more social contact with the residents which would discourage the view that residents are 'objects'. Hence staff would, as part of their work routine, be expected to have conversations with residents. They would be accountable to senior staff for this activity in a similar way to bedmaking. This would of course founder immediately without an associated change in philosophy about work and talking to residents which would have to be promoted by senior staff. One can
imagine the horrendous scenes of stilted conversations being ticked off by staff as 'done'. However it is necessary to start somewhere and change in views/theories and change in practice are inextricably interlinked and associated.

Re-organise Workload

In order for staff to be able to accommodate new work in their already overstretched days, some space would have to be made. It is suggested that following the models discussed in Chapter Seven and Eight a re-organisation of the participants in the types of tasks might make more time for staff. If maintenance work was given more to residents and non-staff there would be room for staff to include different tasks on their daily round. It might also be possible to use more part-time staff in repair work and quality of life tasks. *

Advocacy Role - Extended Keyworker

One of these tasks could usefully be an advocacy role. Clough, (1981b) suggests that a main task for the staff is to encourage the individual to decide how she wants to live, (See Chapter 12/13). Staff should maintain a low profile and be seen as a background resource.

* Miller & Gwynne discuss the advantages of part-time and voluntary staff who are less institution-bound (1974:217)
Clough supports the idea of key person or sponsor and urges a re-examination of needs and routines.

The advocacy role could be made part of the job description so introducing an element of accountability. This has been introduced in the guise of the key worker schemes and may well be successful in some areas. In the homes under study and in other studies the suggestion is that key worker comes to mean those who bathe a particular resident, thus diverting the social intention of the task to a purely physical task.

In order to avoid the advocacy role falling into this trap a clear description of what it is to act as advocate must be given to staff (probably through training) and this must be supported by some system for monitoring progress. The study suggests that the report book and talk in sessions can be used as a medium for staff to transmit their ideas and practice to gain feedback from seniors.

Strauss (1964) was concerned with the quality of nursing care and suggested effective methods for discovering actual biography rather than 'general comparative knowledge'. He suggested that gathering psychological information about patients should be part of a nurse's formal responsibilities. He recommended
that the informal interview should be seen as part of a nurse's skills. This biographical detail would encourage more informed discussion about patients and work associated with them. Similar practice in residential homes for the elderly would discourage myths and inaccurate information from growing up concerning residents. This in turn would encourage a more adult relationship with residents. The study showed that Fell View staff who collected little biographical detail, were inclined to treat residents as sub-adult, whereas Deer Park staff who did collect biographical details were less inclined to do so.

**Clear Philosophy**

Staff must be supported and encouraged in their daily work and the importance of senior staff in establishing and transmitting a positive and clear philosophy to staff is paramount. Senior staff roles must include a system for dissemination of information to staff and opportunities for staff to feed back, through discussion groups of some sort. This helps to de-isolate staff and remove them from the traditional front line position.

Uncontrolled talk and staff opportunities to discuss work without a proper structure would be reduced by organisational manoeuvres which limit staff
time in non-resident areas as well as by offering the opportunity to discuss more professionally.

In this way staff could become more aware and less isolated, better informed and more part of a team. However, it should be reiterated that public opinion and social policy contribute to both poor practice and acceptable practice depending on the awareness of actual staff work.

For changes in the daily practice of staff to be fully effective however, they must be accompanied by a change in the social policy for residential care for the elderly. In the main this must include a re-appraisal and the clear assertion of the goals of residential care and a means of achieving them. This must take place both at national and individual home level. There is an urgent need for a collective and self conscious examination of what residential care for the elderly is for. This can only come about by consultation with those who participate most fully in residential care - the staff and the clients. From a basis of actual practice, possible and desirable goals can be drawn with a built-in recognition that as needs change, intermediate and individual goals and purposes change. Both individual homes and homes for the elderly generally need a clearer purpose.
A lack of a clear philosophy is partly accounted for by a view that residential care will not be around for long. To continue to argue that residential care should be gradually abandoned and entirely replaced by sheltered housing and more community and domiciliary support is not productive in a climate that militates against state support for community care policies. Once it is accepted that residential care will not wither away the path is clear for attempts to improve an inevitable, if not welcome, resource. Residential care for the elderly has been dogged by general disapproval. To encourage and support it is perhaps viewed as tacit approval of it. This unfortunate approach to residential care for the elderly has inhibited change and development. *

The findings of this thesis suggest that practical changes to staff role can start the process of regeneration and goal examination while also positively affecting the lives of those who now live in residential homes and will continue to do so in the future. This should be linked to a wider view of what residential care should be - what we aspire to.

