IMAGES OF THE PROTECTED
IN
NURSING HOME REGULATION

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I declare that the work presented in this thesis is all my own.

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Abstract: In a simple model of regulation, three different types of actor, "the regulator", "the regulated" and "the protected" are positioned in relationship to each other by a legal framework. Academic scholarship has mainly focused on the first two types of actor, with little attention paid to "the protected". Yet "the protected" are the *raison d'être* of nursing home regulation and "the resident" is at the centre of many key rules. Without an image of "the resident", such rules are without meaning. The central question for this thesis, then, is how are nursing home residents represented in the regulatory system which aims to protect them?

Within this regulatory regime a number of social networks in which the category of "the resident" has meaning were identified. These included elements of the system that are key to the interpretation of regulatory rules – specifically, the practices of nursing home inspectors and the appeal system for nursing home owners – as well as the discourses of nursing and health policy. The practices of nursing home inspectors were observed, the decisions of the Registered Homes Tribunal analysed, and the construction of "the resident" in the discourses of nursing and health policy was explored. Taken together, these methods provided a broad multiperspectival understanding of influences and constraints on the construction of the term "resident" .

As a group, the residents of nursing homes are elderly people in poor health and at the end of their lives. This thesis concludes that there are great difficulties in understanding extreme old age either as a lived experience or a sociological construct. In nursing home regulation, these difficulties are compounded by a framework of normative and fiscal policies where the state ensures that the term "resident" remains unstable or ill-defined. Against this background, the articulation of any clear moral purpose for nursing home regulation becomes extremely vexed.

CONTENTS

Chapter 1

IMAGES OF "THE PROTECTED" IN NURSING HOME REGULATION

That there is something not right around care homes for the elderly is evident in the language associated with them: it's swampy, terms do not quite fit and categories start to slip. A home is not a home but neither is it a hospital nor a hotel. What do we call the old people who live (and die) there? Are they residents? Patients? Inmates? No word altogether suits. And who looks after them? Nurses? Not really since very few of them are qualified. As Mam herself pointed out ... "They are not nurses, these. Most of them are just lasses."

Alan Bennett *Untold Stories*[1]

INTRODUCTION

One in ten people in England and Wales aged 85 and over live in nursing homes[2]. Of the 180,000 nursing home residents in England in 2000, three quarters were women, four out of five were over 65, and nearly half were over 85 (Department of Health 2000a). The residents of nursing homes are in poor health. The Health Survey for England 2000 classified 91% of residents as having a severe disability. Over 80% needed help with personal health care, for example, feeding, dressing, washing or going to the toilet. They are more likely to be underweight than the non-institutionalised population in the same age group and around half will suffer from anaemia. Other ad hoc surveys suggest that between 60% and 86% suffer from cognitive impairment or Alzheimer's disease (MacDonald 2002; Netten et al 1998). At least half will be incontinent of urine (Durrant and Snape 2003). The

[1] Alan Bennett (2005) *Untold stories* London: Faber and Faber p116.
[2] Based on population estimated and Department of Health Community Care Statistics 2000 (see n3 below).

residents of nursing homes are rendered vulnerable both by their disabilities and the fact that many are at the very end of their lives. As an acknowledgement of these vulnerabilities residents have been afforded additional legal protection in the form of the regulation of nursing homes. This thesis focuses on "the resident" and their relationship to this particular regulatory framework.

One simple way of understanding regulation would be to view it as a set of targeted rules. In nursing home regulation, the rules are targeted at the nursing home industry with the intent to protect vulnerable elderly people against unacceptable levels of care, abuse and exploitation. Within the legal language of this traditional form of "command and control" regulation, elderly residents are referred to as "the protected". The primary legislation, the Registered Homes Act 1984, makes little reference to "the protected" but where it does so, they are referred to as "persons". For example:

> It shall be a condition of the registration....that the number of persons kept at any one time in the homes ... does not exceed such number as may be specified in the certificate of registration.
> Registered Homes Act 1984 c29.

In the secondary legislation and guidance "persons" have become "patients". For example:

> The registered person having regard to the size of the home and the number, age, sex and condition of the patients therein ... provide adequate professional, technical, ancillary and other staff.
> Nursing home regulations 12(1) (Statutory Instrument 1984/1578).

Thus "patients" are the point of reference for regulatory rules key in providing care. Without a robust construct of "the patient" and an evaluation of "adequate", such rules are without meaning. The term "patient" is one possible way of constructing "the protected". A slightly different description can be found in the first paragraph of this chapter. In this paragraph people who live in nursing homes are singled out from the general population by their age and health status

and epidemiological categories are used to describe them as a group. This thesis focuses on how the meaning of regulatory rules in nursing home regulation is drawn out from different representations of "the protected" in the various discourses of law, health and social care policies.

THE LEGAL FRAMEWORK FOR NURSING HOME REGULATION

For most of the twentieth century, nursing home regulation was based on broad rules accompanied by a highly discretionary enforcement system. The regulation of nursing homes began with the Nursing Homes (Registration) Act 1927. The impetus for legislation was both protection of the public and protection of the reputation of a new nursing profession, where registration had begun eight years previously with the Nursing Registration Act 1919. At that time, nursing homes were to provide a space for the new profession to practise without competition from unskilled or unqualified nurses and without the interference of doctors. Since 1927, the basis of regulation has been legally enforceable rules which turn on the vague words "fit", "adequate" and "suitable", used in conjunction with a registration or licensing system. The framework remained unchanged but the legislation was consolidated in the Registered Homes Act 1984, to take into account the organisational and administrative changes occurring in the intervening sixty years. As this Act was in force at the time of the fieldwork, the legislative framework referred to in this thesis is the 1984 Act[3].

The Registered Homes Act 1984 defined two distinct legal categories of homes: "residential homes", registered and regulated under Part 1 of the Act, and "nursing homes" regulated under Part 2. In c21(1) of the Act a nursing home was defined as:

[3] The basic framework changed fundamentally in 2002, when the Care Standards Act 2000 came into force. The changes brought about by the 2000 Act will not be considered in the thesis.

> ... any premises used, or intended to be used, for the reception of, and the provision of nursing for, persons suffering from any sickness, injury or infirmity....

The requirements for a nursing home differed from those for a residential home. In particular, a nursing home must be in the charge of a qualified nurse or medical practitioner at all times. Significantly, there were no requirements for nursing homes to employ doctors or other members of a multidisciplinary health care team. That is to say, it was not intended that nursing homes should provide health care in general but were strictly for the provision of nursing. The Act also made a distinction between general nursing homes and mental nursing homes for the mentally ill, with different requirements for the latter. This thesis focuses on the former - general nursing homes. In 2000, more than four out of five beds were in the general nursing category (Department of Health 2002a) and this type of home is occupied mainly by frail elderly people[4].

Over a period of years, the Act was embellished with regulations and some guidance. Some of the rules were specific - for example:

> The person registered shall provide for the home to be connected to a public telephone service.
> Nursing home regulations 12(2a) Statutory Instrument 1984/1578.

But the key rules relating to the care of persons in homes, in both the regulations and the guidance, remained broadly framed and referred to "the protected" as "patients". For example:

> The person registered shall keep a case record in the home in respect of each patient which shall include ... an adequate daily statement of the patient's health and condition.
>
> Nursing home regulations 7(4) Statutory Instrument 1984/1578.

[4] In 1999-2000, the most recent year for which figures are available, 89% of beds in general nursing homes are occupied by people aged 65 and over, 46% of the beds are occupied by people aged 85 and over. DH Community care statistics 2000 Bulletin 2001/7

The legal intent explored further in Chapter 3 was that "adequate" and "suitable" should be interpreted with reference to the nursing needs of frail elderly people. Thus the measures required to protect residents were legally framed in terms of nursing and nursing work.

With the steady growth in regulation in the latter part of the twentieth century, there was a requirement for nursing homes to comply with a web of other legislation. This web of legal rules included occupational health and safety laws, employment legislation, infection control rules, immigration laws, fire regulations and consumer protection acts. Some of this legislation, for example, the Health and Safety at Work etc Act 1974, provided an important additional tool for nurse inspectors. For instance, nurse inspectors might use the provisions of health and safety legislation to insist that equipment was regularly serviced and safe. The involvement of police and the prosecution of individuals for assault of vulnerable adults also became an important option. But as nursing homes were heavily bound up with nursing, the other regulations with most significance remained those requirements which pertain to the professional registration of nurses.

Until 2002, the enforcement of the Registered Homes Act 1984 was the responsibility of more than one hundred separate Health Authorities in England and Wales. Health Authorities usually employed nurses as inspectors to carry out their regulatory functions, but little was known about these nurses or their activities. Little guidance on how the rules should be interpreted was provided by the Department of Health. The only guidance of significance that was issued for nursing homes – *Registration and Inspection of Nursing Homes: A handbook for Health Authorities* (National Association of Health Authorities in England and Wales 1985) – noted that inspectors should ensure the provision and maintenance of "adequate" standards of care and accommodation "comparable to good standards in NHS establishments".

Prosecutions under the 1984 Act were few: five in the two years 1998-2000 (Department of Health 2000b) for some 5,800 nursing homes[5]. Therefore courts played little role in fixing the meaning of the legal rules. The regulators – Health Authorities – and their field enforcement officers – nursing home inspectors – had considerable administrative powers and considerable discretion in their use. The most significant sanction was refusal to register or removal of registration, which would result in closure of a home, as carrying on the activity without registration was unlawful. Where the legislation made provision for Health Authorities to apply such sanctions or to make rules in relation to numbers of residents or staffing, the owners could appeal against a Health Authority's decision to the Registered Homes Tribunal. This independent Tribunal operated under the auspices of the Council on Tribunals, with a legal chair and membership drawn from health care professionals. It was thus able to adjudicate, and to interpret the rules and the Health Authority's actions in relation to both a health care and a legal discourse. As I shall discuss in Chapter 6, the Tribunal was one of the few systems for potentially providing cohesion for interpretation of particular key rules (Day, Klein and Redmayne 1996). But not all rules were subject to appeal. So, in the absence of clear guidance, Health Authorities or, more specifically, nursing home inspectors – themselves nurses – were left with the task of translating broad rules into practices capable of ensuring care for frail elderly people. Clearly, at the outset in 1984, there was some ambiguity about how "the protected" should be framed, with inconsistency between the primary and secondary legislation. The intention in the latter was that the broad rules referring to care should be interpreted using the NHS as standard, with "the protected" viewed as the patients of professional nurses. But as I will describe in later chapters, over the lifetime of the Registered Homes Act, changes in health policy and the structure

[5] Figures from Laing and Buisson (2001); the figures include dual-registered homes, that is homes registered under Part 1 of the Act as residential homes and under Part 2 as nursing homes.

of the market made this framing of rules untenable. First, I consider how "the protected" can be conceptualised within regulation.

"THE PROTECTED" IN THE REGULATORY FRAMEWORK

Galligan (1986a p129) suggests that legal authority can be understood in two ways: either through a descriptive account of roles and functions of the institutions involved in the exercise of state powers, or normatively as a system of rules. Thus regulation may be described either in terms of regulatory agencies, tribunals and officials who have legal powers within a particular regulatory framework, or as "sustained oversight by reference to rules" (Scott 2003 p xi). How can "the protected" be conceptualised using these two views of nursing home regulation? When regulation is considered in terms of legal institutions, "the protected" may be conceived of as agents or active subjects interacting with those institutions. Where regulation is conceived normatively then "the protected" are a construct within that normative framework.

"The protected" as agents in legal institutions of nursing home regulation

Ayres and Braithwaite's work published in 1992, *Responsive Regulation*, suggested that "the protected" should be involved in all aspects of regulation. Constituted as political actors, public interest groups could balance the power of firms and thus provide a means of avoiding regulatory capture. Thus the protected should be granted procedural rights to be involved at all stages of regulation – rule formation, negotiations about compliance, and enforcement. Braithwaite and colleagues (1993) suggested that in the nursing home context involvement of the users would require residents to be involved in discussions about compliance, have rights of access to all information available to the regulator and have the same standing to sue or prosecute under statutes as the regulator (Kerrison and Pollock

2001). In the US, user involvement in nursing home regulation has taken the form of provision of web-based information about nursing homes and their regulatory deficiencies (Harrington C, et al 2003ab). Although "rights" for legal subjects as service users are increasingly construed by UK and European law as participatory and transformative (Clements and Young 1999), such procedural rights within regulation are nevertheless controversial. Advocates of public involvement such as Graham (1998, 2000) consider that it is now essential for political reasons. The shift from public to private providers in the provision of public services, including care of the elderly, has raised major issues for public lawyers about the accountability of such services. Regulation now comes to be seen as "government in miniature", opening up the issue of the arrangements for public participation (Prosser 1997). But sceptics cite the US experience, where there is evidence that procedural rights for "the protected" encourage legalism (Kagan 1994). That is to say, regulatory officials ignore the "spirit" of the law and enforce the "letter" of the law.

In the UK in general, "the protected" have been increasingly empowered through regulatory designs and other legal mechanisms which provide them with enhanced individual rights. First, wide-ranging legislation framed to provide enhanced individual rights has been enacted, such as the Human Rights Act 1998, the Data Protection Act 1998 and consumer protection laws. Some regulators involved in these areas, such as the Office Fair of Trading (1998, 2005), the Financial Services Authority (2000) and the Food Standards Agency (2001), also have specific policies directed towards consumers, including policies which pay special attention to vulnerable consumers. For example, the Office of Fair Trading has now undertaken two inquiries into consumer rights in the nursing homes industry: one in relation to complaints (Office of Fair Trading 1998) and the other as a result of a "super complaint" into unfair contracts (Office of Fair Trading 2005).

The agency of "the protected" is also promoted by both involvement in negotiations about interpretation of rules and dispute resolution. For example, McHarg(1999) reports that utilities regulators, such as the Office for Electricity Regulation, encouraged the involvement of the protected in dispute resolution processes. Unlike the Registered Homes Tribunal described in Chapter 6, where a dispute raises matters of general concern, "the protected" may be involved so that the dispute can be re-cast as a means of overt policy development rather than resolved as a bipolar issue. Such an approach is compatible with human rights principles which argue for interventions for all parties who have an interest (Justice 1996).

Yet residents are given little voice in nursing homes regulation and they have no procedural rights in the regulatory system whose aim is to protect them (Kerrison and Pollock 2001a). This is in contrast to other regulatory legislation – for example, the Health and Safety at Work etc Act 1984 – where tripartite consultations which involve the protected or employees is built into the framework (Hutter 1997). Even though consultation is part of the framework, Hutter(1997 p172) found that the willingness of inspectors to contact employees varied considerably. Similarly, despite policy initiatives which encouraged enforcement officers to listen to residents, the Social Services Inspectorate (Department of Health 2000c) found little involvement with residents on inspection visits[6]. Moreover, residents had no legal rights to speak in regulatory conversations. In other words, nursing home regulation under the 1984 Act was a very traditional model in which residents were construed as "the protected" with no agency and no formal mechanisms through which their voice could be used as an interpretive force. Indeed, it was not until 1998 that the reports of nursing home inspections became public documents (NHSE 1998). Prior to that date they were confidential reports to the Health Authority, unavailable to the public or the residents. Regulation was,

[6] 17% of time on inspection visits was spent in consulting residents. 20% of residents surveyed said they had seen a copy of the inspection report (DH 2000).

quite literally, a private conversation between Health Authorities, acting on behalf of the state, and the nursing homes – the regulatees. But notions of "the protected", based on agency where the individual is constructed as an economic, political or legal actor whose power can be enhanced through procedural or other legal rights, sit uneasily with characteristics of nursing home residents who are likely to be physically and cognitively impaired.

"The protected" in the normative version of nursing home regulation

When regulation is viewed as a system of norms, then there is debate over the relative importance of different types of norms. Some scholars regard legal rules as central (eg Black 1995), while others place more emphasis on social or organisational norms (Hutter 1997; Gunningham, Kagan and Thornton 2004).

In the version of regulation where legal rules are considered central, the framing of rules (Baldwin 1995; Black 1997) and the relationship between rules, compliance and system design (Black 1995; Black 1999a) are all topics for scholarship. As described in the opening section, rules may be framed broadly and where this occurs they may be referred to "standards". Alternatively, rules may be specific or detailed. Black (1999a p95) suggests detailed rules are seen to provide certainty, predictability, consistency and a benchmark against which to assess the regulator's performance. Regulators associate specific rules with greater control. Such rules are thought useful in circumstances where the behaviour of the regulated needs to be specified in order to get them to act in the required way. When associated with appropriate sanctions, specific rules are thought to aid enforcement as they are easier to prosecute. Kagan (1994) and Hutter (1997) note that specific rules can lead to more stringent enforcement, particularly when accompanied by complaints and public pressure.

Broad rules are favoured by rule makers for a number of reasons. First, to enable the judge to determine the "true" character of the individual (Schneider 1992) – for example, in Tribunal decisions described in Chapter 6, whether the person registered is "fit", where "fit" is ill defined. Second, the circumstances in which a rule must be applied will be so complex that no effective rule can be written. Discretion inherent in broad rules allows the decision- maker to deal with that complexity (Jowell 1993; Galligan 1986; Schneider 1992; Black 1995). Third, the rule maker concludes that better rules would be made if the decision-makers were allowed to develop rules for themselves as they go along (Schneider 1992). Fourth, because members of government bodies responsible for instructing the decision-maker cannot agree on rules and deliberately pass responsibility to the decision-maker (Galligan 1986; Schneider 1992).

In the context of UK nursing home regulation, broad rules clearly have had their advantages. "Suitable" and "adequate" have little intrinsic meaning. Elastic and malleable, they can be freely adapted to the exigencies of different circumstances and more importantly to the complexity of care required for different types of patients. Examples of how "adequate" has been interpreted to fit different circumstances can be found in the decisions of the Registered Homes Tribunal described in Chapter 6. For nursing home regulation, these circumstances include the type of building and the type of patient. As "adequate" has a temporal dimension, the term can accommodate change – specifically, changing expectations and professional practices and a changing policy environment, described in Chapter 3. "Adequate" has a potential to allow standards of care to be driven up over time to meet contemporary expectations. In addition, the changing role of nursing homes within the health care economy can also be accommodated. The flexibility of the term, interpreted in relation to the type of patient, allows for the change in use of nursing homes. This has enabled the regulatory framework to adapt to a sector catering for an increasingly dependent type of patient as the

NHS has withdrawn from the care of the frail elderly. Similarly, the term also allows the economics of the industry and in particular policies in relation to the level of public funding to be taken into account. In other words "adequate" can be interpreted in terms of what can be expected from the level of funding in a publicly funded service.

Yet both types of rules are considered to have their drawbacks. Detailed rules can create loopholes, lead to rigidity and inappropriate or arbitrary treatment. They can result in a system in which the letter of the law trumps its social ends (Black 1999b). Empirical evidence from the Australian nursing home sector suggests that the numerous precise rules of US nursing home regulation (Braithwaite and Braithwaite 1995) appear less reliable than small numbers of broad standards. But broad standards can also be vague and uncertain, lead to inconsistent and unpredictable treatment, and permit inadequate compliance (Black 1999b). Broad rules are unsuitable for some circumstances and to work effectively require specific conditions. Negotiation and mutual education presume a particular type of regulatee, one who is well intentioned and would benefit from education. Where the regulatee does not have good intentions, broad rules provide an opportunity for arguments with enforcement officials. A shared understanding between regulator and regulated about interpretation is required to give the rule some certainty and predictability (Black 1995). To work well, such rules therefore need a closed interpretive system where all regulatory actors – rule maker, regulator and regulatee – share a common understanding of the meaning of the rule (Jowell 1973; Black 1995). Courts can cut across such interpretation; broad rules, therefore, work best when they are associated with administrative rather than legal sanctions. Moreover, in such a closed situation there is no place for the involvement of other interests, in particular those of "the protected". In this situation, both the regulated and "the protected" may develop considerable distrust in the regulator. The framework

for nursing home regulation under the 1984 Act conforms to some of these requirements, in that many broad rules are accompanied by administrative sanctions. But the key question to be explored in this thesis is the extent to which there is a consensus in the interpretive community of nursing home regulation about the meaning of such rules.

As Galligan (1986b) notes, irrespective of whether rules are broad or specific, regulatory officials are never passive appliers of any rules but must give them meaning. Discretion is considered to be inherent in the application of all rules because of "the vagaries of language, the diversity of circumstance, and the indeterminacy of official purposes" (Galligan 1986b p1). But he goes on to argue that:

> ... these characteristics of rules do not exhaust the notion of discretion for they do not accommodate its stronger more central sense as an express grant of power conferred on officials where determination of the standards according to which power is to be exercised is left largely to them.
> Galligan 1986b p1.

Therefore, for Galligan, discretion is seen as one of the central concerns of regulation and of law in general, irrespective of legal rules or their structure. This recasts the problem in terms of legal decision making where legal actors are viewed as being guided and constrained by rules which are not legal, but social and organisational in character (Hawkins 1984; Manning 1992; Hutter 1997; Hutter 1999; Hawkins 2002). Drawing on the empirical research which explores this view (eg Hawkins 1984; Hutter 1998, 1997; Lange 1999), Hawkins argues (2002 pviii) that law is not a formal set of rules "but constantly shifting, negotiated, emergent matter, a system of meaning, constantly evolving and constantly dependent on social context". Thus in this version of regulation legal rules play an ill-defined and variable role in their interactions between regulators and firms to the point that the centrality and authority of formal law may be called into question (Gunningham and Johnstone 1999).

Discretion is viewed as constrained by non-legal factors – time, resources, professional norms and political pressures on the decision makers (Jowell 1973; Hawkins 1994, 2002). Alternatively, rather than a system of constraint, discretion may be viewed as the process of deciding among different courses of action for good reason. Galligan (1986 p113) suggests that the factors influencing discretionary decisions are

- nature of the task including effective and efficient ways for its execution
- political and social environment which provide guidance and direction in the exercise of powers
- moral background which includes community views as well as those of the deciding officials
- economic considerations including those of the agency
- organisational structure

In subsequent chapters, I consider how factors such as economic considerations, the social and political environment and moral background all shape the construction of "the protected" and hence the interpretation of rules in nursing home regulation.

Conceptualising compliance

For analytic purposes legal institutions and norms have been considered separately. But when it comes to considering the application of rules or enforcement then the two interact. In the version of regulation which emphasises the centrality of legal rules, three different types of actors, "the regulators", "the regulated" and "the protected" are positioned in relationship to each other by a legal framework. Legal rules structure this relationship, provide authority and are central to communications between the three parties. Regulators ensure that the regulated comply with the rules, either by persuasion or under threat of sanction. Compliance with rules is seen as the key to the system, fulfilling its purpose where the purpose is

the public interest objective of protecting individuals, populations or the environment (Ogus 1994; Baldwin, Hood and Scott 1998).

In some countries, notably the US, and in some industries, specific rules still predominate. The violation of such specific rules is easy to record and enforcement is construed as compliance with rules. The large datasets thus generated by the regulatory agencies invite a particular type of analysis. For example, there is considerable work on the US nursing home industry which attempts to relate non-compliance with structural factors such as resources or ownership (eg Harrington and Carrillo 1999; Harrington et al 2000, 2004). In the UK, where enforcement action is less common, compliance, perhaps of necessity, has been conceptualised differently. All rules – broad or specific – are seen as discursive resources providing a *source* of influence for interpretations and a *resource* to be used in persuasion or negotiation or as a defence (Hawkins 1992). For Hawkins (1984), enforcement officials will use their discretion to bend or interpret the rules to fit their own broad vision of good regulation. Thus the role of inspectors has been reconceptualised from identifying rule violation to identifying problems and minimising risks (Hutter 2001). Rather than conformity to rules, the aims of regulation are more easily articulated in terms of the achievement of socially desirable goals (Hutter 2001; Hawkins 2002). How do the actions of inspectors persuade regulatees to comply, where compliance is seen in terms of the wider social ends of the regulation? The exploration of this question has led to increasing awareness that inspectors and regulatory agencies are subject to large numbers of contextual influences which determine both their interpretation and willingness to enforce rules[7].

A focus on compliance or enforcement puts the spotlight on the work of inspectors and the regulatory agencies. However, attention has

[7] Hawkins (2002), in his book *Law as Last Resort* has explored these influences in relation to prosecution under the Health Safety at Work Act etc 1974 while Kagan (1994) reviewed a large number of empirical studies for evidence of the influence of organisation and political context on regulatory enforcement.

recently shifted to a second type of regulatory actor - "the regulated" (Hutter 2001; Gunningham, Thornton and Kagan 2005, Thornton, Gunningham and Kagan 2005). How do firms understand and respond to regulation? How might they be persuaded by argument, incentives or public pressure to comply? How can regulatory frameworks be re-engineered to increase their effectiveness? Enforced self-regulation (Ayres and Braithwaite 1992), meta-regulation (Coglianese and Lazer 2002; Scott 2003) and smart regulation (Gunningham and Grabosky 2004) have all been promoted as attempts to redesign regulation in a way which encourages firms to redirect their activities towards regulatory goals. The attitudes and actions of the public also appear high on the horizon when firms are considering their response to regulation (Gunningham, Kagan and Thornton 2004). But the third type of regulatory actor, "the protected" – the focus of this thesis – has been merged with the general political context for regulation receiving far less focused attention.

Although residents do not have an active role as agents within the institutions of nursing home regulation, the protection of residents nevertheless provides one of its major social justifications. It is the social purpose or *raison d'être* of such regulation. This is reflected in the literature on nursing homes and nursing home regulation, which is marked by a strong concern with what is referred to as "the resident". There are concerns about how the life in general in nursing homes can be improved (eg Weiner and Kayser-Jones 1990; Kerrison and Pollock 2001ab; Braithwaite 2001) and with the design of nursing home regulation to meet such ends (Braithwaite 1993). This purpose carries through into the regulatory rules where "patients" are the point of reference for many such rules. With such broad rules it might be expected that inspectors had limitless discretion to persuade, if not mould, the behaviour of nursing homes to meet the needs of patients.

In the early days of the fieldwork in a large nursing home with a high proportion of fee-paying residents, I recorded the following incident:

> We were shown around a newly built wing ... The rooms all had en suite bathrooms .. seldom used said the home manager .... because the showers had lips and the equipment required to get very dependent people in and out would not fit in the en suite bathroom. "We call them 'the relative's bathrooms'... because it's what the relatives want to see," said the manager.
> Field notes June 6th 2001.

The Health Authority inspectors must have approved the plans for those bathrooms and registered such bathrooms as fit for use, although clearly very unsuitable. Had there been a centralised regulatory agency, then all this might have been explained by the agency being out of touch with the field. But as described in Chapter 3, there was little by way of central guidance and inspectors were left to decide their own standards. Why did qualified and skilled nurses acting as inspectors agree standards and employ inspection methods which were so inappropriate to the condition of patients they saw on inspections visits? In these circumstances, it was difficult to understand what the requirements for the home to provide services "suitable" to the "condition" of "patients" meant in practice. As Hawkins (2002 p431) notes, the conventional notion of discretion as the freedom to choose between a range of legally permissible options is often routinely constrained in practice by legal decision makers into a narrow range of options. So, what constrained and ordered the inspectors' discretion?

The rules of nursing home regulation beg questions. Fit for what? Suitable for whom? Adequate for what purpose? Such words point to the need to imagine or invoke the image of the *raison d'être* of such regulation, the overarching moral or policy point of reference, namely "the protected". How is the point of reference for this construct determined? The initial rationale for regulation of nursing homes conceived "the protected" against a background of professional

nursing. In the 1984 Act, the primary legislation was concerned only with the neutral term of "persons", while in the regulations and guidance "the protected" were construed as "patients" and suggested standards were those of the NHS. To what extent do the legally sanctioned meanings of the regulation and guidance remain viable given changes in the health care system? Where else might one look for options for sanctioning to give meaning to the construct?

In the following sections of this chapter, I draw on other constructs of "the protected" in the wider legal and social discourses. In doing so, I move from using the term "protected", which is a specific legal term within regulation, and from the term "patient", which is specifically associated with health care systems, and use the more general term "resident".

WAYS OF CONSTRUCTING THE RESIDENT

The social constructionist approach

This thesis has taken a social constructionist approach to understanding "the resident". For Jorgensen and Phillips (2002 p5), social constructionism starts from the perspective that knowledge of the world should not be treated as objective truth, as the ways we understand and represent the world are historically and culturally contingent. Reality is only accessible to us through categories which are created and maintained by social processes. Within a particular world view, some forms of action become natural, others unthinkable. Thus different social understandings of the world lead to different social actions, and therefore the social construction of knowledge and truth has social consequences (Jorgensen and Phillips 2002 p5). As Wodak and Meyer (2001 p21) note, social actors do not exclusively make use of their individual experience and strategies; they mainly rely on collective frames of perception. Noting that this is not a new

idea but one with a long sociological tradition, Wodak and Meyer refer to these as social representations. These socially shared perceptions form the link between social systems and individual cognitive systems and perform the translation, homogenisation and co-ordination between external requirements and subjective experience. Or to put it another way, in a tradition stretching back to Goffman which has been used frequently in regulatory and organisational research (Hawkins 1984; Manning 1992; Dingwall and Strong 1997), "images" or social representations are seen as providing a set of framing assumptions that guide how rules are interpreted or decisions are made within nursing home regulation. In terms of discourse analysis (Jorgensen and Phillips 2002 p145), "the resident" is a "myth" - an object imagined to make actions in nursing home regulation meaningful. By representing "the resident" in one particular way rather than another, certain types of actions are relevant and others are unthinkable.

But as this thesis will elaborate, the meaning of the term "resident" is not fixed within any particular discourse. In the quote at the start of this chapter, Alan Bennett illustrates this eloquently by noting that the terms referring to people who live in nursing homes are "swampy". 'Are they residents, inmates or patients?', he asks. Different actors will attempt to fill the term with meaning, struggling to make their own understanding the prevailing one. In doing so, different ways of organising the world are promoted with different social consequences.

The various meanings of the term "resident" are drawn from the context in which nursing homes operate, but before moving on to discuss this, one final point. Subjects come to understand themselves and act reflexively through the meanings attached to terms used to describe them. In doing so, they are promoting different ways of organising their world and social change. But the ability of nursing home residents to act reflexively is highly circumscribed by their

mental and physical frailty. That is to say the capacity of residents to be agents of any form of change is very limited.

The context of nursing home regulation contains a number of separate discourses which draw upon each other. Some are legal, others arise from health policy or nursing, but as these discourses draw on more fundamental cultural ideas about the person, this is where I will begin.

The resident as a legal person

Naffine (2003) argues that despite deep divisions in legal thinking about the nature of law's 'person', three different types of legal persons can be identified. 1. The pure, legal artifice - a formal capacity to bear rights and so to participate in legal relations – a state which applies not just to humans but also to animals. 2. The biological and metaphysical human from birth to death. 3. The responsible subject with agency and intent. The second definition includes people who lack cognition or capacity, as is the case with many nursing home residents, while the third has no place for such persons. The third type of legal person reflects the key characteristics of the self in Western culture (eg Rose 1996 p3) as:

> ...coherent, bounded, individualised, intentional, the locus of thought, action and belief, the origin of its own actions, the beneficiary of a unique biography.

This is on the ascendancy in regulatory law in general, but emphasis on this image creates an uneasy relationship between law and health care, as many seeking help, for example very frail elderly people, do not fit this image (Douzinas and McVeigh 1992).

The increased emphasis on rights-based notions of the subject (Sarat and Kearns 1997) has led to the institutionalisation of the third type of person, the responsible subject. For example, Oliver (1997 p154) explains that there are now increased requirements in law to listen to subjects:

> ... the law now imposes, through statute and case law, duties on the stronger party to consult the weaker party and listen to their views, and duties of reasonableness, so that the less powerful party is not arbitrarily deprived of the social status and security derived from the relationship and, at the same time, can retain their dignity, autonomy and respect within the relationship... it is now a matter of responsibility for the state to take the interests of individuals into account when making decisions, where once decisions were a matter of right deriving from sovereignty and authority.

Such notions underpin the current vogue enhancing the *agency* of "the protected" in regulation referred to above. But in legal terms, most residents lack competence, and others must act as proxies, assuming or imputing their will and wishes. A further problem with this image is its individualised nature. Individuals are members of social groups, in particular families. Ethnographies of nursing homes emphasise the role of relatives, in particular daughters or daughters-in-law (Foner 1995; Dupuis and Norris 2001; Krause et al 1999). But the law has difficulty in accommodating groups. Relatives had no formal role in the regulatory framework, although they may have acted as legal proxies. Thus the key characteristics which mark out residents as needing legal protection, make their engagement with law far from straightforward.

Conceptualising people in extreme old age

Hazan (1994) notes that old people are segregated and without a clear economic or social role and yet they are the subject of considerable "at a distance" theorising, investigation and measurement by a whole range of social science disciplines. The discourses of gerontological disciplines combine a vocabulary of moral order with that of material need, constructing a picture of the old people as a "mass of need bound together by the stigma of age" (Hazan 1994 p21). But while old people as a social group can be meaningfully described by reference to other social groups, the same is not true of the individual who is a member of that group. For Estes and Linkin (2000), exploration of the

cultural and social meaning of old age as a lived experience is a neglected area. In extreme age, cultural representations of the person reach the limit of meaningfulness. Woodward (1991 p193-194), quoted by Featherstone and Hepworth (1998), argues that as death is approached the tension between the *social construction* of the body, the self as a representation and the lived experience of the body, the materiality of the body is sharply encountered. The body becomes the "bottom line" and the natural triumphs over both the self and the social.

Yet the conceptualisation of the body as a material entity is a complex and contested area in social theory. Turner (1995) notes that there has been little serious attempt by sociologists to understand, comparatively and historically, the interaction between various forms of human embodiment, the physiological process of aging, and the sociocultural definitions of aging. The conceptualisation of extreme old age is thus very difficult. On the one hand, Williams and Bendelow (1998) argue, there is the tendency in much social theory to prioritise the social over the material. At the same time, in extreme old age, bodily decay compromises the ability to maintain a coherent self which can reflect and report on the experience. Drawing from an ethnographic study of dying in a hospice, Lawton (2000), suggests that certain physical capacities are required to maintain selfhood. These are described as a bounded, physically sealed body and ability to act as agent of one's embodied actions and intentions. A high degree of dependency, incontinence or inability to move, which often occurs at the end of life, radically compromises a person's capacity for maintaining a sense of themselves as a coherent entity. That is to say, an intact, functioning body is the essence of self. Similarly, Leder (1990) argues that the body is largely "absent" until it becomes dysfunctional, when it removes us from activities, alienates us from the social world and forces us into its limited sphere (Leder 1990 p84). It would thus seem that there are great difficulties in understanding extreme old age either as a lived experience or as a sociological

construct. Therefore it is not surprising that, in absence of other coherent ideas, the cultural notion of the self as autonomous and independent dominates in discourses of health/illness/disease, including those relating to nursing. However, the nursing discourse is not unitary and other important strands to theorising about self, such as the role of emotions and the body, now appear with increasing prominence.

Extreme old age in health/illness/disease and health care

One of the functions of the discourses on health/disease/illness might be seen as giving meaning to people who because of bodily or mental incapacity do not fit the contemporary cultural ideal of self. Similarly, one of the primary purposes of health care might be thought of as providing help to individuals whose capacity for thought and action are compromised. Yet the basic image of the self which predominates in health/disease/illness discourses, sits uneasily with health care, as it marginalises or excludes those with differing capacities. Therefore, theorising which attempts to incorporate other attributes of self, in particular the body (Lawton 2000; Williams S and Bendelow G 1998) and emotions (Williams SJ 2000) is an important part of health/illness/disease discourses.

But for much of the twentieth century, being and becoming old have not been the subject of expert medical discourse. Old age was associated with natural processes and with needs which were undifferentiated and uncategorised by medicine (Herkovits 1999). Thus the problems of old age were of little interest to medicine as they were not amenable to therapeutic intervention. In the face of extreme old age medical technology is fairly powerless. As the medicine of old age is unable to ameliorate the effects of natural bodily declines, it tends to have more of a social function, with status of the discipline and modes of operation linked to social or health policies on aging. Grimley Evans (1997), a professor of clinical

geratology[8], notes in his brief history of the discipline that it was slow to develop, with the first chair in geriatric medicine not established in the UK until 1965. In some other countries, such as Japan, Italy and France, the specialism of medicine focusing on old age is still not recognised as a separate discipline. As will be described in Chapter 7, the place of medicine of old age within medicine has more to do with the organisation of the health care system than with a specific knowledge base.

Until the mid-1980s, the nursing home industry was marginal to the provision of care to the frail elderly, as care for this group had been provided by public sector organisations. From 1980 onwards, a strategic decision was taken that the NHS should no longer be the provider of long-term care (Klein 1995ab) and the nursing home sector was to be expanded. In 1970 there were around 20,000 places (Laing and Buisson 2001) in nursing homes. By 2000 there were 180,000, around half of the health care beds in the UK[9]. However, while services were to remain publicly funded, the trend was towards a mixed economy of providers (Kerrison and Pollock 2001a).

In line with the view of old age as "natural decline" with undefined needs, the Registered Homes Act 1984 placed no requirements on the expanded sector for the services of health care professionals other than nurses. The resident's need for these services, including those of doctors, were to be met by the NHS on an exceptional basis. This view of a nursing home fitted well with the politics of nursing at that time, as nursing homes were promoted in the NHS as locations where nurses could develop their own nursing models for care, practise their profession without interference or oversight from doctors or competition from other professions (Pearson 1988). Clearly, as well as

[8] In the same article, Grimley Evans notes that gerontology is the study of old men. Geratology is a gender neutral term.
[9] In 1999 there 179,000 NHS beds available in England in 1999. Data from "Bed Availability and Occupancy in England" Department of Health published annually. In the same year there were 202,000 beds in private or independent hospitals or

being popular with the nursing profession, this form of home had distinct economic advantages as it avoided a medical construction of the "elderly person" with the potential requirements for expensive interventions. This perpetuated the historic situation where nursing homes were closely associated with the nursing profession and other forms of care were excluded from the scope of the regulatory framework. Therefore the strategy was to transfer care from large long-stay hospitals to a mixed economy of providers of undifferentiated nursing care in a residential setting (Kerrison and Pollock 2001a).

The image of undifferentiated needs to be met mainly by nurses has created other problems. First, the exclusion of doctors from the regulatory framework means that their work in nursing homes is ungoverned by it. In the absence of the other therapeutic strategies, the control of residents who have behavioural disturbances associated with dementia (Marshall 2001; Denning 2002) means the use of psychotropic drugs. The use of such drugs is considered to be excessive – a form of "chemical restraint" (McGrath and Jackson 1996; Royal College of Physicians 1997; Furniss 2002) – but the control of this is outside the protective scope of nursing home regulation as it is prescribed by independent general practitioners. Secondly, with the emergence of the disease category "Alzheimer's Disease" in the 1980s, the senility of old age has become a disease category with a specific pathology. So, rather than residents having undifferentiated nursing needs envisaged by the regulatory framework, they have been reconstructed as objects of medical work requiring specific interventions. In the case of Alzheimer's Disease, these interventions draw on a conceptualisation of self which is not based on autonomy and independence but instead on life histories or emotions. These different therapies construct an image of the person from their social networks which is used to interpret actions and

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nursing homes. Data from "Community Care Statistics" Department of Health, published annually

utterances. For example, the therapeutic model may involve recall of life stories and emotional memories[10]. But with less favourable opportunities for continuing professional development in the private sector (UKCC 2002), the opportunities for promoting these methods in nursing homes are scarce.

Extreme old age in the discourse of nursing

Part of the attempt to professionalise nursing was to discard traditional models of care. As I shall describe in Chapter 4 these models were based on objectification of the body, in the sense that everyday work has focused on its maintenance, care, repair and hygiene (May 1992). Task-centred nursing was to be eschewed in favour of "nursing models". Such models tend to derive from theories of "self", and, in the main, focus on autonomy and independence. For example, the philosophy of the widely used Roper-Logan-Tierny model (Tierny 1998 p78) is that the patient/client is seen:

> ...as an active participant in the process, not merely a passive recipient, with the emphasis on building on pre-existing abilities, aptitudes and preferences rather than focusing on deficits, deficiencies and norms.

According to this model, illness or other impairment does not exclude or excuse people from participating. Patients are seen as agents who must co-operate and actively play their role as "health care" workers (Strauss 1985). A further thread is that health is a responsibility and an object of work for each individual including taking informed choices about risks and lifestyle (Rose 1996). Although adaptations are made for people who have limitations, such as children and old people, the basis of the underlying model remains.

This philosophy has been carried through into policy. This latter view of elderly residents, endorsed by health care professions and in many Department of Health policies, such as the National Service

[10] eg Mills (1997) 'Narrative Identity and Dementia: a Study of emotions and narrative in older people with dementia' or Kitwood (1993) 'Towards a theory of

Framework for Older People (Department of Health 2001), potentially exerts considerable normative pressure on interpretation and enforcement. The English National Board, which was responsible for the accreditation of courses for continuing professional development in nursing, commissioned a two-year study to evaluate the role of nurse education in promoting client autonomy and independence. In their findings Davies and colleagues (1997) noted common themes in empirical studies promoting particular nursing models in the care of older people, including encouraging patients/clients to participate in decisions about their care and attempts to modify the environment to promote autonomy and independence.