What is the overall purpose of residential care of the elderly to be? If residential care is a specialized housing provision (as Clough 1981b for one suggests) those who manage the house are more or

* Janet Finch (1984) has recently argued that residential care has the potential for providing the basis for a less-sexist form of care, compared with the recent Community care policies.
less 'servants'. They are part of the housing services like the electricity, and they are used as needed and on the command of the resident. If residential care is a therapeutic social work oriented arrangement that provides a nurturing environment for residents to maximise their potential, a social work approach would be appropriate. If, as many workers in residential care believe, it is a para-medical service that deals with decrepit elderly people and more and more requires nursing skills, a medical approach with associated skills is appropriate.

It is commonly assumed that the meaning of residential care is understood and understood by all participants in a similar way. It is suggested here that many of the skills required for all the options noted in the above paragraph are used by staff during the course of a morning in daily practice. Before it is known what staff actually do, training programmes might seem at best 'interesting' and at worst irrelevant. Whilst asking what residential care is for we must ask what resources in terms of training, staff levels, building design and so on are necessary to achieve those objectives. Actual practice is affected by resources. Lack of time, inefficient work surroundings, inappropriate training and short staffing hinder enlightened staff practice and leave caring people to the point at which alternative practice or
ways of accomplishing care seem impossible and inappropriate.

It is suggested here that it is not only lack of resources of time, staff and facilities and failing residents that dispirit the staff in residential care but the lack of purpose. Vague and unclear goals manifest themselves in vague, demoralised and purposeless daily caring that is at the mercy of routinization and mixes objectives of housing, punishment, treatment and therapy into an unholy alliance that brings out the worst in all forms of care. Furthermore, residential care is, as a result of its unclear purpose, likely to be taken over by social work without proper debate as to the appropriateness of this merger. There must be discussion as to the relationship between social work and residential care for the elderly before the infiltration of social work language into residential care language makes a separation of the two difficult. We have seen in this study that despite a rejection of social work roles by staff, goals are couched in social work language and 'therapeutic' aims are thrust upon the residents.

The thesis has examined the role of staff in two very different old people's homes and found that very different roles existed contrary to expectations. Drawing on the less institution orientated role certain
suggestions have been made. These comments might act as a stimulus for discussion in homes and as a basis for action research that could develop a programme for staff development.

These suggestions are offered in the knowledge that morale is low, resources overstretched, staffing poor and residential goals unclear. They are offered also as an attempt to help draw attention and even assist the beleaguered staff who do their best in very difficult circumstances. They are particularly offered to the staff of Fell View and Deer Park for whom I have a great deal of respect, admiration and affection.
### APPENDIX A(i)

#### SURVEY INTERVIEW

27.01.81

<table>
<thead>
<tr>
<th>NAME OF HOME:</th>
<th>SUPERINTENDENT:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CLASSIFICATION</th>
<th>ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TELE. NO.</th>
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<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

When did the Home open?  
How many beds are there?  
How many of those are Single Rooms  
Double Rooms  
More  

Are you at full capacity now?  
How many have you in residence at the moment?  
(if applicable how many in hospital?)  
Male ....  Female ....  

Is this a fairly typical week?  
How old is your oldest resident?  
And your youngest?  


Are any of your residents related?
- mother/daughter
- husband/wife
- cousins
- others

How many of the residents are single?

Are the rest all widowed?

Do any of your residents go to Day Centres?

If yes - is it for medical or social reasons?

Do you provide day care yourselves for any elderly people?

Do you have any residents who used to come here for day care who are now full time?

Are you able to provide any holiday relief?

Did any of your residents go on holiday last year?
(either to relatives or other local authority accommodation)

Have you many residents who are incontinent?
- Bowel
- Urine
- Night
- Day
- Double

How many residents are wheelchair bound?

How many residents walk unaided?
How many are using chairs at the moment? ........................................

How many are bedfast? ..........................................................

Is that fairly average? .........................................................

Have you many residents who you would describe as -

Confused .................................................................
Dementia .................................................................
Other .................................................................

What form does their confusion tend to take -

Wandering .................................................................
Obsessional .................................................................
Aggressive .................................................................
Memory Loss .................................................................

In the last year can you tell me how many residents have left through -

Death in home .................................................................
Death in hospital .................................................................
Transfer .................................................................
To community (home etc.) .................................................................
Hospital .................................................................

How many residents have you had in the last year? .................................................................

Community .................................................................
Transfer .................................................................
Hospital .................................................................

Do you have a formal way of communicating with the residents (for instance a residents' committee) or do you tend to use less formal channels? .................................................................

Do you find the reviews of the residents enable them to voice any worries they have? .................................................................

Who attends? .................................................................
When was the last review? ........................................

Do you find that you get "self appointed" spokesmen from the residents anyway? ........................................

Are they men or women? ........................................

How many staff are employed here? ........................................

<table>
<thead>
<tr>
<th>Part time</th>
<th>Temporary</th>
<th>Senior</th>
<th>Schools/Projects</th>
<th>Job experience</th>
<th>Domestics</th>
<th>Cooks</th>
<th>Gardener</th>
<th>Volunteers</th>
</tr>
</thead>
</table>

Do you have staff who have undergone or are at the moment doing any training? (if yes)

<table>
<thead>
<tr>
<th>COURSE</th>
<th>CARE ATTENDANT</th>
<th>SENIOR</th>
<th>SUPERINTENDANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>RMN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ISS</td>
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<td>CQSW</td>
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<td>SRN</td>
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<tr>
<td>CSS</td>
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<tr>
<td>COOKS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FIRST AID</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you ever been able to organise any in-service training at the home for the staff? ........................................

How? ........................................
Are there any members of staff who had already got experience of working with the elderly before joining your home?

Own relatives
Other L/A home
Different job description e.g. home help/domestic
Hospital

Do you find that staff turnover is quite high?

How many have left in the last year?

How many new staff have you employed in the last year?

Do you get regular visits from:-

Chiropodist
Ministers
Salvation Army
Social Workers
Hairdressers
Line Managers
District Nurse
Doctors
Researchers
Entertainers
Volunteers

Do you or the visitors arrange these visits?

Do any of the residents manage to get out and about by themselves?

Do you have any group outings?

What are the meal times/shift times?
APPENDIX A(ii)

SUMMARY OF A REPORT OF FINDINGS OF SURVEY CONDUCTED IN *
IN FEBRUARY 1981 INTO ASPECTS OF RESIDENTIAL CARE
FOR THE ELDERLY

The main purpose of the survey described below was to
give myself the opportunity to become familiar with the
Local Authority provision of residential care for the
elderly, and particularly to place Fell View into some kind
of context. The survey was conducted in the form of a semi
structured interview that covered four main areas which were
developed out of my work at Fell View. The areas were:-

a) the structural and physical features of the home
b) the characteristics of the residents
 c) the movement or activity within the homes
d) the staff.

In the findings I have grouped the discussion around thesis
areas. A further source of data came from ex or post
interview discussion with the interviewees who tended to
express common areas of concern independently. These I
have described in the section on themes.

Methodological Comment

One of the major problems in any survey is to agree
on definition of meaning. Hence in one or two areas,
those dealing with incontinence, and confusion
particularly, the definition was not necessarily
medically accurate. In some cases responses were
estimates or not known and therefore have been ignored
in the sample - this is indicated as appropriate in
Table 1, where column S and N denotes Sample number of
homes and population size respectively. Where they are
left blank S = 22 and N = 751. All percentages that
relate to the total population refer to this figure 751
unless otherwise stated. Since the sample is small, I
have rounded averages to the nearest whole number. 0.5
rounded up. I interviewed the superintendents where
possible, but in some cases, due to shift work or
course commitments of the superintendents I saw either
one or deputies. I found the interviewees extremely
helpful, all sharing a genuine concern about their
roles and the role of the home in the care of the
elderly.