What these models share is an expectation that nurses will take a holistic view of patients' needs, including exploring the emotional and everyday "lifeworld" of the patient, and will work with them in deciding the pattern of care. Despite the fact that much of the development work was based on the views of older people who did not have significant cognitive impairment (Davies 1997), this image of individuality and independence is much promoted in the rhetoric of the industry. For example, the advertisement for BUPA care homes (undated) states that "every person we care for is encouraged to explore their individual interests and talents ...." " for care as individual as you are". Such an image is used to counter the Goffmanesque (1961) view of nursing homes as total institutions where organisational procedures and imperatives strip residents of their identity. In practice, however, there are many factors which undermine this image of autonomy.

Despite promotion of a culture of independence and autonomy, much work in nursing homes harks back to the older view of nursing as "body" work. Gubrium and Holstein (1999) have argued that if institutions could be said to think, then the language that nursing homes would use is that of the aged body. Fieldwork in nursing homes

suggests that most of the work centres around care of the body. Work largely consists of a relentless round of lifting, toileting, and washing people whose skin is so fragile that it is easily damaged and whose bones are so brittle that they easily break. Fragile skin means not only a tendency to bruising but an increased likelihood of open wounds that are difficult to heal and require constant dressing. Residents may have difficulty swallowing and may need feeding. Communication may be difficult as sight fails and hearing is lost. Minds are often fragile, so residents may be unwilling and unable to assist in the process of self care. Finally, nursing homes are places of terminal care, although they do not view themselves as such and are not viewed so in public policy (Hockley 2002).

The description of people which underpins nursing models, based on the dominant contemporary western ideas of self as autonomous and independent, exerts considerable normative pressure on nursing homes and on the work of inspectors. But if such dominant ideas are seen as core cultural values then they are transgressed by many of the residents of nursing homes. As Herkovits (1999) notes, the failure to meet these cultural mandates damages the sufferer's status as an adult and indeed as a full human. Residents are almost rendered inadmissible as objects for contemporary forms of nursing work.

The economic discourse of nursing home regulation

In all public interest regulation a significant tension exists between ensuring the economic viability of the industry and protecting the public. These two discourses compete to enact ideas of regulation. By qualifying the rules in a way which gives inspectors discretion to balance competing views – for example, the use of the qualifying phrase "as far as reasonably practicable" in Health and Safety regulations, a compromise is reached. Evidence presented in Chapter 3 will suggest that the nursing home industry is a marginal industry. Profitability is low and the workforce is uneducated and poorly

qualified. Therefore in this sector, the tension between the economics of the industry and protecting the public is exacerbated. In practice, the economics of the nursing home industry was a significant constraint or ordering force on inspectors. By 2000, 66% of nursing home places were wholly or in part publicly funded (Laing and Buisson 2001), but profit margins, reported to be around 10% of capital costs (Department of Health 2002b), were constrained by government funding. In 2000, the average cost of a place in a nursing home was around £450 a week. For an elderly person recovering from a hip replacement in an NHS acute hospital bed, the cost *per day* would have been £450 (personal communication). In other words, if the view was accepted that elderly people at the end of their lives needed multidisciplinary health care as opposed to nursing care then the costs would escalate. Such financial constraints speak of the status of elderly people at the end of their lives.

Laing and Buisson (2001) estimated that, in 2000, 90% of general nursing homes were operated by for-profit organisations. There was also a handful of NHS nursing homes, but as there were no requirements for their registration, no information about these was available. Until the late 1990s, the nursing home industry was a cottage industry, with many homes owned and managed by nurses. In 1989, "major" providers with three or more homes accounted for 12% of homes and 32% of the beds. By 1999, this had risen to 19% of homes and 43% of the beds (Laing and Buisson 2001). However, by 2001, the majority of nursing homes providers were private companies, with one in five homes owned by large corporates, but only six out of the 91 major providers were publicly quoted companies. Homes were small, with an average size of 34 beds in 1999 and many were not purpose-built but were converted domestic premises, ill suited to meeting the needs of very dependent people. Yet in decisions analysed in Chapter 6, the Registered Homes Tribunal took the view that the "fitness" of the building did not mean making structural alterations which might challenge the financial viability of

the business[11]. Thus for many physically dependent people, the environment itself was likely to be a major constraint on autonomy and independence. A resident who could not have a bath because the bathroom was too small for the equipment required to hoist her in and out of the bath had her agency curtailed by this significant resource problem. As will be described in Chapter 6, in this decision, as in many others, the Tribunal took the view that it was their role to ensure that Health Authorities did not interpret rules in a way which destabilised the economics of the industry. In doing so, they legally sanctioned the government's cost-constraints on service provision and reinforced an image of the residents as requiring a lesser form of care. Drawing on Fairclough's work (1992), Jorgensen and Phillips (2002) note that representations that reproduce a given discursive practice also tend to reproduce the social order in which it is embedded and the power relationship prevailing there. The effects of this might be clearly seen in the increased formalisation of organisational life.

As nursing homes increase in size, life in them is more likely to be subject to more organisational rules – rules which work against the ideals of autonomy and independence. The current vogue to constrain professional discretion through standards protocols, audit, and requirements to follow institutional policies (Power 1997) leaves less room for negotiations of individual patterns of care. Enhanced individual legal rights also have a paradoxical effect on the agency of residents. Rather than being a matter of professional judgement, homes now have legal duties to protect residents. Such duties may make homes risk-averse, so that it is no longer up to the discretion of individual nurses whether, for example, an elderly resident prone to falls should be allowed to walk around the garden – the resident's relatives must give consent first, to absolve the home of responsibility. Braithwaite (1993) argues that institutional practices can have a profound effect on the everyday experience of life in a

[11] see decisions 60 and 158 http://www.doh.gov.uk/rht/

nursing home. In the US, for example, he argues that the organisational structure of nursing homes has been driven by the regulatory structure. In particular, there is a culture of discipline and surveillance where the federal government disciplines states, states discipline inspectors, inspectors discipline home operators, operators discipline staff and staff discipline residents, to the extent that all residents are subjected to close surveillance (Braithwaite 1993).

Resources in nursing homes in terms of skills were also subject to legally sanctioned constraints. The industry employed older nurses with an average age of 45 years (Morrell et al 1995). Ninety per cent of the homes in one survey did not employ any graduate staff and 92% did not identify any staff who had a specialist nursing qualification in the care of elderly people (Davies et al 1999). Despite the regulations being framed in terms of a requirement for homes to employ staff "adequate" for the "condition of the patients therein", inspectors who placed requirements on nursing homes to employ nursing staff with particular qualifications faced their decisions being overturned on appeal. To keep costs down, most of the work in nursing homes was undertaken by untrained low-paid care assistants. In 1998, the year before the introduction of the minimum wage, Laing and Buisson (1997) in their annual review of the nursing home sector commented that its introduction would be a major cost pressure. Similarly, the EU Working Time Directive with the right to paid leave was expected to have a big impact on the industry (Community Market News 2000). These structural problems, reinforced by the Tribunal decisions described in Chapter 6, conveyed the view that little expertise was required to care for elderly residents. In other words, residents had simple needs which could easily be met by staff with limited skills. The work force in nursing homes was not at the forefront of the nursing profession and practices are therefore likely to be rigid and difficult to change, adding to the perception that this was low status work. The legally sanctioned structure of the workforce, coupled with the stigma of dementia, suggests that it would not be easy for

inspectors to stamp a meaning on the term "resident" that would imply complex skills were required.

EXPLORING REPRESENTATIONS OF THE PROTECTED

The central question for this thesis is how nursing home residents are represented in the regulatory system which aims to protect them. This question is answered through an examination of the work of nursing home inspectors, the decisions of the Registered Homes Tribunal and an analysis of the key discourses associated with nursing home regulation. Full details of the methodology for the fieldwork and documentary analysis are given in Chapter 2. Chapter 3 sets the scene by providing a historic account of government policy towards the sector and its regulation. These policies are also reviewed for what they imply about the nature and status of the resident. In regulation, the practices of field-level officers are seen as central to achieving compliance and thus central to achieving the social aims of regulation. In their attempts to persuade and justify their actions, nursing home inspectors are seen as drawing upon different discourses. These discourses constitute subjects or objects in particular ways, making certain types of action relevant and others unthinkable (Jorgensen and Phillips 2002 p145). One important discourse for nursing homes is nursing. Therefore chapter 4 sets the scene for the fieldwork on nursing home inspection by considering how the resident is constructed within the literature on nursing. Chapter 5 considers the persuasive strategies used by two groups of nursing home inspectors in seeking compliance and how those strategies link to an image of the resident. Legally, the Registered Homes Tribunal acts as a constraint on the inspectors' interpretations of rules. Therefore in Chapter 6, I consider how particular constructions of the resident are used to justify the decisions of the Tribunal. Social policy and the specific discourses of health policy and medicine provide an overarching backdrop to nursing, nursing homes and their

regulation, and Chapter 7 analyses how elderly people at the end of their lives are constructed within these discourses. The conclusion, Chapter 8, suggests nursing homes regulation operates in a perplexing world where many differing ideas, generated in different social communities, compete to provide an interpretation of "the resident". The implications of these multiple and competing views of the resident for regulation are considered.

Chapter 2

LOCATING THE RESIDENT — METHODOLOGICAL ORIENTATIONS AND PRACTICE

INTRODUCTION

The central question for this thesis is: how are nursing home residents represented in the regulatory system which aims to protect them? This question is of some significance because residents are the point of reference and at the centre of many of regulatory rules which are key to their care. For example, premises, staffing levels and care should be "suitable" and "adequate" to the number and "condition" of the residents. Without a conceptualisation of the resident, such rules are empty and without meaning, providing no firm basis for an authoritative argument.

At the outset, a decision needed to be made about where to look for evidence to build the picture of "the resident". In Hacking's terms (1999 ch1), there is a need to identify the social networks in which this category works. For the purpose of this thesis, the regulatory system itself is seen as a network of various distinct social formations or representational worlds. The decision about which formations to incorporate was guided by a preliminary analysis of three areas: the regulatory literature, the characteristics of this particular regulatory system, and health care policy for very old people approaching death, the group to which residents belong. The regulatory system for nursing homes is a typical command and control system. Rules are promulgated by an authoritative agency and a mechanism is in place for monitoring and ensuring compliance with these rules. The regulatory literature suggests that for such a system, the following elements will be influential in the interpretation of rules: adjudication by the courts (Black 1997; Ogus 1994), appeal systems (Baldwin 1985), the policies of regulatory agencies (Hawkins 2002; Kagan 1994) and the

day-to-day practices of field officers (Hutter 2001; Hawkins 1984). As discussed in Chapter 1, there was no central regulatory agency and little central guidance for the interpretation of the vague rules of nursing home regulation. Thus inspectors had considerable discretion in their work. However, the system was designed to have one check on the decisions of inspectors. That was an appeal by nursing home owners to an independent appeal tribunal – the Registered Homes Tribunal. But law is not the only authoritative influence on nursing homes. Homes were uniprofessional institutions, managed and, in many cases, also owned by nurses. Few, if any, other professional staff were employed as there was no requirement to do so. Until 2002 nursing homes were always inspected by professional nurses, and empirical studies of their work highlighted nursing as one of their main frames of reference, for example Woods (2001 para 1.8). Therefore nursing as an institution might reasonably be expected to have a significant influence on the interpretation of rules in nursing homes.

There are also good reasons to explore governmental policy in relation old people as an influence on nursing home regulation. The state is a major player in this sector as two thirds of nursing home places are subject to reimbursement by the state (Laing and Buisson 2000). As described further in Chapter 3, the Secretary of State for Health had overarching powers to define many key characteristics of the nursing home industry, for example, the characteristics of staff, including what constituted a nurse in the nursing home context. Moreover, the Department of Health, as the Registered Homes Tribunal's sponsor department, also controlled the conditions under which the Tribunal operated. The nursing home industry is therefore highly controlled by central government not only through the regulatory framework and mechanisms hidden deep within it but also through mechanisms which were outside the regulatory framework. Therefore the policy intent towards residents or, more generally, towards elderly people at the end of their lives, is one way through which ideas of "the resident" can be explored.

As described in Chapter 1, this thesis has taken a social constructionist approach to understanding "the resident". From this social constructionist perspective, reality is only accessible to us through categories which are created and maintained by social processes (Jorgensen and Phillips 2002 p5). Within a particular worldview, some forms of action become natural, others unthinkable, with different social understanding of the world leading to different social actions. Therefore the social construction of knowledge and truth has social consequences (Jorgensen and Phillips 2002 p5). Thus "the resident" is a construct created and maintained by social processes whose function is to make actions in nursing home regulation meaningful. By representing "the resident" in one particular way rather than another certain types of actions are relevant and others are unthinkable.

Fairclough (2003 p31) argues that complex modern societies involve the networking together of different social practices across different domains or fields and different scales of social life. Texts are crucial to these networks, with different social practices requiring the chaining together or networking of texts in specific ways. For example, governance concerns the appropriation of elements of one textual practice within another, and transforming it in particular ways in the process. Texts networked in this way are thought to be important in structural relationships between different domains. "The resident" is therefore seen as a creation of the practices, discourses and texts from particular constellations of self-referential communities significant to nursing home regulation – some legal and some governmental. Discourses of legislation, of government policy, of appeal Tribunals, of inspectors and of nursing may be drawn upon to give meaning to the term "the resident" in a particular context. Actors from within different social communities may compete to make their own understanding the prevailing one. In this struggle, different ways of organising the world are promoted with different social consequences.

Having identified the relevant communities, the next issue is: what methods to use to explore these different representational worlds? Prior (2004 p317) notes that, in both qualitative and quantitative research, there is a focus on "the knowing subject who reveals to the investigator some conscious aspect of social life or social behaviour". Thus knowledge is produced from a particular standpoint – that of the subject. However, Flick (2002 Ch1) notes that, in qualitative research, knowledge is a co-production between the researcher and their subjects. The researcher's communication with the field and its members is taken as an explicit part of the knowledge production. The emphasis is on understanding the social world of the subjects through the subject's own eyes rather than the researcher's. The researcher's reaction to the subject and the subject's views are also part of the research process. In order to do this, an observer must participate, that is engage in activities alongside the research subjects while at the same time keeping enough distance to maintain a critical external perspective. In the classic ethnographic method, participant observation is coupled with interviews and the analysis of documents or other artifacts to provide a perspective on matters of interest from the viewpoint of the subject.

However, in this thesis, the tenuous nature of access granted, described below, meant that methods have been used which do not foreground the views either of nursing homes inspectors or of residents, with no privileging of the experience of either. As noted in Chapter 1, the characteristics of nursing home residents make it difficult to access their lived experience. Instead, methods have been used which are more relevant to understanding aspects of social life and dimensions of human activity not directly accessible to respondents or contained in the consciousness of the isolated subject. That is, the focus is on the resources available to nursing home inspectors from the system as conceived above, to fill the category "the resident". Because the focus is on authoritative sources in the regulatory system as conceived above, no attempt has been made to

engage with the owners' views or with the discourses which owners use to construct the resident.

The focus for data collection is "the resident" in the work of the inspectors and in other more publicly available discourses influential in nursing home regulation. Specifically the two methods used are

(i) observation of inspectors' routines on inspection visits;

(ii) documentary analysis of

a. decisions of the Registered Homes Tribunal
b. nursing as an institution in relation to nursing homes
c. health policy for very old people at the end of their lives
d. inspection reports and publicity brochures from the nursing homes visited.

In the case of the former, what is being asserted is that particular social representations of the resident are continually reproduced in the routinised practices of inspectors during inspections visits. In order for inspectors to competently undertake these activities, they must pay attention to the social, economic and legal context in which they work. These "contexts" are explored using documentary analysis.

Thus the starting point is that the representations of the resident are shaped by representational worlds far beyond the immediate environment of the nursing homes. This "multiperspectival'" approach is based on the premise that different perspectives provide different forms of knowledge about a phenomenon so that together they produce a broader understanding (Jorgensen and Phillips 2002 p154). More traditionally, this is known as "triangulation" where "triangulation" does not refer to convergent to a fixed point or to some kind of truth but to the use of evidence from different systems to deepen the understanding of or refine of the object of study. As Seale (1999 p60) and Dingwall (1997) have noted, triangulation may also be used as a way of explaining how actions and accounts in one setting are influenced and constrained by those in another.

OBSERVATION OF NURSING HOME INSPECTORS

Routine inspection visits to nursing homes are undertaken by nursing home inspectors to assess the homes' compliance with regulatory rules. Such visits provide an opportunity for observing how the actions of inspectors in managing or negotiating compliance construct or constitute residents in a particular way.

Requesting access

Gaining the agreement of inspection units to observe inspection visits proved a difficult and protracted process. Between September 1999 and the autumn of 2000, I wrote to twenty-five Health Authority inspection units, approximately a quarter of all those in England. The majority were contacted after May 2000 using a letter in which the fieldwork was described to potential participants in the following way:

> The purpose of this study is to establish how, in the absence of formal standards, inspectors seek to influence the quality of care in homes. More specifically, what models of care do inspectors support? What strategies do they use to enforce such models? and To what extent are the proposed new standards and regulatory framework in harmony with those models ?
> Extract from letter to participants, May 2000.

I described what I would expect from them and enclosed a copy of my CV. All twenty-five refused or did not respond. In an attempt to understand their reservations, I telephoned ten of the non-respondents. But my enquiries were met with comments such as "I don't have to explain why" and "... over my dead body", or they were concerned that research coupled with the impending changes would be too much work for their staff.

I then approached the Department of Health Unit charged with preparing for the introduction of the new regulatory framework. In preparation for the reforms, the Unit had commissioned the Social Services Inspectorate to undertake a review of six Health Authority

units (Woods 2001). The Inspectorate had no official jurisdiction over Health Authorities or nursing home inspectors and the civil servant explained that she was not surprised by my problems. The Department of Health itself was also having great difficulty in obtaining access to units run by Health Authorities. It was not clear that all the nursing homes inspectors would be transferring to the new National Care Standards Agency, so any review of work of inspectors at this time was a very sensitive undertaking. The Department of Health unit then introduced me to the social services inspectors undertaking the review. One of the inspectors introduced me to a former nurse inspector who was acting as consultant to their team. She arranged for me to meet two of her friends who were currently in charge of inspection units.

Seven units finally agreed to meet me and four of these eventually refused. I visited one unit three times before receiving a final rejection. In other units, negotiations were also protracted from November 1999 to May 2000. Visiting units also reinforced the view that nursing home regulation was something of a neglected area. Two of the units were housed in very unsavoury premises – prefabricated leaky huts, next to the commercial refuse disposal area. Another unit was housed in a building which seemed to have been the subject of an arson attack. The front was blackened and boarded up and the entrance was at the back, past very large industrial rubbish bins.

At these initial interviews, the proposal to look at how inspectors interpreted rules often met with the response that, as inspectors, they did not have any discretion. Such meetings usually involved the whole team who were keen to tell me that the way they worked was with a pro forma and the standard was either met or not met - they had no discretion. They were also very concerned that the study would upset their relationship with homes. Another potential impediment was that units pointed out that they would have to have the agreement of the home for me to visit. Homes, they argued, were made very anxious by

their visits and would need a great deal of reassurance and explanation as to what I was doing[1]. While managers in charge of the unit often seemed keen on the study, the inspectors were not, and seemed to exercise a veto over it. So, I had difficulties in obtaining access and the access which was granted was fragile. For example, I also requested access to documents, but this was limited to those in the public domain. The period leading up to the implementation of the 2000 Act resulted in a major increase in paperwork for both inspectors and people providing clerical support. This provided a "good reason" to refuse my requests for further documentary information or access.

Units, inspectors and their backgrounds

Access was eventually agreed with three inspections units which, to preserve their anonymity, I shall refer to as County, Suburban and City. The County unit and the City unit were joint with their respective local authority. The Suburban unit was a commercial consultancy contracted by a number of Health Authorities to carry out inspections. The City unit had two inspectors. Both inspectors had been nurse managers in the NHS, one in the community nursing service, the other in a large mental hospital which had been closed. The County unit had three inspectors and a head of unit. The head of unit was absent on long-term sick leave for the entire period of the fieldwork and we never met again after she agreed access. All the inspectors in the County unit had backgrounds as nurse managers in the NHS: one in mental health, the second in the community nursing service and the third in the acute sector. In the Suburban unit, the commercial consultancy had four staff, one of whom I never met. The head of the consultancy had been a chief nursing officer for an NHS community nursing service and also had a background in professional risk management. The other two nurse inspectors I observed in the

[1] The implications of this reluctance to allow an outsider to observe their work, is considered further in the conclusion (Chapter 8).

Suburban team had managerial experience in the private sector as well as in the NHS. One had been deputy manager of a nursing home in the UK and the other also had experience of nursing home management.

It is difficult to know to what extent the sample of nursing home inspectors was typical. A literature search revealed no information about the background or qualifications of nursing home inspectors which could be used as comparison. The difficulties in obtaining access would suggest that the sample was atypical in that they had sufficient confidence in their work to allow observation by an external observer.

Non-participant observation

In contrast to participant observation which requires the engagement of the researchers with subjects, the aim in simple non-participant observation is for the observer to merge into the background so as not to disturb the phenomena under study.

> Simple observers follow the flow of events. Behaviour and interaction continue as they would without the presence of researchers, uninterrupted by intrusion. Alder and Alder quoted by Flick 2002 p135.

In practice, there is a continuum of interaction or involvement, from full participation with considerable disturbance, to observation of a public space or covert observation where subjects may be entirely unaware of the observer's presence. In this thesis, the aim was to undertake simple observation, so as not to disturb the routine of the inspection visit. As Flick notes, the problem with this method is how to observe without being drawn into being a participant and thus influencing the field. I took notes of the flow of events during inspection visits as they occurred, but at the same time maintaining a social relationship with the inspector by occasionally commenting or answering their questions. Some inspectors would try to involve me in the visit by assigning me the role of "lay person" and asking me to say

whether the complaint leaflet, for example, was comprehensible. These interactions provided an opportunity to inquire about the inspector's background and as part of this interaction additional information was volunteered by the inspector. This often included the compliance background of the home, the inspector's relationship with the manager and the latter's strengths and weaknesses. But it was difficult to obtain further information from inspectors outside of visits — access to inspectors was limited.

Announced visits lasted all day, from 9am to the evening, with both of us traveling independently to the visit from home. At the end of a very long day, there was little opportunity for casual conversations with inspectors.

As described below twenty of the twenty- two visits were announced inspections. For all inspection units, the purpose of this type of visit was to check all the relevant documentation, take up any outstanding issues from the last visits and any issues arising from complaints, to walk round the home looking at the condition of residents and to have a very long interview with the manager. Irrespective of the size of the home, these announced visits lasted all day. In larger homes, more than one inspector would be involved with the visit. Only two were "unannounced" - that is to say the home staff appeared to be taken by surprise and clearly were unprepared for the visit. These were shorter, as on both visits there was no one on duty who could answer questions. Nevertheless the inspectors walked round the home, looked at case notes and other matters of interest, and talked to residents and staff.

On all visits I accompanied the inspector round the home and observed interviews with the home manager, staff and residents. "Open" methods of observation were used with a focus on the following questions:

(i) What rules, standards or other concerns formed the focus for the inspector's attention?

(ii) What information was sought out and used as evidence for compliance/non-compliance?

(iii) What issues were taken up and what evidence was used with managers to support claims about compliance or non-compliance?

(iv) What inferences about the inspector's image of residents can be drawn from the visit, the information sought and the evidence used?

As there was little direct access to the inspector's or the home manager's perspective, I was required to "construct meaning for myself which I supposed directed the actors in the way I perceived them" (Merkens quoted by Flick 2002 p138). No tape recorder was used as I felt that this was likely to be too intrusive, potentially jeopardising the fragile access. The field notes consisted of single words, sentences, quotes and records of activities which were expanded into a full account written the next day. Inferences about how inspectors imagined the resident were then drawn from their patterned actions.

Although non-participant observation provides data which is not enriched by an inspector's perspective, Flick (2002 ch12) notes that the spontaneous activities and statements observed and recorded can to be more reliable than responses to an observer's direct question. The further advantage of non-participant observation is that it requires a focus on factors which are not necessarily obvious or of interest to the participants. Remaining an outsider, it is possible to doubt routines whose purpose is self-evident to insiders. But, as an outsider, some activities were undoubtedly hidden from view. For example, the impending reforms had generated anxieties about the impact of the new legislation both on inspectors and home managers. Inspectors were concerned about whether there would be a job for them in the

new agency. Thus the homes were chosen for me by inspectors, as homes where my presence was unlikely to cause any difficulty with managers– for example, my presence might be particularly unwelcome when the visit might involve discussions over a contentious matter. This meant that I had difficulty in establishing what behaviour inspectors would find totally unacceptable or unlawful. The method also suffers from the limitations common to all observations, participant or otherwise, that events or practices which seldom occur can be captured only with luck, if at all. But according to Flick (2002) the main problem with simple observation is that the restriction to an external perspective with no access to the interior perspective of either inspectors or nursing home managers is a major difficulty in assessing interpretations. The important question is how likely the observed activities and statements are to occur independently of the observations. Observations of the visits were supplemented by analysis of each inspection unit's standards for nursing homes in their area and the publicly available inspection reports of nursing home visited.

Homes and inspection visits

Table 1 shows the number of inspection visits carried out with each inspector. Only two inspection visits were carried out with the City unit. The chief inspector left shortly after the fieldwork began and the temporary staff employed were unwilling to be observed. Ten visits were carried out with the County unit and 10 with the Suburban unit. The analysis in Chapter 5 focuses mainly on the work of these two units.

Table 1 HOMES AND INSPECTORS

Home	Inspector	Type of ownership	Number of residents
Suburban Unit			
Hanson Rise	Mary	Small corporate	15
Apple Tree House	Mary	Owner/Manager	15
Robin Walk	Mary	Owner/Manager	9
Trafalgar Court	Mary	Large corporate	67
Lewis Hall	Mary	Large corporate	94
The Pines	Mary	Small corporate	30
Holly View	Violet	Owner/manager	23
The Strand	Violet	Large corporate	72
Beatrice Lodge	Violet	Owner/Manager	14
Prince Regent	Violet	Not for profit	39/31

Table 1 HOMES AND INSPECTORS (Contd)

County Unit			
Victoria House	Derek	Large corporate	30
Cherry Lane	Derek	Small corporate	27
Greenwood Grange	Derek	Large corporate	25
St Alsagers House	Denise	Small corporate	52
Abbots Court	Denise	Owner/Manager	33
West Tuns Hall	Denise	Small corporate	13
Spiney View	Fillipa	Large corporate	71
The Oaks	Fillipa	Large corporate	31
White Sands Lodge	Fillipa	Large corporate	38
Penlee Court	Fillipa	Large corporate	48
City Unit			
Glenburn House	Judy	Not for profit	40
Pear Tree Lodge	Frank	Small corporate	15

The homes visited can be categorised in a number of ways. First, size - eight of the homes had less than twenty beds, ten had between twenty and fifty beds and four had over fifty beds. Three of the small homes have since closed - probably as part of general reshaping of the sector to larger homes which occurred as a consequence of the 2002 reforms (Holden 2002). The types of ownership of the other twenty

homes are shown in Table 2. In line with the definitions used in the Laing and Buisson annual survey of care homes (see for example Laing and Buisson 2000), large corporates have been classified as companies owning three or more nursing homes. Nationally in 2000, 19% of homes were owned by large corporates, therefore the sample of homes visited is disproportionately represented by homes of this type (Laing and Buisson 2001).

Table 2 TYPES OF OWNERSHIP OF "FOR PROFIT" NURSING HOMES (n=20)

	Owner/Manager	Small corporate	Large Corporate
Suburban	4	2	3
County	1	3	6
City	0	1	0
Total	*5*	*6*	*9*

The type of premises is shown in Table 3. Some premises were situated in quiet rural areas, others in suburbia and one in an inner city. About half the premises were modern and purpose built, others were small converted domestic residences or other converted property.

Table 3 TYPES OF PREMISES (n=22)

	Converted private residence	Converted other building	Purpose built
Suburban	3	3	6
County	1	3	4
City	0	0	2
Total	**4**	**6**	**12**

Coding and categorising the data

Guided by the first three questions above, the data from each individual inspection visit was coded using "open" coding, that is coding without the use of predefined categories. Although there were

differences between inspectors in the same units, the analysis focused on similarities in their approach. For example, it was noticed that all inspectors in County Unit spent a considerable time talking to individual residents and then pursuing individual complaints. As Flick (2002 ch15) points out, attitudes deduced from activities in the group are most likely to be shared by the group, because otherwise activities would have been corrected or commented on by other members. Throughout the coding process, the presence or absence of "residents" was noted and where present the rationale or justification for reference to them was coded. The different foci for the inspectors' visits and the evidence referred to in compliance negotiations with home managers were used to build a category to describe the inspection "style" for the unit. The similarities and differences between the two units were compared to further flesh out and clarify the different "styles" of inspection. The characteristics of these nascent categories were compared with publicly available discourses which inspectors might draw upon to organise their practices. The styles of the two units in terms of their content and arguments were most resonant with two separate discourses: "risk management" and "professionalism". Having clarified and built the categories, these were then applied analytically to the data : and the data was re-coded using these new categories until no further material could be found which could be related to them – that is, until the categories were saturated. This approach has been referred as "focused coding" (Nagy Hesse-Biber and Leavy 2004, Introduction to Part IV). Inferences were then drawn about how the resident was constructed through the operationalisation of these inspection styles.

DOCUMENTARY ANALYSIS

Approaches to documentary analysis

There are a number of different perspectives on the analysis of texts. First, texts might simply be analysed for information they contain. But the use of texts in this way when the text is the sole empirical data source is usually cautioned against, as all texts are seen as artfully produced or contrived (Wolff 2004). Second, on the basis that the production of texts is artful, texts are analysed as sources which point to underlying social phenomena associated with their production (Wolff 2004 p285). Analysis from this perspective is usually achieved by conducting research with people or organisations responsible for production of such documents. But even so, work from an ethnomethodological perspective suggests that documents can only be understood by competent actors in the social world in which they were produced. That is to say, documents, such as hospital case notes, may be difficult to interpret when taken "out of context" and read by actors who are not part of that social world which produced them. From a third perspective, official documents in particular are seen as 'institutionalised traces'. Thus such documents can be used to draw conclusions about activities, intentions and ideas of their creators or the organisations they represent (Wolff 2002p284). In a variation of this, Prior (2004) notes how documents have been constructed to enable people to think. That is they are used as tools to enable people organise and systematise their symbolic worlds.

Scholars working from the perspective of Critical Discourse Analysis (eg Fairclough 2003; Wodak and Meyer 2001; Jorgensen and Phillips 2002) suggest that texts work in many different ways, simultaneously. They have "ideational", "interpersonal" and "textual" functions. Fairclough (2003p 27) notes that texts simultaneously

> ...represent aspects of the world (the physical world, the social world, the mental world); enact social relations between participants in social events and the attitudes, desires and values of participants; and coherently and cohesively connect parts of texts together and connect texts with their situational contexts.

Within both sociology and anthropology, it is increasingly being claimed that language is *the* cultural force. As one commentator noted

> ...language is now auditioning for an *a priori* role in the social and material world, a role that carries constitutional force - bringing facts into consciousness and therefore being. ...our representations may well come first, allowing us to selectively see what we have described (Van Maanen 2004 p 435).

As language is now seen as making notions of thought and culture inseparable (van Maanen 2004, Swidler 1995), the analysis of language and text is seen as fundamental to any understanding of the social world.

Approaches to the exploration of language as a cultural force are usually referred to by the umbrella term "discourse analysis" (Gill 2000; Parker 2004). The basic premise of discourse analysis is that when representations "come first", subjectivity is constituted by language. But as there is no clear consensus of what discourses are or how to analyse them (Jorgensen and Phillips 2002 p1), different approaches are used. For example, there are fundamental disagreements about the extent to which individuals are both products of discourse and producers of discourse. In some versions of discourse analysis, individuals are viewed solely as the subjects of discourse (Jorgensen and Phillips 2002 p1) positioned by the discourse in a particular way (Gill 2000). Thus through language, a network of symbolic connotations is evoked - connotations which not only refer to the world but reflect an unchanging and universal order of things

(Parker 2004). In the interactions between groups and individuals, discourses work in the sense of being persuasive because they evoke these wider systems of power and ideology. Meaning can be thus located in public symbols and rituals rather than in ephemeral subjectivities (Gill 2000). A further difference is that some analysts are concerned with everyday social interactions, while others concentrate on public discourses which circulate in wider society (Jorgensen and Phillips 2002).

The focus for this thesis is on how representations of residents are constituted in documents or texts associated with nursing home regulation. "The resident" is viewed here as a "floating signifier" – that is, one whose meaning is not fixed by any particular discourse (Jorgensen and Phillips 2002). Different actors attempt to fill the term "resident" with content, struggling to make their own understanding the prevailing one. In this struggle, different ways of organising the world are promoted. The aim in this thesis is to find out how "the resident" is ascribed meaning discursively and the social and practical consequences this has for the regulation of nursing homes.

Discourse analysis has been criticised for the reliance it places on the subjective views of the researcher. As there is no clear methodological technique, there is lack of transparency about how the researcher's subjectivity has come into play. However, in a sense, all qualitative data is authored by the researcher, as interpretations or analysis of subjects' views and experience must be made in the process of writing up the research. But as in discourse analysis, subjects do not speak directly, nor is data enriched by the subject's perspective. These factors add to the charge that insight is lost and the work is biased (Seale 1999 p60). Other critics argue that discourse analysis is largely concerned with power relationships. As such it is largely employed by researchers engaged in emancipatory projects (Denzin 2004) or those explicitly concerned with the analysis of power relations and mechanisms of domination (Wodak and Meyer 2001).

This is explicit in Critical Discourse Analysis where such analysis is described as taking the part of the underprivileged and trying to show up the linguistic means used by the privileged to stabilise or even to intensify inequities in society (Meyer 2001). As a method for exploring power relations and mechanisms of domination, discourse analysis would seem a relevant technique for the analysis of regulation where one of the main purposes might be construed as social control. A form of discourse analysis is used in this thesis to analyse the decisions of the Registered Homes Tribunal and the nursing and health policy literature.

Analysing decisions of the Registered Homes Tribunal

The Registered Homes Tribunal was set up shortly before the 1984 Act to provide a specialised legal forum for home owners to appeal against the administrative decisions of Health Authorities and their inspectors. As will be described in Chapter 6, the Tribunal has a legal chair and is primarily a legal forum. Residents or their representatives have no direct voice in the Tribunal. The Tribunal heard the first appeal under the 1984 Act in 1986 and the last appeal under the same Act was heard in 2004. Between 1986 and 2004, 86 appeals pertaining to general nursing homes were heard. The decisions of the Tribunal were first printed then published on the web, initially at http://www.doh.gov.uk/rht and from 2002 at http://www.carestandardstribunal.gov.uk/rht. Sixty cases of these were available for analysis. As indicated in Table 4, around half the appeals were about withdrawal of registration, three quarters about registration and around one in four about conditions of registration.

Table 4 APPEALS WITH FULL HEARING (n=60)	
Refusal of registration	14
Withdrawal of registration *(n=32)*	
Emergency (Section 30)	7
Other (Section 28)	25
Condition of registration *(n=14)*	
Buildings/number of residents	9
Staffing	5

In the two decades of the Tribunal's operation, there have been no appeals from a large corporate about the withdrawal of registration. The only appeal from a large corporate was about the conditions of registration. This appeal concerned staffing levels. In the late 1990s, 19% of homes and 43% of beds (Laing and Buisson 2001)were owned by large corporates, so owner/managers and small corporates are disproportionately represented in appeals.

Tribunal decisions form part of the public record for nursing home regulation but the audience to whom they are primarily addressed is nursing home inspectors, nursing home owners and their legal advisors. This thesis is not concerned with the practices of production of these decisions – for example, by observation of Tribunal hearings – instead they are analysed as communicative acts aimed both at regulators and home owners. Their function is to persuade the audience that the Tribunal did the "right thing" (Brooke and Gewirtz 1996 p10) and thus they set out moral as well as a legal framework for nursing home regulation. So the focus of interest is the impact of these decisions, if any, and on the messages they convey. From a discourse analysis perspective, the analysis of such institutional texts provides an insight into the operation of authority in this context (Miller1997 p91) and hence the presence or absence of "the resident" in the construction of that authority.

The analysis of the Tribunal cases was primarily concerned with the following discursive strategies which were applied to the entire corpus of Tribunal decisions relating to nursing homes:

i. strategies of argumentation – that is, the logic of the legal argument and the evidential and authority claims or "warrants" used to support the argument for dismissing or supporting the appeal.

ii. referential strategies or strategy nomination where the linguistic devices of interest were membership categorisations of "the resident" and "the home owner".

The Tribunal cases were initially coded using predefined or "closed" categories. Two initial categories were used: appeals concerned with refusal or cancellation of registration and appeals concerned with the imposition of conditions on the registered person. These categories were chosen because they provide a fundamentally different context for the appeal. In the first type, appeals are about whether the home owner should be allowed to participate in the nursing home market. The second type brings into play economic factors such as staffing levels. Within each category, cases were then coded into those which succeeded and those where the appeal failed. The nature of type of evidence used to support the Tribunal's decision was analysed in each of these four categories, with the data coded to note the presence or absence of "the resident" and "the home owner" in the argument and, where present, their function in the argument.

Nursing and the nursing subject

As noted above, there is good reason to think that nursing as an institution is a key part of the context for nursing homes. In terms of discourse analysis, the discourses of nursing evoke wider systems of power and ideology, laying out one field of action in which individuals, nurse inspectors and nursing home nurses understand themselves and

others, including "the resident". Two publicly available discourses on nursing were used:

- the literature directed internally to members of the occupation
- the sociological or policy literature which provides an external commentary on nursing and nursing activities

The first type includes literature drawn from two databases: the British Nursing Index (BNI) and the Cumulative Index to Nursing and Allied Health Literature (CINAHL). The former is aimed at the UK-based nursing profession and is comprised of "over 250 of the most popular and important journal sources in the nursing and midwifery fields". It is indexed from 1992. CINAHL database, indexed from 1982, is described as a comprehensive source of information for nurses and allied health professionals. It indexes over 1200 publications, and includes books, book chapters, standards of practice, government publications and pamphlets. It also includes nursing magazines such as Nursing Times and Nursing Standard which are more directed towards the non-professional nursing sector. Additionally, the catalogues of the Royal College of Nursing, the Bloomsbury Health Care library – one of the major libraries for nursing publications in London – and the King's Fund Library were used to locate key nursing textbooks. For the second type of literature, bibliographic searches in the sociology of nursing, health policy and administration were undertaken. Information about non-professional nurses or "health care assistants" was also sought from trade unions and research units concerned with the labour force and health policy, such as the Institute of Public Policy Research.

The analysis of the nursing literature used the following search terms: elderly, old people, dementia, nursing homes, nursing home owners, care homes, care home managers, nurse managers, geriatric nursing, gerontological nursing, long term care, health care assistants. These searches identified the key authors – Davies, Nolan, McCormack and

Nazarko – and further searches were conducted using their names. The subjects and roles within nursing were identified. Clearly, with such a body of literature one cannot analyse the entire corpus. Instead, Jager (2001 p51) notes that the arguments and content about what can be said or heard on a particular theme in a particular societal location at a particular time are limited. Therefore the analysis of typical examples or exemplars of common positions or arguments is justified (Wodak 2001). So, the following discursive strategies in relation to these groups in typical texts were explored:

(i) What typifies the categories of professional nurses, non-professional nurses and "the nursing home resident"?

(ii) What arguments are used to justify inclusion or exclusion of professional and non-nurses to particular categories?

(iii) How ideally should (a) elderly people and (b) nursing home residents be treated by both professional and non-professional?

The resident and health policy

As a starting point for this analysis, residents were categorised *a priori* as "very old people at the end of their lives". The information presented in Chapter 1 suggests that this is a fair assumption. An analysis of how this "subject" was constructed in the following discourses was then undertaken:

- the medical literature – in particular, the literature of old age
- health and social policy literature
- the sociological, anthropological and social history of old age.

That is to say that at the outset "residents" were located within the discourse of health and social policy. The medical literature was

accessed through the Medline bibliographic database using the following search terms: geriatric, elderly, old age, geriatric medicine, gerontology, care homes, long term care, nursing homes and dementia. Additional resources included University College Medical School Library which was used to locate texts including textbooks by key geriatricians. Again rather than analysing the whole corpus, examples or exemplars of common positions or arguments were sought (Jager 2001; Wodak 2001). The analysis focused on the following discursive strategies:

(i) Within the medical discourse, what typifies the category of "very old"? Are they classified as sick, dying or just old? That is, referential or nomination strategies where the linguistic devices of interest were membership categorisations.

(ii) strategies of argumentation used to justify inclusion or exclusion of people to these categories

(iii) delineation of different voices or discursive logics in the text, concerned with "health/disease", "dying" and "old age", particularly those originating from other texts. This strategy is based on the discourse analytical premise of intertextuality – that is, the premise that all utterances inevitably draw on, in corporate or challenge earlier utterances (Jorgensen and Phillips 2002 p151).

LIMITATIONS

Selection of social formations to study

Two potentially important discourses are absent from this thesis. For the reasons given in Chapter 1, the lived experience of nursing home residents is very difficult to access. Therefore the thesis does not explore the views of the residents themselves. Neither does it explore the industry's view of the resident. As described in Chapter 3, when

the field work was planned, the nursing homes sector had entered a period of change from a cottage industry to corporate ownership and there was no easy access to a data source for the industry's view, as the sector lacked a cohesive voice (Holden 2002). With the consolidation in ownership and the reforms, organisations representing owners, such as the Registered Nursing Homes Association, came to the fore and there was, therefore, a potential for a view of "the resident", separated and distinct from nursing to emerge. During the fieldwork, I was approached by a group of home owners who wanted to talk to me. However, the inspection unit became very alarmed at this and said they would withdraw their co-operation if I met the home owners. It appeared that they were in dispute with these owners and were afraid that I would be co-opted on the side of the owners. A decision was therefore taken not to pursue this for fear of jeopardising access, which had been difficult to achieve and maintain. The views and policies of the sector and, in particular, large providers would be important to any future study of nursing homes.

Limitations in the study of individual communities

The exploration of each of the chosen social communities of nursing home regulation also has some limitations. The impending regulatory reforms had major effects. When the study was being planned, nursing home regulation was at a point of major change. In the latter two decades of the 20th century, the nursing home sector had expanded fourfold and become central to health care policy. Yet, as will be described in more detail in Chapter 3, the regulation of nursing homes was a neglected area, with the regulatory framework largely unchanged for eighty years and with little known about the activities of registration or inspection. However, in 1997 a new Labour Government announced a reform of care home regulation with the establishment of a new central agency - the National Care Standards Agency - which was to be operational from 2002. Therefore, in 2000 and 2001 when access was negotiated and the fieldwork undertaken,

change was in the air with all that brings in terms of anxiety about the unknown and expectation for improvements. More importantly, there was the feeling that a dark – and, perhaps, for some – a murky corner, was about to be exposed to a searching bright light.

The thesis suffers from the limitation common to many forms of data collection in that it is difficult to know the typicality of the sample or of any particular situation or context. Hence it is difficult to draw robust general conclusions. In particular, because of the methods used and the lack of speaking subject, the interpretation is more open to question than when methods which involve greater participation are used. In this thesis no attempt has been made to privilege the category of experience either of the nursing home inspectors or of the residents. The reasons for the former were pragmatic, for the latter the extent to which the experience of nursing home residents can be assessed or filled with meaning is debatable. However, this means that my own voice as author is privileged over others, but, as van Maneen(2004) argues, this is the case with all such work, even that heavily based on the experience of subjects.

The Care Standards Act 2000 marked a major reform of nursing home regulation, as that Act abolished the term "nursing home" as a legal category. As a consequence, no comparative information is available about the nursing home sector after 2002. Therefore the study is bounded by a particular historic moment for health and social policy, concerned with a particular type of resident, a particular type of ownership, and regulation of a particular design. Nevertheless, by employing different methods a 'snapshot' of a particular regulatory system has been obtained. Not only can this snapshot be used as a comparator for other regulatory situations but the thesis also offers some tentative reflections on the use of different methodologies to explore large systems.

RESEARCH ETHICS

Over the period of researching and writing this thesis, research ethics in social sciences has come into increasing prominence, with the British Sociological Association issuing a statement in 2002 and the Economic and Social Research Council issuing a report in 2005 (ESRC 2005). The increasing attention being given to research ethics could be attributed to three factors: rise of emancipatory politics, discourses of the contemporary self as unique rational, autonomous subject, particularly the discourse associated with legal rights and spill-over from increased external regulation of medical research. The aim of all research ethics is to set out a normative framework for conduct of the relationship between the research subject or research subjects and the researchers.

The British Sociological Association's Statement of Ethical Practice is based on the following principles: professional integrity including requirements to comply with legislation such as the Data Protection Act, respect for the rights of research participants and awareness of their responsibilities towards them, and careful management of conflicts of roles, obligations and interests. The document notes that the aim is not to be prescriptive but to set out basic principles which could be further developed by the discipline and enforced by self-regulation. The ERSC framework is far more prescriptive and in many ways mirrors the Department of Health Research Governance Strategy (Kerrison, McNally and Pollock 2003). The six key principles are: focus on quality of design, full information should be supplied to research subjects except in exceptional circumstances, confidentiality of research subjects must be respected, participation must be voluntary, harm to participants must be avoided, the independence of the research must be clear and any conflicts of interest explicit. To implement these principles there is an expectation of ethical review by the institution seeking or holding the reward. That is to say each

institution must put into place appropriate policies to ensure that research complies with these regulations.

But within social sciences the ideal characteristics for such a normative framework are highly contested, partly because particular frameworks are seen as jeopardising the research enterprise itself. Putting such principles into practice can be tricky. In the US and, increasingly, in Europe, informed consent is asserted as a universal right for all research, social as well as medical. As Thorne (2004 p159) points out, developing a relationship with those one wants to study has always raised ethical questions about what to tell them, how the identity of the researcher should be portrayed and issues of confidentiality and publication. But when consent is highly formalised, it can raise many further difficult issues. At what point in the process of negotiating access does one ask for consent? Often qualitative researchers do not know the precise focus of their research or the analytical framework in advance, so how can they inform the subjects about this? Highly formalised processes which ask subjects to sign consent forms can have the effect of making the research seem more "risky" than is warranted. Others have advocated consent as a process not a one -off event which therefore should be renewed periodically throughout the research, so that subjects are reminded that the researcher is not a friend or confidant. But as trust is necessary to obtain good data this can seem like an attempt by the researcher to sabotage the research. A further problem is that the need to obtain informed consent can give elites the opportunity to refuse outside scrutiny of their activities. For example, the difficulties in gaining access for this study led me to question whether it was appropriate for inspection units to so strongly resist my attempts as an outsider - just a student - to look at their work of protecting a very vulnerable group, nursing home residents.

More generally, consent in this study might be considered as far from straightforward, for the initial focus or subject was the resident, but

the resident through the eyes of the inspectors and others, so no consent was sought from residents. Had I done so, then I would have come up against one of the more fundamental problems with the doctrine of consent. The types of people who are most vulnerable and most in need of protection cannot give consent, for they do not fit the ideal of rational and autonomous subjects. For these reasons, a normative framework for protecting research subjects which rests on consent alone, is unlikely to be effective. The consent of the inspectors in this study was implied in the sense that in allowing me to observe their activities, inspectors had consented.

A further criticism of the emphasis on consent is that it is "context" free (Root Wolpe 1998). Little emphasis is placed on balancing the rights of groups or collectivities. In both social science and medicine this is counteracted by the advocacy of the involvement of the participants in shaping the research and its outputs, particularly where the participants are from a "disempowered" social group such as ethnic minorities or women. But again, in practice, these principles have proved controversial. What happens when there is a fundamental difference of view between the researcher and the participants ?

Viewing participants as active subjects with full information and voice can divert attention away from a requirement for researchers to elaborate and operationalise a sophisticated code of moral conduct towards vulnerable people. In the "the age of Innocence", as van Maanen (2004) terms it, there was an assumption that subjects or facts spoke for themselves. Now this has ended and there are concerns with ethical values embedded in the "authoring" of texts. For example, Denzin (2004) notes that 'Women of Color' are concerned with the creation of texts where ethical values of caring, personal accountability and of solidarity are apparent and where texts have emotional content that the other can enter into. Although this might be of value for some groups, this has little meaning for the most vulnerable nursing home residents who are precluded from using such

texts as an emancipatory resource. Some vulnerable people cannot be treated as just another disadvantaged group.

Finally, if research ethics is about the generation of a normative framework for the relationship between research subjects and researchers then who decides what the rules should be? The preference of professional groups is for rules agreed internally within their profession or for the matter to be left to their own professional conscience (Hopf 2004), both a form of self-regulation. But the increasing advocacy of formal review by "research ethics" committees, as recommended by ESRC, can call this into question, particularly where such review is external. For one unit in this study, access was conditional on a review by, and approval of, the local NHS District Research Ethics Committee. An application to the committee was made and at the meeting many questions were asked as to why I did not want to interview residents. Weren't their views important? My explanation that many of the residents in nursing homes were likely to be cognitively impaired and therefore this would required special techniques to obtain their views was accepted. Approval was granted unconditionally.

But where it is left to the individual or profession then there are further concerns about their capacity to withstand the factors which might bias research or distort findings, or potentially or actually affect the rights and welfare of research subjects. Usually referred to under the umbrella term of conflict of interest, included within this are individual or institutional conflicts of duties, role, responsibilities and financial interest. Such factors are perceived to be increasing because, as funds become tighter, researchers have multiple competing roles and institutions are required to commercialise their activities. The most obvious example of such a conflict is one which can develop into clear pressure from funders not to publish, or to publish distorted findings. For institutions, "conflicts of interest" are a "reputation risk" and institutions have developed policies to manage

such risks. While these are usually concerned with individual conflicts, occasionally the policy may include the stance of the whole institution (Walt et al 2002). I have no competing financial or other interests in this thesis.

Chapter 3

POLICIES FOR NURSING HOMES REGULATION: PLANNED NEGLECT ?

INTRODUCTION

This chapter sets the scene by reviewing the policies - legal, social and economic – which have had a major influence on the dynamics of nursing home regulation in latter decades of the twentieth century. I explore these factors with a dual purpose in mind, first as an introduction to understanding regulation in this sector and, in particular, as a context for the interpretation of regulatory rules. The second aim is to review the public policy context for what this implies about the status and nature of nursing home residents.

The choice of factors which may influence enforcement has been adapted from Kagan's (1994) review of this subject. Kagan identifies four major explanatory factors in enforcement style: regulatory legal design, the agency's social and economic environment, its political environment and its internal leadership. But as there was no central agency in nursing home regulation under the 1984 Act, this chapter concentrates on legal design and the political, economic and social environment. In relation to the former, Kagan (1994) identifies three important characteristics of legal design relevant to enforcement style: (1) the way the authorising legislation defines the regulatory mission; (2) the powers granted to regulators and the rights granted to regulatees and the advocates of strict regulation; (3) the specificity of standards to be employed. These are considered in some detail in this chapter.

The nursing home sector primarily provides institutional care for old people at the very end of their lives who are deemed to be incapable of living independently because of physical or mental frailty. The first

point of focus for this chapter is therefore the nature of institutions which provide such care. Institutions dedicated to the care of such people have always existed. But from the inception of the post-war welfare state to the mid eighties, the major part of institutional care was provided by state institutions, either NHS long-stay hospitals or local authority residential care. From the 1980s onwards, the NHS and local authorities withdrew from the care of this group. At the same time, the privately owned nursing home sector and the sector providing social care – the residential home sector – began to expand to such an extent that private sector homes, governed by regulation, became central to the care of the most frail group of very old people. Therefore, the first major factor to be considered is how health and social care policies have shaped the care provided, the market for nursing home places and the economics of the sector. But, while government policies since the 1980s have led to major expansion in nursing homes and a concentration of ownership, as noted in chapter 1, the regulatory framework has remained unchanged for the major part of a century. Nevertheless, despite the stability of the regulatory arrangements, changes in government policies have clearly influenced the standards employed, their interpretation and the institutional organisation of enforcement.

The evidence on which the analysis of nursing home policy is based is dispersed within a fragmented and disparate literature. There is a long consistent thread of published academic policy research on the residential care homes sector. Such homes have until recently been run by local authority social service departments and thus have come within the ambit of the longstanding Department of Health-funded research unit, the Personal Social Services Research Unit. This unit has helped to develop and provide cohesion for research on residential care homes. In contrast, the academic literature on the UK nursing home sector is disparate and sparse. Because the very dependent elderly have sometimes been cared for in the NHS and, more recently, in nursing homes, the literature is fragmented between different

disciplines – geriatric medicine and nursing – with a very sparse health policy literature in the UK. While there is much of relevance in the residential care sector literature, it does not deal with health care matters. Issues central to nursing homes, such as the role of health care professions, the regulation of nursing homes by the health care sector, and the health needs of the client group, are largely absent from the residential care home literature.

Turning to availability of routine data, there is little centrally collected official data on the care home sector in general. Apart from the decennial census, the only source of official data for the nursing home sector is the Department of Health publication, *Community Care Statistical Series - Private Nursing Homes, Hospitals and Clinics*, published annually. This publication focuses on the capacity of the sector by geographical area and contains little other information. As regards other official sources, a Royal Commission on Long Term Care reported in 1999 (Department of Health 1999a) but as its focus and terms of reference were the demand for and funding of long-term care for elderly people, the information contained is not central to the matters considered below. However, since 1987, the private company Laing and Buisson have surveyed the sector annually to provide market intelligence. Their survey provides an important source of information. More recently, the baton of collecting information seems to have passed to the Office of Fair Trading. To fulfil its requirements to protect vulnerable consumers, the Office of Fair Trading has recently completed a very thorough market survey of the care home sector (OFT 2005). Although this report is packed with data on the sector as a whole, it does not distinguish between care homes with nursing provision and other homes. As a result information about provision for the most vulnerable groups is hidden.

This chapter concludes by considering the information available about the residents of nursing homes and implications of the foregoing policy analysis for the status of this group.

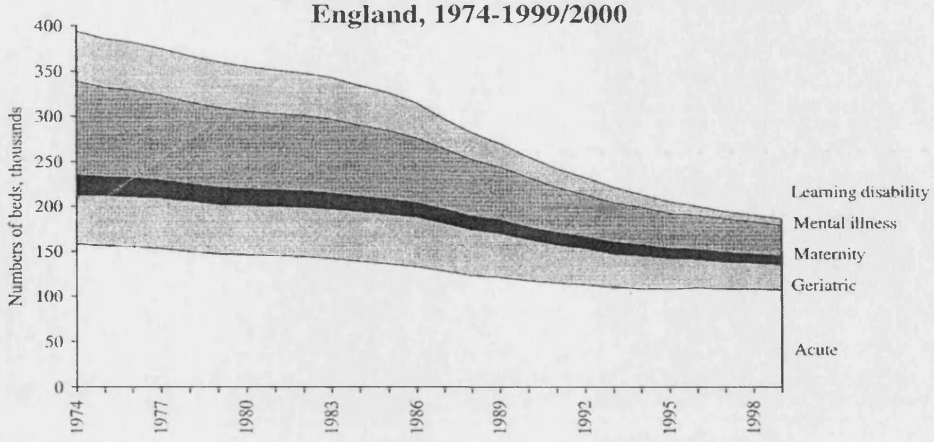
DEVELOPING THE NURSING HOME SECTOR

Before the inception of the NHS, the bulk of care for very dependent old people was provided by local authorities, either in former workhouses or in residential homes. The 1921 census enumerated 2,189 nursing homes with 26,000 residents in England and Wales and a further 133,000 people categorised as "inmates" of public workhouses. The workhouses were subsequently taken over in 1947 by the NHS as long-stay institutions, while the residential homes remained with local authorities as the residential care sector. Thus until the 1980s, nursing homes were marginal to the health care system, with the number of places in the independent nursing home sector estimated to be 20,300 in the 1970s (Laing and Buisson 1999). Such homes catered either for women giving birth or for the well-to-do who had the means to pay for nursing care in their old age (Klein 1995b p 158).

Favourable times for expansion

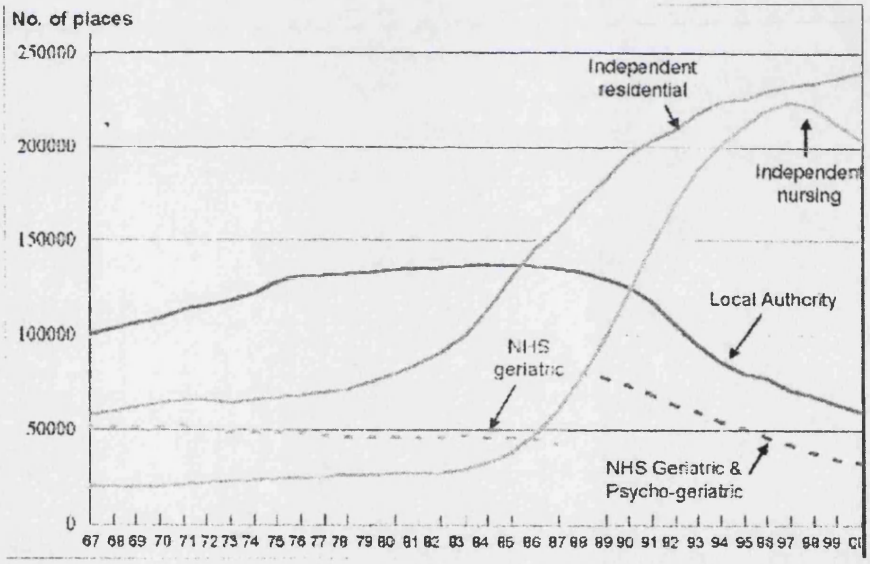
From the mid-1980s onwards, the state began to withdraw from the provision of care for all dependent groups – not just the provision designated for the very old, geriatric and psychogeriatric provision – but also the provision of care for those with learning disabilities and long term mental illness. The decline in state provision and the change from state to private care can be charted through the official Department of Health Annual Statistical series and the Laing and Buisson market survey. As Figure 1 shows, between 1974 and 1999 there was a major decline in the number of NHS long-stay beds designated, while at the same time a major increase in care home places in both nursing homes and residential homes, as illustrated in Figures 2 and 3. The main decline was in NHS beds for the mentally ill and those with learning difficulties. Many old people who were "senile" – suffering from what now would be termed as dementia – would have been classed as mentally ill and would have occupied a bed in that category.

Figure 1 Average number of NHS beds available daily, England, 1974-1999/2000



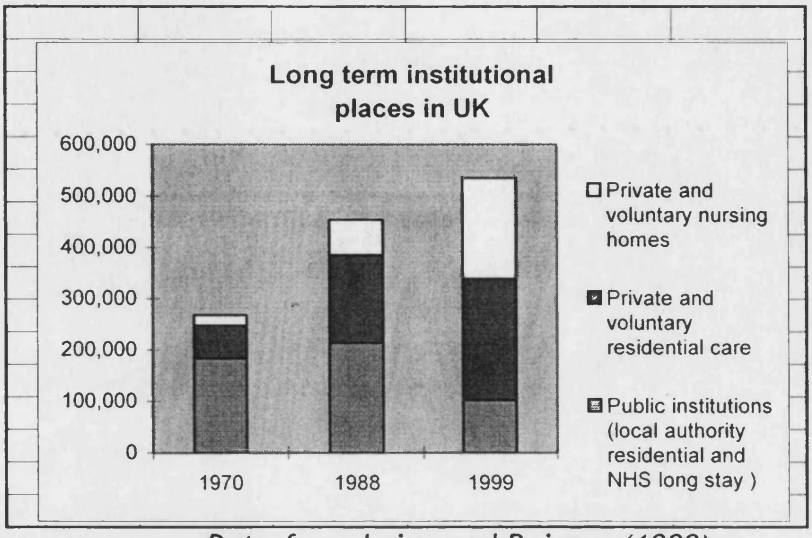
Source: DHSS and DH statistical bulletins 5/85, 1995/20, 1997/20 and 1998/31and KH03 1998/99, 1999/2000. Graph by Alison Macfarlane

Figure 2 Number of long term places by sector 1967-2000



Source :
http://www.laingbuisson.co.uk/longtermcare.htm
accessed 02/08/05

Figure 3



Data from Laing and Buisson (1999)

But there was no commensurate expansion in the numbers of specialist places for these groups in the independent sector. Instead, the main expansion occurred in residential homes or homes providing general nursing care. The private nursing home sector expanded tenfold between the 1970s and 1997, when the sector peaked at around 195,000 places – more than the number of NHS acute hospital beds in the UK (Department of Health 2002b). General nursing homes are mainly occupied by elderly people, with some 82% of the beds in 2000/01 occupied by people aged 65 and over, and 38% occupied by people aged 85 and over (Department of Health 2002a). The average age of nursing home residents aged 65 years and over in 2000 was around 84 years (Bakejal 2002). The other point to note is that there was a change in ownership of the care institutions from state to private ownership as most of the growth was in the private sector. By 2001, around 90% of the beds were in nursing homes operated by for-profit providers (Laing and Buisson 2004).

The development of the sector was fuelled by a number of government policies favourable to its expansion. An uncapped social care budget (Barlett and Phillips 1996; Klein 1995b p158) was considered to be a major factor aiding that expansion. Under a little-

known provision of the 1948 National Assistance Act, social security offices had discretion to make allowances to those living in nursing homes or residential homes. By 1983, the cost of these payments to some 16,000 people had reached £39 million a year. Through this mechanism, which became increasingly visible in the 1980s, financial need rather than health need became the criterion for admission to institutional care with costs and places expanding to meet the demand. By 1992, when these arrangements came to an end, the costs had risen to £2,530 million a year and contributed to the care of some 271,000 people (Klein 1995b p158). This arrangement provided a secure guaranteed income for owners (Andrews and Philips 2000; Holden 2000) and a demand-led expansion of the market was stimulated. A property boom and relaxation of planning controls which allowed conversion of domestic properties were further helpful factors (Andrews and Philips 2000). The irony was that, despite explicit policies to de-institutionalise the long-term care of elderly people, discussed below, the expansion of the sector was fuelled, albeit unintentionally, by government funding policies (Klein 1995b p159).

But in the 1980s and early 1990s this was not the only major policy favourable to the sector. For the Conservative government of the 1980s and early 1990s, small businesses like private care homes were seen as the cornerstone of a thriving economy. To aid such businesses, deregulation was in vogue (Baldwin 2005). However, this did not go unquestioned. Using Braithwaite's (1993) cross-national comparisons of regulation in the nursing home industry, questions were raised about the most appropriate type of regulation design (Day and Klein 1987). Arguments for deregulation persisted through the first part of the 1990s. In 1995, the Department of Health issued a consultation document – *Moving Forward* (Department of Health 1995) – where one of the options for residential sector was deregulation. Concerned by these proposals to deregulate the residential sector, the Joseph Rowntree Foundation commissioned a

review of regulation in the sector. Published with the title *Why Regulate?*, Day and colleagues (1996) concluded that regulation of the sector was essential to protect vulnerable residents. There were problems with regulation, in particular the lack of a central organisation to coordinate experience and develop cohesive standards, but rather than deregulate the problems of obtaining cohesion should be addressed.

In the mid-1990s the National Health Service Management Executive issued guidance (HSG (95) 41) to Health Authorities about the conduct of regulation in the nursing homes sector. The general tone was one of dialogue and negotiation with the industry. Thus Health Authorities were required to operate according to the principles outlined in the DTI's *Working with Business: A Code for enforcement agencies*, where a "reduction in paperwork" and "transparency" were among the requirements. They were also to ensure that the process "was not unnecessarily onerous to ... nursing homes". Clearly, the climate was that regulation should be undertaken with a light touch. In the same year, the National Association of Health Authorities and Trusts produced "Raising the Standards" (NAHAT 1995). This document set management standards for Health Authority regulation and inspection units based on the HSG (95) 41.

As well as economic and regulatory circumstances conducive to expansion of the sector, care policies were also favourable. Goffman's famous work on *Asylums* formed part of academic critique of institutionalisation in the 1950s and 1960s. In the 1970s, this was taken up by the government in Department of Health and Social Security consultative documents such as *Priorities for Health and Personal Social Services in England* (1976) and *The Way Forward* (1977), where the aim was to shift resources to the community. Care in institutions in general, and in large institutions in particular, was seen as depersonalising and promoting dependency, and "care in the community" was promoted as an alternative. The advantages of

independent living in the community in a small homely environment were emphasised, despite the fact that this is an unrealistic aim in this group of highly dependent people whose powers and skills are declining (Sainsbury 1989). Finally, as explored more fully in Chapter 4, nurse-led units were also being promoted and several NHS nursing homes were set up. These favourable policies contributed to the expansion of the nursing home and the residential sector, primarily as a cottage industry in which nurses left the public sector to become owner entrepreneurs (Andrews and Kendall 2000).

An end to expansion

In the early 1990s, this favourable climate for the expansion of nursing homes changed fundamentally as the government began to recognise the extent of the uncapped expenditure. The NHS and Social Care Act 1990, which came into force in 1993, introduced an internal market for residential and nursing home care with the local authority as the lead purchaser for both. With this Act the government put in place arrangements to ensure that the level of fees paid by local authorities were fixed by central government reimbursement policies. The consequence was to produce a cash-limited budget for nursing and residential home care. Throughout the 1990s, the cash-limited fees failed to keep pace with the cost pressures on nursing homes (Andrews and Gavin 2000). Nursing homes residents were becoming more dependent as places in the NHS declined dramatically. Partly as a consequence of increased dependency, general practitioners began to charge retention fees for their services to the sector, as the BMA (1987) considered that providing care to a large nursing home with residents with multiple pathologies and requiring polypharmacy was outside the generally accepted meaning of the GP contract to provide "General Medical Services" (Livesley and Ellington 1996 para 3.22-3.48). In the late 1990s, the cost pressures of other legislation such as the minimum wage and the European "Working Time Directive" began to bite. Machin and Wilson (2004) report that, in 1999, 32% of workers

in care homes were paid less than the minimum wage of £3.60 per hour for workers 22 and over, £3 for those aged 18-21 years. Their survey data suggests that introduction of the minimum wage had a moderate negative effect on employment but little effect on home closures could be demonstrated.

The plans to revise the regulatory framework and introduce new standards, published as *Fit for the Future* (Department of Health 1999b), gave rise to further unease among small nursing home owners. The proposed standards included requirements for new minimum staffing ratios which required one third of the staff in nursing homes to be registered nurses, and new space standards requiring single rooms. The Department of Health's own regulatory impact assessment, published with *Fit for the Future*, estimated that one in ten nursing homes would not meet the space standard and over half would not meet the staffing standards. Thus, in 1998, research published by Joseph Rowntree Foundation (Laing 1998) suggested that there was a disparity between the fees paid by state providers and the level of fees which would provide a reasonable return on investment. This, despite the fact that providers with a good reputation also introduced "top-up" fees, that is they charged residents or their relatives fees even though their care was reimbursed by the local authority. With major problems in profitability, it is not surprising the sector began to contract and homes surveyed by Andrews and Philips (2000) cited cost pressures and financial problems as a major reason for their closure.

Thus towards the end of the 1990s, the owners of small nursing homes operating in less efficient converted buildings and faced with new space standards began to leave the market and the sector began both to contract and to concentrate into the hands of fewer providers (Holden 2000; Netten et al 2005). Large organisations were more able to weather the adverse financial conditions. Their ability to borrow capital at favourable rates to invest in large purpose-built homes was

advantageous (Holden 2000) and larger homes could more easily carry vacancies. In addition, local authority purchasers seemed to favour such homes, despite the rhetoric about community care in small homely environments. Some also reported that the corporate providers were prepared to run at a loss in order to obtain a strategy position in the UK health care sector, as they foresaw the state releasing its hold on the provision of other health care facilities (Player and Pollock 2001). Thus while in 1989 providers with three or more homes accounted for 12% of homes and 32% of beds, by 1999 this had risen to 19% of homes and 43% of beds (Laing and Buisson 2000). The average size of a home had also risen, from 28 places in 1989 to 38 places in 2000. However, despite this concentration, the majority of nursing home providers are still small businesses – mainly private companies with only a handful publicly quoted.

Quality of care

The change between NHS care and nursing homes was not just a change in ownership; there are other differences that place constraints on the type and quality of care which can be provided. As noted in Chapter 1 and described further below, little is known about the needs of residents in nursing homes. In the official literature, their needs are largely undifferentiated, categorised simply as "general nursing". Apart from the requirement to ensure that there is a registered nurse on duty at all times, the staffing of nursing homes is a matter of negotiation between the inspectorate and the nursing home manager. There are no requirements for nursing homes to employ doctors or other members of the multi-disciplinary health care team, such as physiotherapists. As described further in Chapter 7, the 1960s marked the beginning of a new interest in health care and the elderly. But under these arrangements for nursing homes, geriatricians who are expert in the care of elderly people at the end of their lives would have no institutional base in the sector. They were forcibly disengaged from the majority of their client group.

Medical care was left to GPs, who when a large nursing home opened in their area, suddenly found themselves unable to cope with 150 elderly patients with complex medical needs (Livesley and Ellington 1996).

With the expansion of the sector, the number of registered nurses employed in nursing homes more than trebled between 1985 and 1995, when it reached 42,428 whole time equivalents (WTE) for around 200,000 beds (Royal College of Nursing 2003ab). But compared with other sectors this is a low ratio of qualified nurses to beds. For example, the independent hospital sector employed some 8,000 WTE for around 10,000 beds. Although the independent care home sector is the largest employer of nurses outside the NHS, there is plenty of evidence to suggest that professional nurses employed by nursing homes are not the cream of the profession (see chapter 4). Such nurses are likely to be older and less well educated. In addition, nursing in nursing homes is something of a thorn in the side of the profession. Since 1992-93, the nursing home sector has been the single largest source of complaints to the registration authority for nursing – the UKCC, now the Nursing and Midwives Council. Between 1994 and 1998 complaints from the sector ranged from a quarter to a third of all cases before the Council's professional conduct committee. In 1994, the Council issued a special report expressing concern about the standards of care in nursing home (UKCC 1994). Their concerns included lack of training, lack of records, mismanagement of residents' monies, lack of supervision, abuse of residents and unsafe systems for the administration and storage of medicines.

Although nursing homes employ professional nurses and provide nursing, the majority of care is not carried out by professional nurses. The majority of "general nursing" in nursing homes is provided by unqualified care assistants, paid at the minimum wage; care homes compete with supermarkets for workers. Thus it is unclear whether

nursing homes should be considered to be part of the health care sector or some other type of provision. Recently changes in the regulatory framework and arrangements for enforcement have moved nursing homes even further away from being characterised as part of the health care sector. In the Care Standards Act 2000, the category of "nursing home" was abolished and such establishments are now called "care homes with nursing". Such homes are now regulated by the Commission for Social Care Inspection, rather than by the regulator for the health sector, the Healthcare Standards Commission, and there is no requirement for inspectors to be nurses or have any expertise in health care. But even before these changes, it was difficult to fit nursing home care into any distinct category. Are they part of the health or the social care sector? Do they provide professional nursing care or social care? As nursing homes, and the care they provide, cannot easily be put into any category, then there are problems in deciding which norms of practice apply. How should standards be framed? Exploring this question is a major focus of further chapters in this thesis.

THE ARRANGEMENTS FOR REGULATION

As the independent nursing home sector has expanded to become central to the provision of care for the elderly, regulation has assumed increasing importance. Kagan (1994) identifies three characteristics of legal design which have influence on enforcement style: (1) the way the authorising legislation defines the regulatory mission; (2) the powers granted to regulators and the rights granted to regulatees and the advocates of the strict regulation; (3) the specificity of standards to be employed. Each of these factors is considered below. This is followed by an analysis of the situation and context of Health Authority inspection units, whose activities were central to registration and enforcement.

The authorising legislation and the regulatory mission

The focus for this thesis is the Registered Homes Act 1984, in force in between 1986 and 2002. But the regulation of nursing homes began with the Nursing Homes (Registration) Act 1927. In 1926, a select committee was set up to consider whether "the general condition of nursing homes rendered it advisable or necessary, in the public interest, that the institutions should be liable to supervision by a public body" and to recommend the most effective means of supervision (Select Committee 1926). After fourteen meetings, hearing evidence running into some 200 pages from thirty-six witnesses, the committee concluded that there was an urgent need for registration and supervision.

The committee recommended that inspecting officers should consider the following:

(i) suitability of the person in charge
(ii) suitability of the structure of the buildings
(iii) sanitary arrangements
(iv) accommodation for staff and patients
(v) adequacy of the staff both as to numbers and training
(vi) preparation and storage of food for both patients and staff
(vii) general domestic arrangements such as the cleanliness of rooms
(viii) arrangements for the prevention of infection
(ix) arrangements in the event of a fire.

This resulted in a Bill where the conditions for registration were:

(i) "the applicant is to be a fit person"
(ii) "the situation, construction and accommodation and staffing and equipment are all to be in accordance with the needs of the situation"
(iii) "there is to be a proper proportion of qualified nurses engaged".

In moving the second reading of the 1926 Bill (Nursing Homes (Registration) Bill Second Reading Hansard 1927 Vol 207 c1628), the intent was summarised by Mrs Mabel Philipson MP as follows;

> ...a safeguard against abuse without unduly interfering with well equipped and well run establishments and without impairing the privacy of treatment that patients and their medical advisers desire ... it aims at raising the standards of the condition under which the sick are treated.

The regulatory intent remained the same throughout the century - not to be prescriptive about how well-run establishments should undertake their business, to exclude unsuitable poor providers and to raise standards. Moreover, the Registered Homes Act 1984 turns still on the same vague but common legal terms – the "fitness" of the registered person and the "suitability" of the premises.

Part II of the Registered Homes Act 1984 set out the legal framework for nursing homes, which were defined as any premises used or intended to be used for nursing. Part II also divided nursing homes into two categories – mental nursing homes and general nursing homes. In the late 1990s, 15% to 20% of all nursing homes were designated mental nursing homes - around 900 homes and 30,000 beds. A further complication is that nursing homes, with the agreement of the registration authority, could decide to designate the home or the beds for a specific client group, such as learning disabilities, physical disabilities, alcohol and drug abuse, although there was no reference to this in the primary legislation. However, irrespective of the potential for the creation of places for other client groups, in 2001 some 82% beds in general nursing homes were occupied by people aged 65 and over (Department of Health 2002a).

Powers of regulators and rights of home owner and residents

The Act gave the Secretary of State for Health powers to register homes, to make conditions of registration, withdraw registration,

make regulations and authorise persons to inspect homes. District Health Authorities were authorised to inspect homes and all of the Secretary of State's powers, apart from the power to make regulations, were delegated to them. As it was unlawful for any person to carry on a nursing home without being registered in respect of that home, all nursing homes had to be registered. The Act operated in the following way. An application specifying the type and number of patients catered for had to be made to the Health Authority for registration in respect of a particular home. The applicant named in the application, if registered, was issued with a certificate of registration. Under c25 of the Registered Homes Act 1984 the Health Authority could refuse to register the applicant in respect of a home on the following grounds:

(i) that the applicant was not a "fit" person whether by reason of age or otherwise to carry on a home of the type described in the application;

(ii) that any person employed or proposed to be employed by the applicant at the homes was similarly not a "fit person";

(iii) the home was not, or any premises used in connection with the home were not, "fit" to be used for such a home. The reasons for refusal were those connected with the situation, construction, state of repair, accommodation, staffing or equipment;

(iv) that the home was not or will not be in the charge of a person who was either a registered medical practitioner or a qualified nurse;

(v) that the number of nurses possessing the qualifications specified in the staffing notice must be on duty at the times specified.

In preparing the notice in (v) above, Health Authorities were legally required to take into account the type and number of patients provided with nursing care in the home.

In c28 of the Registered Homes Act 1984, Health Authorities were also delegated the powers to cancel registration on the following grounds:

(i) any grounds which would entitle them to refuse an application for registration

(ii) that the person had been convicted of an offence against Part 2 of the Act

(iii) the person had been convicted of an offence against the regulations

(iv) the person had not complied with any condition of registration

(v) the annual registration fee had not been paid

The registered person could be prosecuted both for offences under the Act and offences under the regulations. As the registration also could be withdrawn, the regulatory framework had both legal and administrative sanctions. Offences against the primary legislation included non-compliance with conditions of registration – in particular, non-compliance with the Health Authority's requirements in relation to the number and type of person accommodated, the qualification of the person in charge and the numbers of nurses on duty. Offences against regulations included failure to notify the Health Authority of specific events, failure to keep the required records, failure to provide the Health Authority with required information and failure to comply with the provision of regulation 12 – the requirement to provide "adequate" facilities and services. For such offences, Health Authorities were required to serve notice on the registered person in writing before bringing proceedings in a magistrates court. With the possible exception of refusing to allow an inspector admission to the premises, which was punishable by three

months in prison, the fines for offences were low, not exceeding level 4 on the standard scale, a sum of £2,500.

As regards the administrative sanctions, registration could be cancelled in two ways: by giving notice to the registered person or with immediate effect by order of a Justice of the Peace. In the latter case, the Health Authority was required to demonstrate that there was a serious risk to the life, health or well-being of patients in the home. In the case of administrative decisions such as refusal of registration, cancellation of registration and changes to the conditions of registration, home owners had the right of appeal. Such appeals were heard by an independent tribunal - the Registered Homes Tribunal. The impact of Tribunal decisions on nursing home regulation is analysed in Chapter 6.

With the increase in all types of regulatory legislation in the last decades of the twentieth century, the Registered Homes Act was not the only legislation important to the protection of nursing home residents. Of relevance were the Health and Safety at Work Act 1974 and its accompanying regulations concerning fire and control of infection, the Medicines Act 1968, employment regulations and registration of nurses. In the late 1990s, the Office of Fair Trading also began making important excursions into the sector, discussed below. The Health and Safety at Work etc Act 1974 is of considerable importance, as the Health and Safety Executive (HSE) inspectorate has successfully prosecuted a number of nursing homes. The potential fines are considerably larger than those available under the Registered Homes Act. Convictions are also publicised on the HSE website[1]. Between 1998 and 2002, there were 16 convictions of nursing homes under the Health and Safety at Work Act and, in four of those cases, the fines were in excess of £25,000. In one case, the fine was £50,000 plus costs for fatality involving lack of assessment in the use of bed rails. In another, where a 72-year-old drank de-greasing

[1] http://www.hse-databases.co.uk/prosecutions accessed Aug 5th 2005

fluid which had been left unattended, the fine was £40,000. Many of these incidents had resulted in the death or serious injury of residents.

The specificity of standards for nursing homes

Both the regulation and the standards for nursing homes were in the main non-specific, and referred to residents as patients. In Statutory Instrument 1578, *The Nursing Homes and Mental Nursing Homes Regulations 1984*, the Secretary of State for Health made requirements to keep records, in particular an adequate daily statement of the health and condition of the patients, to furnish inspectors with information and to notify the Health Authority of events, in particular the deaths of residents. Regulation 12 set out a large number of requirements in relation to facilities and services. The registered person was required to provide "adequate" professional, technical, ancillary and other staff, and "adequate" food, furniture and equipment. The arrangements for the disposal of waste, prevention of infection, handling and disposal of drugs must also be "adequate". "Adequate" precautions must be taken against accidents and "adequate" facilities must be provided for patients to be interviewed or to receive visitors in private. In the preamble to the regulation, "adequate" is defined as meaning "sufficient" and "suitable" for the size of the home and the number, age, sex and condition of the patients. Thus the Act and regulations allow Health Authorities to set *specific* conditions in only three key areas: the number of patients, types of patients and the number of staff. Some nursing home regulations were also clear cut. For example, a registered nurse must be on duty at all times and the home must be connected to the public telephone system. But a major part of the regulatory requirements required local interpretation by Health Authorities.

In 1985 and 1988 the National Association of Health Authorities (1985,1988) issued guidance to assist District Health Authorities with drawing up their own guidelines and with the interpretation of regulatory rules under the 1984 Act. The guidance advised Health Authorities that, where no statutory legislation existed, standards "should be comparable to good standards in NHS establishments". Similarly, officers were to use their own expert opinion or "subjective impressions of the quality of care at the home". This is tantamount to saying that the rules rested on the authority of Health Authorities and their officers. With over 100 separate Health Authorities regulating nursing homes, as we shall see in Chapter 6, this soon led to charges of inconsistency and partiality. Moreover, home owners challenged the authority of Health Authorities to interpret rules by appealing to the Registered Homes Tribunal and, in some key cases, such challenges were supported by the Appeal Tribunal.

Vague rules in key areas relating to provision of care and facilities, coupled with neglect of the Health Authorities enforcement functions, described below, would not have been conducive to stringent enforcement activities.

Arrangements and context for inspection and enforcement

Under powers delegated by the Secretary of State for Health, Health Authorities became responsible for the registration and inspection of nursing homes under the Registered Homes Act 1984. During the last decades of the twentieth century, Health Authority inspection units were neglected by the Department of Health with no information about their activities collected centrally. However, to plan for the new regulatory framework implemented in 2002, the Department of Health undertook an *ad hoc* survey. Unfortunately, in this survey, the Department of Health did not use the same classification of homes as in its own statistical series but instead used the categories frail elderly and elderly mentally infirm (EMI). Despite these

inconsistencies, the survey provides useful information about the workload of Health Authority inspection units. Data from the Department of Health survey can be compared with information collected by Day and Klein (1987) some twenty years previously, as shown in Table 1. This suggests that the resources of the inspectorate did not keep pace with the expansion of nursing homes. By 1999, each inspector was covering twice the number of homes and places as in the mid-1980s.