* Name of Study Town
FINDINGS

Characteristics of the Homes:

All the homes were post-war with ten that were converted from private houses or private nursing homes, the earliest being 1946. There are only two that have any connection with the old workhouse in terms of original intake. Twelve out of the 22 homes were purpose built, which is over half. Two homes have opened since January 1980. Two homes operated a group living system, one from its opening and one has converted recently. Six homes are single sex, four of them for women and two for men; the two all male homes however could be put into a rather different category since one caters for men who have spent some time 'on the road' and the other is for men who have been discharged from St. Nicholas' psychiatric hospital and tends to act more as a sheltered hostel. Of the total sample of 22 homes there are 789 beds available at the date of the survey (16th February to 9th March) 751 were occupied - the remaining 38 beds either represent very recent discharge or those in hospital. The overall percentage of women was 71% and there was a high age span averaging 31 years between oldest and youngest resident. This can be explained in part by a number of 'young' elderly being either physically or mentally handicapped - thus needing earlier care. Fourteen of the 22 homes provide some day care and 64% of the homes provided holiday beds, or short term care in the last year. The number of single bedrooms available is 394 which represents 50% of the total number of beds. However, this was disproportionately distributed amongst the homes with 6 providing less than 10% single bedrooms and 6 providing above 80% single bedrooms. Four out of the 22 homes have a residents' committee.

Characteristics of the Elderly

The average oldest age of the residents was 95 years and the average youngest was 64. This indicated a gap of more than one generation between residents. 17% of the residents are single and single sex homes (numbering 6) contain the highest proportion of single residents ranging from 20% to 57%. 2% of the residents have spouses still living elsewhere with whom they were living prior to entry into the home. There are ten homes with related residents including husband and wife, sisters and mother and daughter.
Mobility was measured by the ability to walk unaided by staff. Of the 751 residents, 279 were described as needing some kind of help and they represent 37% of the total population. 6% were permanently chairbound, although one home accounted for nearly half the figures (of 48 chairbound, 20 were in the one home). 4% were temporarily chairbound at the time of the survey. One factor affecting individual home figures is the presence or absence of a lift of course.

Confusion was estimated to be apparent in 23% of the total residents. This was measured by the number of residents who displayed one or more of the following behavioural traits; memory loss, aggression, (physical and verbal) obsession, disorientation, wandering, to the extent that it required staff attention. On some occasions the above behaviour was exhibited but was not seen as a staff problem and was therefore discounted. It should be emphasised that these and the figures on incontinence are rough estimates but give a general picture of perceived levels of both states. A tendency to initially over-estimate levels was balanced out after discussion.

Night incontinence was measured by the average of wet beds in the morning and shows 16% of the total population suffer from this. Day incontinence is measured at 12%. The percentages are somewhat affected by the use in some homes of toilet training programmes which then reduces the day figures to zero.

Movement and Activity within the Home

Turnover, as measured by the number of admissions (from January 1980-81) with the number of residents the last year and of this figure (150) 70% died in the homes rather than hospital. This represents 18.5% deaths in the homes over last year. Twenty residents out of 18 homes (where N = 570) returned to the community, which is 3.5%.

5% of the residents attend day centres for either social or medical purposes. There is a shifting population of about 4% between the homes. 8% of the residents went on holiday last year.
Characteristics of Staff

The outstanding characteristic of the staff was that of the 186 care staff and 78 night staff, 87% and 97% respectively were women. Of the Deputy staff 71% were women and of the superintendents 43% were men. Staff turnover was around 11%, 68% of a population of 633 leaving last year. There did, however, tend to be quite high staff mobility within the homes, although there were no figures for this. Previous hospital experience was shown in about 9% of the total staff; this covered, however, anything from orderly to ward clerk. 6% of the staff had medical training (although 7 homes had no medically qualified staff) and 7% some kind of social training (6 homes had no person with social qualifications). In a large number of cases the medically qualified personnel are also the ones with social qualifications. Only one person was doing CSS who was not a deputy.