Table 1. Changes in workload of nursing home inspectorate

	1983 (i)	1999 (ii)
Number of homes	820	5692
Number of places	28,000	182,500
Number of inspectors	100	285
Homes per inspector	8.2	20.0
Beds per inspector	284	640

Source: (i) Day and Klein (1987); (ii) Department of Health (2000ab)

In 1999, inspectors visited each home on average 2.1 times a year (Department of Health 2000b) – only slightly above the legal minimum number required of two visits per year. Overall Health Authority expenditure on registration and enforcement of the 1984 Act was estimated to be £11.3m – in a sector valued at £3.3bn in 1998-99 (Department of Health 2000b) – or £1.18p per bed per week – a very small proportion, about 0.33% of the national average cost of a bed per week of £360. Yet at that time, in the mid-1990s, the NHS Executive remained "unconvinced that the current fees are insufficient to enable authorities to carry out their statutory functions to ensure the standards required ... are being met" (NHS ME HSG (95) 41).

To carry out these duties, Health Authorities usually employed nurses as inspectors but occasionally the inspection responsibilities were

contracted out to specialist contractors. In the fieldwork for the thesis, the inspection activities of one such contractor were observed. As part of the preparation for the new regulatory framework, the Social Services Inspectorate also carried out inspections of six Health Authority Inspection units. The Inspectorate concluded that although nurse inspectors did well in promoting aspects of nursing care, there was some evidence that the regulatory function was not properly understood (Woods 2001). This was also apparent in the criticisms of the Registered Homes Tribunal described in Chapter 6. Given that this group was largely neglected by their employer, the NHS, this is hardly surprising. Nurse inspectors did not form one of the several hundred categories of nurses in the annual census of NHS staff (Department of Health, personal communication). Thus, for the purpose of counting NHS staff, they officially did not exist. Neither was there any formal recognised training or qualifications for the work.

Between 1984 and 1997, the Department of Health took little interest in Health Authorities' responsibilities for nursing home regulation. Apart from HSG (95) 41 referred to above, emphasising a light regulatory touch, no other guidance was issued until a new government came into power in the late 1990s. Similarly, after an early flurry of activity to coincide with the 1984 Registered Homes Act coming into force, the National Association of Health Authorities issued no advice apart from that associated with HSG (95) 41. Nursing home regulation was something of a backwater, with even government inspection bodies for the NHS, such as the Audit Commission, showing no interest at all in NHS registration and inspection units. Similarly, inspection activities seldom reached the courts – between 1998 and 2000, the only years where figures are available, there were only five prosecutions under the Act (Department of Health 2000b). As inspection reports on nursing homes were not public documents until 1998 (HSC 1998/047), nursing home regulation was, quite literally, a private conversation. It was an activity with low public visibility and internally lost among the more

pressing duties of Health Authorities implementing the government reforms of the NHS of the 1980s and early 1990s.

With the introduction of the internal market in the early 1990s, the main duties of Health Authorities were concerned with the planning of local services in line with government policies and purchasing care according to those plans. As one of these key policies was to withdraw from long-term care, Health Authorities were required to close long-stay services for the elderly. This meant there was often a conflict of interest between the promotion of nursing homes, which Health Authorities required to enable them to meet government objectives, and their responsibilities to regulate the sector. The most obvious example was that, under s.42 (2) (1D) of the 1990 NHS and Community Care Act, local authorities were not allowed to commission services from homes which had been convicted of breaches of the Registered Homes Act or its regulations. As the period of this requirement coincided with the period when Health Authorities were under the greatest pressure to close beds, this must have provided a major disincentive to prosecute. A further possible reason for the lack of prosecutions is that vague rules do not lend themselves to securing prosecutions easily (Hawkins 2002 ch12; Hutter 1997; Lloyd-Bostock 1992), as the court may operate with a different interpretive framework from the Health Authority (Black 1997). This makes the evidential requirements uncertain. Yet, the withdrawal of registration is a drastic act, a form of corporate capital punishment. In a sector where the public is aware that the quality of care was low, this act has the symbolic effect of preserving public confidence in regulation.

Just as the currents from the deregulation movement were strong enough to reach the backwater of nursing home regulation, so too were the waves from "consumer empowerment". For local authority registration and inspection units, implementing the Citizen's Charter meant a requirement to appoint lay assessors and set up advisory

groups to be consulted about standards. No such requirements were placed on Health Authority inspection units. However, as a third of all nursing home residents pay their fees in full, the sector has not escaped the attention of the Office of Fair Trading. In 1997, as part of a project to assist vulnerable consumers (OFT 1998a), the Office of Fair Trading initiated research into older people as consumers in care homes. The research found that fewer than one in five residents were aware of being a signatory to a contract. Moreover, many contracts examined by the Office of Fair Trading broke regulations on unfair terms. The Office also found that relatives and residents had serious criticisms of the way inspection units handled complaints. It considered that complaints were handled in a way that favoured the regulatee and were unfair to the complainant. As described further in Chapter 7, relatives who are aware of the interest of the Office of Fair Trading are now keen to use this regulator for their grievances against the sector.

Relatively few scandals about nursing homes seem to attract national attention, rather there tends to be a low rumble of public concern. In 1992, the Royal College of Nursing indicated nurses' concerns about quality of care in a publication entitled *A scandal waiting to happen.* However, one scandal coinciding with a change of government did attract considerable public attention. East and North Hertfordshire was required to close long-stay geriatric beds to meet government policy objectives. But in the view of its inspection unit, the proposed alternative provision provided by a nursing home operated by Takare was inadequate. In particular, the unit had argued that the home was proposing to operate with a level of staffing far below the dependency levels of the patients. The Health Authority would have been well aware of the needs of these patients as it was already caring for them. The Health Authority was advised by the Strategic Health Authority that it could not refuse to register the home on these grounds as the provider would appeal, and it was highly likely that the appeal would be successful. The home was registered, opened and

patients transferred, then many allegations about poor care were made. A subsequent TV programme and independent report (Livesly and Ellington 1996) revealed many problems with the home. The relatives pursued their complaints with the Health Service Ombudsman and matters were finally reviewed by the Parliamentary Committee on Public Administration. The behaviour of the Health Authority in transferring patients to this home, where they knew staffing standards were below acceptable levels, was heavily criticised. The home remained open and standards improved after consistent monitoring by the Health Authority. Yet despite the unfavourable reports on the home and surrounding publicity, this had little effect on the standards in nursing homes in general. As noted in Chapter 6, an appeal by the same provider later that year to use similar staffing levels was upheld by the Registered Homes Tribunal, as Takare had convinced the Tribunal that it was an exemplary organisation.

A further scandal erupted in 2002 around Lynde House - a nursing home in Twickenham owned by Westminster Health Care. One of the directors of Westminster Healthcare was Chai Patel, a member of the Better Regulation Taskforce and adviser to the government on private health care. The concerns were poor care and failure to listen to the complaints of relatives, some of whom were paying in excess of £70,000 a year for the care of their parents. The relatives were very successful in targeting Patel, who was subsequently removed as a government advisor and investigated by the General Medical Council for serious professional misconduct. The GMC investigation was dropped after a successful judicial review. These developments suggest a growing consumer rights movement. However, it is a movement where the consumers are not the residents but their more powerful relatives – an issue discussed further in Chapter 7.

WHO ARE THE RESIDENTS OF NURSING HOMES ?

What is known about nursing home residents is their number and their broad age group. Apart from these facts, no other information is routinely collected on this group. Despite the availability of many tools to measure health needs in this group – for example, the Resident Assessment Instrument developed by the US federal government (Challis et al 1996), and one developed by the Royal College of Nursing (2004) – the Department of Health has avoided the standardised collection of data, even though this would be the logical development of the new requirement to assess eligibility for NHS care in care homes. Chapter 7 describes how, unlike the case of NHS patients, no comprehensive data set is routinely collected on this group of people.

The lack of administrative data is compounded by the fact that all major government surveys, apart from the decennial census, take households as their sampling frame and therefore gather no data on the institutionalised population. There are just two official surveys which included this institutionalised population in the past 30 years: the 1987 OPCS survey of disabilities, and the 2000 English Health Survey (Bajekal 2002). While the latter found residents to be more underweight, more anaemic, and with high levels of severe disability when compared with the non-institutionalised people in the same age group, the survey provided little information about other disabilities important for the management of shaping of services for this group, such as the prevalence of dementia and urinary and faecal incontinence. Information about such people must be obtained from *ad hoc* surveys which, because of their nature, provide different definitions and a range of estimates. These surveys suggest that between 60% and 80% of residents will be cognitively impaired (Netten el al 1998; MacDonald 2002).

Apart from their high care needs, nursing home residents are marked out in other ways. If nursing home care is considered health care,

then the rights of residents to care are provided on a different basis. The care provided in nursing homes is subject to co-payment, unlike health care which is free at the point of delivery. In the late 1990s, around two-thirds of residents contributed to their fees wholly or in part (Laing and Buisson 1999). Although recommendations of a Royal Commission, and several court cases – discussed in Chapter 7 – mean that the boundary has shifted, with the NHS now paying for more care, the principle of co-payment remains. Socially, residents are marked out as old people close to death, with around a third of all nursing home residents dying each year. As one geriatrician notes, they enter what is referred to as the stone age of old age where mind and body are stone (Issacs 1981). The body begins to disintegrate and becomes unbounded, leaking fluid, skin becomes like tissue paper and bones break very easily. Incapacity of mind means that the personality disintegrates to the extent that the reciprocity of human relationships disappears. Thus nursing home residents appear to transgress the contemporary ideals of what constitutes the category of human (Herkovits 1999).

CONCLUSION

In the 1990s, there were in effect over 100 Health Authorities operating as separate enforcement agencies for nursing home regulation. They were operating in a climate which favoured light touch regulation, in a market with low profitability and with a regulatory framework designed some seventy years previously for different market conditions. The Department of Health took little interest in the activity and there was little central co-ordination. By the end of the 1990s, the sector had changed from a cottage industry to one where nearly half the beds were owned by large providers. The rules were vague, turning on words such as "type", "fitness", "suitability", "adequacy" and "condition" - terms which are elastic and malleable with little intrinsic meaning. The anchor point for key

rules was meant to be "the condition" of the patient. But contrary to recent trends in other sectors of health care to formalise and codify practice, central developments to codify nursing home activities were resisted. No attempt was made to further develop standardised measurement tools to specify different "types" or "conditions". These problems were exacerbated by the fact that residents, as a group of very old people, have very questionable status as people. For women in particular, becoming institutionalised and dependent results in reversal of social role from carer to being cared for, with a complete loss of social identity (Evers 1981). In the absence of such socially defined points of reference, interpretation of rules which require an idea of the resident tended to be based on the expert opinion of the Health Authority or its officers. As explained in future chapters, such interpretations are open to challenge.

Such broad rules are advocated to set the tone of enforcement as educational and as a means of driving up standards through negotiation to meet changing expectations, professional practices and a changing policy environment. Rules framed in this way can be freely adapted to the exigencies of different circumstances. Indeed, they allowed the changing role of nursing homes to be accommodated within the health care economy, enabling the regulatory framework to adapt to a sector catering for an increasingly dependent type of patient as the NHS withdrew from the care of the frail elderly. While in other contexts such discretion may have been useful, in this context it allowed rules for which there was no anchor, with a strong possibility that standards would drift downward. As Kagan (1994) found, where standards are broad, the possibility of excessive leniency is greater, particularly where industries are economically marginal. The government's increasing reliance on the sector to provide care, coupled with the strained profitability, meant that stringent enforcement of the Registered Homes Act 1984 seemed unlikely. In fact, it would seem that the sector had far more to fear from other regulators, such as the Health and Safety Executive, the

Office of Fair Trading and the United Kingdom Central Council for Nursing and Midwifery. Coming under the provisions of other government departments, some of these other regulators were not subject to the same conflicts as Health Authorities, whose regulatory decisions had to be taken with one eye on the overarching objectives of its departmental masters. In the mid-1990s, in their defence of regulation of the residential sector, Day and colleagues (1996 p30) argued that the function of any regulatory system must be to ensure that standards are not compromised by pressures on purchasers' budgets. However, for the nursing home sector in the UK, this was happening. As Cheng and Chan (2003) describe in the case of nursing homes in Hong Kong, when an industry is economically marginal, compliance only improves when the government injects a large quantity of both educational and economic resources.

What does this reveal about residents? The major neglect of the regulation of the sector would suggest that, at least to the 1990s, the government was not very interested in the care of elderly people. This group was a low priority.

Chapter 4

A DIFFERENT VERSION OF NURSING

TWO VERSIONS OF NURSING

At first sight, professional nursing as an institution would seem to be central to the culture of nursing homes and hence central to the development of effective regulatory strategies. Indeed, care in nursing homes is provided not by a multidisciplinary team as in other areas of health care, but by nurses alone (see Chapter 7). Yet, as Dingwall and colleagues (1988) pointed out, nursing never has been a unified occupation. Different versions of nursing – as a profession or an occupation with a "trade" – are played out in different historical or political contexts. Prior to the twentieth century, nurses were tradeswomen or handywomen (Abel Smith 1960). They made a living by assisting women in childbirth and preparing the dead for funerals - "the lying in" of women and "the laying out" of the dead. At the start of the twentieth century, when entry to the professions in general was largely barred to women, nursing came to be seen as the route to obtaining professional status for middle class women. Sections of the occupation aspired to having the same status, financial rewards and control over their own work as doctors. Yet, professional closure on elitist terms has never been allowed to succeed, mainly for economic reasons (Dingwall, Rafferty and Webster 1988; Abel Smith 1960; Davies 1995). As a consequence, two main versions of the same occupation - the professional nurse or nurse clinician and the "tradeswoman" or handywoman - still coexist (Dingwall et al 1988).

The nurse clinician is described (Dingwall et al 1988, Porter 1992) as aspiring to a model of a relationship with clients, in terms similar to nineteenth-century private medical practice. Nurse clinicians have their base in academia, in the Royal College of Nursing and in some large teaching hospitals. They are influential in the training of nurses

and in the development of nursing theory and models of practice. Throughout the occupation's history, the professionalist segment has sought to "squeeze out the handywoman class from the care of the sick" and "gentrify the plot of work owned by the occupation" (Dingwall et al 1988 p227). As I shall describe, the dynamics of this struggle has created a new occupational group, essential to the nursing home labour force - the health-care assistant. Nursing histories written from the profession's perspective have always excluded the so-called "pauper nurses", the inmates of poor law institutions who assisted the master by feeding and looking after the sick (Kirby 2002; Lorenzon 2003). Similarly, the workforce in the nursing home sector have low status and are largely isolated from the mainstream of professional activity and debate.

This chapter explores the version of nursing enacted in contemporary nursing homes in two ways. First, through an exploration of how the characteristics of nursing home residents relate to the professional nursing subject discussed in professional nursing journals - the presumption here is that, where professional nurses practise, the ideals of professional nursing might be enacted irrespective of the organisation or setting. Second, through an analysis of the professional qualifications and credentials of those undertaking nursing in nursing homes. I conclude that nurses in nursing homes have difficulties in drawing on the strength and knowledge of professional nurses. They have little access to the discourse of professional nursing. The version of nursing being acted out in nursing homes has more similarities with the "tradeswoman" version of the occupation than the professional version. Nursing home nurses - qualified and unqualified - are primarily concerned with the harsh reality of making a living from dealing with the social problem of people at the end of their life. Where nursing homes are owned by the same nurses who manage them, then concern with making a living is to be taken literally.

As described below, these different versions of nursing give rise to different ideas of the resident – one concerned with the professional nurse-patient relationship, the other with images of the resident which attract business. In the case of the former, the predominant ideal of the subject who can articulate, participate and reciprocate has posed considerable conceptual difficulties in developing professional nursing models appropriate to the characteristics of nursing home residents as demented individuals. But, although more appropriate models have been developed, the struggle for professionalisation, coupled with social policy in relation to old age, has created conditions which militate against the likelihood that such enlightened models could ever be put into practice in nursing homes. In this sector, elite forms of nursing and social policy are irreconcilable. The implication for regulatory compliance is that any strategy that rests on persuading nurses to comply with "a professional nursing licence", will be far from straightforward.

NURSING IDEALS

Maintaining growth, supporting the self and nurturing reciprocity

All concepts of health rest on an ideal view of what it is to be human. Nursing, and health care in general, are concerned with restoration to the ideal and, where that ideal cannot be restored, providing support. Thus a more extreme definition of nursing (Boykin and Schoenhofer 1993 p15) is that it:

> ...focuses on the knowledge needed to understand the fullness of what it means to be human and on the methods to verify this knowledge.

However, definitions of what it is to be human and the aspects of humanity which are legitimate objects for restorative or supportive nursing work have varied. The Royal College of Nursing and the Association for Care of Elderly People (1996 p6), in one of their few

publications about nursing homes, quotes the following as one of the most widely accepted definitions of nursing:

> ...primarily helping people, sick or well, in the performance of those activities contributing to health, or its recovery, or to a peaceful death, that they would perform unaided if they had the necessary strength, will or knowledge. It is likewise the unique contribution of nursing to help a person to be independent of such assistance as soon as possible, the nurse is temporarily the conscious of the unconscious, the love of the life of the suicidal, the leg of the amputee, the eyes of the newly blind, .. a voice for those too weak to speak .....

Thus there are models of nursing which are restorative or supportive of the physical, mental, emotional, "holistic" and more recently existentialist functioning of an individual - that is they aim to provide restoration of the self.

But not all aspects of supportive work are valued. Supporting people, who, through illness or disability, can no longer undertake everyday activities means engaging in tasks that involve "dirty" work. That is work which involves contact with bodily fluid and excreta - activities which, from an anthropological perspective, are usually thought to contaminate or devalue the people who undertake them (Lawler 1991 p75-83). Nursing has developed two ways of dealing with this. One strategy is to expel such work from the remit of professional nursing by delegating these "dirty" activities to unqualified staff (Jervis 2001). For most of the 20th century, student nurses undertook these tasks as a rite of passage to the profession. However, when nurse training moved to universities, these tasks were delegated to untrained nursing assistants. The alternative strategy has been to transform the work from the profane to the sacred – historically this was through the association of nursing with a religious calling. In its modern manifestation, either this becomes a special calling for women who have the essential feminine quality of "caring" (McCance et al 1999; Davies 1995), or such tasks become framed by highly sophisticated theories. In developing such theories, nurses have

sought to carve a different space, avoiding science and technology as masculine - a space occupied by doctors. Instead, nursing theories are dependent on a sophisticated psychosocial analysis of the interpersonal which involves ideas such as "reciprocity" and maintaining a sense of "identity" or "self". Thus nursing is heavily dependent on, and reflective of, developments in social theory - particularly sociological theories of illness. But some such theories do not sit easily with the characteristics of nursing home residents.

The philosopher, Agich (1993), in his book *Autonomy and Long Term Care,* written as a result of work for the US Retirement Association, notes that models of human growth and development assume a steady progress towards a particular finished product - the autonomous subject, the independent, competent, rational and free decision taker. Human development seems to end with this product as development models have no analysis of subsequent human aging or decline. Such models, which place great importance on the empowerment of patients, independence, participation and reciprocity, are strategically attractive to the nursing profession because they offer the potential for an alliance with patients against the hegemonic power of medicine and/or the health care system. Thus, a major review of how seventeen nursing models might be used to support the process of ageing found that the models were based on the restoration of functions, emotional state, or health, seen as "growth" (Wadensten and Carlsson 2003). None explicitly took into account the problems of decline in old age.

Another ideal, central to much modern nursing theory but often not realised in old people who are mentally and physically frail, is reciprocity. Clearly, in order to reciprocate, residents must be helped to maintain a sense of self or identity. Traditional nursing models were based on the objectification of the body, where everyday work focused on its maintenance, care, repair and hygiene (May 1992). With criticisms of the "medical model" by sociologists such as Stacey

(1977) and Strauss (1985), this traditional model has fallen from favour, at least with the professional elite. As part of the struggle of nursing to develop its own knowledge base distinct from that of medicine, "holistic", "whole person" or "biopsychosocial" approaches to nursing were developed (May1992; Pearson 1988). In a process called "primary nursing", patients are seen as active participants in the therapeutic endeavour (Savage 1995; Manthey 1992; Pearson 1988). In vogue in the late 1980s, this model attempts to merge aspects of the life world. So, for example, for the patient with a gangrenous foot, there are a number of possible nursing approaches. To treat the foot as a disconnected object: how is your foot ? To address the patient's psychological concerns: how to you feel about your foot ? Or to try and treat the issue in a holistic way: how do you feel now you have seen your foot? (Lawler 1991 p162). Primary nursing would advocate the last of these approaches. But in practice even empirical studies of elderly people who are cognitively intact have found that their active involvement in decision making is an ideal which is difficult to realise in practice. Baar, a Dutch nursing home doctor, notes:

> It has been our experience that the capacity of nursing home patients to assert autonomy is overstretched ... patients no longer have the strength to voice their desires and requests ... often their will has to be reconstructed before a decision concerning their care can be made. Baar and van der Kloot Meijburg 2002 p112.

McCormack (2001) found that it was impossible for elderly people to be involved in decisions about their care, as their limited knowledge of the health and social care system and their lack of understanding of the professional decision-making framework and the need for decisions to be made quickly, all acted as barriers to participation.

Estes and Linkins (2000) suggest that recently there has been an emergence of "humanistic gerontology" – that is, a concern with the lived experience of old age. Thus, for theorists such as Cohen (1994),

Agich (1993) and Kitwood (1995, 1997) the problem of old age is viewed in existential terms, echoing ideas about chronic illness representing a loss of self (Charmaz 1983, 1993). In old age, an individual must attempt to hold together an idea of the self while body and mind are in decline. These assaults on the self are exacerbated by admission to a nursing home (Davies and Nolan 2004; Lee et al 2002). The many losses prior to admission, such as the loss of their own home and the financial loss associated with the costs of paying for nursing home care, produce a devalued sense of self worth. As Agich (1993) notes, entry into a nursing home represents economic, social and psychological instability and for many residents the challenge is retaining any sense of self. This is exacerbated when nurses encourage and reward dependent behaviour in order to control the residents, as suggested by ethnographies of nursing homes (Nay 1998; Evers 1981).

The caring/health care task then is to instigate processes which support individuals in maintaining their sense of self against these assaults. For Vallis and Boyd (2002), this means that, in the nursing home context, the well known medical, ethical or bioethical principles of respect for autonomy, beneficence, non-maleficence and justice need to be enhanced by further principles – those of protective responsibility, narrative integrity and candour. Kitwood (1993) suggests that this means taking seriously the personhood of those with dementing illness by focusing on the communicative act, with efforts made to find out the need that is being expressed. Agich (1993) refers to this as a phenomenological approach. He argues that autonomy should be seen as the precarious active engagement of particular agents in the social world striving towards particular ends. Well-being is about support for the rhythms and patterns that make up daily life and maintaining a sense of functional integrity in those areas that the individual values. Thus for Agich, Kitwood and Cohen the issue is not loss of choice but loss of meaning or loss of a world that is open for meaningful action. This constitutes a fundamental assault on

the very nature of being a human person. Thus the problem of the self becomes re-framed from physical or emotional functioning to support for the existential self.

One of the characteristics of the nursing which is based on such theories is that it requires intimacy or closeness with patients (McCormack 2001). Nurses are expected to get alongside the patient or resident in their suffering in a relationship built on reciprocity (Nolan and Grant 1993; Nay 1998 p403):

> ....caring requires that the nurse be with the resident, to recognise the resident as a whole and unique individual in a relationship grounded in reciprocity and transmit to the resident a sense of genuine caring which assures them they 'matter'.

The literature suggests that, in general, the unpleasant aspects of nursing work are eased when the patient is able to reciprocate. For example, one US nursing aide is reported to have said "some folk's shit don't stink" (quoted by Agich 1993 p60). But with nursing home residents and patients who are dying, very little reciprocity may be possible and the model breaks down. The Royal College of Psychiatrists (2000) note in their report on institutional abuse of older adults, that there is need to enable staff to deal with patients who raise strong unpleasant feelings. Patients are "aggressive, resistive, irritating, repetitive, ungrateful, demanding and physically disgusting" (RCPsych 2000 p9). The report considers that repressing such unwelcome feelings increases the likelihood of abuse. Staff working in these situations need considerable support, as such patients are likely to raise a mass of primitive emotions which have the potential to disrupt care situations. In her study of nursing and the body, Lawler (1991 p185) quotes one nurse:

> ...the people I find difficult are the people who go on the longest and suffer and their bodies show it. They actually rot... they rot... During this time the patient is totally dependent on the nurses for all body care.

Lawler (1991 p187) also observes:

> The care of patients during their dying days or weeks, often when they are no longer able to hold a meaningful conversation... is typical of women's work. Nothing is produced... in that the patient will not recover. It is dirty work, and demanding of those who do it. In many ways it amounts to little more than physically tending the body...

In the late 1990s, the Royal College of Nursing developed an assessment tool for nursing older people (Ford 1999; Wills and Ford 2000/01), which explicitly acknowledged the contribution of Agich (1993). The key aspects of this contain many of the elements described above: partnership between nurses and older people; person-centred care; building on individual biography and maximising an individual's potential needs, wants and aspirations, with an emphasis on ability (Wills and Ford 2000/2001). With the development of the Royal College of Nursing tool, a revised view of nursing home residents has become part of a nursing ideology, although some (Hockley 2002; Davies and Seymour 2002; Froggatt 2001ab) argue that the sector still lacked a coherent model for palliative care.

In 2006, models of care in nursing homes were further articulated when the National Care Homes Research and Development Forum (2006) was commissioned by Help the Aged to undertake a literature review of "best practice" in Care Homes. The Forum, which was established in 2003 by academic nursing departments, was described as providing a platform for researchers and practitioners in nursing homes to network and to share information and ideas. The aims of the review set out by Help the Aged included "capturing the voice of those living in care homes" and providing "evidence as to how older people can be supported to have a voice". Perhaps to reflect these aims the review was entitled "*My* Nursing Home – "Quality of Life in Care Homes" (their italics). But the review could be read as the academic nurses' vision of a care home. Traditional models of quality

of care which place emphasis on independence and choice are criticised as unrealistic and unachievable. Instead, the perspective should shift to maintaining the residents' identity through person-centred approaches to care which involve looking at the quality of life from the perspective of older people themselves. A number of initiatives which involve residents in discussing quality of care and their environment have been developed (Reed 1999; Nolan et al 2002). Although accessing the views of those with cognitive impairment represents a particular challenge, with time and skilled techniques this can be achieved (Tester et al 2004; Murphy et al 2005). As described below, these models were developed through action research in care homes - research which attempted to change the institution itself.

What is absent from these ideals is the sense that much work in nursing homes harks back to a traditional view of nursing, that is work with bodies. Gubrium and Holstein (1999) have observed that work in nursing homes is structured by the needs of the aging body. The development of appropriate models for care is always dependent on social theory, but the body as a material entity is a difficult and contested theoretical area. As Turner (1995) observes, there has been little serious attempt to understand the relationship between the physiological process of aging and its sociocultural definition. Even Agich's work (1993) avoids much discussion of the body, despite the fact that he describes his model as phenomenological. However, recent research in anthropology, in particular, Lawton's (2000) study of death in a hospice, have taken an embodied view. Lawton suggests that people cannot maintain a coherent sense of self when their bodies reach a certain point of decay. It remains to be seen how this will be taken up in the context of care in extreme old age.

Creating institutions for 'ideal' nursing care

A number of experimental wards and nursing units were set up in the late 1980s to develop the "primary nursing" model (Pearson 2003; Pearson 1992; Savage 1995). Despite research which suggested that outcomes were better, such units were closed in the NHS reforms which introduced the internal market. Requiring a high level of trained staff and commitment to clinical support, they were economically untenable when severe cost containment measures were introduced to the NHS (Savage 1995). But the model has survived as a nursing ideal which has been carried through into nursing profession recent re-engagement with nursing homes.

In 2003, the National Care Homes Research and Development Forum was established by a group of academic nursing departments whose concern was with the learning experience of nursing students they had to place in nursing homes. They were all involved in attempting to improve the quality of the learning experience by engaging in "action research" in nursing homes (Meehan et al 2002; Nolan and Keady 1996; Nolan et al 2002; Hockley and Dewar 2005; Davies et al 2003) – attempting to change nursing homes from the inside. The model of care they advocated is based on the nurturing of meaningful relationships with both staff and relatives as well as with the residents (Davies 2001). Attention must, therefore, be paid to whether staff and relatives share a sense of security, continuity, belonging, purpose, achievement and significance (Nolan et al 2002) in their work or in their relationship with the home. Thus the home must be seen as a "community" which recognises rights, roles and responsibilities and in which the significance of relationships is understood. Opportunities for giving and receiving and for meaningful activities should also be created (Davies 2003). This model takes on the systemic challenges of working in care homes instead of reducing the complexity to individual staff practice.

But whether such ideals will become part of general nursing home practice is another matter. The Forum acknowledges that such a quality environment requires resources, leadership, continuity of staff, self-awareness and a passion for gerontology nursing - conditions which are unlikely to apply in a nursing home. Moreover, many regard such views as the work of an academic elite who have lost touch with everyday practice. Indeed, there are competing models of care which find more favour in the industry. The main contender is the Minimum Data Set – Resident Assessment Instrument (MDS RAI – Challis, Carpenter and Traske 1996), which was developed by the US Federal government to provide a medical or functional assessment of residents. The nursing profession's criticisms of this tool include lack of residents' perspective, failure to promote the role of professional nurse within the nursing home (Wills and ford 2000/01) and failure to recognise or acknowledge palliative care needs (Parker and McLeod 2002). Nevertheless, as MDS-RAI provides case-mix assessment for nursing home reimbursement – that is to say it can identify the costs of care – it has proved popular with industry (see interRAI website http://www.kent.ac.uk/chss/interrai.htm accessed 29/09/04).

Unlike medicine, nursing as an occupation is not able to control the nature of the work or conditions under which nurses practice. The future of nursing models, whether or not they come into common use, is dependent on much wider issues of interaction between social policy and the occupational struggles of nursing. I shall argue below that those struggles have contributed to the creation of conditions in nursing homes which make the adoption of these new nursing models difficult.

THE TRADESWOMEN OF THE NURSING HOME WORKFORCE

The creation of the health-care assistant

As described in the first section of this chapter, the traditional view is that the purpose of nursing is to provide assistance with activities of daily living that the sick are unable to carry out themselves. Thus it is never clear whether nursing should be a service industry or part of the private everyday activities of families. This ambiguous nature means that the level of skill required and the extent to which the activity should be publicly funded have been continually contested. Professionalisers, such as those whose work is described above, argue that nursing is a highly skilled activity which should only be carried out by skilled people after the appropriate training. But if this argument is accepted, it gives rise to economic problems. With a contemporary workforce of nearly 1 million, shown in Table 1, nursing salaries are reported to be one of the largest single items of UK public expenditure, consuming almost 3 per cent the total (Dingwall et al 1988).

Table 1 Registered and other nurses by sector

	NHS	Independent sector[1]	Total
Registered nurses	580,000	70,000	**650,000**
HCA, Nursing auxiliaries	180,000	150,000	**330,000**
Total	760,000	220,000	**980,000**

Source: Support Staff in Health and Social Care - an overview of Current Policy Issues (Rogers J and IPPR 2002).

[1] No separate figures are available for Nursing Homes but in the early years of the twenty-first century there were only a small number of beds in the independent acute sector – 10,000 compared with around 200,000 beds in nursing homes. The UKCC (2002) have also reported that just over half of nurses working in the independent sector were working part time. The total number of Whole Time Equivalents (WTE) was around 51,200.

A calculation based on public expenditure and the average wage of registered nurses in 2000 produces a similar figure. Therefore, successive governments have recoiled at the cost of professionalisation of the entire nursing occupation. Significantly, in the National Health Service Act 1977, the power to define "nursing", unlike medicine, was retained by the Secretary of State for Health. This has allowed the Minister to decide which elements of care should be considered health care, and therefore paid for by the state, and which are subject to co-payments by individuals.

When broadly defined, the demands for nursing can be unending, but the supply of professional nursing is constrained. For much of the mid-20th century, the resource problem was resolved by the creation of a large apprentice workforce of low-paid nursing students. But as other professions became open to women, nursing found itself in competition for middle-class entrants and in the late 1980s recruitment to the profession was in crisis (Dingwall et al 1988). The profession's solution was to argue that the status of nursing needed be raised by making nursing an all-graduate profession. The recommendation in UKCC Project 2000 was to transfer nurse training to universities. This found favour with the latter due to their own straitened financial circumstances. It also had the added advantage of wresting the control of training from hospitals, where it was seen be much too influenced by the needs of their employer, the NHS. The question about who would undertake mundane nursing tasks when students were no longer so available, never engaged the profession. At that time, the RCN envisaged that care would be delivered by a wholly qualified graduate workforce, while the nursing regulator, the UKCC (1987), considered 70 percent of care would be delivered by registered practitioners. However, the NHS Training Authority (1987) envisaged a much larger role for support workers and began to develop policies for the employment of people limited by past

educational opportunities (see Dingwall et al 1988). The term "health-care assistant" was introduced with the 1990 NHS and Community Care Act. Dingwall and colleagues, writing in 1988 (p229), commented on the newly published Project 2000 that:

> If we ask who will be standing beside the patient's bed... providing the direct hands on routine care in the year 2000, it is difficult to resist the conclusion that it will still be the handywoman class in the new guise of support workers.

Dingwall's prediction has turned out to be extremely prescient. There are no official data on numbers of nursing or health-care assistants employed in the NHS or nursing homes, as they have never been included in official workforce surveys. But *ad hoc* surveys, such as those which form the source of the data in Table 1, suggest that health-care assistant numbers and duties rapidly outstripped official accounts of their limited role (Thornley 2000). The growth of this new untrained occupational group in health care has been officially unrecognised with attempts by the profession to ignore their existence. As recently as 2002, the British Medical Association were still envisioning a future where all nursing care would be provided by qualified nursing staff (see Rodgers 2002). For the government, creation of health-care assistants not only provided a solution to who would provide care in the NHS but also created an occupation which could undertake work at low cost in the expanding private nursing home sector.

However, the history of nursing is that this excluded group of tradeswomen, although more economic to employ, becomes a problem both to the government and the nursing profession. Health-care assistants are low paid, with wages on a par with those in large supermarkets – around £10,000 pa – half that of a registered nurse and well below the Council of Europe level for low pay (Thornley 2001). Scandals abound, and the image of the profession is sullied by the public perception that this unqualified group is "doing nursing"

and are in effect "nurses" (Spilsbury and Meyer 2004). For example, activities of health-care assistants are reported in the nursing press in the following ways: *To catch a thief, abuser, killer – registration of health-care assistants to minimise malpractice* (Nursing Times 1997 17th Sept p12-13). As health-care assistants are unregulated, it is possible for poor carers to move from one home to another with very little check. The excluded unprofessionalised workforce also tends to unionise to combat the low pay and low status. This then poses a political problem – 90,0000 health-care assistants are reported to be members of Unison (Nursing Standard Vol 17 (31) April 16th 2003 p19). The solution for both the profession and the government is to neutralise the group by reabsorbing health-care assistants into the profession. As a result, the excluded group gets better pay and working conditions and professional nurses can exercise more ideological control over them. Initially, there was no career progression in the NHS and very few training opportunities for health-care assistants, particularly in the nursing homes sector. But the new regulatory standards introduced in 2002 brought a requirement for training up to NVQ level 3. In 2003, after much debate (see "Friend or foe? Debate over health-care assistant membership of the RCN ", Nursing Times 1998 Apr 15th p26-29), the RCN agreed to admit health-care assistants with NVQ level 3 into the College. The government has indicated that it intends to regulate health-care assistants (Department of Health press release 2004/0086), but by mid-2005 there were still no firm plans ("Healthcare assistants still unregulated, despite pledges", Guardian March 15th 2005). Regulation of health-care assistants will produce a unified nursing workforce of lower status and the argument for professionalisation is likely to begin again. This pattern of events, played out in the 1930s and in the 1960s with State Enrolled Nurses (Abel Smith 1960; Dingwall et al 1988) may be repeated with health-care assistants.

In 2001, there were approximately the same number of beds in the NHS as in the nursing home sector – around 200,000 (see Chapter 1).

But, as Table 1 suggests, there are many more unqualified nurses in the nursing homes sector than in the NHS and far fewer qualified nurses (for the care home sector in general see Henwood 2001). The Royal College of Nursing (2003b) employment survey found that care homes had a ratio of registered nurses to untrained nurses of around 28 per cent during the day, compared to 60 per cent in independent hospitals. There was also a higher ratio of residents to registered nurses – 18 residents to each registered nurse on the day shift, compared with four residents in a hospice and eight on a hospital ward. Staff in care homes lack qualifications with only three per cent of qualified nurses having a degree compared with 12 per cent in the NHS. Thirty-one per cent of staff in care homes responding to the Royal College of Nursing survey are from Black or Minority Ethnic groups compared with eight per cent in the NHS. With lower ratios of qualified to unqualified staff, there is less opportunity for supervision. Thus most of the care in nursing homes is supplied by an unregulated, uncontrolled and untrained group of individuals. Such an occupational group is unlikely to have awareness of, or understanding of, the elitist nursing models described above. Nor are they likely to have the skills necessary for developing new models particular to the nursing home situation. The people who work in nursing homes, including the professional staff, tend to occupy a marginal position in the labour market.

A search of nursing and other databases– the British Nursing Index and the Cumulative Index of Nursing and Allied Health Literature (CINAHL), identified no studies of health-care assistants in nursing homes in the UK. Studies in other countries and other settings (Spilsbury and Meyer 2004) suggest that health-care assistants concentrate on the routinisation of bodily tasks – hygiene and keeping the residents clean and tidy. Holistic care was too demanding. Nay (1998) set out to explore the contradictions between nursing as caring and reports of nursing home care in Australia where uncaring practices such as neglect, fostered dependency, infantilisation and

depersonalisation were frequently cited. Interviewing both nurses and residents, she found that unqualified staff drew heavily on their experience as mothers or focused on bodily tasks. Staff who had worked or trained in the acute sector also had patterns of behaviour inappropriate to nursing homes. They had been socialised into "the medical model" where they had learnt to concentrate on body parts and diseases rather than on the whole person. This was particularly the case where nurses perceived the patient to be difficult to care for. Staff tended to revert to an approach which involves a focus on tasks, routines and "doing to" ... as this offers protection when the demands of caring are seen as too great (Forrest 1989; Menzies 1960). While residents wanted someone to listen to them, nurses never appeared to have time, nor did the residents see it as part of the nurses' job. This led to dehumanising practices. Nay (1998) concluded that insufficient numbers of appropriately qualified staff and overwhelming demands were the reasons for poor care.

Nurse owners and nurse managers as "tradeswomen"

The organisation and management of care in all settings – hospitals, wards, and nursing homes – has always been an important aspect of nursing. But it is an aspect that can be talked down by the nursing elite as managers are thought to constrain professional autonomy. Part of the nurse's management skills include the managing of people – not only other nurses, but sick people or patients. The iconic figure of Florence Nightingale, celebrated by nurses for the care she provided, is celebrated by social historians for her management abilities. Nightingale was responsible for organisation of the care to the injured in the Crimean War, not for providing individual nursing. She was also one of the first people to collect management data – "outcome" data on infection rates in childbirth (MacFarlane, personal communication). Similarly, one study of nurse training in the US in the early twentieth century suggested that student nurses were evaluated solely on their ability to manage wards and patients (Olson

1996). Recognition of the significance of this work in the NHS came recently when the job title "ward sister" gave way to "ward manager" with very little change in the nature of the work. However, nurse managers can be seen as undermining their profession, as their concerns for cost and efficiency are likely to bring about the employment of cheaper unqualified staff.

Throughout their history, professional nurses have sought to construct environments where they can develop nursing without interference from doctors or managers. In recent times, these have been referred to variously as "nurse-led units", "nursing beds" or "nursing development units" (Pearson 2003). Nursing homes were one of the first settings to be framed in this way. The debate around the 1927 Nursing Home Registration bill which followed hard on the heels of the regulation of nursing was described by its proposer as a "logical consequence" of the Nursing Registration Act of 1919. The College of Nursing declared that they were appalled by the fact that there were institutions which called themselves nursing homes although there were no qualified nurses on the staff. The prevalence of such institutions was "dragging through the mud the name of the noble calling which they pursue" (Nursing Homes (Registration) Bill Second Reading, Hansard 1927 Vol 207 c1629).

The aim of the Nursing Home Registration bill was, therefore, twofold :

> (To raise)... the standards of the conditions under which the sick are treated, and also the conditions under which the nursing profession performs their duties.
>
> (Nursing Homes (Registration) Bill Second Reading, Hansard 1927 Vol 207 c1628).

Nurse-led units within the NHS have a celebrated but controversial history. Critics argue that it has never been clear as to whether their purpose is to improve care of patients, or if the units should be seen as an opportunity to claim a higher status for nurses (Pearson 2003). In the 1980s, when nurse-led units were at their height, the NHS

opened three "experimental nursing homes" for elderly people with no psychiatric problems (Department of Health and Social Security 1983). The evaluation proved positive (Lancet 1990; Bond and Bond 1990) but shortly afterwards came the strategic withdrawal of the NHS from long-term care, although a handful of such homes survived.

Nursing homes were one of the first nurse-led units and recently there has been an attempt to rebadge them in this way. *Nursing Values, Nursing Homes* (Royal College of Nursing and Association for the Care of Elderly People 1996 p17) states that

> as nurses in charge of nurse-led units they have a unique opportunity to deliver high quality research based holistic care. The old image of nursing homes as the last refuge of the unemployable is now totally outdated .

Similarly, as noted above, there are now attempts to re-engage with nursing homes through action research projects, development networks and joint nurse training (Meehan et al 2002; Nolan and Keady 1996; Nolan et al 2002; Hockley and Dewar 2005; Davies et al 2003). But the status of nursing homes still stands in sharp contrast to the public sector nurse-led units of the 1980s. The extensive evaluations of such units and their work (Pearson 1988, 1992, 2003) found that they attracted good-quality nursing staff intent on furthering their profession. As described in Chapter 2, nursing homes expanded in the 1980s in what was then a subsidised business environment (Andrews and Philips 2000; Andrews and Kendall 2000) that encouraged nurses to leave the NHS to set up their own nursing home businesses. Surveys suggested that most of these nurses wanted to be their own boss and hoped for personal fulfilment and financial rewards (Andrews and Philips 2000; Andrews and Kendall 2000). However, when less favourable reimbursement policies were introduced many became trapped, in debt and unable to sell the business as an economically viable operation. Moreover, the requirements for higher standards of accommodation, such as single rooms, meant they were forced to mortgage property to raise

standards. Servicing the debt required reduction in staffing costs, which compromised care (Andrews and Philips 2000).

Partly as a consequence of these straitened circumstances, nursing homes have low status among the professional elite. The nurses working there are perceived as less skilled and knowledgeable and homes are seen as "unrewarding places with unrewarding back breaking workloads and little job satisfaction" (Warner and Goodfellow 1995). Working on salaries lower than those in the NHS and with few training opportunities (UKCC 2002), nurses believe that they will be asked to put profits before patients. Going from the NHS to the nursing home sector is seen as a one way move - there is no going back, as employers will think they will have little motivation and their skills will have atrophied (Warner and Goodfellow 1995). As Stannard (1978) commented many years ago, in a nursing home, the lofty goals of professional practice learned during training give way to more realistic goals of custody and the maintenance of order. This perspective is not counterbalanced in any way as, with a lack of recognised leaders in the sector, few nurses in nursing homes are seen to be promoting their work (Nazarko 1996). A search of nursing databases – the British Nursing Index and the Cumulative Index of Nursing and Allied Health Literature – reveals that nearly all the articles about the management of nursing homes are written by one person, Linda Nazarko. Over a period of years Nazarko, who owned and managed a nursing home, has written about matters which concern tradeswomen – cost savings, skill mix, marketing, regulatory rules and avoiding disciplinary action – all aimed at the individual proprietor (Nazarko 1995, 1996, 1997, 1998, 2000ab, 2002).

The lack of nursing leaders in the sector means a general lack of involvement with professional development, nursing policy development and nurse education. Innovative work is not published and there is little concern with academic pursuits such as teaching and writing. Academic departments and NHS providers who have

ventured into care homes to try and improve practice have found the going very tough. Factors such as high turnover of staff and frequent use of agency staff mean that care homes are resistant to change (Hockley 2002). The UKCC (2002) report that less than half of qualified staff in nursing homes get time off work for training, and at a practice level activities which would allow nurses to share information with each other are limited. Reflecting on this, Nazarko (1996) notes that in stand-alone homes, the proprietor is isolated not only from mainstream nursing but also from other colleagues, as they are in competition in the local area for residents. The barriers to developing a coherent nursing view of the sector are identified (Nazarko 1996) as pressure of work and lack of clear goals, as the sector is at the mercy of changes in government policies in relation both to funding and to its position within the health-care economy. Unlike the NHS there is no funding for innovative schemes, no leadership programmes and little public money to fund the educational development of nursing home staff initiated by nursing homes themselves (RCN 1996). That is to say, the NHS considers this to be matter for the commercial sector.

In the 1990s, as described in Chapter 2, the sector changed from a cottage industry to one where corporate owners began to dominate (Holden 2002). Corporates were more able to provide support and opportunities for networking. But the manager in a corporate environment may have little opportunity to develop professional practice (Hockley 2002). Moreover, in order to run the home, they are heavily reliant on a marginal workforce of health-care assistants who are devalued by their own profession.

Models of care and the tradeswomen

The implementation of a model of care which required a sophisticated understanding of phenomenology does not sit well with the nature of the nursing home workforce as tradeswomen with few educational

opportunities and only ad hoc contact with the professional nursing elite. *Nursing homes; Nursing values* (RCN 1996) notes that nursing home managers must be concerned with hiring and firing, training staff, purchasing all the supplies and maintaining the cash flow. One of the main issues for these tradeswomen is filling beds, as profitability is dependent on a high level of occupancy. Thus the tradeswoman must be concerned with marketing her home for local purchasers. With around two thirds of the places in nursing homes funded by local authorities, marketing must be directed to this group as well as to the private payer or their family. As well as costs, local authorities have an ethos which promotes independence – as Nazarko (1998) notes, local authority purchasers like single rooms, a number of small lounges and a homely atmosphere.

Private payers are concerned with the quality of facilities. In an article entitled "Staying ahead of the competition", Nazarko (2000b) writes that every nursing home claims to offer high-quality care in luxurious surroundings. Potentially this leads to the development of new bathrooms unsuitable for the client group as described in Chapter 1, or the avoidance of hospital beds when the condition of the residents would make their use appropriate. Advertising a home as providing services for people with cognitive impairment may also be unattractive to prospective clients looking for luxurious surroundings. Instead, Nazarko (2000b) advises that homes should provide value-added services such as hairdressing, daily newspapers or chiropody within the fee. Successful homes need to convey to the prime decision maker that the residents receive care and stimulation. Nazarko (2000ab) notes that this meant residents will be provided with not only a high quality of care but also a high quality of life. As the BUPA advertising notes:

> ...every resident is treated as an individual combining the care you need with the freedom you want... each resident is able to exercise choice in all aspects of their care."
> http://www.bupacarehomes.co.uk accessed 05/05/05.

Both types of purchasers – local authority and private payers – tend to avoid the trappings of dependent life. Thus the separation of care from life is perpetuated and the myth of independence and choice is sustained. As Agich (1993 p6) notes, the provider's ready-made vernacular of rights and obligations seems at first glance to provide a hedge against that which bothers us about long-term care, the effacement of autonomy, dependency. He adds that "the existentialist conditions that define the need for long term care make the concept (autonomy and independence) remarkably unsuited to the purposes of concrete ethical assessment". In extreme old age, when people have most need of protection, choice and autonomy have little meaning and ethical systems based on this will be very weak.

Ethnographies of nursing homes, very few of which have been undertaken in the UK (Gubrium and Holstein 1999; Nay 1998; Stannard 1978), tend to stress that, in practice, nursing homes are concerned with "body work". The old nursing models of hygiene and care of the body come to the fore in this context. Indeed, the fieldwork with nursing home inspectors, described in Chapter 5, suggests that they too were concerned with the presentation of residents – whether or not they looked well care for. That is, whether they were acceptably dressed, had clean fingernails and teeth, did not smell and, in the case of the men, were well shaven. Indeed it could be argued that such an approach is intrinsic to the care of very old people, irrespective of sector. For example, Evers (1981) notes that in NHS long-stay geriatric hospitals, patients are "mechanically processed" in a regime that emphasises custody and control.

For a nursing home, however, there is a sense in which the presentable body of an elderly resident is the most visible part of the marketing image of the home. Obtaining that effect, for many residents, requires considerable work – work that is not tailored to the individual but governed by the requirements to get a number of residents presentable within time and cost constraints. As others

have remarked in relation to primary nursing, staff are not rostered in a way that suggests communicating with residents is a priority. More staff are on duty in the morning, when more physical work is required to get residents up, toileted and dressed. Staffing levels are then reduced for the afternoon. As noted above, this is partly because nurses find that the demands of caring for elderly residents in other ways are too great. As Henwood (2001) notes, a lack of training results in technical, attitudinal and coping difficulties. Disengaged "body work" is a defence against anxieties raised by debility, death and decay (Menzies 1960; Agich 1993).

CONCLUSION

This chapter has sought to explain how different social groups within an occupation can form different ideas of the resident. Because the characteristics of nursing home residents call into question their status as fully human, there is an added imperative to work in ways which support and accentuate the humanity of residents. This is a difficult and sophisticated task, as it requires the adoption of a conceptual framework which goes against the predominant cultural view of the individual. Moreover, engaging with people who are perceived as "physically repulsive", "rotting" or dying places great demands on those who attempt it. Yet, in the 1984 regulations, there were no statutory requirements for nurses to demonstrate special knowledge, skills and expertise in the health and social care needs of older people in care homes. Moreover, nurses in nursing homes do not consist of a professional elite but instead might be better described as "tradeswomen". Such nurses have little opportunity for professional development and little professional support, and are more concerned with the market conditions and economics of their trade. There are difficulties in one segment of the occupation understanding, adopting and using products developed by a different segment. These problems are exacerbated by little public funding being available for the development of approaches to care tailored to meet the specific

conditions of nursing homes and their residents. Funding regimes based on separation of health and social care mitigate against the adoption of "lifeworld" models of care. Therefore the structural conditions in nursing homes enhance the image of a resident as "an object"– a body. Other models are irreconcilable with government policy, both on nursing and on care of the elderly.

Finally, the two groups of nurse inspectors observed as part of the fieldwork in Chapter 5 might also be seen as enacting different versions of the occupation. One group's practice appears underpinned by a nurse-client model which emphasises the autonomous subject – they expected nursing homes to respect resident autonomy defined in a straightforward way. The second group were more concerned with nursing home owners and managers as tradeswomen. As a result of being tradeswomen, inspectors impress upon managers their exposure to considerable legal risk – in particular from the Health and Safety at Work Act. The emphasis was on creating systems and procedures which would protect the elderly person's body from harm.

Chapter 5

THE PROTECTED IN THE EVERYDAY PRACTICES OF NURSING HOME INSPECTORS

INTRODUCTION

Ostensibly, the role of nursing home inspectors is to ensure that nursing homes comply with the regulatory requirements, either through persuasion or by employing legal or administrative sanctions. But behind this deceptively straightforward regulatory task lies a great deal of conceptual complexity. This chapter explores how "the resident" is constructed in the interactions between nursing home inspectors and nursing homes engaged in this complex activity of "compliance". Expressing the problem in this way situates the analysis of compliance within a social interactionist approach. From this perspective, compliance is a process "of extended and endless negotiation" (Hutter 1997 p12, quoting Manning 1988) or "the outcome of a discussion" between the regulator and the regulatee (Lange 2004 p549). Viewed in this way, regulatory goals are not fulfilled by seeking conformance to regulatory rules and sanctioning those who do not comply, but the objective is seen as seeking "to prevent harm rather than punish evil" (Hawkins 1984 p4). Compliance proceeds by "remedying existing problems and, above all, prevention of others" (Hutter 2001 p15).

In such negotiations about compliance, the boundaries of interpretation for formal legal rules may become so broad the rules lose their salience (Lange 2004). As Gunningham and colleagues (1999 p22), quoting Hopkins, notes, "the real problem... is not to select the best strategy for achieving compliance but to decide what it is the regulated are being asked to comply with". Clearly, if regulation does not achieve its effects through the adherent to formal rules, then through what mechanism are

any effects achieved? For Hutter (2001 p16), ideally rules are "internalized within the company to the point that there is no longer need to refer to the law since the distinction between the rule and the ruled activity disappears". Regulation is seen as positively constitutive and controlling. In some highly technical areas, both Lange (2004) and Corneillsson (2005) have suggested that the professional practices can become adopted by the inspectors as "customary" rules for regulation. As Lange (2004) observes, this then raises difficult conceptual questions about whether compliance and non-compliance be meaningfully differentiated.

Empirical research suggests that in regulation in the UK, law is used as a last resort (Hawkins 1984 p190) and negotiative or "accommodative" practices predominate. Deterrence strategies which emphasise confrontation and sanctioning of rule-breaking are less common. However, Gunningham and Johnstone (1999 p113) argue that a pure compliance strategy has severe limitations: "The regulated enterprise knowing that, even if it is detected no serious enforcement actions will be taken ... is unlikely to undertake expensive remedial action". A credible enforcement strategy must include a significant deterrent component. As described in Chapter 3, the Registered Homes Act provided a pyramid of sanctions of the type argued for in the literature on regulation (Ayres and Braithwaite 1992): formal notices, prosecutions, removal of registration and finally, immediate closure by order of a magistrate. Such a pyramid is thought to provide a flexible way of escalating action and putting controlled pressure on homes which do not comply. Yet, the information presented in Table 1 suggests that inspectors seldom prosecute, although they are more likely to take the ultimate step of removing a home's registration and forcing its closure. In 1988, the National Association of Health Authorities issues advice to Health Authorities about how to use their enforcement powers.

Table 1. Homes for frail elderly and Elderly Mentally Infirm: — Sanctions April 1998 to March 2000

	1998-1999	1999-2000
Homes	3,300	3035
Compliance notices	100	105
Prosecutions	5	None
Cancellations	30	20
Other closures	1143	185

Source : Activity, Workload and Resources of Local Authority, Health Authority and Joint Inspection Units: Summary results of a survey in England 1999-2000 (Department of Health 2000b).

This advice suggested that prosecution was the most appropriate sanctioning route, as evidence which led to a conviction could not be subsequently challenged in appeal against a decision to cancel the registration. Yet, despite this advice, there were only a small number of prosecutions. To prosecute, regulators would have had to crystallise the vague rules of nursing home regulation into an offence. Instead, a significant number of homes had their registration cancelled. In addition, over a hundred formal notices of non-compliance were issued. So, rather than a smooth escalation of action from enforcement notices, to prosecutions, to withdrawal of registration, enforcement consisted of either enforcement notices or removal of registration. There is little evidence that the intermediate stage of prosecution was used to escalate pressure on homes.

Such patterns of enforcement also occur in other industries. Gunningham and Johnstone (1999) note that enforcement pyramids for health and safety are also fractured, with inspectors only prosecuting in cases of industrial accidents. Hawkins (1984, 2002) also found that the law was a last resort for regulators who were unlikely to prosecute except in cases where there was clear evidence of harm. An explanation for this phenomenon can be found, not in studies of inspectorates, but in recent work which explores firms motivations to comply. Kagan, Gunningham

and Thornton (2003) have suggested that, in the context of environment performance, firms have a "multifaceted 'license to operate'" – social, economic and political. Firms may be controlled by what is described as a "social license" to operate where local communities, environmental activists and the wider political climate all have considerable influence in ensuring that reputation-conscious firms comply with environmental objectives. The terms of that "social license" are determined by a wider social and political community rather than legislators or regulatory agencies, and enforcement is by the public engaging in political or economic activity against the firm. Similarly, serious occupational injuries or deaths at work, can be seen as transgressing the terms of a firm's "social license".

The pattern of enforcement suggests that nursing home inspectors may also operate with a type of "social license". In the case of nursing homes, rather than enforcement by community activists or public pressure, an unequivocal punitive response on the part of inspectorates is required. Homes are closed when they violate their "social license" rather than when they violate regulatory rules. As will be described in Chapter 6, the removal of a home's registration is usually only sanctioned by the Registered Homes Tribunal when a home is operating at a level which is socially unacceptable, with evidence of severe neglect, abuse, risk to life or gross financial mismanagement. In legal terms, the home owner is deemed "unfit", but alternatively the home could be seen as transgressing the terms of its "social license", with the regulatory rules reframed to enforce the "social license". Drawing a parallel with work on pollution by Hawkins (1984), enforcement is a consequence of moral rather than technical evaluations. Other types of licences may also be relevant to nursing homes. In particular, nursing homes may be subject to a "professional nursing" licence, as described in this chapter.

With so few prosecutions or cancellations of registration, inspectors are operating purely through persuasion. The empirical evidence suggests that this is unlikely to be effective with large chains. Research suggests that inspection is likely to have more effect with small firms than large chains (Gray and Shadbegian 2005; Mendellof and Gray 2005), and prosecution has been found to be more effective with large chains concerned about their reputation. Prosecution of small firms is likely to be counterproductive as they divert resources to contesting legal claims. For example, Troyer JL and Thompson HG (2004) found that litigation against nursing home chains in the US improved measures of quality of care, while it had little positive measurable effects on quality in small firms. Overall, compliance is affected by the financial and technical resources which firms can devote to the task. For example, Cheung and Chan (2003) describe how when licensing of nursing homes was first introduced in Hong Kong, the economics of the industry was such that very few could comply. The situation only changed when the government injected a large quantity of both educational and economic resources. Similarly, nursing homes in the UK operate with scarce expertise and low economic resources. As the figures for prosecution in Table 1 suggest, the "social license" is enforced but there is little legal enforcement of other rules. Thus, in this chapter, the inspector's style does not refer to whether deterrence or accommodation is the dominant mode of interaction but to the nature of the techniques or arguments used for persuasion. In a study of US nursing homes, Braithwaite argues that such styles of regulation have a profound effect on the everyday life of residents (Braithwaite 1993). But other studies – of farmers (Winter and May 2001), and the construction industry (May and Wood 2003) – have found that enforcement styles, whether rigid and picky or supportive and helpful, have little effect on regulated groups' willingness to comply with rules. The authors argue that vague styles do little to reinforce rules and can leave the regulated confused as to what is expected.

COMPARING HEALTH AUTHORITIES – STANDARDS AND INSPECTORS

In a comparison of Australian and US nursing homes, Braithwaite (1995) demonstrated that broad rules or standards are more effective than precise ones in obtaining compliance with regulatory objectives. The former forced a negotiative relationship on the regulated (Black 1995) whereas the latter were open to creative compliance – compliance with the letter rather than the spirit of the law. But where, as is the case in nursing homes, rules are broad, what arguments are used to persuade homes to comply with objectives? The two Health Authorities, A and B, and their inspection units, on which this chapter is based, had different solutions to this problem. Apart from attempting to enforce the minimum standards of "fitness", both avoided basing arguments on the Registered Homes Act and its requirements and looked elsewhere for the means to gain purchase on nursing homes. In doing so, they employed very different ideas of "the resident".

While the arguments used by inspectors to persuade were different, the standards published by the two authorities were similar, although the standards for Health Authority A were published in 1993 and those for Health Authority B in 2000. In 1995, the Department of Health issued guidance requiring all Health Authorities to produce standards for the inspection of nursing homes (HSG (95) 41) and both authorities based their standards on guidance endorsed by the Department of Health some ten years previously (National Association of Health Authorities 1985). In both sets of standards, residents were referred to as "patients", reflecting the terminology in the regulations and guidance. With the exception of laundries, where Unit B required separate areas for clean and dirty linen, both units had very similar standards for buildings. The standards covered the requirements for the number of toilets and bathrooms, type of lifts, decoration, kitchens and laundries. There were also a large number of requirements for the keeping of records in three

areas: safety of services, personnel records and nursing and medical care. Records were required on tests, maintenance and insurance for all electrical, gas and mechanical equipment, including hoists, assisted baths and wheelchairs. To comply with requirements under the Health and Safety at Work Act etc 1974, homes were required to keep Control of Substances Hazardous to Health (COSHH) registers and accident books, and to record the temperature of hot water and of fridges used for food and drugs. The requirements for personnel records included employment records, for example, references and UKCC pin number, and training records, which included requirements for staff training in fire safety, food hygiene, moving and handling, an induction programme for new staff and a training programme for untrained care assistants. In terms of the care provided, homes were required to keep care plans for residents, a daily record and assessment on pre-admission and on admission. Residents must also have access to health-care services, such as a general practitioner. In addition, Health Authorities were required to set staffing rules, known as a staffing notice, particular to each home and the needs of the residents.

Given that many of the Health Authority standards could only be enforced by education and persuasion, could ways be found to "talk up" the powers of the inspector? Similarly, how could a coherent message be presented with such a large number of standards? Ways of reducing complexity were needed. The two authorities where the majority of the fieldwork was undertaken had different strategies to address these problems. Although they had basically the same standards, these were presented to regulatees against a very different background.

Appealing to professionalism — Health Authority A

The Health Authority document which governed the work of Unit A tended to underplay the authority of regulatory law. Referred to as "A handbook for nursing home proprietors" [1], the publication emphasises the importance of norms, in particular those deriving from professions. That is to say, the Health Authority aligned itself with professional norms rather than with the Registered Homes Act.

> Legal documents and regulations can not, however, deal effectively with the intangible aspects of taking good care of people who are dependent... it is a service which calls for staff who can meet the highest standards in clinical nursing practice and the personal care of people.
> (Health Authority A 1993.)
>
> The handbook also firmly places an emphasis on the institution providing a homely environment, for example:
> ...this Health Authority is concerned that your home will endeavour to provide the best possible substitute setting for the patient's own home. (Health Authority A 1993.)

While the document sets out the requirements in all the relevant areas, these were seldom backed up by reference to the Nursing Homes Regulations or other regulatory law, such as the Health and Safety at Work Act. Thus the status of many of the requirements is unclear. Moreover, there is no mention of any penalties or sanctions for non-compliance. This distancing from law leaves open the question of the derivation of the inspectors' authority.

Such a view is understandable, as for many years the NHS claimed Crown Immunity from much regulatory legislation. The Health and Safety at Work Act 1974 was the first regulatory legislation that applied to the NHS. Instead, the normative framework was Department of Health guidance and standards of professional practice. Even when there was a requirement to comply with the legal regulations, norms tended to be

[1] "Taking good care: a handbook for proprietors of private and voluntary nursing homes and independent acute hospitals registered with the health authorities".

refracted through Department of Health guidance obscuring their legal origins. Having never been required to comply with regulatory legislation or to introduce a system of compliance, nursing home inspectors, as officers of the Health Authority, without any training would have little understanding of how to construct legal authority. They were much more familiar with the way the Health Authority operates in the nursing profession and in NHS management. The Social Services Inspectorate's review of six Health Authority inspection units carried out in 2000 suggests that an approach based on professionalism rather than the law was not uncommon. The inspectorate overall assessment was:

> (T)here was some evidence that the regulatory function was not properly understood. The problems concerned regulatory activities across registration, inspection and ensuring compliance and did not concern nurse inspectors' clinical knowledge and skills (Wood 2001 para 1.8)

Talking up legal risk — Health Authority B

> In contrast, the introduction to Unit B's document, published by the Health Authority in 2000 and called "Standards and Guidance"[2], suggested that their authority would be derived from the law. The aim of Unit B's guidance was: to assist prospective proprietors and persons registered in understanding and complying with the numerous statutory requirements regarding nursing homes... the guidelines continually refer to legislation and associated regulations concerned with physical standards of nursing homes and the qualifications and suitability of staff. The statutory requirements have been emphasised, as it is felt that a good understanding and compliance with these requirements will lead to high standards of care.
> Health Authority B (2000)

By 2000, the growth of regulation had increased to such an extent that most of the Department of Health's guidance could be underpinned by legislation other than the Registered Homes Act. Thus, each section of

[2] The Registration and Regulation of Nursing Homes, Independent Hospitals and Clinics: Standards and Guidance

the document was headed with a reference to the appropriate legislation. The legislative requirements were reinforced by reference to the risks of non-compliance with respect not only to the regulatory powers but also to the risk of private litigation. Thus good records were a defence in an "increasingly litigious environment". Records of accidents and incidents not only met legislative requirements but "provide the organisation with useful data and evidence in the event of possible compensation claims". The clinical record, as well being a key document in the care of the patient, was central to "the defence of compensation and clinical negligence claims". Health Authority B also linked the requirements to the offences, so while Unit A simply said that "a register of all patients" must be kept, Unit B reminded proprietors that it is an offence not to do so.

> Unit B also reminded owners that the Health Authority expected them to comply with other regulatory legislation, not just the Registered Homes Act. "Inspection by other statutory agencies will be required by the Health Authority and will be followed up by written report or letter ie Fire Authority and the Environmental Health Officer".

It is an interesting point as to whether a change in climate towards nursing homes occurred between 1993 and 2000 which meant that standards written at the later date could be written in a more threatening way. As noted in Chapter 3, deregulation was in vogue for much of the early 1990s. However, the new Labour government elected in 1997 was more interested in reform than deregulation (Baldwin 2005), and was pledged to reform regulation in the nursing home sector. This may have allowed authorities more licence to assert themselves.

Irrespective of any possible differences in political climate, these differences in emphasis followed through into the approach to inspection. In line with the philosophy set out by its Health Authority, Unit A avoided using reference to law when attempting to persuade home

managers. The exception was where homes fell below minimum standards of "fitness" – that is to say, where there was evidence that the home had transgressed its "social license". Otherwise, a persuasive rhetoric of professional improvement which emphasised the "needs" and "choices" of residents was the mainstay of inspectors in Unit A. Unit B attempted to consolidate the large number of rules into overarching schema which, as described below, owes much to modern "risk" management techniques. This emphasised the development of "risk" management systems to protect owners and managers against the risks of litigation and regulatory action, not from the Registered Homes Act but from other regulators who enforced a web of legislation which enmeshes homes and surrounds residents. Legal risks were exaggerated and presented as all-pervasive but there was just enough reality in this to make this bluff a credible threat. Possible explanation for the differences in approach between the authorities and their inspection units may lie in the background and experience of the inspectors or the institutional arrangements for the units.

The inspectors and their backgrounds

In Unit A, staff were directly employed by the Health Authority and all three nurse inspectors had worked exclusively in the NHS as senior nurse managers (their backgrounds are described in Chapter 2). The unit was jointly managed with the local authority. This meant that where the home had dual registration, that is to say both under Part 1 of the Act as a residential home and under Part 2 as a nursing home, then the home would be inspected jointly by both a local authority and a Health Authority inspector. There was also some harmonisation of standards and policies. In particular, lay inspectors were employed to undertake visits to nursing homes. Apart from the Health Authority's own pharmacy

inspectors and the local authority inspectors, the inspection unit had little formal contact with other regulatory agencies.

Unit B was a private company commissioned by a number of Health Authorities to manage all aspects of the regulation of nursing homes. At the time of the fieldwork, this company was responsible for regulation of nursing homes in some four district Health Authorities (the background of the manager and the team is described in chapter 2). Two members of the team were evangelical Christians and nursing home regulation was an important expression of their faith. They were inspectors with a mission to ensure the best for residents.

Although this was not a joint unit, it worked closely with other local regulatory agencies. The Unit had regular meetings and training sessions with agencies who formed part of the regulatory web in which nursing homes were embedded. As well as local authorities, this included the police, the Health and Safety Executive, the fire brigade, pharmacy inspectors, immigration services, and the UKCC, which at that time was responsible for the regulation of the nursing profession.

BACKGROUND TO HOMES AND VISITS

As described in Chapter 2, ten inspection visits were made with each unit. The homes were chosen by inspectors as ones where my presence as an observer was unlikely to cause difficulty with the managers. The homes visited, their ownership, size and location are described in detail in Chapter 2. Homes in a variety of locations and of different types were visited. Some were in quiet rural areas, others in suburbia and or in the inner city areas. The majority of homes were privately owned. Nine were owned by large corporate enterprises and five had owner managers. In size, they ranged from a small home of nine residents to one with

some 94 residents. Some premises were modern and purpose-built, others were converted domestic residences. As we shall see, the structure of the building limits the type of care that can be given to residents and provides a constraint for "suitable" and "adequate".

The regulations required that all homes receive two announced and two unannounced inspection visits per year. Usually these were undertaken by the same inspector. The majority of visits observed were announced inspections. While unannounced inspection visits had the advantage of the home being unable to put on a show for the inspectors, they had the disadvantage that there may be no managers present to hold to account. Nobody with authority would be on hand to provide information which would enable the inspector to assess whether a worrying observation was part of a general pattern, or unusual, with a reasonable explanation. Unannounced inspections were more likely to be used to collect information rather than exercises in compliance.

Most inspections with both units were tense, stressful and very tiring, with nursing staff occasionally bursting into tears during the visit. For large homes, visits usually began around 9am and often did not finish until 7pm, with only a short break for lunch. Visits to smaller homes would finish in the middle of the afternoon. Two of the inspectors had a practice of not accepting anything from the home, including food. While some inspectors accepted lunch, resources in nursing homes were so tightly allocated that only on one occasion was sufficient food available to provide a cooked lunch for two extra people. But sandwiches could always be rustled up. On the one occasion where a cooked lunch was taken, it provided a valuable opportunity not only to sample the food in the home but to chat informally with residents about the quality of care. Hutter (1997 p188) reports that whether inspectors accepted offers of lunch depended on whether the inspector wanted to keep a distance

from the manager. Lunch would be accepted where they had a close co-operative relationship.

For both units, inspection visits usually followed a common pattern which would be heavily focused on the home manager or "person in charge" (PIC). There would be an initial interview with the "person in charge" . A walk around the home followed, with inspectors collecting information about the environment and interviewing staff and residents. The inspection would finish with a further meeting where the "person in charge" was interviewed about the inspector's findings. Although inspection visits in both units followed this pattern, the type of information collected and the way the "person in charge" was held to account differed between the units. For other regulators (eg Hawkins 1984), the reputation of the regulatee was a major factor in shaping the inspector's stance to the firm. But in this case, it was not the reputation of the firm that was a major influence. Reputation did not necessarily rest with the owner – the person or body corporate with legal responsibility – the "registered person" – but with the home manager or the "person in charge" . As Hutter (1997 p173) notes, the inspector's emphasis is on the management. A good owner could be let down by a poor manager, conversely a good "person in charge" could occasionally change the behaviour of a poor owner. Thus the work for a nursing home inspector was focused on holding the manager to account for what had been observed during the visit or what had come to light between visits. As with factory inspectors studied by Hutter (1997 p173), good managers were seen as the key to compliance. And, similarly, a good manager was one who accepted the inspector's recommendation, was able to identify and remedy a problem and who generally could get things done.

The "registered person" or their representative would sometimes attend the inspection, voluntarily. Exceptionally, if the inspectors felt that the "person in charge" was incompetent or unco-operative, or that problems

were getting out of hand, the "registered person" would be summoned. As Hutter (1997 p175) also found, exerting pressure on managers by involving their superiors is also a common tactic used by inspectors. On one occasion, where the nursing home inspector had concerns about the home manager, the regional manager was informed of the visit and told to be present with the instruction that the "person in charge" was not to be told. The "person in charge" was then interviewed by the inspector in the presence of the regional manager. Thus the performance of the "person in charge" and their inadequacies were demonstrated to the regional manager.

The sheer number of standards meant it was difficult to check all of them on one visit but, in general, compliance with standards seemed poor. Of the homes visited, none appeared to meet all the standards, although a few were close. A significant number of homes were out of compliance in many areas. In particular, some eight years after the standards for unit A were published, five homes visited seemed not to have the required number of toilets, bathrooms, lifts and laundries. Unit B also had a large number of homes out of compliance with the building requirements, although their standards had been recently updated. Non-compliance with standards in nursing homes was not unusual. In my sample, compliance in individual homes varied from one home where an enforcement notice was subsequently issued, to one which had facilities and services far above the minimum and not seen in the twenty-three other homes visited. The only national data published on compliance states that less than half of the homes comply with the minimum standards for the storage and administration of medicines (National Care Standards Commission 2004).

The home considered unacceptable, well below the minimum standard, or not "fit" was very dirty, with one cleaner employed for thirty-eight residents. There was a smell of urine throughout which the home

attempted to disguise by a device that periodically emitted a chemical perfume. Equipment was rusty and the bed linen was in tatters. The nursing staff were of poor quality and had worked eighteen hours a day for nine consecutive days over the Christmas period. At the time of the visit, staff were not in uniform and it was very difficult to distinguish staff from relatives. One woman, who was vacuuming the carpet in a communal room, was presumed to be a member of staff but she was actually a relative who had found the home so dirty she had decided to take matters into her own hands. Call bells went unanswered during the inspection visit. At one point, the inspector went off to a lady who had been shouting help for some time, and came back to say that the reason she was shouting was that she could not reach the call bell. The inspector had given her the bell. The staff then commented: "Now she will have great fun with that." The inspectors had put pressure on the regional office to provide a considerable injection of management support but this appeared to be having little effect. The "person in charge" was told that the Authority was close to taking legal action in the form of an enforcement notice. The staffing arrangements in particular were unacceptable.

At the other end of the spectrum was a home owned and managed by a not-for-profit organisation. The home charged about twice the Local Authority rate and had many residents who paid their own fees, but it nevertheless had a waiting list. Nursing staff were paid above the NHS rates and the home employed a multidisciplinary health-care team. It was the only home visited which had access to services of a psychologist who made assessments as to whether a resident was depressed or showing the first signs of dementia. Unlike the many homes where call bell systems were either not working or placed out of the reach of residents, this home had a call bell system which recorded the length of time taken to answer the call and defaulted to general alarm after ten

minutes. It was the only home visited where there was evidence of major structural changes to the building as a result of the inspection process. The laundry had also undergone major renovation as a result of the inspector's requirements. Economics is not the only factor here, as other homes visited also charged similar rates for fee-paying residents but with far fewer facilities and a much lower standard of care.

STYLES OF PERSUASION

The Unit A style — focusing on residents and their needs

Hawkins (1984 p187) found in a study of environmental protection that:

> ...field officers only present themselves as authoritative legal actors when it is tactically appropriate to do so in negotiations... the law... is distant, dimly perceived and little understood. The officer, with few exceptions, has scant knowledge of the precise law he is administering and enforcing.

This was also the case for Unit A and reference to the law or the use of law as a threat or a risk was not a common part of conversation with home managers. Law was only brought into the picture when care in the home fell well below a minimum level.

Thus the Health Authority's philosophy carried through into the inspection process with expertise and authority derived from nursing. The emphasis was on both advocacy for individual residents and a very old philosophy, firmly embedded in the NHS, that residents must be treated or receive care according to their needs. Needs, in this case, are constructed from a nursing perspective which is described in more detail in Chapter 4. In making judgements about the home, Unit A was keen to obtain information from both relatives and residents. Inspectors went to some lengths to make themselves available to both on the inspection

visit. Thus Unit A's view of the resident shared much in common with the vogue for "user empowerment" in health policy and the industry's advertisements of the service they provided, described in Chapter 7. But as I shall explain, the general approach of Unit A based on these values was frustrated by legal and resource constraints.

Establishing needs and authority – the initial interview with the "person in charge"

The inspector's initial interview provided an opportunity to ensure that the home had kept many of the required records. However, a major part of the interview would be taken up with a discussion of residents and their needs – a discussion which had a number of different purposes. First, it provided an opportunity for the inspector to make an informal but professional assessment of the competence, skills, training and trustworthiness of the manager. As Hutter (1997 p174) notes, managers would be tested and this might include setting traps to see if they could be trusted. What did they know about their residents? How much did they know about the requirements for managing this type of resident? This was particularly important where inspectors had no previous knowledge of the manager. Secondly, such a conversation would also be used to establish the inspector's own competence and authority as a clinician and a manager – for example, what type of dementia did a resident have and what medication were they on?

A further important part of this conversation was obtaining the necessary information to make an interpretation of rules governing care and services. These were framed in terms of a requirement to be "suitable" and "adequate" to the number, type and condition of residents. For example, the staffing notice, a rule about the ratio of staff to residents agreed with the Health Authority, needed to be based on the number and type of residents at the time of the visit. Even establishing the number of residents was seldom straightforward, as most homes did not have any

electronic database of residents but relied on paper-based records. Trying to reconcile the number of admissions and deaths and discharges in a log book with crossings out and omissions proved a frustrating experience. In a large home of some eighty or ninety beds, several of which were visited, a considerable time might be spent with the "person in charge" in this activity, causing one inspector to remark that he was "losing the will to live" because the home had such poor records. Having established the number of residents, inspectors needed to make an assessment of "type" or needs of residents in order to match the staffing levels and the equipment such as hoists to these needs. As there had been no investment in the technology required to make a standardised assessment of need[3], the inspector's assessment of this, and of the required staffing levels, was based on a professional conversation between the inspector and the manager. How many residents needed feeding? How many had pressure sores? How many were confused? What was the dependency level? For a large home, this was often done at the level of the floor or unit.

Such questions also provided an opportunity for the home to admit that it was attempting to care for residents with problems outside their registration category. Homes can be registered as a general nursing home, one for the mentally ill or people with learning disabilities, or for those needing palliative care. For each category, there were legal requirements in relation to the skills required of the staff. A person who had a past history of schizophrenia, for example, should not be accommodated within a home registered as a general nursing home. While homes could have their licence withdrawn for accommodating residents outside their registration category, this was unlikely. Homes keen to fill their beds often admitted people without enquiring too

[3] The US Federal Government had funded the development of such a tool, a standardised "Resident Assessment Instrument". A UK version of this was being piloted in some homes (Challis D, Carpenter I and Traske K 1996).

closely about their past problems. Once accommodated, such people would be difficult to move because of the shortages of beds in more specialised homes. The higher fees charged might not suit the payer – the local authority – and geographical location may not suit the relatives. Some inspectors did not enquire too closely into this problem, but a sharp-eyed inspector would see that a particular resident did not fit the category "frail elderly".

Having formed a picture of the type of residents, the inspector would begin the difficult task of working out whether services were "suitable" and "adequate". Part of this was an inquiry into the very vexed subject of whether residents had access to local health services. While in law the NHS has a duty to provide such services for nursing home residents, in practice many NHS community services took the view that it was the nursing homes' responsibility to provide services such as physiotherapy or speech therapy (Jacobs and Rummery 2002; O'Dea G, Kerrison SH, Pollock AM 2000). The effects of the disagreement about responsibility is that residents of nursing homes had considerably less access to health services (Glendinning et al 2002) than elderly people living independently. As homes could not necessarily ensure access to NHS community services, compliance with this requirement could not amount to anything more than ensuring that the manager had attempted to obtain local health services. It was difficult for an inspector to insist on any more when it was not the home's duty but the duty of the inspector's own employer – the Health Authority – to provide such services.

While nurses can manage residents without therapy services, they cannot manage without the prescribing powers of doctors. For instance, residents with behavioural disturbances associated with dementia can only be managed by the home with the help of drugs. The inspectors would attempt to ensure that there were arrangements for general

practitioners to visit the home, and the "person in charge" would often attempt to seek the inspectors' advice about how to manage a difficult GP, but inspectors did not enquire too closely about relationships between the homes and GPs. As described in Chapter 3, the legislation gave them no powers to intrude in this area.

A typical length of time for this initial interview was around two hours. Very occasionally, the initial interview was omitted and the inspector looked round the home and then reported back. Having a picture of the home and with the competence of the manager and the dependency of the residents in his or her mind, the inspector would then set about the difficult task of seeking out further information in support of an argument about whether or not the home provided "adequate" and "suitable" services from observations around the home.

Gathering the evidence with Unit A

The buildings and the environment – sanctioned non-compliance

Both units made an attempt to ensure they looked in every room and at all residents. Bathrooms, sluices, kitchens and laundries were also inspected. Within the nursing home sector, building and skills cannot be easily changed to accommodate the needs of actual residents. Some eight years after the Unit A handbook was published, many premises appeared out of compliance with the Health Authority's requirements, in terms of the shared accommodation and facilities for people with disabilities, including specialised bathrooms and laundries. The lack of specialised bathrooms meant that a home could not comply with Manual Handling Operations Regulations 1992 and 1998, which required employers to avoid the need for employees to undertake any manual handling operations which involve a risk of being injured. Thus, to avoid lifting a dependent person in and out of a bath, an "island" bath is required – that is, a bath in the middle of the room with enough space

around to enable a dependent person to be hoisted into it with an attendant standing at each side. A further requirement was for a bath that could be raised and lowered automatically to prevent back injuries to attendants.

Such facilities were only routinely availability in modern purpose-built premises, and several homes visited had no such facilities. For example, St Agnes was a nursing home with accommodation built at different times, each reflecting a different understanding of the nature of "the resident" or a different positioning of nursing homes within the health-care sector. One type of the accommodation consisted of hospital-style wards shared by six residents, dark and in a poor state of repair, with vinyl tiles coming off the floor, old hospital beds, and a day or sitting area at one end. In another part of the building, there were individual rooms without bathrooms. The shared bathrooms did not comply with modern requirements however, as the baths were against the wall, making it impossible to assist a very dependent person.

There was inconclusive discussion between the inspector and the "person in charge" about the number of usable bathrooms, which merged into a general discussion about the Health Authority's requirements to update the building – a discussion which had been in progress with the Health Authority for some three years. In the car park, work was in progress on a new building, an assisted living unit which the owners were developing. Rather than bringing the nursing home buildings into compliance, capital was raised for new and a different type of facilities. As there was no requirement for this to be registered, the inspector did not know about the new facility until the visit. Although the existing nursing building appeared out of compliance, the inspector concluded that there were no problems with the care but that discussions about the building would need to continue.