The seniors all commented on staff shortages although most of the homes had their full complement of staff or the appropriate numbers of temporaries and reliefs to make this up. Stress was seen as a significant problem and high sickness rates. Turnover was sometimes directly attributed to stress. The low status given to those who work with the elderly was commented on and used as a partial explanation for any lack of commitment on the part of the staff. There was discussion over whether or not staff should be trained nurses and whether or not any kind of training was useful, many unqualified respondents feeling experience was more important. There was naturally a difference in perception of those with training and those without it. The difficulties of staff and seniors attending courses and keeping the homes running smoothly were commented on by most respondents.

The suitability of young men and women (but particularly men) caring for the personal needs of the elderly was questioned. In relation to this, one or two interviewees pointed to the inexperience of the Job Creation youngsters.

The CSS trained seniors tended to view staff as professionals and talked in terms of residential social workers, and social work approaches. The unqualified seniors saw a large gap between themselves and the care staff. The comment below was not untypical:--
'They are only care attendants because they can't work in a shop' (Deputy - at Heads of Homes Meeting).

Administration - Organisation

There were other more general points mentioned more than once. Mixed sex homes tended to be favoured. There was uncertainty over the mixing of rational and confused residents particularly on behalf of the rational residents. There was a notable ambivalence over the provision of day care and short term care again in terms of the interests of the permanent residents. Lack of resources prevented much of the recognised need for change, structural and organisational, from going forward. The review system was generally approved and a six monthly review was suggested by several interviewees. Admission application reports were seen as unrealistic on the whole, and they were often out of date. Social worker contact appeared to be at a minimum and there was, on the whole, disenchantment with and lack of knowledge of the social workers role. This view, it should be noted, was not held by all the superintendents.

The Elderly - Management

One or two interviewees suggested that the elderly in care displayed particular characteristics and personality traits which other elderly groups not in care, did not. The elderly were generally thought to be getting frailer and the work load therefore was increasing.

Group living was seen to create its own problems of management and staff tended to find 'standing back' most stressful. Relatives were reported to find group living philosophy apparently in direct contradiction to traditional care philosophy.
APPENDIX B

STAFF QUESTIONNAIRE

Please fill in as much of this questionnaire as you can. Some of the questions will not apply to all of you for various reasons, in which case just put NA. Some of the questions need your opinions rather than just facts; I've left a fair size space for this, but if you find there isn't enough room continue on the back of the sheet. Thank you for your help.

1. What is the name of your job: _______________________

2. What sort of work does this involve:____________________

3. How long have you worked at your present job: ____________

4. Have you ever worked in residential homes for the elderly before: ______________________

5. If so, approximately how many years have you worked in old people's homes: ______________________

6. Have you ever done any voluntary work with the elderly: ______________________

7. If you have, what did the work involve: ______________________

8. What other jobs have you had: ______________________

9. Do any of your relatives work in residential care, or have they in the past: ______________________

10. What relation are they to you: ______________________

11. Were you born in * if so whereabouts: (just give area e.g.)

12. If not, where were you born: ______________________ (just give County of City)

13. Have you lived in * all your life: ______________________

14. If not how long have you lived here: ______________________

15. Which area do you live in now: ______________________

16. Were your parents from *   Mother ______________________

* Name of Study Town
17. What did/does your father do: ________________
18. Did/does your mother have a job: ________________
19. What is it: ________________
20. How many brothers and sisters have you: ________
21. How old are you: ________________
22. Are you married: ________________
23. Have you ever been married: ________________
24. How many children do you have: ________________
25. How many of them still live with you: ________
26. Have you any grandchildren: ________________
27. Do any of them live with you: ________________
28. Have you any elderly relatives living with you: __
29. Who: _______________________________________
30. Have you any other elderly relatives who live near you and who you see quite regularly: ________
31. Do you see them: Once a day ________________
   Once a week ________________
   Once a month ________________
   Other ________________
32. Are any of your relatives in residential care: __
33. Which area did you go to school in: ________
34. How old were you when you left school: ________
35. Have you got any school certificates: ________
   (please indicate: e.g. CSE, O level etc.)
   ________________
36. Have you got any other qualifications, certificates or diplomas: ________________
37. Have you ever attended any courses on aspects of ageing: _____________________________
38. What aspects were covered: _____________________________
39. Are there any aspects you would like to learn more about: _____________________________