A further small nursing home visited was a converted Victorian house which provided a service for a discrete rural community. The pictures around the walls of former residents who had celebrated their hundredth birthday gave testimony to a homely atmosphere. The manager and owner clearly knew all the residents, their habits and those of their families as well. Such personal care was much prized by the inspectors. However, the home used an unacceptable type of stair lift and the bathroom facilities were inadequate. The latter was not big enough to accommodate the hoist needed to enable one resident to get in and out of the bath. This resident had not had a bath since she took up residence some three years previously, and was articulate enough to complain. The problem of the bathroom could not be resolved because the home was on an economic knife-edge with an uncertain future. The inspectors, however, did not want the home to close as they thought it provided good care for the local community.

In the face of difficulties with buildings, it would seem inspectors could only ensure that care did not fall below standards and continue negotiations with owners. "Twenty-five residents benefiting from two bathrooms... I would like to help get that sorted sooner rather than later" was the comment of one inspector. However, owners were reluctant to invest in improved facilities, as the financial returns on nursing homes were low and new regulatory law was pending. As described in Chapter 3, times in the nursing home sector were very uncertain.

Leaving aside these major problems with buildings, inspectors in Unit A encouraged and expected to see a homely atmosphere. The state of décor, the type of flooring, the bed linen and whether the home smelt of urine were all matters of concern. The inspectors considered any flooring other than carpets to be too institutionalised. However, many homes considered carpets unsuitable because they were continually

soiled with the urine of incontinent residents. The resultant smell would indicate not only a hygiene problem but failure to manage incontinence.

Views of staff and residents

The walk around the home provided an opportunity to talk to staff, in particular the cleaning staff. How many were there of them? How many hours did they work? Had they received any training? The nursing staff views of the home were sought far less often, although they might be asked for information about the ways things worked and whether they had had any training. However, a particular feature of inspections with this unit was talking to residents.

In advance of their visit, this unit asked homes to put up notices and display leaflets saying that they would be available to talk to residents and relatives. Although no relatives or residents were observed waiting, inspectors said that relatives did occasionally phone up and comment after seeing the notice. Inspectors would ask residents questions, such as, what could be better here? Do they come when you call? As a large number of home residents are cognitively impaired, finding residents who could answer such questions could be quite a difficult task. But it was part of the ethos of the team to listen to residents and bring their complaints to the attention of the "person in charge" . Inspectors also had a "case load" of residents for whom they appeared to be acting as advocates, pursuing the residents' complaints and dissatisfactions with the home. Such residents, including the one mentioned above who could not get in the bath, would be visited and progress with their case would be discussed.

Some residents had complimentary things to say about the home. Staff in one home were described by a resident whom the inspector always visited as "friendly, thoughtful and kind... they don't pull you about and holler at yer... you know what I mean... they keep you clean and tidy",

"lovely little workers". The relatives at St Agnes said "Mum is always nice and clean and the staff do her nails with nail varnish... it's nice". A married couple felt very comfortable, well looked after and pleased they got out to various treats. Residents could have different views of the same home. While one severely disabled man complained about the lack of a social life and his need to go out, another resident described the same home as "very relaxing... they really care... the food is very good... beautiful surroundings... couldn't fault anything". Another resident commented that she was fine as she had two young men with her, "will power" and "perseverance" ! Some residents were passive, they did not like to worry the staff because they are very busy and they "aren't always on duty for me". Another, when asked whether staff came promptly when called, remarked "people don't have call bells "cause they use them too often"!

Few had complaints they were prepared to voice. A resident who had been in one home for nine years, commented that the place was going down hill. The food was no good... cold with poor ingredients. She said the top brass had been cutting back and the staff had been pared to a minimum and were working at top speed. The toilet paper was far too flimsy! In a different home, Ben complained that the food lacked variety. He would like curry or Chinese. He was fed up to the teeth with peas and there were no condiments like pickles and no roast potatoes, only mash. He also complained about the way he was lifted. Some of the staff were "heavy handed". He knew that they have to wear rubber gloves but his skin got twisted and torn (he has bandages around both upper arms). It hurt. At this point he burst into tears. He also complained that he could not get out of the building because he could not get his wheelchair over the high door sills unaided. As noted below, this was discussed with the manager but with little effect.

In a home where the inspectors were on the point of taking enforcement action, one resident summed up the problems – problems of which the inspectors were only too well aware. He said that he had not seen a doctor in a year. He had only seen the last matron once in the last year and only one person came in all day. He thought he would be better off in a hotel, all the money he is paying. He also commented that he always ordered the cooked breakfast as "there was a chance that they might get you up... otherwise you are stuck in bed all morning".

But the numbers of residents from whom it was possible to obtain a view of the homes were few. The complaints above were all that could be documented from full day visits to ten homes with a total of 368 residents. In five homes, there were no residents sufficiently aware to be able to articulate complaints. This is not surprising given that a level of cognitive impairment between 60% and 90% has been found in nursing homes (MacDonald A 2002; Netten et al 1998). Moreover, these few articulate residents tended to divorce themselves from the majority who were cognitively impaired. They said they ate separately, having meals in their rooms because, as one such informant put it, other residents had "irritating habits". They were also able to co-operate with the staff and engage in social conversation and thus could be more rewarding to care for. It was therefore quite likely they would be treated differently, so their view of the home might not be that representative.

Inspecting care planning

Whilst talking to residents, inspectors would also note their cleanliness, their teeth and their hair. They would also notice whether they appeared to have wounds or bruises or significant weight loss. The case notes of such residents might then be examined and the findings taken up with the "person in charge" . Inspectors would also look at a random

sample of care plans as well as the care plans of people about whom they had concerns.

Inspectors would often criticise the adequacy of such plans. For example, the daily record or statement - a legal requirement – often did not reflect the care plan. A resident may receive a high score in a risk assessment for pressure sores but no plan for action would follow from this. Nurses would write that a wound was infected, but there was no record of any subsequent action. In four homes visited, there were some very visible indications that all was not well with care planning. In these homes, relatives, frustrated that important issues were overlooked, would write out sets of instruction for staff, or "care plans", which they affixed to the wall in the resident's room – for example: "Please do not give Bill confectionery of any sort"; "Una needs her glasses to see... please put them on for her"; "Please do not pull on Harry's left arm, it is very painful and we spent six hours at hospital with suspected shoulder dislocation. Harry can assist you as far as he is able... if you ask him".

Inspectors also encouraged the staff to place more emphasis on emotional and social issues in care planning - an approach which would suggest an holistic model of the individual. A number of nursing home managers seemed to have little understanding of what this might involve. However, where nurses were competent to make such assessments then this led to other problems. Considering the level of cognitive impairment in nursing homes is known to be between 60% and 90% (Chapter 1), the conclusion of such assessments in many cases would be that the resident needed skilled help. But it was unlikely that this could be delivered. No home visited with this unit employed a psychologist. NHS community psychiatric nurses were usually thin on the ground for NHS patients, with nursing homes facing the additional problem, common to all NHS community services, that the local NHS was likely to see this as the home's responsibility. Inspectors would criticise homes with large

numbers of cognitively impaired residents for lacking any therapeutic programme. But as dementia was not a legal category under the Act, they could not require such programmes. Instead, skilled care was replaced by a poorly paid activities co-ordinator. Thus, in homes with large numbers of demented residents, the activities co-ordinator supplying sing-songs and craft took the place of any therapeutic intervention. The Health Authority had set a standard for such activities co-ordinators of one hour per week per twenty residents, and the inspectors also liked to see a varied programme of activities in the homes. But this was clearly not an issue which inspectors had many powers to persuade or enforce. That is to say, it was likely that this professionally defined need remained unmet and there was little inspectors could do.

Assessing staffing, training and equipment

The rule that a Health Authority made about staffing was a condition of registration, but there were many ways in which the intent of these rules could be thwarted. The first problem was that the home might have far more heavily dependent people than when the notice was agreed. Therefore the notice would be inappropriate to the needs of the residents. The second problem was that inspection of duty rotas suggested that staff work very long hours – fifty hours a week was not unusual. The third problem encountered was that, in homes with separate units, the legal requirement was for the staffing notice to be set for the home as a whole. So while the home as a whole would comply, the staffing in individual units may be well below the level the inspector thought was adequate. Associated with staffing are the training needs. As well as the legal requirements for training in areas such as fire safety, inspectors would argue for training in care for dementia. Homes also should have sufficient hoists, pressure-relieving

equipment and weighing scales, and appropriate beds. It was not usual to find homes lacking such basic equipment.

Holding the "person in charge" to account

Within Unit A, inspectors varied considerably in the extent they were prepared to engage with the "person in charge" in the final interview. Some merely announced the problems they found unsatisfactory while others engaged in considerable persuasive argument. Inspectors in this unit described their job as little different from NHS management - monitoring performance and using their management skills to provide advice. Therefore, where the home had reached the minimum standard, the interview provided an opportunity for inspectors to point out issues which they felt to be problems, to persuade the home to improve, and to compliment the home on improvements.

Professional values tended to provide the persuasive force in these conversations, with strong disapproval being expressed as nurse to nurse rather than in terms of a requirement to be compliant with the regulations. For example, in one home the inspectors became aware that there were insufficient hoists. On one floor in particular there was one hoist for seventeen highly dependent residents. Rather than being reminded of the requirement to comply with the moving and handling regulations and the subsequent legal liabilities of failing to do so, the inspectors noted there was some rough handling going on, the staff needed more training in manual handling and they needed more hoists. When the inspector considered the staffing levels inadequate he remarked, "I don't consider this to be professional, do you... it's not adequate to cover the risk". Where the staff worked unacceptably long hours the "person in charge" was asked: "Are you happy they are producing quality care?" Although control of infection regulations are enforced by environmental health officers, the inspectors' choice was to

draw on the manager's professional conscience: "How can you say as a nurse... you can't have handwashing facilities?" Intractable problems with the buildings and environmental hazards were simply stated with little expectation that progress would be made.

Residents' views were nearly always taken up with the "person in charge" but criticisms from this source seemed to cut little ice. When inspectors challenged the "person in charge" with Ben's comments about being roughly handled and that he was unable to get out of the building, the "person in charge" replied that he was rude and demanding, and wanted everything his own way. He had great difficulty in coming to terms with his situation. In another home, when a resident's complaint about the food was reported to the "person in charge" , she said that the resident was difficult to please and the food was cold because she insisted that she ate in her own room. The inspectors had also spent considerable time negotiating on behalf of the quadriplegic resident who wanted to go out more often and wanted more entertainment. Little had been provided and the inspectors felt that, for £400 a day, the home could do better. The compromise situation for the resident who could not have a bath because it was not possible to get a hoist into the bathroom was that the home had been persuaded that the resident's feet be should washed more frequently.

As well as the denial of residents' expressed needs, the "person in charge" would deny the inspector's judgement of need. For example, a home lacked hoists because, in the manager's view, it was unsafe to use them. In another home, where we had had great difficulty in finding anyone to interview because all the residents appeared confused, the inspector told the manager that she had noted a number of confused residents and there seemed little in the way of care planning around mental health. The manager refused to acknowledge this, stating that she did not admit people who were confused. There was no one in the

home posing a problem to the home or themselves. In the face of such disagreements, some inspectors would continue to press their point, others would not argue but nevertheless write it as a finding in the report.

While there could be much disagreement between inspectors and managers about compliance and the evidence on which it was based, inspectors did have one strategy, also common to Unit B, for getting alongside managers. The final interview provided an opportunity for the inspector to collude with the "person in charge" to obtain more equipment and other resources for the home - a tactic which Hutter (1997) reported as also being used by factory inspectors. Inspectors would ask: "What do you think of your beds? Honestly? Is this something I can help you with?", "What else do you need? I will put it in the report." However, on occasions this tactic might be foiled by area managers from large corporates who attended to make sure this did not happen.

Going public – the Unit A report

For Unit A, "putting it in the report" carried a considerable threat. Unit A's reports[4] give the reader a clear picture of the strengths and weaknesses of the home, where standards have been meet, where the home is failing and where regulations are being contravened. The reports use the term "resident", or sometimes "client", rather than patient. As such reports are public documents, the adverse publicity must have been unwelcome. For example, in a home close to legal action the report noted that:

> Piles of clean and dirty washing filled the laundry and containers of dirty washing were parked in the corridor.

[4] To preserve the anonymity of homes and the inspection units, these reports have not been referenced.

> Most visitors expressed concern regarding the quality of care provided... four said that they would like to move their relatives out of the home. Staff continue to work excessive twelve hours shifts with two short breaks. This is unacceptable to the registration authorities and has been raised in previous reports.

Reports might also be used to support and pursue the complaints of individual residents:

> There is one outstanding matter identified in a recent complaint investigation. It was agreed by the "person in charge" that carpet would be replaced in one of the resident's bedroom after the bedroom had been inadvertently flooded. This has yet to occur.

Or to send warning signals:

> Staff training records were not available at this inspection but will be monitored at the next inspection.

Anyone who had a choice in the matter might think about placing their relative in a home with the following report – however, those with no choice might be waiting a long while for an improvement:

> The home has 32 single rooms and 4 double rooms. All rooms have en suite bathrooms, however, none of the residents' bathrooms can accommodate a hoist. The majority of current residents need to use the two assisted bathrooms. There is therefore insufficient provision of assisted bathrooms for the current client group. This issue has been raised in the last two inspection reports and has still not been addressed. The manager stated that she was still awaiting a review of the premises. A meeting will be set up to discuss progress.

The professionally defined resident

The inspectors avoided using the law except where standards were well below an acceptable level. Instead, they relied on professional values, the resident's voice and the limited publicity of the report as a persuasive force. The resident is therefore constructed as a person with agency whose needs are professionally defined. In reality, not only do

few residents fit that definition but even when supported by regulatory officials their views seem to carry little persuasive force. As Stannard (1978) notes, in a situation where patients are unreliable by definition, it is all too easy for staff to deny the legitimacy and validity of their views and to account for them by referring to the discredited attributes of the person making them. Two out of three of all residents had their fees paid at least in part by the local authority, therefore they had little power in the market place. Similarly, professional definitions of needs for this client group are not supported or underpinned by the Registered Homes Act or any other institution associated with it, such as the Registered Homes Tribunal - an issue discussed in more detail in Chapter 6. The concept of "needs", professionally defined and measured, has always been contested in health care, with people treated or assessed according to the resources available rather than according to their "needs". Nevertheless, the concept of "need" does hold some rhetorical force in a publicly funded service where equity is a political goal. However, in the nursing home context, the law prescribes nursing care only, and through other decisions which define and place boundaries around Health Authorities' powers, denies other definitions of needs. The vague definitions of the Registered Homes Act allow standards to be driven down. For example, the decisions of the Registered Homes Tribunal described in Chapter 6 indicate that residents must be fitted to homes rather than the other way round. Professional nursing values hold little sway when it comes to structural problems such as inadequacy of buildings, equipment or the employment practices of nursing home owners. Similarly, because there is a legal category of homes for people with mental illness, an inspector could assert that placing an individual with manic depression in a home for the elderly was a very serious matter as "it denied the man his rights to be treated according to his needs". But no similar assertion was ever heard to be made or could be made in the case of the large number of confused elderly, as there is no

legal category for people with dementia. The rhetoric of inspectors in this unit seemed to have less potential to persuade nursing homes to develop their everyday practice in the desired directions. In this context, promoting professional values and a view of the resident which is counter-factual does not seem to be a greatly productive force. However, their emphasis on public shame may have proved just as powerful. The literature on firms' motivation for compliance suggests that large chains in particular are very sensitive about their reputation (Gray and Shadbegian 2005; Mendellof and Gray 2005). But, as noted in Chapter 7, until recently political activism on behalf of nursing home residents is weak compared with other sectors.

THE UNIT B STYLE — "TO PROTECT YOU FROM THE LAW"

Unit B's approach was described to me by one of the inspectors as "bringing to bear any law they could lay their hands on". In practice, this meant not only working closely with the other regulatory agencies and the police, but also intimating that private prosecutions against nursing homes were an increasing risk. As described above, the unit worked with many other regulatory agencies to obtain an understanding of their requirements. The strategy was to portray these other types of law as a threat which could be lessened by practices recommended by the inspector:

> ... this is to cover you for the UKCC[5]... it is far worse than any court... don't know whether you have been there... it's terrifying.

The Coroner could also be brought into play. One manager was informed that the Coroner was now taking an interest in deaths in nursing homes, particularly if the deceased appeared emaciated or otherwise in poor

[5] United Kingdom Central Council for Nursing and Midwifery - a body which at that time controlled the registration of nurses.

condition. The inspector had been asked to give evidence at a Coroner's inquest, reported in the local paper, into two deaths in one particular nursing home. Because the nursing homes had good records she was able to testify that they had done all they could, but "with your records, Mavis... ?" Homes were also portrayed as being at increasing risk of private prosecution. Families were reported as being increasingly aware that pressure sores meant inadequate care and would sue. Tales were related where scratches from furniture in need of repair, had been left unattended and became infected, resulting in lower limb amputation, with the relatives suing. Given the difficulties of proving cause and effect in such situations as described in Chapter 6, it would seem that the inspector was bluffing. In their empirical studies of the inspectorate, Hutter (1997) and Hawkins (1984) both found that bluffing is a very well used technique in the regulatory context.

The strategy was to exaggerate the risk from all inspectorates and the law in general. But while the powers of other regulators were talked up, when called upon to provide support for the nursing home inspector, their response could be disappointing. One of the inspectors from Unit B described the local Health and Safety Executive inspectorate as "very caught up with the airport... not too interested in the little old man falling out of a nursing home window onto the rose beds". Similarly, the same inspector described the UKCC (the professional body responsible for registration of nurses) as "disappointing... had several cases we have referred where they have said they could not act". But these legal risks were not entirely without foundation. In 1994, the regulatory body for nurses – the UKCC (1994) reported that complaints against nurses working in nursing homes formed the largest category of complaints. Similarly, as described in Chapter 3, the Health and Safety Executive database records many successful prosecutions against nursing homes since 1998, with fines in excess of £20,000. This is by far the maximum

allowed under the Registered Homes Act. Having built up the powers of these other regulators, inspectors attempted to form an alliance with the "person in charge" to reduce the legal risks they had exaggerated. The purpose of the inspector's job as described to the "person in charge" was "to protect you from the law"!

Fixing the uncertainties in the Registered Homes Act by invoking "other law" had advantages. The inspector's recommendation could be portrayed as protective not only against the risk of legal action against the nursing home but also against professional disciplinary action by the UKCC. On occasions, nurses in charge of a floor seemed to appreciate the "training" they had received and would remark they had learnt an awful lot. The approach also gave inspectors a persuasive lever for improving the environmental standards in nursing homes, instead of being impeded by the constraints arising from the decisions of the Registered Homes Tribunal. Unlike guidance under the Act, which was considerably weakened by the Tribunal decisions discussed in Chapter 6, Health and Safety Executive guidance carried more force. The inspectors were well aware of this. As described below, this Unit required much higher standards of laundries and kitchens. A further benefit was that the inspector's argument that such risks would be lessened with increased documentation had the effect of making the care provided in the home more transparent to inspectors (Power 1997).

Like Unit A, focusing on and assessing the calibre of the "person in charge" was central to the task. Inspection visits would be tailored to the inspector's perception of the "person in charge" . For example, where the inspector felt that the "person in charge" was competent and there were no problems with the home, the focus would be on developing nursing practice: "where we see willing we will put knowledge in then we can see things moving forward". Where the situation with the home was delicate but improving then the inspectors

would temper their criticisms with praise for improvements. Being overly critical could result in the "person in charge" resigning and the home being left in a worse situation. In situations where there was uncertainty about the integrity or competence of the "person in charge" , the announced inspection visit might be arranged so that the "person in charge" could be put to the test by the inspector in front of the owner, who had been summoned for that purpose.

Unit B also had a more structured approach to inspection. They expected nursing homes to not only have a comprehensive suite of policies but systems in place to check whether such policies were "alive". They expected audits to be undertaken to ensure that policies had been put into practice by staff. They had also devised their own series of audit tools around issues such as wound management and nutrition for checking the integrity of a nursing home's systems. The use of one such tool is described below.

Getting alongside the "person in charge"

For Unit B, the interview with the "person in charge" provided an opportunity to check the various licences, the requirements of other inspectorates, other documents and employment records that are a requirement of all homes. On inspection visits, it was the practice to ask for the most recent reports of other inspectorates, make a note of the requirements and establish whether action had been taken. Where these other inspectorates had not visited the home recently, or the inspector thought such an inspection necessary, then they would be called in. The home was also required to produce a large number of policies which inspectors would read and comment on practical or other flaws — for example, complaints policies that made no mention of the right to complain directly to the Health Authority. Inspectors would also make a note of aspects of policies to pick up later with staff.

As noted above, inspectors from this unit were focused on environmental issues and the management of risk. For example, they would expect special arrangements to reduce risks of accidents to be made for residents who smoked. They would also focus on arrangements for maintenance, including the records. It was not unusual to find that the maintenance was undertaken by migrant workers with poor English, and the records, where they existed, would be very difficult to understand. Where such records were of poor quality it provided an opportunity to remind the "person in charge" of the risks they were running by not clearly documenting the proper maintenance of equipment:

> Forget the Registered Homes Act .. this would apply if you were running a factory. Wheelchairs require maintenance... not in the Registered Homes Act but people do get nasty accidents and when they do you need a clear paper trail to show that the wheelchairs have been checked... if something happens the HSE will be all over you like a rash... they say its only guidance... but they will on to you as though it's a legal requirement.

As with Unit A, the initial interview also provided a chance for the inspectors to establish their credentials with the "person in charge" , with inspectors often mentioning that they had managed nursing homes. Nurse inspectors from this Unit would also take the time to describe to the "person in charge" the focus for the day and what they would require of them. For example, whether they intended to inspect the kitchens and whether they wanted to talk to staff.

As with Unit A, inspectors would want to know the number of residents and whether there were any who should not be accommodated in such a home either because of the home's legal category or because the home did not have the staff or equipment to meet their needs. Again, part of the job was to make sure that homes did not admit people whose needs they could not reasonably meet. In the case of poorly equipped homes,

the inspectors would seek to put the owner in a position were they would lose revenue unless they provided better equipment:

> There are no hospital beds... only divans? How does the equipment go under the bed? You are the gatekeeper here, Mary... the owner must provide the building and equipment or you must severely restrict the clients you take... you must make the owner aware of who you are turning away.

Looking at systems and practices with Unit B

The environment as risk

Because the Health and Safety at Work Act provided a powerful lever, many of the problems found in nursing homes were reconstructed in terms of health and safety standards. For example, furniture in poor condition was noted as an infection risk rather than a problem of aesthetics or not providing a "homely" environment. An elderly resident may have a wound which would get infected from the furniture in poor condition and the relatives would sue. For the control of infection, laundries were required to have clean and dirty areas with soiled linen placed in red bags which were then placed unopened in the washing machine. Gloves and aprons needed to be available to staff as nursing homes provide a pool of infection for MRSA and outbreaks of scabies are also not uncommon. Cleaning agents must be locked away, the laundry and cleaning cupboards must be locked. Similar attention was paid to the kitchen, including the recording of fridge temperature, fly screens and so on. Systems, schedules and records for cleaning were also required. The inspectors would often get the laundry and kitchen staff to describe these practices. This could be difficult, as such staff often had poor understanding of English, but they seemed pleased that someone was showing an interest in their work. On an announced inspection it was clear that many backroom staff were making a considerable effort not to let the manager down! As with Unit A,

inspectors would also collude with the managers and encourage other staff to try and obtain improved resources for the nursing home, saying directly to kitchen staff... any thing you need... now is the time to ask ?

Bodies and the adequacy of systems

With Unit B, inspection of the care followed a purposeful routine. Although the inspectors did talk to residents, rather than attempting to obtain their views, the aim of the conversation was to make an assessment of individual care. The inspectors' efforts to communicate with patients or relatives during visits were largely symbolic: "That's a really pretty blouse you are wearing." Such casual interest in residents provided an opportunity to notice the state of the residents' teeth, nails and hair. Did they smell? Relatives, where present, were asked about the care, although no attempt was made to inform them in advance of the inspectors' visit.

While walking around the home, inspectors made a note of anyone in bed, anyone who had bruises, bandages, evident weight loss or anything else they considered to be of concern. The case-notes of these residents were then inspected. Where it was suspected that the cause of an injury was an accident, the inspector expected to see a relevant report in the accident book and an appropriate treatment plan in the nursing notes. Documentation of the accident which would stand up in court was expected: Who was there? Witnesses? Any equipment involved? Where was the resident's head? What did you do? While inspecting the accident records, one inspector told the "person in charge" that she took the view that the criteria for all documentation in a home should be "the day we are going to court - we never are, of course".

If the explanation for the accident appeared to involve moving or handling the resident then the inspector reviewed and commented on the appropriate part of the care plan. Further questions would be raised

about the adequacy of staffing levels, training in moving and handling and the adequacy of the equipment. Where these proved to be inadequate, the manager might be reminded of the financial risks from litigation: "Did you see the latest award for back injury – £200,000." Clearly, the home would be covered by employer's liability insurance but such a claim would be very damaging for the home's reputation. The inspector spotted a resident with bandages on both legs. She asked the resident how she got the injury. The resident, who was cognitively impaired, said that children tripped her up with string. The inspector then asked the nurse who replied that she did not know the cause, the resident had very frail skin. The inspector then examined the accident book and the notes. The fact that there was no record of the injury in either of these places was taken up with the "person in charge" . In another case, a resident had a bruise on his wrist, and there was no accident report and nothing recorded in the care plan. The inspector explained that, because of the lack of documentation, she did not know what was happening and it was not acceptable. Although the residents looked well cared for and the staff were well motivated, she was concerned that there was no account of Lesley's bruise. She did not want to be getting the police in. The sister, alarmed by these threats and the demands on her, bursts into tears. Inspectors often remarked on the under-reporting of accidents and wanted to see more reporting. Like the factory inspectors studies by Hutter (1997), they had no hesitation in using bluff, drama or hyperbole to press their point.

Similarly, where inspectors had previously noted problems with residents such as significant weight loss or pressure sores, care plans were examined to assess whether these problems had been dealt with. With some inspectors this examination of nursing records could turn into a lengthy teaching session on care planning with the nurses in charge of the floor. At other times, it could be much more threatening, as inspectors

attempted to find out the extent to which nurses on the floor understood the home's policy. For example, a nurse was asked what procedure she would adopt if she suspected a case of abuse. The recommendations were often for more detailed protective documentation:

> Your records need to prove that you have done everything reasonably practical if you get hauled up around a duty of care.

With this group of inspectors, little time was spent establishing the current staffing level or the dependency levels for the home as whole. Instead, inspectors would demonstrate the inadequacy of staffing levels by using difficult individual cases. On one floor of some thirty beds, the inspector asked the sister to produce the records for the most dependent patient they had. She remarked that, in the care plan, three people were required to toilet this resident. The inspector then asked for the duty rota and noted that there were only three people working on the floor on this shift. "What happens to the other 15 residents when they are toileting Fred?", she asked. She considered this level of staffing was unsafe; however, for the announced inspection, the home would be unlikely to be non-compliant with the staffing notice. Instead the inspectors describing the problem as "an issue of professional accountability".

Inspection visits might also be uniquely tailored to engage the home in an audit of a particular topic. On one such visit, as well chasing up the outstanding requirements in relation to the kitchen and laundry, the inspector decided to audit nutrition. The process began with the "person in charge" being informed that part of the day would involve a "professional discussion" about nutrition. In the presence of her manager, the "person in charge" was asked to identify all the standards – legal, Health Authority and professional – which governed the home's practice in relation to nutrition, and to tell the inspector how these had

been operationalised into policies for the home. Prompted and helped by the inspector, the "person in charge" was required to discuss the health and safety requirements and environmental health standards for kitchens, the requirements for staff training in food handling, the UKCC requirements in relation to nutrition and the home's policies and records in these areas. The "person in charge" was then required to identify the systems the home had in place to ensure that staff were competent in these areas, the records that were kept and the quality control processes that were in place to ensure that policies were adhered to. This was followed by observation of lunch in the home, which included the arrangements for feeding residents who could not feed themselves, and the recording of nutritional matters in a sample of case notes and an inspection of kitchens.

The inspection report

Unlike the reports for Unit A, reports for this inspection unit just recorded compliance or non-compliance with the Health Authority's standards, to the extent that there was no mention of the "patient" or "resident". The report did not give the reader any clear picture of the care in the home and appeared to be addressed to an internal audience with little or no information that would give the public an idea of the home's quality of care or the home's problems.

Using law to protect bodies

The style of Unit B has a great deal of similarity with an approach to regulation of risk seen in the Health and Safety at Work Act (Hutter 1999). In a practice that is simultaneously constitutive and constraining, inspectors attempted "to constitute structures, routines, and procedures... which will be incorporated into organisational routines and also become part of everyday individual activity" (Hutter 1999). Unit B

were engaged in a kind of enforced self-regulation where the inspectors are making use of key elements in homes' own internal logic practices (Black 1999; Ayres and Braithwaite 1992). This unit attempts to use all the formal resources of a regulatory network consisting not only of the Registered Homes Act but the burgeoning amount of other legislation, to constitute an environment of procedures and practices to protect residents. Thus, the environment appears to be conceived not only in terms of the state of the buildings and equipment but the systems of care, including staff employment and training. With this approach, elderly residents are constituted as though they were very delicate china. The home must therefore have systems in place to protect the bodies of very frail elderly people from harm. For this unit, there was no need to ask residents for their views or experiences of the home. The failure or absence of routines, procedures and systems was written on the residents' bodies. This model fits well with the nature of the residents, as their protection is not dependent on their ability to articulate and express views. However, the process appeared to be directed toward the internal management of the system, with expressed views of residents, their relatives' or wider public lying outside the system.

CONCLUSION

Health Authorities were very unlikely to prosecute nursing homes. They were more likely to take the administrative action of removing the licence of a home operating well outside the terms of its "social licence". The licence for nursing homes is best described in these terms because, as the decisions of the Registered Homes Tribunal analysed in Chapter 6 suggest, licences are removed for actions considered immoral and which cause residents actual harm - abuse, neglect and gross

financial mismanagement – rather than transgression of legal rules. Thus, the traditional view of regulation as compliance with formal legal rules under the threat of legal sanctions bears little relationship to how nursing home regulation is actually conducted. Instead, this study has identified a number of persuasive strategies that are used to encourage nursing homes to adopt practices considered appropriate. With enforcement action unlikely, these strategies are not backed by any sanctions beyond improvement notices. As Gunningham and Johnstone (1999) have observed for occupational health and safety in Australia, the criminal law has lost a significant role in enforcing standards for either of these inspection units.

Unit A appeals to nursing homes as sites of professional nursing activity, with inspectors finding it difficult to distinguish their current role from their former one of nurse managers. Therefore inspectors are concerned with what could be described as the "professional licence" for nursing homes. However, as discussed in Chapter 4, the hold that a professional licence has on a nursing home is likely to be weakened, as nursing homes employ few professional nurses and those that are employed are on the periphery of the profession. Motivated by the need to earn a living in the harsh financial circumstances of the nursing homes sector, rather than maintaining professional standards, they perhaps should be seen as tradeswomen. But Unit A's stance as professional nurse managers also leads them to be interested in providing advocacy for individual residents, involving the public and shaming a home by publicising their findings, particularly where a home shows no inclination to improve matters for its residents. These are all strategies advocated by regulatory scholars such as Gunningham and Johnstone (1999) who have researched firms' motivation for compliance. However, their effectiveness in situations where the protected are marginalised and have little power is questionable. The approach of Unit B, with its

insistence on the development of systems to militate against risks, is similar to the model of enforced self-regulation proposed by Ayres and Braithwaite (1992), or to the systems approach to occupation health and safety advocated by Gunningham and Johnstone (1999). It appeals to the "person in charge" as "tradeswoman" or "tradesman", rather than as professional nurse.

As for the image of the resident, Unit A's professional approach means they were concerned with empowerment and view the resident as subject whose autonomy should be promoted. As noted in Chapter 4, this approach is related to the professional ethos of nursing but is out of step with residents' actual characteristics as highly dependent people who are cognitively and physically impaired. In contrast, Unit B's emphasis on compliance with environmental standards means that the resident's body becomes the object to be protected. This is more in tune with the working practices of homes but runs counter to advertising of nursing homes as places where individual needs and preferences are catered for.

Chapter 6

UNRELIABLE EVIDENCE: RESIDENTS AND THE REGISTERED HOMES TRIBUNAL

THE REGISTERED HOMES TRIBUNAL AS A LEGAL FORUM

From 1985 to 2004, the Registered Homes Tribunal operating under the Registered Homes Act 1984 heard appeals from nursing home owners against the decisions of Health Authorities. The types of decisions which could be the subject of an appeal were refusal to register a nursing home, withdrawal of registration or the imposition of conditions on registration. In this period of some 18 years, 86 appeals were heard – around four or five a year. The Tribunal fulfilled the very traditional legal purpose of adjudicating a rights claim (Ogus 1994 p116; Rubin 1991) – the claim of home owners to pursue their business without unreasonable interference of government officials charged with the task of protecting the welfare of residents.

The arrangements were for the Tribunal chair to be chosen from a legal panel appointed by the Lord Chancellor and for two other members to be selected from an expert panel of nurses and doctors. The Tribunal had the freedom to decide on the type of legal process used in the appeal – mediatory, inquisitorial or adversarial. But it operated mainly as an adversarial legal forum (see Council on Tribunals 1998 para 2.129) with both parties represented by counsel. Although there was a potential for decision making from the perspective of health care professionals, the decisions remained primarily legal in character. But throughout the Tribunal's history, the people who live in nursing homes were sometimes referred as "patients" and sometimes "residents", with no consistency. Using the recorded Tribunal decisions, this chapter explores how

representations of nursing homes residents were brought into play in these legal decisions.

As in other legal fora, the stakes in an appeal could be very high. For the reasons described in Chapter 2, prosecutions under the Registered Homes Act 1984 were rare. Therefore, the main sanctions available to Health Authorities were administrative. Such sanctions included those which could result in a particular home being immediately closed, with the dire consequences for the home owner of the loss of their business and their reputation, and exclusion from the industry. The main function of the Tribunal was to provide a constraint on such decisions. Much could be at stake for Health Authorities too, as their authority and competence could be called in question. Boyle (1994) notes that Tribunals, in general, are usually confined to ensuring the correct application of rules whose content and objectives are decided elsewhere, with complainants seldom being given the rights to challenge the merits of decisions. However, the Registered Homes Tribunal could take *de novo* decisions, overturning any regulatory rules or any sanctioning decision made by a Health Authority.

In the Registered Homes Tribunal, appellants and respondents were represented by a small group of barristers whose names appeared frequently. There were also a small number of appeal chairs, with around a quarter of all appeals being heard by the same person. Thus, through a small group of lawyers providing advice to Health Authorities and home owners and through the published decisions made freely available to all those with an interest, messages about the Tribunal's view of the law and the behavior of Health Authorities and home owners were transmitted within a relatively small community. In a system where operational guidance to the inspectorate was vague and prosecutions rare, the Tribunal was potentially one the few cohesive forces among the one hundred or so Health Authorities responsible for regulating the sector. It is difficult to directly demonstrate that the decisions of the

Tribunal had any effect on the inspectors. There were no instances in the fieldwork observations where inspectors referred explicitly to Tribunal decisions. But it would seem that some of the actions of the two groups of inspectors studied took into account Tribunal decisions. For example, in questioning care assistants about their duties, inspectors were keen to ensure that not too much of their time was taken up in domestic tasks – clearly a reflection of decision 237, discussed in this chapter. Similarly, in discussion about the needs of residents, particularly in homes where many of the residents were cognitively impaired, there was no attempt to insist that the home employed staff with appropriate training or qualification in this area. Tribunal decision 296, also discussed in this chapter, indicated that it was unlawful for Health Authorities to insist on this.

LAW, THE TRIBUNAL AND RESIDENTS

Yeung (1999) suggests that two models are used to justify approaches to punishment for traditional criminal offences. One model is based on the philosophy of criminal responsibility. This involves the notion of individual wrongdoing, generally with a degree of awareness of the act or its consequences. In contrast, the second approach, which Yeung refers to as the deterrence approach, is based on the classic utilitarian principle that punishment is warranted by reference to its crime prevention consequences. Many regulatory offences are based on the second type of thinking. Regulatory law is primarily concerned with discouraging behaviour which is considered to be inimical to shared social goals. The punishment of regulatory offences is a practical means of controlling an activity, without necessarily implying the element of social condemnation which is a characteristic of traditional crimes. Criminal offences based on the first model, that of the philosophy of criminal

responsibility, depend on proof of some form of *mens rea*, be it intent, knowledge or recklessness. But regulatory violations often discard *mens rea* so that a regulatory offence may be committed without the need to establish any mental element on the part of the offender. In other words, they are strict liability offences in which the offender may be liable without any need to prove their culpability or subjective wickedness.

The effectiveness of strict liability offences in regulatory law is controversial. For some, the presence of strict liability favours the regulated since it serves to marginalise their non-compliance and to distinguish it from "real" crime where moral questions of fault or intent come into play (Richardson 1987). It is also suggested that the inclusion of a strict liability principle may also result in a hesitancy to prosecute or sanction offenders (Richardson 1987). However, irrespective of the legal basis of strict liability, many empirical studies of regulation suggest that regulatory agencies will often consider the notion of fault when exercising their discretion to prosecute strict liability offences (Richardson 1987; Hutter 1997; Hawkins 2002). But the picture is not entirely clear-cut, as Hutter (1997) found that in certain circumstances utilitarian reasons for prosecution came into prominence, particularly where there was a widespread risk of serious accidents and persuasion had failed.

While there may be grounds for considering some of the offences under the Registered Homes Act 1984 as strict liability offences, for example offences which involve violation of the conditions of the licence, this is not apparent from the Tribunal decisions. Instead, decisions are justified with reference to two distinct types of moral argument. The first is concerned with the character of the home owner. This is partly a consequence of the framing of the Registered Homes Act 1984, where registration of a nursing home is conditional on the continued "fitness" of

the applicant. At first sight, it might be expected that this type of argument would be most associated with appeals about registration, but such arguments are also brought into play in all types of appeal. In arguments of this type, residents are sometimes absent and the Tribunal's focus is on other matters, for example, the financial viability of the business or whether the inspectors had found the proposed registered person impossible to work with. A second type of legal argument is about the culpability or blameworthiness (Walker 1991; Hawkins 2002 p409) of the home in relation to harm caused to residents. Apart from the most obvious of cases, such as the appropriation of a resident's property, such arguments are beset with problems. For example, evidence of physical harm in extreme old age can be unreliable as it is difficult to relate the actions of home to the state of the resident's health or body. More fundamentally, as will be explored in later chapters, the rights of residents and more generally of elderly people at the very end of their lives are contentious. Brooke and Gewirtz (1996 p10) suggest that one of the functions of legal opinions, such as Tribunal decisions, is to persuade the audience that the Tribunal or court did the "right thing". But in the case of nursing home appeals, the "right thing" is a very vexed concept as it is very difficult to know whether the point of reference for the "right thing" should be the home owner or the resident. The appeal process by its very nature requires the rights of residents to be balanced against the "right thing" for home owners in undertaking their business. Unfortunately this balance must be done without any guidance from the Registered Homes Act 1984 and its regulations, as they contain no explicit framework of rights for residents, nor even a statement of the Act's principal objectives (Brooke Ross 1989 p263). Brooke Ross (1989 p276) also argues that clear objectives should be set out in the legislation, since in this area of welfare provision, providers, consumers and regulators may have different and sometimes seemingly irreconcilable objectives and strategies. As she also notes

(p265), guidance which accompanies the regulations for the residential sector also provides more principles for safeguarding the rights and welfare of residents than the parallel for the nursing home sector (see Chapter 3).

As well as the legal rationale for punishment, two other factors need to be considered as potentially important in shaping the outcome of Tribunal decisions. First, in offences which involve *mens rea*, the law provides appropriate procedural protections for the accused. In dealing with corporate regulatory crime, such protection often works against the pursuit of regulatory objectives (Simpson 2002 p50; Scott 2003 pxiv). Corporate entities are accorded all of the constitutional safeguards and protections that are granted to individual defendants. Such rights were conferred on individual defendants as a means of protection against potential abuses of state power. However, Simpson (2002) argues that corporations neither qualify as weaker adversaries *vis à vis* the state, nor do they suffer the same consequences as individuals upon conviction.

The second factor is that legal fora such as the Tribunal, where professional lawyers ply their trade, are thought to operate with particular patterns of argument. Those interested in law as narrative – for example, Brooks and Gewirtz (1996) or Porter Abbott (2002 ch11) – suggest that such forms of legal argument can place limits on the kinds of stories that can be told and on the ways stories can be told. The concern is that legal fora can become prisoners of stereotypical arguments. For example, the Critical Legal Studies movement has sought to articulate ways in which marginal groups such as women, ethnic minorities and others on the margins of power were excluded from legal processes by low representation from such groups on juries and in the legal profession. At the same time they are represented in such processes in stereotypical ways which cause grave injustice (Porter Abbot 2002 ch1) – for instance, as "loose" women, or black men who had "stepped out of their place".