* Name of Study Town
40. Which bit of your work do you find the most difficult to cope with:

________________________________________

41. Which aspect do you most enjoy:

________________________________________

42. Do you see your job as a career that you want to develop:

________________________________________

43. Do you consider your job:
   Secondary to your family commitments: _________
   Equally important to you: ____________________
   More important: ____________________________

44. Does your spouse see your job as:
   just a job that you do: ______________________
   respects your work/encourages you: ___________
   doesn't really have a view: ___________________
   doesn't know much about it: __________________

45. Do you consider your job to be as important as your spouses:

________________________________________

46. What does your spouse do: _________________
**APPENDIX C  INTERVIEW SCHEDULE JULY 1982**

<table>
<thead>
<tr>
<th>NO.</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>CAN YOU TELL ME HOW LONG YOU HAVE WORKED IN RESIDENTIAL CARE?</td>
</tr>
<tr>
<td>2.</td>
<td>AND HOW LONG HAVE YOU WORKED AT DEER PARK?</td>
</tr>
<tr>
<td>3.</td>
<td>CAN YOU TELL ME YOUR OFFICIAL JOB DESCRIPTION?</td>
</tr>
<tr>
<td>4.</td>
<td>WHICH WING DO YOU CURRENTLY WORK ON?</td>
</tr>
<tr>
<td>5.</td>
<td>HAVE YOU ALWAYS WORKED ON THAT WING?</td>
</tr>
<tr>
<td>6.</td>
<td>WHAT ABOUT WHEN YOU ARE SHORT STAFFED?</td>
</tr>
<tr>
<td>7.</td>
<td>WHAT DO YOU SEE AS THE MAIN PURPOSE OF YOUR JOB?</td>
</tr>
<tr>
<td>8.</td>
<td>WHAT ASPECT DO YOU THINK IS THE MOST IMPORTANT BIT OF YOUR JOB? (Never mind whether you like it or not).</td>
</tr>
<tr>
<td>NO.</td>
<td>QUESTION</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>NO. 9</td>
<td><strong>WHAT IS THE FAVOURITE BIT OF YOUR JOB?</strong></td>
</tr>
</tbody>
</table>
| NO. 10 | **WHAT IS THE LEAST FAVOURITE BIT FOR YOU?**  
(why?)                                   |
| NO. 11 | **DO YOU PREFER BACKSHIFT/DAY SHIFT/NIGHTS**  
(why)                                      |
| NO. 12 | **DO YOU FEEL QUITE HAPPY IN YOUR JOB?**                                 |
| NO. 13 | **IS THERE ANYTHING ABOUT IT THAT YOU DON'T LIKE?**                      |
| NO. 14 | **WHY DID YOU APPLY TO WORK AT DEER PARK?**                              |
| NO. 15 | **HAVE YOU HAD OTHER JOBS YOU'VE PREFERRED?**  
(what were they, why)                  |
| NO. 16 | **IF YOU WERE OFFERED ANOTHER JOB AWAY FROM RESIDENTIAL CARE WITH THE SAME CONDITIONS WOULD YOU TAKE IT?** |
NOW I WANT TO TALK ABOUT THE POLICY OF RESIDENTIAL CARE GENERALLY AND DEER PARK IN PARTICULAR