Nursing home residents are a marginalised group. When this is coupled with a traditional legal culture which affords procedural rights to "the defendant" or home owner, then it is not surprising that residents or their relatives had no right of standing before the Tribunal. Residents never appeared in person as witnesses and their relatives were seldom called. In the twenty years of operation of the Tribunal, relatives were called on only three occasions. One of these cases (decision 264) involved theft of a resident's property and the other two (decisions 452 and 453) involved abuse. Brammer (1994 p433) notes that even if residents were called they would be unrepresented, subject to coercion and powerless. Residents (and their relatives) were limited to reporting actions to the registration authority and, if dissatisfied with its response, had recourse only to judicial review (Brammer 1994 p433). Given the absence of residents, what was the nature of these stock legal arguments used in the Registered Homes Tribunal and how were residents represented within them ?

THE TRIBUNAL'S OWN STORY

The first decade of the Tribunal's operation from the late 1980s onwards was marked by both positive and negative reviews of its operation. Brooke Ross (1989), reviewing the first two years of the Tribunal's operation, considered that it was regarded as an impartial and competent forum and on the whole gave great weight to the welfare and wellbeing of residents, present, past and future. However, Brooke Ross mainly reviewed cases from the residential homes sector where she notes that more principles promoting and safeguarding the rights and welfare of residents can be found. In contrast, Harman and Harman (1989) and Brammer (1994) were critical. Brammer (1994 p229) suggests that the role of the Tribunal must be focused on safeguarding the interests of

residents rather than protecting home owners from what they may perceive as excessive bureaucratic interference. After reviewing a number of cases both Harman and Harman (1989) and Brammer (1994) concluded that the Tribunal favoured the private entrepreneur and had a tendency for inconsistent decision making.

Since 1994, nothing has been published on the Registered Homes Tribunal and little on the operation of Tribunals in general. In 1999, a review of all tribunals was set up, chaired by Sir Andrew Leggatt - the first systematic review of tribunals since the Franks review was published in 1957. However, Leggatt (2001) left regulatory tribunals on one side to concentrate on tribunals which concern individual citizens and the state (Bradley 2002).

A view of the operation of the Registered Homes Tribunal can be found in some of the appeal decisions[1]. Running through these decisions is a story of the Tribunal labouring under very difficult circumstances, for example:

> ...many of the appeals coming before the Tribunal these days are complicated, difficult and lengthy... documentation, of which there was in abundance, continued to arrive throughout the hearing... it was a most difficult case.
> Registered Homes Tribunal 272.

And:

> "...extremely large bundles of evidence... with duplication... and confusion."
> Registered Homes Tribunal 457.

At the root of many of the Tribunal's difficulties were flawed procedural rules. Indeed, throughout the 1990s it was argued that these resulted in severe delays which jeopardised the entire regulatory system as it

[1] A record of these appeals in terms of the decision, and the reasons for the decision was published on the Tribunals website http://www.doh.gov.uk/RHT until 2002 and from that date at http://www.carestandardstribunal.gov.uk.

prevented Health Authorities sanctioning homes (Day et al 1996; Council on Tribunals 1998). The responsibility for formulating the procedural rules lay with the Tribunal's "sponsoring" Department, the Department of Health. For nearly a decade, concerns about this state of affairs were repeatedly expressed in the annual reports of the Council on Tribunals, the body with oversight of all tribunals, but changes were mired in the Department's intent to conduct a major review of care home regulation[2]. Leggatt (2001 para 1.19), in his general review, commented on the "uneasy relationship" between most tribunals and the departments on whose decisions they were adjudicating. He notes:

> In those tribunals which are paid for by the sponsoring departments, the chairmen and members feel that they cannot be seen as independent, however impartial they are, and however scrupulous departments are. Indeed, plainly they are not independent. ... At the same time, paradoxically, many tribunals do not enter into the appropriate dialogue which would enable departments to learn from adverse tribunal decisions and thereby to improve their primary decision-making.

The majority of 86 appeals to the Registered Homes Tribunals relating to nursing homes were settled by adversarial contest – a minority by negotiation between the parties or the withdrawal of one or other or the parties. In appeals of the latter type, little information apart from the statement of facts of the withdrawal is provided. Therefore the appeals analysed below are the appeals which were fully heard, some 60 in all. The final disposition of the appeals is shown in Table 1.

In the two decades of hearing appeals under the Registered Homes Act 1984, the Tribunal had 21 different chairpersons. Two chairpersons, Margaret Rutherford (13) and JCR Fieldsend (9), heard twenty-two cases in all, more than one third of those which went to a full hearing. In an

[2] See Annual Reports of the Council on Tribunals from 1993-94 to 1998-1999.

early Tribunal (decision 27) which Fieldsend chaired, Home Life was deemed not applicable to the nursing home sector. This guidance for residential homes emphasised the rights of residents. Margaret Rutherford was a past Chair of the Chartered Institute of Arbitrators. Her interest in this method of dispute resolution seemed to be reflected in the Tribunal's decisions.

Table 1. Disposition of Registered Homes Tribunal Appeals 1986-2004

	Total	Negotiated settlement	HA withdrew	Home owner withdrew	Full adjudication	Allowed	Dismissed
Refusal to register	**15**	0	1	0	**14**	4	10
Emergency closure (Section 30)	**12**	0	3	2	**7**	4	3
Non emergency closure (Section 28)	**38**	1	4	8	**25**	5	20
Sub total	65	1	8	10	46	13	33
Buildings and/or number of residents	**13**	3	1	0	**9**	4	5
Staffing	**8**	3	0	0	**5**	2	3
Total conditions of Registration	**21**	6	1	0	**14**	6	8
Total	**86**	7	9	10	**60**	19	41

For example, in appeals about conditions of licence around staffing (decisions 237, 296 and 305) she was at pains not to adjudicate but to force the parties to negotiate a settlement between them:

> It seemed at times incredible that both parties should go to such lengths, and incur such heavy expenditure, to have the matter decided before a Tribunal. During the hearing the concern felt by the Tribunal was expressed to the parties (Registered Homes Tribunal 305).
>
> Co-operation is the key word with each of the parties being ready and willing to acknowledge the other's reasoned point of view, always bearing in mind the welfare of the patients which is the *raison d'être* of the process.
> Registered Homes Tribunal 296.

In forcing the parties to negotiate about staffing levels, the Tribunal avoided setting clear standards. Yet the agreed settlement between the parties is often set down in the documentation of the Tribunal decision and thus came to be seen as the definitive interpretation of staffing rules for a particular type of home. Both Fieldsend and Rutherford were instrumental in ensuring that a high standard of proof was a requirement for the emergency closure of homes under Section 30 – for example, decisions 123 and 187 – and in operationalising the concept of fitness – for example, decisions 136, 187, 220, and 243. The operation of the Registered Homes Tribunal was clearly a very specialised area for lawyers, with two firms of solicitors providing the representation for the majority of hearings. Undoubtedly, they would also have provided advice for Health Authorities about the Tribunals' stance in particular issues. In this way, lawyers may have provided Health Authorities with an interpretation of the regulatory norms which was backed by the authority of the Tribunal (McCahery and Piciotto 1995). That is to say, lawyers may have provided one means through which Tribunal decisions became influential in Health Authorities' actions.

TYPES OF APPEAL

Appeals can be divided into two broad types. The majority of fully heard appeals (46) were about cancellation or refusal of registration where the home owner cannot operate or must cease operating unless the decision of the authority is overturned by the Tribunal. The Registered Homes Act is framed in terms of the concept of "fitness", either of the "registered" person, usually the home owner, or occasionally the "fitness" of the building. Fitness is a legal concept vested in the characteristics or personal qualities of the registered person. *Stroud's Judicial Dictionary of Words and Phrases* (Greenberg 2000) defines "fitness" as:

> ... honesty, knowledge and ability; honesty to execute (his office) truly, without malice, affection or partiality; knowledge to know what he ought duly to do; and ability, as well in estate as in body, that he may intend and execute his office, when need is, diligently and not for impotency or poverty neglect it.

Framing the legislation in this way would suggest that "fitness" should be an important concern in these Tribunals, with such appeals setting the "minimum" standards for participation in the sector. The minority of fully heard appeals (14) were against the conditions of registration set by the Health Authority. This second type of appeal usually concerned the number and type of staff or the number of residents. Appeals of the second type bring into play economic factors, such as the power of the Health Authority to constrain the profitability of the business. Challenges to the conditions of registration seemed particularly successful, with nearly half of these allowed. Overall, nearly half of cases of this type that went to full appeal were successful. I shall return to this later.

Ostensibly, appeals of the first type are concerned with the character or moral standing of the owner, for that is the way the law is framed. But in many Tribunals, the argument turned on harm or potential harm to residents where this could be clearly demonstrated. The character of the owner also comes into the argument in circumstances where its relevance is less obvious. At first sight, it might be thought that appeals about numbers of residents and staffing would be matters where the debate would turn around the residents, their rights and characteristics – for example, how many residents with particular sorts of disabilities should be accommodated in a home of a particular design? While arguments about residents and their needs were presented in these appeals, often this was not the deciding factor, for there was little firm basis for such arguments. Instead, decisions rested again on a traditional theme in criminal law, the moral character of the home owner. As

Simpson (2002 p49) points out, there are difficulties in pursuing legal claims where the "crimes" lack moral offensiveness or blameworthiness. The success of regulatory sanctions in this and other areas (eg Hawkins 1984) depends on the extent to which society believes that particular acts should be prohibited.

CHARACTER OF HOME OWNERS AND HARMS TO RESIDENTS: APPEALS ABOUT CANCELLATION OR REFUSAL OF REGISTRATION

Refusal to register

In the fourteen appeals about refusal to register which were fully heard, ten failed and four were allowed. In these appeals, the Tribunal was being asked to make a judgement about the potential risk to residents and often did this with reference to the character of the owner. The reasons for failure of the ten appeals are shown in Table 2.

Table 2. Failed appeals against refusal to register (n=10)

Reason	Number	Appeal reference
Failing to meet the 1984 building standards	2	8, 29
Financial	3	238, 366, 389
Poor practices in other industries	2	159, 223
Unmanageable	3	31, 91, 154

Two early appeals (decisions 8 and 29) were refused because the Tribunal considered that the homes did not come up to the standards required for the 1984 legislation. As noted below, owners who got into severe financial difficulties were declared unfit and excluded from the industry. Thus appeals against refusal to register from three potential owners (decisions 238, 366 and 389) who had been declared bankrupt, had

convictions for debt, provided no bank references and had property which was repossessed, failed. Entrepreunerial failure was deemed a risk to residents.

Appellants with a history of bad management in other industries where they had contact with vulnerable people also failed – for example, an appellant who had a previous registration for a residential home withdrawn (decision 223). Another appellant, with a history of being a bad landlord with allegations against him of assault and harassment (decision 159), also had his appeal dismissed. The character of this applicant (one or more?) was called into question. The appellants (one or more) in 159 had neither "a caring attitude towards those they have obligations, nor the balance and composure necessary for dealing with elderly people". A further three appeals (31, 91 and 154) were from the same person, who was considered unmanageable as she refused to change, learn or listen to advice: "(she) is still the same uncompromising person she was in 1985. Until she changes her attitude there can be no question of registration" (decision 91). As noted below where the regulators found it impossible to work with the regulatee, then this formed part of the evidence that the regulatee was unfit and the appeal would be refused.

In three of the appeals which succeeded, the Tribunal took the view that convictions for assault, obstructing a police officer, gross indecency and personification (decisions 234, 168, 6) were no bar to being approved as long as the offence was unconnected with the care of vulnerable people. The fourth appeal to succeed (decision 136) concerned an entrepreneur. As discussed in Chapter 2, during the 1980s the expansion of the nursing home industry meant entry into the sector not only of corporate businesses, but also of individual entrepreneurs who had no qualifications

in health care[3]. When a Health Authority refused to register such a home owner (decision 136) who had a poor knowledge of care of the elderly and an unsatisfactory financial plan, the Tribunal disagreed. It argued that owners had no need for knowledge about care of the elderly as long as they employed someone who did. Owners should also be allowed to take the financial risks. However, as noted above, the Tribunal was less sympathetic to "failed" entrepreneurs. This group posed a risk for further management and financial failure which might adversely effect residents.

Cancellation of registration

Registration could be cancelled in two ways. The Health Authority could obtain an emergency order for immediate closure from a magistrate under Section 30 of the Registered Homes Act. In this case the Health Authority was required to prove that there was a "serious risk to the life, health and well-being of the patients in the home" (Section 30.1.a.ii). The other route was for the Health Authority to cancel the registration without a magistrate's order under Section 28. The latter could not take effect until any appeal by the owner had been heard. This could be a very slow process as the lack of procedural rules meant it was possible for the appellant to delay by asking for postponements and adjournments. By the early 1990s, these tactics had caused a backlog of cases in the Tribunal (Day et el 1996).

Magistrate's orders were very controversial as they could be heard *ex parte* with the owner finding that his or her business had been shut down without any warning. Clearly, this could have devastating consequences

[3] In 1989, major providers with three or more homes accounted for 12% of homes and 32% of beds. In 1999 this had risen to 19% of homes and 43% of beds (Laing and Buisson 2001). However, Laing and Bussion's most recent review (2005) suggests that the majority of nursing homes providers are still small businesses. Only six out of the 91 major providers are listed companies – five are listed in London and one overseas.

for the residents, who would have to be uprooted to other homes at short notice. Therefore such orders were disapproved of except in extreme circumstances. Full hearings occurred for seven appeals against emergency closure, with four being upheld and three dismissed. In all four appeals which were dismissed, the evidence was suggesting extreme neglect or physical assaults on residents. The harm to residents was documented in some detail in the record of the Tribunal decision. Thus there is a sense in which evidence about the condition of individual residents is used to shame the home owner and to justify the Tribunal's decision. The nature of the home owner's character is left in no doubt. In decision 272 the Tribunal concluded:

> ... the (appellant's) demeanour clearly demonstrated how difficult it must have been for the Respondents to deal with him and to engage in any kind of meaningful constructive dialogue. It must have been difficult for them to repose any kind of confidence in him sufficient to develop a good working relationship... His letters to respondents... show that he was at times aggressive, unco-operative, hostile and confrontational. He appears to have no recognition of past failures and does not concede there have been problems. He seemed unable or unwilling to change... He showed a lack of effective leadership, competence and control, and inconsistency and irresponsibility in his dealings with the Respondents.

In appeal 255 the inspectors made an unannounced visit as a result of a complaint from a former member of staff. The front gates were padlocked; there were no staff in the home, apart from the owner, as the staff had walked out, and the owner's sons were sleeping on camp beds in the lounge. The patients were lying on plastic sheeting, with evidence of pressure sores and, instead of incontinence pads, net knickers filled with gamgee and cut-up sheets were being used. Medication for administration the next day had been decanted the night before and sheets hung over the banisters, posing a fire risk. The

Tribunal took the unanimous view that conditions in the home on this night did pose a serious risk to the health and wellbeing of residents.

In appeal 272, the Health Authority produced an impressive array of 21 witnesses to testify to the blameworthiness of the registered person. Evidence was heard from consultants, nurses, hospital representatives and other professionals. Part of the health authority argument was that the home continually operated with one qualified nurse for 22 patients. Not only was this in breach of the staffing notice, but the lack of staff had caused harm to residents. In particular, there had been a failure to recognise when residents should be admitted to hospital. One resident had been crying in pain for a number of days before she was admitted to hospital where she was found to have a fractured femur. Another had been admitted in an appalling condition – "dehydrated, with a urinary tract infection, blistered lips, scalp and hair infestations, a bleeding crusted mouth and legs blistered from the knees down". Yet another was admitted with multiple infected pressure sores, malnourishment and septicaemia, with no evidence in the nursing home records of any interventions to alleviate matters. A stroke patient who was immobile was placed too close to a radiator and suffered severe burns. The care plan indicated that she should have been turned every two hours, so the Tribunal asked, did the staff not see the burns or smell the burning flesh?

Appeal 240, which failed by a majority decision, illustrates the difficulties of establishing harm and culpability when the only witnesses may be disaffected staff. Staff at the home had alleged that the owner used physical abuse, was violent and force-fed the residents. The owner was also felt to be challenging and provocative. The home was in financial difficulties and this was thought to have been the reason why staffing levels were at the bare minimum. However, the staff withdrew their allegations, the residents showing no physical signs of abuse or

injury when several of them were removed to hospital. The Tribunal was split, with the chair arguing that the case had not been proved on the high standard of probability. The expert members felt that the staff had been intimidated by the owner into withdrawing their statements. They argued that on the night when the magistrate's order was obtained staffing had been inadequate and the owner's attitude gave grave grounds for concern.

Turning to the four appeals under Section 30 which succeeded, in decision 187 there were many allegations from the staff of the owner hitting residents and using abusive language. The home was also unacceptably cold as the boiler frequently broke down. The owner was found to have lied to the Health Authority about the staffing levels and his integrity was seriously in doubt. However, the allegations were made by three extremely young inexperienced care staff. The Tribunal considered that there was no serious risk to the life, health and well-being of the patients in the home at the time when the magistrate's order had been sought and the appeal succeeded. Had the Health Authority just withdrawn the registration under Section 28, the Tribunal stated that it would have had no difficulty in finding the owner unfit.

In decision 174 the Tribunal agreed that care in the home was poor, but lack of attention to patients at night and lack of a qualified nurse on duty did not constitute a serious risk to life, health or well-being. There was no strong case for immediate closure. In the third case where the appeal was upheld, there were many problems in the home because of building work. The Tribunal was highly critical of the Health Authority for seeking such an order instead of applying "properly focused pressure" – for example, issuing improvement notices and if the regulatee then failed to comply, prosecuting (decision 369). The fourth case (decision 457) is considered below as it was heard in conjunction with an appeal under Section 28.

The second way a Health Authority could cancel the registration was under Section 28. This states that the Health Authority could cancel registration on the following grounds:

(i) any grounds which would entitle them to refuse an application for registration

(ii) that the person had been convicted of an offence against Part 2 of the Act

(iii) that the person had been convicted of an offence against the regulations

(iv) the person had not complied with any condition of registration

(v) the annual registration fee has not been paid

Twenty appeals against cancellation under Section 28 were dismissed and five were allowed. The main reasons for dismissal are shown in Table 3.

Table 3 Dismissed appeals for cancellation of registration (Section 28) n=20

Reasons	Number	Appeal reference
Residents robbed or property misappropriated	4	67, 180, 264, un-numbered
Business failure	8	85, 138, 204, 220, 258, 289, 397, 408,
Assault or extreme neglect of residents	2	87, 453
Chaotic management practices	5	121,204, 210, 359, 393
Other	1	244

In these twenty appeals there was a group of some twelve cases where the harm or potential harm to the residents was clear-cut. In four cases (67, 180, 264 and un-numbered), evidence was presented that residents or their estates had been robbed or their property misappropriated. Owners in these cases were declared unfit. In a further eight cases the

business had failed, with homes in receivership, and creditors such as utility suppliers about to cut off the gas or electricity supply and the staff unpaid (cases 85, 138, 204, 220, 258, 289, 397 and 408). In appeal 138 the Tribunal was unsure whether the owner did not have the financial resources to maintain proper standards or had the resources but was not prepared to use them. These owners were also declared unfit.

In a further two cases where the appeal was dismissed (87 and 453) there was evidence of extreme neglect and treatment which bordered on assault. In appeal 87 it was alleged that a regime which relied on threats and punishment had been instituted. Residents were intimidated, taunted and punished by limiting relatives' visits and denying telephone calls, TV or radio. A resident who was incapable of walking was dragged on the ground with the owner kicking and swearing at him. There were allegations of slapping, punching, force feeding and inappropriate use of restraint. Residents were bound to beds and chairs with rope and left all night unsupervised and unable to summon help. One resident who wandered was restrained in this way for nine consecutive nights. Forty witnesses gave evidence for the respondents but one of the unusual features of the case was that the owner documented her practices in the nursing notes – that is to say, she felt that tying a resident to a chair with rope was an appropriate professional response to the behavioural problem of the resident wandering. Similarly, taking away a resident's privileges was an appropriate method of sanctioning or behavioural control for the demented people. The owner was declared unfit and also faced criminal charges.

In appeal 453 there were complaints from agency staff, relatives and social services about the care and the state of premises. The relatives of one resident gave evidence that their father was in pain with a horrible smell about him but the strong painkillers prescribed by the doctor were unavailable in the home and when they complained nothing was done.

Their father was removed to another home, where he arrived with no antibiotics and just paracetamol despite a massive infected pressure sore and a high level of pain. He was subsequently given morphine, and died the next day. A resident who suffered from dementia was attacked by another resident with mental illness, known to be violent, who was inadequately supervised. Another had been complaining of pain for some days but medical advice was only sought at the inspector's insistence. The resident was subsequently found to have a fractured head of femur. Other relatives witnessed semi-conscious residents being "dragged off commodes". The Tribunal concluded that the owner was not a fit person. Notwithstanding the harm to residents, the Tribunal notes that the owner was also unco-operative and had an aggressive attitude to other professionals.

A further group of appeals which failed turned on the owners' ability to run a home in a proper manner (cases 121, 204, 210 and 359). In appeal 121, the general practitioner who had visited the nursing home at fortnightly intervals over a period of years gave evidence that he had serious misgivings about the professional knowledge, expertise and clinical judgement of the new owner. There was no management structure, a lack of staff, lack of a planned regime and the owner had been unable to establish a satisfactory medicines policy, despite help from the inspectorate. The consequence of the poor management practices were seen in the condition of residents admitted to hospital. In appeal 210, the owner refused to employ staff and was rostered to be on duty herself for 24 hours a day, seven days a week. In appeal 359, the owner condoned the absence of staff, with the result that the home was left unattended with no staff on duty. At the tribunal she lied about this and therefore lacked integrity. In another case, 204, drug addicts and alcoholics were admitted to a home for the elderly. In appeal 243, the owner employed people who he knew had bought their identity as nurses.

In appeal 393, the home operated below the agreed staffing levels and there was a management vacuum with no manager appointed for nine months. Finally, there was one case, 244, where the Health Authority had secured a conviction in the magistrates' court for breach of regulations.

Five appeals succeeded. In appeal 65, the Health Authority had withdrawn the registration because the home had failed to provide a qualified nurse at all times. The Tribunal visited the home and thought it a small pleasant well-run home, which for the most part gave a good service. They accepted there had been staffing difficulties but they allowed the appeal with the condition that a qualified nurse be employed as matron. Part of their reasoning was that the owner had listened to and implemented advice – that is to say, as discussed below, she had the right time type of character for a regulatee. In another appeal (92), new owners had taken over a badly run home with a poor structural fabric. Consistent with the view that entrepreneurs should be given a chance, the Tribunal decided that the owners should have been given more time to rectify defects in the property but that this should be a condition of the registration. In appeal 149, the Health Authority argued that there were problems with staffing and lack of a lift. The Tribunal decided that the failure to provide professional staff on the odd occasion was not of great significance. Instead, the Tribunal's decision seemed to turn on their favourable impression of the matron. She was described as a responsible, capable and caring person, devoted to the welfare of the home and of the patients, and a person whose judgement could be relied upon. The appeal was allowed with the proviso that the owners installed a lift as a condition of registration. In appeal 452, there had been allegations from employees and ex-employees of assaults on patients which was contradicted by the appellant's witnesses. The Health Authority did not seek to corroborate the employees' accounts with

evidence from residents, relatives, medical practitioners or others whose opinions carried weight with the Tribunal. Given the conflicting evidence of abuse and a lack of other defects severe enough to warrant cancellation, the appeal succeeded.

Finally, appeal 457 was a long and complex case. The Health Authority withdrew the registration because of concerns around administration of medicines, cleanliness and alleged abuse of residents. The home owner appealed. While waiting for the appeal to be heard, a resident, Mr C, was admitted to hospital in an extremely poor condition. Mr C subsequently died and the findings of the post mortem indicated neglect. The death precipitated action by the Health Authority who applied for a magistrates' order for immediate closure. The Authority also arranged for a nurse to assess residents in order to collect evidence about possible neglect. In evidence, the nurse charged with providing the assessments stated that she obtained verbal consent from the residents but she did not know what the assessments would be used for and therefore could not provide an explanation of their purpose to the residents. Her approach to obtaining consent from residents who lacked capacity was also unclear. The Tribunal took the view that consent was not properly obtained and warned the nurse that she was in breach of Articles 6 and 8 of the Convention on Human Rights and by giving further evidence she would incriminate herself. At this point, she withdrew her evidence and the Health Authority's case collapsed. After the post mortem on Mr C, the police became involved and commissioned a further expert review from a geriatrician. The reviewer concluded that Mr C had had a long history of self-neglect and therefore the culpability of the home was in doubt. The Tribunal concluded that while there were inspections which brought to light a number of relatively minor issues, these did not point to a failing home. There was no evidence of unfitness, although standards were not high.

What do these cases illustrate?

These cases illustrate the difficulties in obtaining evidence based on actual harms to residents to justify the Tribunal's decisions. The Tribunal has no investigatory resources and therefore, apart from an occasional excursion to view a home, it is reliant on the evidence placed before it. But the nature of nursing homes as total institutions in the Goffman sense, combined with the characteristics of residents, means that evidence can easily be contested. For the respondent – the Health Authority– reliable evidence is difficult to come by. The most likely witnesses are staff but, typically, nursing home staff – described more fully in Chapter 4 – are young, unqualified and inexperienced. They may be also disaffected if they have left the home. This means that their evidence is contested and seen as unreliable as in decision 452.

Little reliable evidence can be gained from residents. Cognitive impairment and the ravages of the aging process, particularly in people close to death, mean it is very difficult to disentangle the effects of aging on the body from the effects of poor care or abuse. Thus it is very difficult to relate harm to residents and blameworthiness of the home. For example, residents may have frail skin and be easily bruised. This makes it difficult to distinguish accidents or poor care from intended or deliberative harm, particularly as residents may be too confused to provide an account themselves. Even causes of death are contended, with different views from medical experts. In appeal 457, where the admitting doctors and the post mortem suggested neglect by the home, the subsequent expert opinion argued that this must be seen against a history of alcohol abuse and self neglect. In the Takare case discussed below, the GP who examined a resident at the home noted that he had a pattern of sores on his toes and knees which the doctor described as "carpet burns" (Select Committee Public Administration 1997-98 para 723) – that is, burns consistent with being dragged face down along a

carpet. The home subsequently became the subject of a large-scale investigation into poor care. This culminated with a review by the Select Committee on Public Administration, but the combined resources of a review by a Professor in Care of the Elderly, an enquiry by the Health Ombudsman and the Parliamentary Committee failed to establish the cause of these sores. The Health Ombudsman deemed the home to be "guilty" of the lesser charge of "inadequate" nursing care. The great difficulties in agreeing causes of damage to a body in extreme old age, mean that reasons other than non-accidental injury or poor care are always credible. Blameworthiness is difficult to establish.

Since decision 457, in 2003, it has become even more difficult to provide evidence about care from the bodies of residents. As described above, a nurse examined patients at the request of the Health Authority to gather evidence about their care in order to make a decision about the home's registration. As she had not obtained appropriate consent from the residents, particularly those who were cognitively impaired, the Tribunal argued that she had breached the residents' human rights. When asked how she should have proceeded, the Tribunal stated that where a resident's capacity was in question, then there was a requirement to obtain an opinion of the resident's capacity from a consultant psychiatrist before consent is obtained. In a large nursing home, this is potentially a difficult and expensive process. Thus the Tribunal attempted to protect the privacy of a person who cannot experience or enjoy that privacy in any meaningful sense.

While it is also difficult in other health care settings, such as acute hospitals, to disentangle disease processes from harm caused by the institution or its staff, in other settings the authority structures are far more secure and this allows the problem to be framed in a more reliable way. In the nursing home world such structures are ambiguous, insecure or contested. For example, as explored in some detail below, it is

unclear whether a nursing home is a home or a hospital. Do the norms for health care facilities apply? What types of actions are permissible to deal with violent, aggressive residents? Do the norms of professional nursing apply? After all, the qualifications of nurses in nursing homes are defined by the Secretary of State for Health, not by the profession, and the majority of staff in nursing homes are not professional nurses. When it is not possible for the Tribunal to provide reliable answers to these types of questions, the Tribunal often returns to the character of home owners as a more justifiable basis for decisions.

APPEALS AND THE ECONOMICS OF THE NURSING HOME INDUSTRY

In appeals about conditions of registration, home owners challenged the authority of regulators to interpret the rules in a way that placed economic constraints on their business. It might be expected that appeals about premises or staffing would turn on what could be allowed given the characteristics of residents and their rights to particular facilities and treatment. However, this was not always the case and decisions sometimes turned again on the character of home owners. In these cases, we meet 'the exemplary owner' for whom allowances must be made and for whom standards must not be applied rigidly. As Hawkins notes, it is clear from a large number of studies that assessments of moral character made by legal decision makers are one of the most pervasive and persistent features of the exercise of discretion (Hawkins 1992 p43; Hawkins 2002p 367).

Premises and the character of home owners

To improve the economics of the home, some owners would try to adapt their premises to accommodate more residents. As more rooms were pressed into use, the amount of communal space per resident

diminished, thus breaching the Health Authority's space standards. When the Health Authority refused to register the new arrangement, the resulting appeal tended to bring to sharp focus the purpose of a nursing home. Is the purpose to cater for inhabitants deemed to be "residents" or "patients"? Are nursing homes meant to be "homes" with facilities which encouraged independent living, which would suggest that communal space was important? Or alternatively, are they more like hospitals – places for the dependent sick? There are no easy answers to these questions, as nursing homes cannot be clearly positioned in the care sector (see Chapter 7). So the Tribunal had to look for other justifications and turned to the character of the home owners.

In cases concerning communal space that was less than recommended by the national guidelines, "exemplary" home owners had their appeals allowed. These people were seen as honest, caring and reliable. In an early decision (28), a home owner who was "a caring person who was concerned about the welfare of his patients", who was " a good witness" and whose evidence was regarded as "entirely reliable" had his appeal to increase the number of residents allowed. Similarly, in 1987, the appellant who had all the "experience, personality and ability that could be wished for in running a small nursing home" (appeal 61) had her appeal to turn one of her single rooms into a double room allowed. On a visit to the home, the Tribunal detected a "happy atmosphere deriving from harmonious relationships throughout, under the leadership of the appellant".

Reliance on motive or character was also apparent in decisions about other aspects of buildings. For example, in decision (207) the appellant wanted to provide continuous and intensive care to people in the last weeks of their lives in a four-bedded room. The Health Authority inspector, however, argued that it would be insensitive to remove patients from their own room to a public facility when death approached.

The difference of professional opinion was settled through recourse to the motives of the appellant. The Tribunal were satisfied that his reason was not connected with securing maximum occupancy in, and hence maximum income from, the home and therefore allowed the appeal. However, such cases only succeeded where the Tribunal considered that the home provided the basic facilities adequate for the increase in numbers of residents (175, 124 and 76). Thus the Tribunal encouraged Health Authorities to make exception for home owners with an exemplary character.

Although the Tribunal could rule that guidelines should not be strictly applied to home owners with such a character, in later appeals, it was minded to articulate the rights of residents as a basis for decision making. Communal space was needed as the resident had a right to "freedom of choice, personal privacy and proper opportunities to retain their individuality and self-respect" (124). In another decision a communal room needed to be available and attractive, for the reason that, "residents must be offered a choice about where to sit and eat and the Tribunal is unconvinced that they have that choice at present" (175). But the issue of communal space or the rights of residents to a particular sort of accommodation remained an area where the foundation of the Tribunal's decisions remained unclear.

In other cases, where the home owner was of good standing but there were concerns about the structure of the building, residents could be fitted into existing buildings not necessarily suited to their needs. The Tribunal would impose restrictions on the type of resident that could be accommodated in particular rooms or on particular floors (decisions 60 and 158). For example, ambulant residents had to be accommodated only on the second floor. This sends a clear message to the industry that you do not necessarily need purpose-built premises to participate, the population of residents is heterogeneous and malleable. Consequently,

residents are fitted to nursing homes with a lower standard of facilities rather than more costly option of upgrading the home to meet the general needs of a highly dependent group.

Staffing

Staffing notices, set by a Health Authority for a particular nursing home, specify the number and type of "nurses", qualified and otherwise, to be employed by the home as a condition of registration. Staffing levels should be set to reflect the level of dependency or the "condition" of residents in the home. As staffing levels are known to be the major determining factor in the quality of care (Harrington et al 2000), the staffing notice encapsulates a major trade-off between care and the economic viability of a nursing home. As the Tribunal notes, one of the givens, or the "ceiling" in this situation, is the level of government funding for nursing home places. They noted:

> We do not accept the health authority's argument that financial viability can never be a legitimate argument because... the health authority cannot expect standards that cannot be achieved by anyone at the level of publicly funded fees (Registered Homes Tribunal 434).

Ultimately, the Tribunal argues, it is the constraints imposed by the level of fees decided centrally by the Department of Health which determines the standards for quality of care rather than the Registered Homes Act, regulations, guidance, the Tribunal or the condition of residents. Thus Health Authorities' actions in pursuit of improved care for residents were only legitimate if they were framed within the limitations of government policy.

In the appeals on staffing that were heard prior to 1996, the Tribunal seemed reluctant to become involved, in some cases taking the view that it had nothing authoritative to offer, and matters should be negotiated between the parties. In 1991, the Tribunal took the view that a home

must have a Registered Mental Nurse on at all times to care for thirty patients with severe dementia (207). A later Tribunal (296), considered this to be the wrong interpretation of the Registered Homes Act and criticised the inspector for letting his specialist experience as a mental health nurse cloud his judgement. The Health Authority has the power to specify, and set out in a notice serviced on the proprietor, the qualification of the person in charge of the home, but not of other staff. The registered person must then provide "adequate" and "suitable" staff, but it is left up to their discretion how that is interpreted. Thus Health Authorities had no powers to specify the qualifications of staff.

In 1994, a home owner challenged the legality of the staffing notice which specified the numbers of care assistants or non-registered nurses required to be on duty (RHT 237). The Tribunal somewhat reluctantly provided a ruling that care assistants were nurses within the terms of Section 25(3) because, under the terms of the National Health Service 1977, the Secretary of State has discretion to decide what constitutes nursing qualifications and activities in a nursing home. The report of the Tribunal then went on to document the staffing notice agreed between the parties. Although the Tribunal was keen to point out that it neither approved nor disapproved of this notice, Health Authorities nevertheless began to see this as the standard, and the equivalent of a "national staffing standard" was produced. Reluctantly, the Tribunal had been cast into the role of providing the mechanism through which cohesion of staffing levels was achieved.

In 1996, this unofficial "national standard" was challenged by a large corporate, Takare (appeal 306). Takare operated 62 homes in 37 different health authority areas, all with the same staffing pattern of two care assistants in the afternoon in each 30-bedded unit. The respondent Health Authority had, however, set a standard for all of the other 37 nursing homes in its area of four care assistants in the afternoon.

Summoning an impressive array of sixteen witnesses, including a member of the Tribunal panel, a consultant geriatrician and a specialist psychologist, Takare argued that its staffing level was settled after extensive research. None of the other 37 Health Authorities had complained about the adequacy of this level of staffing, neither had any of the commissioning managers who had been monitoring Takare since 1987. In evidence, the Health Authority stated that it had based its requirement for staffing on its past practice and arguments about the general dependency of elderly people in their area. However, the Tribunal did not find the Health Authority's arguments convincing. It noted that the Authority's guidelines were not produced by identified experts and were produced for purposes other than use in nursing homes, and that their basis was subjective. The Health Authority had failed to justify its standard in relation to the dependency levels of potential residents. In allowing the appeal, the Tribunal declared it was most impressed by Takare's array of expert witness, the organisation's professionalism and the quality of many Takare matrons. That is to say, having dismissed the authority of the Health Authority to decide on staffing levels, the Tribunal was left with basing its judgement on the "the character" of a large corporate organisation – a character which it judged as exemplary. Although the Tribunal might reliably form a view of the integrity and truthfulness of an individual owner standing before it, assessing such qualities in a corporate organisation which, by 1999, owned 43% of the beds in the sector (Laing and Buisson 2001) was much more difficult. No registered person from large corporates has appeared before the Tribunal with their fitness in question in twenty years of the Tribunal's operation. The regulatory literature (Kagan 1994; Reichman 1998; Grabosky and Braithwaite 1986 p214; Pearce and Toombs 1991: 418) suggests that the imbalance of resources between large companies and regulators makes this unlikely. As Simpson (2002 p47) notes, "the little guys" are more likely to be prosecuted as they are too small to

fight the Justice Department effectively or to obfuscate a legal inquiry. As I describe below, the Tribunal's assessment of Takare as an exemplary owner was subsequently judged and found to be extremely ill founded.

What do these cases illustrate ?

A significant issue in many cases was that in coming to a decision the Tribunal was solely reliant on the evidence placed before them as they did not have their own investigatory or other support staff. As Leggatt (2001 para 12) remarked, all Tribunals need "... the support of expert, highly-trained, investigatory staff, with specialist knowledge". Considerable technical expertise is required to understand the staffing levels and accommodation that might be required for residents with particular conditions. But as it is unable to command such a resource of its own, the Tribunal is reliant on balancing the evidence presented by the parties. Whether or not such expertise is persuasive depends on its authority. This brought to the fore not only difficulties about what norms should be applied, but who had the authority to decide those norms.

Appeals about accommodation brought to the fore the difficulties in deciding which standards were applicable. Steeped in the idea that the purpose of closing long-stay hospitals in the 1970s/80s and the expansion of nursing homes was to encourage independent living in the community – "community care", some authorities took the view that the aim of a nursing home was to promote this. Therefore the relevant standards were those within *Home Life*, the guidance for the residential sector which was based on promoting independence. But *Home Life* was never endorsed for nursing homes and when home owners appealed, Health Authorities which tried to adopt *Home Life* standards were told by the Tribunal that they had been "carried too far by (their) enthusiasm" to improve standards (decision 61).

Registration and Inspection of Nursing Homes: A Handbook for Health Authorities (NAHA 1985) was the guidance that Health Authorities were required to use. Among other things this set standards for communal space. When owners appealed because their homes did not meet the requirements for communal space, they argued that their residents were not of a type that needed or would use communal space. In fact, it was claimed that residents preferred not to be moved about because of pain, inconvenience and embarrassment about their disabilities (cases 28, 62 and 75). Patients preferred to remain in their own rooms and any home owner attempting to move them could be seen as unkind. The Tribunal refused to directly support Health Authorities in this matter. Instead, it took the view that it was not bound by the NAHA guidance. Guidelines, it noted :

> ... are regarded as of interest and in some cases, of persuasive authority, but are not regarded as laying down any rules of particular application which the Tribunal is bound to follow. (Registered Homes Tribunal 124).

In this later appeal, heard in 1990, the Tribunal did try to articulate the rights of residents in relation to accommodation. These were stated as

> a warm and homely atmosphere in which the patients should have freedom of choice, personal privacy and proper opportunities to retain their individuality and self respect.... Clean, comfortable and safe... (Registered Homes Tribunal 124).

But without anchoring decisions to Department of Health guidelines, with the lack of clarity about the purpose of a nursing home and a vague statement about rights, the Tribunal then had difficulties in deciding the basis on which appeals about this matter should be decided. As noted above, in many cases the Tribunal fell back on the character of the home owner.

Hawkins (1984) concluded, in relation to the regulation of pollution, that only those whose actions are clearly recognisable as amoral – the malicious, the negligent, and the conspicuously "bad" – are subject to severe sanctions, in this case exclusion. In the context of the enforcement of Health and Safety regulations, Hawkins (2002 p367) also argues that blame is frequently attributed or abandoned in response to the perceived personal character and attributes of those involved, rather than by virtue of what the regulatee has done or failed to do. Companies are socially constructed with a human character and personality. For inspectors much depends on the firm with a poor attitude equating to a negative evaluation. Similarly, the behaviour of the appellant to the Health Authority inspectors was also an important consideration for the Tribunal. Regulatees who showed willingness to respond to the requirements of regulators, such as, for example, an appellant who "listens to advice" (case 65) or one who is "learning what is required of him" (234) had a good chance of having their appeal allowed. One who was obdurate and had an "uncompromising attitude to criticism" (31) would be deemed unfit (204, 272). Refusal to accept authority, and ignorance of the functions, duties and power of inspectors would also be cited as grounds for the failure of appeals (121). The regulatory system requires that inspectors must be able to put their trust in the regulated person, thus falsifying records (cases 174, 243 and 272) and not honouring promises (402) also provide grounds for the dismissal of an appeal. Integrity and willingness to negotiate are characteristics that make governance possible. Thus fitness for individual home owners appears to have as much to do with the capacity to submit and work productively with authority, with the requirements for such characteristics justified by the vulnerability of residents.