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A1</strong></td>
<td>CAN YOU TELL ME WHAT YOU THINK THE MAIN PRINCIPLES BEHIND DEER PARK ARE?</td>
</tr>
<tr>
<td><strong>A2</strong></td>
<td>HOW DOES THAT DIFFER TO OTHER HOMES?</td>
</tr>
<tr>
<td><strong>A3</strong></td>
<td>ARE THERE ANY RULES THAT THE RESIDENTS HAVE TO ABIDE BY?</td>
</tr>
<tr>
<td><strong>A4</strong></td>
<td>WHAT ABOUT FOR THE STAFF? (apart from time keeping and usual work requirements like that)</td>
</tr>
<tr>
<td><strong>A5</strong></td>
<td>DO YOU THINK THAT DEER PARK IS DIFFERENT TO OTHER HOMES? (In what respect - explain)</td>
</tr>
<tr>
<td><strong>A6</strong></td>
<td>WHAT SORT OF PERSON DO YOU THINK WOULD BE SUITED TO LIVING IN A RESIDENTIAL HOME?</td>
</tr>
<tr>
<td><strong>A7</strong></td>
<td>WHAT SORT OF PERSON DO YOU THINK WOULD HAVE DIFFICULTIES LIVING IN RESIDENTIAL CARE?</td>
</tr>
<tr>
<td><strong>A8</strong></td>
<td>WHAT SORT OF PERSON DO YOU THINK IS SUITED TO WORKING IN A RESIDENTIAL HOME?</td>
</tr>
<tr>
<td>A9</td>
<td>WHO, TO YOUR MIND, REALLY SUITS RESIDENTIAL CARE AT DEER PARK (out of the residents)</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>A10</td>
<td>IS THERE ANY PRESENT RESIDENTS YOU SEE AS BEING QUITE UNSUITABLE FOR DEER PARK? (why)</td>
</tr>
<tr>
<td>A11</td>
<td>DO YOU THINK THEY WOULD BE SUITABLE FOR ANY TYPE OF RESIDENTIAL CARE (what/why)</td>
</tr>
<tr>
<td>A12</td>
<td>DO YOU THINK THE RESIDENTS LIKE LIVING AT DEER PARK?</td>
</tr>
</tbody>
</table>

NOW I'M INTERESTED IN CHANGES YOU HAVE SEEN, AND WOULD PERHAPS LIKE TO SEE

<table>
<thead>
<tr>
<th>B1</th>
<th>HAS YOUR JOB CHANGED SINCE YOU'VE BEEN HERE? (how)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B2</td>
<td>IS THERE SOMETHING THAT STANDS OUT IN YOUR MIND THAT YOU FEEL NEEDS CHANGING?</td>
</tr>
<tr>
<td>B3</td>
<td>HAVE YOU NOTICED CHANGES IN INDIVIDUAL RESIDENTS' ABILITIES (who, how, probe for positives and negatives)</td>
</tr>
</tbody>
</table>
B4 | HOW HAS THIS AFFECTED THE RESIDENT GROUP?  
   | example

B5 | HOW DO THE NEW RESIDENTS GET ON IN THE GROUPS?

B6 | CAN YOU GIVE EXAMPLES OF GOOD AND BAD ACCEPTANCE?

B7 | WHAT HAS BEEN THE MOST PLEASING THING SO FAR ABOUT WORKING IN DEER PARK FOR YOU?

B8 | WHAT HAVE BEEN THE DISAPPOINTMENTS? (if none, probe...)

B9 | HAVE THERE BEEN ANY MAJOR DIFFICULTIES FOR YOU PERSONALLY IN TRYING TO APPLY DEER PARK PRINCIPLES (can you elaborate)

B10 | DO YOU THINK THAT ANYTHING COULD BE CHANGED TO MAKE THINGS EASIER AT DEER PARK?

B11 | IF YOU HAD A FREE HAND WHAT WOULD YOU DO IN YOUR WING TO IMPROVE THINGS?

B12 | HAVE YOU WORKED ON OTHER WINGS? (which ones)
B13 | IF YOU COULD CHANGE TO ANOTHER WING, WHICH WOULD IT BE? (why)

B14 | HAVE YOU EVER WORKED ON WING ONE/ DO YOU ENJOY IT? (if already working there ask.. DO YOU ENJOY WORKING ON WING ONE?)

B15 | (if never worked on wing one) WOULD YOU LIKE TO WORK ON WING ONE?

NEXT SECTION: COMMUNICATIONS AND INFORMATION

C1 | PRESUMABLY YOU GET PROBLEMS ON THE WING FROM TIME TO TIME? CAN YOU GIVE ME AN EXAMPLE?

C2 | WHERE DO YOU GO IF YOU NEED HELP OR ADVICE ABOUT THIS SORT OF THING (refer to example C1)

C3 | IS THIS GENERALLY HELPFUL/USEFUL SOURCE OF INFORMATION AND ADVICE?

C4 | DO YOU FEEL YOU CAN CHALLENGE INSTRUCTIONS IF YOU FEEL THEY ARE NOT RIGHT FOR THE WING? (give examples)

C5 | DO YOU HAVE DIFFICULTY GETTING INFORMATION PASSED ON AND ACTION TAKEN ON IT? (example of experience)
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C6</strong></td>
<td><strong>WHAT DO YOU FIND IS THE BEST WAY OF GETTING THINGS DONE?</strong></td>
</tr>
<tr>
<td><strong>C7</strong></td>
<td><strong>HOW DO YOU MAINLY FIND OUT ABOUT WHAT'S BEEN HAPPENING ON THE WING?</strong></td>
</tr>
<tr>
<td><strong>C8</strong></td>
<td><strong>DO YOU FIND THE SHIFT CHANGEOVER REPORTS USEFUL?</strong></td>
</tr>
</tbody>
</table>
| **C9** | **DO YOU FIND THE WING BOOKS USEFUL?**  
(probe.. change? read every day?) |
| **COMMITMENT/CAREER ETC.** |   |
| **D1** | **WHAT SORT OF TRAINING HAVE YOU HAD ABOUT RESIDENTIAL CARE?** |
| **D2** | **DO YOU THINK THERE IS A NEED FOR TRAINING IN THIS KIND OF WORK?** |
| **D3** | **WHAT SORT OF THINGS DO YOU NEED TO BE TRAINED ABOUT?** |
| **D4** | **HAVE YOU EVER CONSIDERED APPLYING FOR TRAINING?**  
(why not/what was it etc.) |
D5  HOW ARE NEW STAFF TRAINED WHEN THEY START AT DEER PARK? (if interviewee not started at opening ask about training)

D6  ARE THERE ANY PROBLEMS WITH TRAINING OF NEW STAFF? (examples)

D7  WHAT DO YOU THINK OF THE KEYWORKER SYSTEM?

D8  WHICH RESIDENTS DID YOU CHOOSE TO WORK WITH? (why?)

D9  HAVE YOU EVER ATTENDED A REVIEW? (whose? comments on it)

D10 HAVE YOU EVER HAD INFORMAL MEETINGS WITH SOCIAL WORKERS THAT HAVN'T INVOLVED SENIOR STAFF?

RELATIVES/ VISITORS

I KNOW THE RELATIVES ARE ENCOURAGED TO VISIT..

E1  ARE THERE EVER PROBLEMS WITH RELATIVES? (examples)

E2  HOW DO YOU THINK THESE PROBLEMS COULD BE SOLVED?
-365-

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
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<tbody>
<tr>
<td>E3</td>
<td>CAN YOU GIVE ME AN EXAMPLE OF SUCCESSFUL RELATIVES? (why)</td>
</tr>
<tr>
<td>F1</td>
<td>WHO IS YOUR FAVOURITE RESIDENT? (why)</td>
</tr>
<tr>
<td>F2</td>
<td>WHO IS YOUR LEAST FAVOURITE RESIDENT? (why)</td>
</tr>
<tr>
<td>F3</td>
<td>WHICH RESIDENT WOULD YOU WANT TO BE LIKE?</td>
</tr>
<tr>
<td>F4</td>
<td>WHICH RESIDENT DO YOU THINK YOU'LL BE LIKE?</td>
</tr>
<tr>
<td>F5</td>
<td>DO YOU EXPECT TO LIVE IN A HOME DURING YOUR LIFE?</td>
</tr>
<tr>
<td>F6</td>
<td>WHAT DO YOU THINK YOU WOULD MOST DISLIKE ABOUT RESIDENTIAL CARE?</td>
</tr>
<tr>
<td>F7</td>
<td>WHAT WOULD YOU MOST LIKE?</td>
</tr>
</tbody>
</table>

The end. Thank you very much indeed. Have you got any comments on the questions or your answers?
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