Health Authorities prosecuting appeals tended to presume that they had that authority to decide standards, both in law and by virtue of their role

at that time within the NHS. Enforcing the Registered Homes Act was only a minor task for Health Authorities. Their main task, delegated to them by the Secretary of State for Health, was to plan all NHS services for large populations within a defined geographically area. Therefore setting the type of service, including the staffing levels, required for a small population of nursing home residents should have been a simple task. For example, before the expansion of the nursing home industry, Health Authorities planned services for a group they referred to as Elderly Mentally Infirm – people who now might be diagnosed as having dementia. Livesley and Ellington (1996) described this as a term which has entered common usage referring to patients as having "specialist care needs because of an accompanying range of other physical and medical problems that may eventually include immobility". For such a client group within the NHS there was an expectation of a particular level of staffing and staff with a particular type of experience.

However, in the context of the Tribunal, Health Authorities were forced to justify their decisions and frequently failed to do so. Health Authorities' decisions were overturned because they relied on the professional judgement of inspectors, as in 296, or on their own guidance, which it was argued was developed for other circumstances, as in 306, rather than countering the appellant's case with robust technical evidence from independent experts. Part of the problem lay in the design of the Tribunal. For other industries, Baldwin (1985) has observed that because the Tribunal had the power to take *de novo* decisions, the appeal body was turned, albeit reluctantly, into the regulator or norm setter and the Health Authority into the prosecutor. This is problematic for two reasons. First, as noted above, the Tribunal had no access to specialist technical expertise of its own – it was reliant on the evidence presented. Secondly, the Health Authority could be perceived as having a conflict of interest between its role as prosecutor and its role as expert

witness in the appropriate care for elderly people. The Health Authority role was a conflation or conflict of interests – that of the NHS, the regulator and the resident. Therefore, unless the Authority produced independent witnesses, its expertise was likely to be discounted. In the Takare case this meant, that as Reichman (1998) has argued, the sophisticated challenger's expert evidence was seen as persuasive. Thus a large company seemed to have the "cultural authority" to determine their own standards.

With all these uncertainties, making an assessment of the character of the owner standing before the Tribunal must have been attractive alternative. But as we shall see, the Tribunal proved to be a poor judge of character. In the Takare case, the Tribunal concluded by giving the Health Authority advice on how to safeguard the public, given the new staffing standard:

> Takare is subject to scrutiny from thousands of relatives, outside professionals and forty three other health authorities. It will carefully assess needs and increase staffing upwards from the minimum when circumstances require. It would be foolhardy for them to do otherwise. If respondents felt there was a shortfall they should enforce regulation 12 (1)a with the consequent potentially damaging publicity.
> Registered Homes Tribunal 306.

But in another part of the country, Takare had already been the subject of much adverse public opinion, which had had little effect on their willingness to "increase staffing upwards".

THE LARGE CORPORATE AS AN EXEMPLARY OWNER ?

Takare in Hertfordshire

The Tribunal case referred to above was heard in October 1996 in Stoke on Trent. Early that year there had been major problems with a Takare nursing home in Hertfordshire. The nursing home was built to take patients from the closure of local NHS facilities. The local Health Authority were very unhappy with the proposed arrangements for the new nursing home. In particular, they were concerned that the staffing levels proposed were well below those they felt appropriate for managing this group of patients. However, they were advised by the Regional Health Authority that they could not refuse to register the home as they would be unlikely to be successful in the resulting appeal because they would not be able to prove that quality of care would be compromised (Select Committee on Public Administration 1997-98 para 780). The home opened in October 1994 and throughout the spring of 1995 there were many complaints, culminating with a television documentary. In August 1995, Professor Livesley, a Professor in Care of the Elderly and a Justice of the Peace, was commissioned by the Health Authority to undertake an investigation with Sue Ellington, Chief Nursing Officer for Bedfordshire Health Authority.

Livesley and Ellington (1996) reviewed some 25 cases and interviewed both staff and relatives. They found that far from being an "exemplary" owner, by the standards of other appeals Takare could have been judged "unfit". They found that Takare had misled the Authority about the qualifications of its staff. It had claimed that the matron had qualifications in terminal illness and had supervisory care of people with mental illness. This was not the case: the matron's qualifications in these areas consisted of voluntary work (para 1.49). The home had major staffing problems. The turnover of staff was high, with half

leaving within six months. It continually operated with staffing at a level below the staffing notice, although this was set lower than the Health Authority thought manageable. Over Christmas 1994, there had been only one qualified nurse and one care assistant to care for 30 mentally ill infirm patients. The staff were inexperienced and unqualified, with only half of the qualified staff having experience in caring for elderly patients (para 1.70). Of the unqualified staff, more than half were either under 21 or over 45 years of age and 50 per cent had no previous experience of care work. After recruitment they only had three days training with Takare, who insisted that this was all that was required. The review concluded that the staff did not have the skills necessary for the effective handling and care of elderly patients with the high levels of dependency they encountered. A large number of patients were admitted to the local hospital with falls. The reviewers concluded that one of the main reasons for this was the high temperature of the home, coupled with lack of staff. Many residents could not drink unaided and the low staffing levels meant that there were insufficient staff to help them drink. Residents were thus becoming dehydrated – prone to falls and other problems of dehydration. Thus Takare could have been considered as "unfit" as it had lied to the Health Authority and had caused harm to residents.

The independent review was published in January 1996. The Health Ombudsman then took up the complaints of many of the relatives and a report of the home and the Health Authority's role finally appeared in the record of the Select Committee on Public Administration in 1998. Despite its experience in Hertfordshire that its staffing levels had been found to be a high risk and the adverse publicity it had attracted, Takare nevertheless appealed against the decision of Stoke on Trent Health Authority to refuse to register a home with the same staffing pattern. As noted above, this appeal, heard in October 1996, was successful. What is

extraordinary is that neither the Health Authority and its legal advisors nor the Tribunal, appeared to be aware of the independent review published some nine months previously or of the adverse publicity surrounding Takare in Hertfordshire. The Tribunal's decision, which set the standard for all large nursing homes, appeared to be based solely on the evidence before it that Takare was an "exemplary" owner. But as Hawkins (2002 p409) reports, criminal proceedings tear selected facts about events from the complex social reality of the workplace, transforming them into individualistic criminal law conceptions of responsibility and sanctioning, thereby depoliticising the issues.

CONCLUSION

To return to the original question of how representations of residents are used in the Tribunal's decisions, the answer appears contrary to what might be expected. Although appeals about fitness turn on the character of the appellant, harms done to residents, such as robbery or assault, play an important part in the consideration of that character. At first sight, appeals about the conditions of registration – staffing levels and the nature of the building – might be seen as more directly related to the characteristics of the residents. However, because of the uncertainty in justifying a decision based on the condition of the residents, such appeals often turn on the character of the registered person rather than the quality of care offered.

The Registered Homes Tribunal has been criticised by lawyers who argue that it favours the interests of home owners over the rights of residents (Harman and Harman 1989; Brammer 1994). But this chapter has sought to argue that behind this apparent bias lies a set of complex issues. Many books on corporate crime carry chapters on nursing homes (Braithwaite 1993) which attempt to demonstrate that for nursing homes

the legal definition of "crime" does not encompass actions which are thought to be morally problematic or which produce grave social harms. Teubner (1984) suggests that one of the major criticisms of command and control regulation is that it is cognitively inadequate to deal with the governance of complex organisations. Norms generated in other systems cannot be reliably translated into the legal system. The Takare case in particular provides another example of where, for complex reasons, the legal response has been inadequate to encompass activities in nursing homes which are considered to morally problematic.

The solution proposed by Teubner is "proceduralisation". One version of this includes an emphasis on the involvement of all those who have an interest in the regulatory processes (Black 2000; Justice 1996). In the case of nursing homes, it has been suggested that this would mean an appeals procedure which allows consumer groups the same standing as the regulatee to appeal the regulators' decision (Ayres and Braithwaite 1992). As noted above, the Tribunal stands out by the absence of the subject of the legal protection. The resident is absent in person and appears only as an unclear representation – referred to both as "a patient" and "a resident" with no consistency or apparent pattern. The rights of residents, occasionally articulated by the Tribunal as homely environments, individuality and choice, are constrained by governmental policies for the sector, ill-defined and even inappropriate to govern procedures required to care for residents with friable skin who are cognitively impaired, incontinent and immobile. With the authority of the Health Authority compromised by the fact that it is perceived to have a conflict of interest between its expertise and its role in the Tribunal as prosecutor, there are no mechanisms, procedures, or institutions which add appropriate operational flesh to these skeletal concepts. Yet the contemporary legal framing of the resident as a rights bearing subject works against the ability of the inspectorate to collect evidence about

the state of the resident's body. Technical issues such as the one articulated by Livesley and Ellington (1996), about the effects of ambient temperature of a nursing home when coupled with lack of staff, have much valence for the problems of governance of nursing homes. But such issues do not appear within the records of the Tribunal. They are norms generated elsewhere requiring articulation by expert witnesses.

This chapter also suggests that development of such an "interpretive community" may be more complex than procedural rules which allow different groups the right to speak. The presence of health care professionals in the majority on the Tribunal does little to address the complex issues identified here. But the more fundamental problem for elderly residents as a group is that while residents are, without a doubt, marginalised, they cannot be dealt with as just another under-represented group. The solutions advocated for other groups, such as participatory inclusion or even notions of fairness or justice, are very vexed in their application to this group, as will be apparent in later chapters. It is difficult for residents to be present because of their frailty. Although the Tribunal was anxious to state that welfare of the residents was its primary concern, without any clear anchors either in the primary legislation or subsequent guidance, it was difficult for the Tribunal to operationalise that concern in a robust way.

Chapter 7

THE NURSING HOME RESIDENT AS "SICK PERSON": A CONTESTED IMAGE

INTRODUCTION

Theories of old age have changed in the last decade to accommodate new sociological ideas of the self, a concern with social divisions of race and gender and the changing nature of the welfare state. The literature on social policy and old age used to be dominated by the theory of "structured dependency" (Gilleard and Higgs 2000; Estes and Linkin 2000), where the relationship with the welfare state became the sole defining characteristic of a particular age group. The welfare system was seen as creating a situation where when people retired they became economically dependent on the state when there was no need for them to be so (Estes and Linkins 2000). This theory has now given way to a postmodern view of old age (Gilleard and Higgs 2000) which incorporates contemporary concerns with "the self" and other social divisions. Thus, attention is now being paid to the lived experience of ageing and to acknowledging the heterogeneity of old people in terms of race, class and gender (Estes and Linkin 2000). However, for Gilleard and Higgs (2000), the significant divisions are not race, class and gender, but concern a person's ability to function according to the standards required of a contemporary individual. People who can function in such a way are referred to as "third agers" and those who have become too frail to do so as referred as "fourth agers" (Gilleard and Higgs 2000). The third age is portrayed by a picture of consumerism, self-improvement and self-development rather than being portrayed in the language of social rights (Featherstone and Hepworth 1998). People in this group, increasingly spatially separated into modern retirement communities (McHugh 2003), are described as typifying the "agentic construction of the life

world which is the epitome of the modern self" (Gilleard and Higgs 2000). When they can no longer successfully exercise the appropriate technologies of the self, and a progression to disability and dependency occurs, they are reclassified as "fourth agers". Thus there is no longer any common status in being old. Indeed, the characteristics of "third agers" are accentuated to the detriment of "fourth agers". The institution most associated with the "fourth age" is the nursing home. This chapter explores the status of "fourth agers" within social and health policy and considers how this status provides structural constraints on the regulation of nursing homes.

Many institutions occupy the "regulatory space" (Hancher and Moran 1989) of nursing home regulation – government, legal institutions, residents and their families, nursing home providers and health care professions. This chapter analyses how the image of "the resident" is contested in this particular regulatory space. The particular point at issue is whether the debility and disability that characterise residents means they should be classified as "sick". A number of key conceptual themes are linked to notions of the "sick person". First, the notion of "expert" knowledge about "sickness" or "illness" and secondly, ideas about the construction of the self. "Expert" knowledge about "sickness" has been developed and separated from "lay" or "everyday" knowledge by the institutionalisation of the former into health care professions (Bury 2000 p5). Thus the rise of the medical profession is related to a parallel emergence of disease and disorders, and medical competence is legitimated as the proper means for dealing with them. Such knowledge is increasingly organised and mediated through institutions responsible for the delivery of care, for example hospitals and government health care systems (Hogle 2002; Friedson 1986). The second group of major conceptual themes is related to Foucauldian ideas about the construction of the self. Both the disciplines of medicine and the state "objectify" their subjects by collection of information about them, for example statistics. Such information then becomes the

means through which individuals construct their identity or ideas about their self. That is to say, it is used "reflexively" to "subjectify" individuals (Rose 1996; Bury 2000).

The preceding chapters, in particular Chapter 3, have built up a picture of nursing homes and their residents as marginalised – a neglected area for policy development. This chapter explores further the theme of deprivation and its consequences for the status of the resident. It is suggested that, as well as the withdrawal of economic resources, residents are also denied access to the professional and symbolic resources which, in the contemporary UK context, constitute the category of "sick person". Neither can residents be classified as "dying people", for many of the resources considered appropriate to the dying are also unavailable. This chapter describes how residents are excluded from the practical application of professional medical and nursing expertise. Little investment has been made to produce "expert" knowledge to describe, measure or control residents as "sick people", and what expertise there is, has been separated from the provision of care.

Twentieth century institutions for very old people: development, resources and conditions

The sequestration of old people at the end of their lives into special institutions is not a new phenomenon. Over the past hundred years institutions catering for such people have increased in size and in number. Thane (2000), in a social history of ageing, notes that prior to the interwar years few old people at the end of their lives survived infections. But advances in nursing and in treatment generally meant the proportion of the population which is over 65 has risen from around 2% in the early 1900s to 20% in 2001 (ONS population series). Over the last 40 years there has also been a substantial change in the age composition of older people. The proportion of people in the UK population aged 85 and over increased from 0.7 per cent in 1961 to

1.9 per cent in 2002 – over 700,000 people[1]. However, institutions catering for the increasing number of such people are not, nor ever have been, a high priority. For most of the century they were typified by few resources, poor conditions and restricted access to health care, in particular medicine. Indeed, part of the rationale for introducing nursing homes regulation in 1927 was to improve the conditions. A Select Committee inquiry which reported in 1926 concluded that conditions for "senile chronic cases" warranted an "urgent need for registration" (Select Committee 1926). Around the time nursing home regulation began, the Local Government Act of 1929 transferred Poor Law institutions into the hands of local authorities, also in the hope of improving conditions (Thane 2000 p436).

But conditions in these local authority institutions which catered for the chronically supposedly incurably ill, very many of them aged, remained poor. A rationing system that provided inferior medical care for most older patients was firmly in place (Thane 2000; Isaacs 1981). Throughout the period to the inception of the National Health Service, there were very few doctors in these local authority hospitals, and the district, voluntary and teaching hospitals which specialised in acute medicine had an unwritten policy of excluding elderly people. One of the pioneer professors of geriatric medicine, Bernard Isaacs (1981 p224), writing in 1981, described how the rationing system worked in the 1940s:

> House physicians of my day were instructed to repel all applicants for admission if they were over the age of 65 on the unarguable ground that "we don't take that type of patient in here". The GP could be unpleasant about this at times, but his invisible reproaches were much to be preferred to the wrath of the Chief next morning when he found one of his beds put to such inappropriate use. Thus these good and famous men, our teachers, transmitted to us, their students, their blind rejection of the elderly.

[1] http://www.statistics.gov.uk accessed Oct 4th 2005

Doctors in training had no contact with such patients and therefore whole careers could be spent without any experience of people at the end of their lives. At the inception of the National Health Service in 1947, conditions in these former Poor Law hospitals were still inferior. Once qualified, Isaacs (1981 p225) was taken to a former Poor House – the place where the elderly people he had excluded were likely to be sent. Notice how he describes how the conditions had rendered the residents other than human:

> unbelievable sight... day rooms unheated save by a great iron stove discharging yellow smoke; unfurnished save by wooden kitchen chairs; and peopled with upwards of sixty old men, dressed in calico nightshirts of umbilical length and coarse cloth jackets and trousers, urinating on the floor beneath them, and countering the odour with that of indifferent tobacco. Pipe smoking was the only occupational therapy provided – the pipes lighted by the attendant, for the ownership of matches was forbidden. The patients left in bed in the cheerless ward were so distorted by contractures that their only human resemblance was to the foetus in the womb. They were there because they were ill, old and poor. They were there because, when the GP telephoned the teaching hospital, he was told "try elsewhere". I did not like the sight of "elsewhere".

One of the nursing homes I visited, described in Chapter 5, might be also viewed in such terms, providing a modern equivalent. It smelt heavily of urine and had call bells which went unanswered as agitated demented patients cried out.

Conditions in the old Poor Law institutions taken over by the National Health Service as long-stay hospitals and in residential institutions remained grim with recurrent public scandals (Allsop 1984) until the early 1970s. Partly because, at the creation of the National Health Service, consultants did not wish to work in the former workhouses, a two-tier system of "acute" and poorly staffed, "chronic" hospitals was created (Grimley Evans 1997). At the same time, in 1948 geriatric medicine was created as a specialty – an invention of the post-war NHS (Grimley Evans 2005). In the early 1970s, the height of the post-

war welfare state, there was an intent to improve conditions for old people, and in the 1970s, the specialty enjoyed a special relationship with the Department of Health (Grimley Evans 2005). With the introduction of the District General Hospital in the NHS Reorganisation Act of 1973, the division between acute and chronic hospitals was abolished (Klein 1995a,b; Allsop 1984) Thus a full range of services including geriatric services was required of the District General Hospital, and departments of geriatric medicine sprang up in all District General Hospitals (Grimley Evans 1997; Barton and Mulley 2003). But despite the policy intent, it proved difficult to transfer resources to geriatric medicine and as late as this was described as the treatment of under-privileged patients by under-privileged doctors in under-privileged buildings (Isaacs quoted by Thane p456).

No sooner had the brief period of accommodating old people in the mainstream of the NHS begun, than the state began to withdraw from the provision of long-term care and the expansion of the nursing home industry began. In 1970, the total number of long-term places in institutional care in the UK as a whole was 270,000, with **!Unexpected End of Formula** places in NHS geriatric hospitals and local authority residential care – the state sector (Kerrison and Pollock 2001c) – and very few, 20,300 places, in the independent nursing home sector (Laing and Buisson 1999). Between 1979 and 2000, the total number of beds in the NHS in England decreased from 480,000 to 189,000 while the number of beds in the independent sector, mainly in nursing homes, increased from 23,000 in 1983 to 193,000, with around 450,000 of beds in the nursing home and residential sector combined.

The 1970s also saw the development of the hospice movement (James 1994). Hospices developed as charitable institutions, outside the NHS, specialising in the care of the dying. In contrast to nursing homes, hospices have easy access to specialist medical advice from doctors with expertise in care of the dying, a higher ratio of nurses to untrained staff and nurses with qualifications in care of the dying

(Lawton 2000). Consequently, care is more sophisticated and expensive. However, hospices are not populated by dying old people. Instead, hospices are almost exclusively geared towards younger patients with incurable cancer. In one survey of UK hospices in 1997, 97 per cent of the patients had cancer, two thirds were under 65 and only 7 per cent were in the 85 and over age group which has 14 per cent of the cancer deaths (Eve and Higginson 2000). Traditionally, one of the aims of the hospice movement is to enable patients to retain control of their lives until death. Thus hospice philosophy is congruent with the contemporary notion of the choosing self and consuming self (Lawton 2000). The cognitive problems of very many old people do not fit easily with this image of the self. Instead, old people are more likely to die elsewhere. Of the deaths of people over 75 in England in 1998 – some 350,000 people – about half occurred in NHS hospitals, 15 per cent in nursing homes, 15 per cent at home, 12 per cent in other communal establishments (mainly residential homes) and less than 1 per cent in hospices (Registrar General DH1 series). In other words, there were approximately 51,000 deaths in one year in the nursing home population of around 190,000 (Registrar General DH1 series). Yet, despite the fact that more than a quarter of the population of nursing homes will die in a year, older people in care homes have been described as being "systematically disadvantaged" in relation the provision of palliative care (Davies and Seymour 2002). The model of palliative care based on a multidisciplinary approach, where there is commitment to caring for bereaved relatives as well as the dying individual, does not fit easily with a nursing home with one discipline, nursing, and where relatives may be seen as a disruption to the work of the home (Foner 1995). Recent attempts to develop palliative care schemes in private nursing homes have faced many barriers (Hockley and Clark 2002). For not only do care homes lack doctors, psychologists and social workers, they also lack "experts" in spiritual care, and there are no chaplaincies associated with care homes to organise priests (Orchard 2002).

In the 1990s, policies were implemented to further separate old people at the end of their lives from the health care system. As a consequence there is now empirical evidence which suggests that care is inadequate, with poor monitoring of chronic disease and overuse of inappropriate drugs in nursing homes (Fahey et al 2003). The 1990 NHS and Community Care Act, which came into force in 1993, transferred the responsibility for purchasing long-term general nursing care from the NHS to local authorities. In practice, this meant that care which was previously free at the point of delivery was subject to co-payment between the recipient and the authority. That is to say, the rights of elderly people as citizens to free comprehensive health care had been removed. Or, to put it the other way round, care delivered in nursing homes was no longer classified as health care. The process of reclassification of nursing homes as outside the health care system continued in the present decade when the term "nursing home" was abolished in the Care Standards Act 2000.

Modern institutions for the care of very old people – nursing homes – are set apart for other reasons. Many of the processes which have been described as central characteristics of modern life – that is "the desire to know, and to organise and control" (Bury 2000 p17) – are absent from nursing homes. As described below, compared to the rest of the health care system, little effort has been put into the accumulation of knowledge about residents or nursing homes. Compared with other groups, representations of residents are impoverished.

EXPERT KNOWLEDGE AND THE NURSING HOME

Separation of sophisticated knowledge from action

The development of a sophisticated health care system requires taking knowledge originally embedded within everyday life and subjecting it

to specialist development (Bury 2000 p5). Despite the fact that old age is increasingly associated with specific diseases such as Alzheimer's disease rather than "natural" decline, the state has managed to separate old people from expert knowledge. A growing amount of research evidence suggests that there is lack of health care provision in nursing homes, with inequity between the "free living" and those in nursing homes (O'Dea et al 2000; Janzon et al 2000; Jacobs and Glendinning 2001; Glendinning et al 2002; Jacobs 2003). Currently, geriatricians do not have an institutional base in nursing homes and specialist advice must be accessed through that general gatekeeper of specialist NHS services, the general practitioner. But the medical needs of care home residents have been deemed "to exceed the original expectation for general practitioners' present general medical services (GMS) contract" (Royal College of Physicians, Royal College of Nursing and British Geriatric Society 2000 para 7.1; Glendinning et al 2002). The result is that GPs may charge homes retainers, with extra costs being passed on to fee-paying residents. Similarly, residents may lack the services of both specialist nurses and therapists (O'Dea et al 2000). As noted above, throughout the history of institutions for old people in transition between life and death, expertise becomes divorced from where care is being given.

Residents are admitted directly, without a medical assessment, and, as noted in Chapter 4, most of the care is provided by unqualified nursing staff who are supervised by fewer qualified nurses who are less well educated than their counterparts in the NHS. One independent enquiry (Livesley and Ellington 1996) found that the care assistants had been recruited from an advertisement in a local superstore and started work some three days before the home received residents. Sixty-six per cent had had no previous work experience in the provision of care in any form, and a third were younger than 21. In the first six months of the home's opening, 43 per cent of the care assistants had left. As noted in Chapter 3, the primary legislation places few requirements on nursing homes in terms

of employment of qualified staff and, in its adjudication, the Registered Homes Tribunal, discussed in Chapter 6, may have further weakened these requirements. Thus there is a return to the "everyday knowledge" through the employment of untrained staff, and the everyday point of reference for interpretation of rules is not specialist health care expertise in elderly people.

The impoverishment of symbolic resources

Similarly, nursing homes and their residents stand outside the mainstream of a management culture in health care of calculation, measurement, audit and other rituals of verification deemed important in contemporary society (Power 1997). Put simply, there is lack of interest in knowing about nursing homes or their residents, and older people are increasingly sequestered into those parts of the health and care systems that statistics do not reach (Grimley Evans 2005 p80). Miller and Darton (2000) note that almost no information is available about the health status of nursing home residents. All nine official continuous surveys excluded this group, as they use households as their sampling frame, as do the majority of ad hoc official surveys. Although one in 20 people aged 65 and over is in institutionalised care (Bakejal 2002), the recent English Longitudinal Study of Aging, which began in 2001[2], does not include an institutional sample, although it will continue to follow people in institutional care. Apart from the decennial census, which includes people in institutions, the only official surveys undertaken since 1980 which include institutions are the 1984 OPCS surveys of disabilities, the 1997 National Diet and Nutrition Survey and the 2000 Health Survey for England. The administrative data which might be used to indicate the performance of care homes also suffers from considerable neglect. The only other source of routine data is prescriptions which are returned to Prescription Pricing Authority for analysis. This source of data accounts for literature being populated with papers about drug

prescribing in nursing homes (eg McGrath and Jackson 1996). The sector received an estimated £9.1 billion of public funding in 2001, and this sum is likely to have increased since then. Despite this, the only official data collected were the capacity of the homes and the numbers of residents. There is no basic information about the utilisation of care homes, let alone information which could be used to assess residents' health needs or monitor the quality of services provided by homes. Although the Office of Fair Trading has recently completed a market review of care homes (OFT 2005), they did not produce any separate data for care homes with nursing. Therefore the shape of the provision for the most vulnerable group still remains hidden.

From the late 1990s, public debate over the funding of long-term care added impetus to the collection of information about residents. Following criticism from both a Royal Commission on Long Term Care (Department of Health 1999a) and from the Court of Appeal (R v North East Devon Health Authority *ex parte* Coughlan), the government decided to fund nursing care in nursing homes provided by a registered nurse. Eligibility was to be assessed by an NHS nurse but the use of standardised residents assessments scales such as those developed by the Royal College of Nursing (2004) or the US Federal Government – the MDS RAI (Challis, Carpenter and Traske 1996) was avoided. Each Health Authority and now each Primary Care Trust has been given the discretion to decide on its own assessment tool. The lack of a common scale meant that there was no possibility of generating comparative data which might fuel the public debate about the funding or draw attention to other issues such as levels of care or geographical and other inequities.

This lack of information stands in sharp contrast to the data available about the NHS. Basic information about a 10 per cent sample of individuals has been collected since the 1960s as the Hospital In-

[2] http://www.natcen.ac.uk/elsa/docs/facts_links.htm accessed 12/12/05

Patient Inquiry. Since the 1990s, a 38-item minimum data-set was collected for every person admitted to an NHS hospital (McFarlane et al 2000). As well as recording basic demographic details, this describes the diagnosis, treatment or type of operation, and the outcome, with extra data items required for pregnancy and birth, psychiatric and intensive care. The information is collated centrally and provides the Hospital Episode Statistics. In addition, a vast amount of information is returned to the Department of Health to enable the government to manage the performance of the service.

Old people, at the end of life, seem to be left out of the pursuit of knowledge. For example, Cox and Cook (2002) note that it is only recently that needs of people with dementia who are dying or the needs of those dying in nursing homes in general have been explored. Research in this area is exploratory and tentative to such an extent that it is "inappropriate" to identify "best practice" (Nicholson 2006). But those who have attempted to undertake pilot palliative schemes in nursing homes have raised questions about the transferability of that model. There are many differences between a death at the end of a long life and the death of a younger person with cancer. For example, nursing home patients are likely to be cognitively impaired. This means that it is difficult to use assessment tools to describe and monitor pain and a different approach to pain management is required. In addition, as described in Chapter 3, a culture of normalisation exists in many nursing homes, therefore death and the need for appropriate care at this time is denied. Thus one manager is quoted as saying "We find it better not to encourage residents to talk about God as this may lead to thoughts of death" (Orchard 2002 p69).

Without expert codification of their condition or "needs" little argument can be made for the provision of services. If people are constructed by discourse then nursing home residents are not people. The lack of management information or information which could be used to externally judge performance means that the sector lies

outside the "audit" society. In many ways, nursing homes and their residents are an uncharted territory. As the symbolic resources with which to achieve this knowledge are absent or denied then elderly people might be seen as being on the periphery of life.

KNOWLEDGE AND RESOURCES FOR OLD PEOPLE IN GENERAL

Historically, and contemporarily, institutions providing care for people at the very end of life have existed against a general background of low priority being given to describing or meeting the needs of elderly people (Davies and Seymour 2002). Despite the fact that the NHS was meant to provide a comprehensive health care service from the cradle to the grave, from its inception it was taken for granted that the needs of older people took lower priority than those of the young. Thane (2000 p440) observes that even the Beveridge Report of 1942, the blueprint for the post-war Welfare State, asserted:

> It is dangerous to be in any way lavish to old age until adequate provision has been assured for all other vital needs, such as the prevention of disease and the adequate nutrition of the young.

Thus it is not surprising that post-war social reformers, such as Rob (1967) "Sans Everything" and Townsend "The last refuge" (1962), in studies of the 1950s and 1960s, concluded that the elderly received a lower standard of care than the rest of the population.

At turn of the 21st century, inequity between old people and the rest of the population appears to be increasing. The withdrawal of the NHS from long-term care and the expansion of the nursing home sector has occurred at the same time as a comparative decline in the rise of expenditure on the health of elderly people. In a cross-national comparison between England and Wales and Japan, Canada and Australia over the period 1985-87 to 1996-1999, Seshamini and Gray (2002) noted a decreasing proportion of general expenditure allocated to older people in England and Wales. The proportion of

total expenditure allocated to the population aged 65 and over decreased from 40 per cent to 35 per cent, despite the increased numbers in this age group. Per capita health expenditure increased by 8 per cent for ages 65 and over, compared to 31 per cent for ages 5-64. The per capita expenditure on health for ages 65 and over in Japan, Canada and Australia over the same period was 12 per cent, 20 per cent and 56 per cent respectively. The authors concluded that the cost of care for elderly people in England and Wales had declined and suggest that one possible reason lies in the expansion of cheaper forms of care, in particular nursing homes. They note that from 1988 to 1998 the market value of the nursing and residential care sector for older populations increased by 43 per cent from £5.1 billion to £7.3 billion, while the value of long-stay hospital care in the NHS decreased by 52 per cent from £3.3 billion to £1.1 billion. A further factor is that costs have been shifted to the individual by classifying nursing home care as social care which is subject to co-payment.

The lack of information which would allow sophisticated description of the nursing home industry and its residents, occurs against a background of a general lack of information about health in old age. In the early 1990s, a wide-ranging report by the Medical Research Council (1994) argued that, despite a large demographic change whereby people over 65 formed an increasingly large proportion of the population, there was little information about whether the health status of the older population has improved, deteriorated or remained static during the decades of mortality decline. At an individual level, disease in old age is known to present differently and old people respond differently to treatment (Grimley Evans 1997; Baron and Mulley 2003). But because the elderly are largely excluded from medical research, little is known about the best methods of treatment for the majority of health problems that are typical of old age, such as instability and incontinence.

Isaacs (1981 p231) notes:

> The transport of sodium ions across cell membranes has attracted more medical interest than the transport of human beings across rooms... The balance between anion and cation absorbs many more shelf miles of medical literature than the balance between right and left foot... Doctors fascinated by the incompetence of (his) mitral valve are turned off by incompetence of (his) urethral valve, yet the mechanics are no less delicate and failure no less disabling.

Similarly, as a result of exclusion of elderly people from clinical trials, it is not known whether much new treatment is harmful or beneficial for old people. For example, Grimley Evans (2002 p94) laments the lack of impact of the MRC 1994 review, commenting on one of the major advances in the treatment of heart attacks by noting that:

> It is seven years since an overview concluded that thrombolytic therapy given to a thousand patients aged over 75 with acute myocardial infarction will save the lives of 35 but kill or shorten the lives of 26. A problem clearly exists as clinicians still do not have an evidence base for identifying which older people with heart attacks should not be given thrombolysis.

The impoverishment of geriatric medicine itself has meant that it has few specific advances to offer old people. As Thane (2000 p254) notes, old people stand to benefit most from medicine where those benefits were shared with younger people. For example pacemakers, cardiac surgery and artificial joints have proved of benefit to the old and young alike. However, inequities or age discrimination mean that their access to such advances is restricted. For example, in 2005, the National Institute of Clinical Excellence decided that drugs to treat Alzheimer's disease should be banned from the NHS as they were outside the range of cost effectiveness that might be considered appropriate where cost effectiveness is measured in terms of increased life expectancy. That is to say, if the same drug was used to treat disease in a young person then it would be deemed "cost effective" (Harris 2005). Grimley Evans (2005 p79) noted the same

ageist policy at work in formulation of the National Service Framework for Older People published in 2001. He pungently remarks:

> ..there can be little doubt that the central policy preoccupation ..was to exclude older citizens from expensive medical care in acute hospitals not, as would be hoped by a geriatrician... to improve their well being.

WHAT INTERPRETATIONS CAN BE OFFERED FOR THIS MARGINALISATION ?

Identified above is a clear pattern of the removal of resources from the very old or fourth agers and their social exclusion to the margins of society. What explanations are offered such exclusion? From the perspective of a social historian, Thane (2000 p1), notes that the increasing numbers of old people in the population has been greeted with alarm and pessimism, with fears of the degeneration of society. Thane attributes this prevailing pessimism to an expression of an economic fear that increasing numbers of old people will be dependent on a decreasing population of working age. Vincent (2003 ch4) suggests that this is largely a manufactured problem as the number of people over 64 tripled between 1911 and 1991 without a problem. Therefore a further rise of 50 per cent in the next 50 years should not be onerous. The purpose of generating this fear is to create a sense of inevitability that public pension provision will fail, driving policy towards individual market-based pension provision. The latter is advantageous to capitalism as it provides finance for markets on a global scale. Vincent (2003 p107) concludes that such arguments "define an aging population as a potential disaster rather than the human success it actually represents".

Turner's (1998) sociological contribution to this debate is to point to a significant and growing conflict between generations. For Turner, a generation shares a culture grown out of a particular historical social movement and has a strategic temporal location to a set of resources

as a consequence of historical accident. Generation is a collective strategy to secure and maintain resources with social struggles between generations over limited resources. With life expectancy increasing, there is a generational difference between third agers and fourth agers. However, an analysis based on struggle or conflict seems inappropriate for explaining the situation of fourth agers. While, clearly, third agers could be very active in a generational struggle, by definition fourth agers could never have the capacities to engage in such a combat. Resources are removed by successor generations because those closest to death are in no position to struggle or resist.

For a more befitting explanation, I turn to an anthropological perspective. In a major review of the anthropological literature on old age, Cohen (1994) describes the situation of old people in terms of intergeneration violence. A central dynamic of generational politics is the challenge posed to the continuity of the social body by the potential degeneration of each successive generation. Symbolically, continuity is maintained by preventing such degeneration by an act of intergenerational violence. Those who show the ominous symptoms of decay are symbolically put to death. For Cohen, there are then interesting questions relating to the politics of debility. When do societies mark the powerful body as senescent? How do societies dissociate the individual from the social body? What is the means of destruction ? What are the semiotics of exchange ? How is a new body seamlessly enabled to become the social body? Some of these questions have significance for this thesis. In the description of nursing homes as bereft of resources, the means of destruction is identified. An individual is separated from the social body by being denied access to the resources – economic and symbolic – that are attributed to full people. Major structural forces are in place to ensure that access is denied.

In the next section, I consider the influence of institutions which have tried to resist this type of classification of residents – in particular, health care professions, law and families.

MEDICINE, LAW AND THE FAMILY - ATTEMPTS AT RESTITUTION

Geriatric medicine and nursing as compromised professional work

The medical specialty for old age, geriatric medicine, has a difficult relationship with its patient group. Old people can either be framed as sick and in need of medical care or as suffering from a natural decline which is not amenable to medical intervention. The profession has an interest in framing very old people as sick, as there is little status and few resources in a discipline based on a marginalised group. So, much professional interest and rhetoric is concerned with reclassifying such old people as sick. Articles with polemical titles such as "There is no such thing as ageing: old age is associated with disease, but does not cause it" (Peto and Doll 1997) and "Should be encouraged – the medicalisation of old age" (Ebrahim 2002) are not uncommon even in the professional medical press.

Indeed, the ethos of the speciality is based on the ability to reclassify old people, and the pioneers of the profession – Warren, Coisin, Amulree – are revered for their success in this against impossible odds (Barton and Mulley 2003). Marjorie Warren is attributed with establishing a distinct role and purpose for modern geriatric medicine (Barton and Mulley 2003, Grimley Evans 1997, Thane 2000). In the early 1930s, she inherited a Poor Law hospital when it was taken into local authority control. Warren (1948) introduced serious diagnosis of the patients' conditions in place of the previous, largely silent, taken-for-granted assumption that whatever the precipitating cause of hospitalisation, older people were close to death. She introduced incentives to get out of bed, promoting physiotherapy and other forms

of rehabilitation – therapies which became the backbone of geriatric medicine. By these methods, Warren discovered that cure, or at least considerable improvement, was possible and 200 out of the 700 patients she inherited were discharged home or to their families or friends. Warren (1948 p841) noted that such reclassification redeemed inmates from a less than human state where killing could become morally acceptable: ...in this miserable state, dull, apathetic, helpless and hopeless, life lingers on sometimes for years, while those round them whisper arguments in favour of euthanasia.

While the modern speciality of geriatric medicine describes itself as being based on such redemptive acts, historically and contemporarily few benefit from the application of these skills. Major structural factors ensure that reclassification is limited.

Until the mid-1970s, geriatricians and the majority of elderly people were excluded from the main hospitals and consequently from the most sophisticated forms of medicine. When the distinction between long-stay and acute hospitals was phased out in the 1970s, elderly people began to be admitted to general hospital in larger numbers. At this point, an arrangement was needed to ensure that resources were not inappropriately spent on attempting to arrest "natural" decline. Thus, to make general hospitals run more effectively (Grimley Evans 1997), geriatricians were employed to undertake a form of triage. That is to say, to quickly establish whether it is worthwhile putting any NHS time and resources into the treatment of an elderly person or whether they should be discharged to await death. A triage decision in effect means classifying the very old as "sick people" or non-people. However, as geriatricians have no base in nursing homes and no oversight of the residents, this expert triage cannot be used to redeem residents as "sick people". As a joint working party of the Royal College Physicians, Royal College of Nursing and British Geriatric Society (2000 para 2.9) noted, "Care home residents have often become medically dispossessed in spite of their

complex health care needs". Arguably, Marjorie Warren's work of sifting through the institutionalised population to look for those to actively treat, no longer takes place, for to do so might have a major effect on the demands for health care services. The legend which sustained the speciality no longer has any basis in practice. Instead, the system is arranged in a way which ensures that only old people who are close to death linger in a hospital bed.

Recently physicians specialising in geriatric medicine, now the largest speciality within the Royal College of Physicians (Grimley Evans 1997), have acquired increased responsibility for acute medical care. They have become dissatisfied with their assigned role, as it has given them little opportunity to work on the rehabilitation of elderly people (Bowman et al1999; Young and Philp 2000; Royal College Physicians, Royal College of Nursing and British Geriatric Society 2000; Grimley Evans and Tallis 2001). Instead they are "fire fighters of acute exacerbations of chronic disease" (Bowman et al 1999). In a report (Royal College Physicians, Royal College of Nursing and British Geriatric Society 2000) which criticised the current "ad-hoc arrangements" for providing health care homes and aimed to influence the new framework for regulation of care homes following the Care Standards Act 2000, they argued that there was an urgent need for specialist geriatric medicine and old age psychiatry to re-engage in a structured manner with the care home population. The report offered mechanisms for re-engagement not only of geriatricians but also of a whole multidisciplinary team. Significantly, this was not to be achieved through changes to regulatory standards but through the commissioning process. They costed the arrangements at about £1,000 per year extra for each nursing home resident or an increase of 4 per cent in the cost of care – costs which they argued would be recovered, as the lack of rehabilitative work may be responsible for rising and inappropriate acute hospital admissions and inappropriate prescribing.

Nurses, too, argue that their role in relation to the elderly is to restore their functioning (Ford and McCormack 1999) but they are prevented from applying these specialist skills where they are most needed, in nursing homes. With no requirements for nurses in nursing homes to have specialist knowledge, skills or expertise in care of older people, the scope for specialist gerontological nurses to develop and lead care in homes is unrecognised (Ford and Wild 2001). As a result, many older people who have clear nursing needs are often receiving only social care because of inadequate assessment. Ford and Wild (2001) notes that it is ironic that a government which has done much to acknowledge the professional skills of nurses by creating the role of nurse consultant and supporting the development of nurse specialist for older people has, at the same time, compromised the professional nursing role in nursing homes. Structured by funding arrangements, legal requirements and regulatory rules, nursing in nursing homes has developed in a way that does not fit a professional model. In homes, nursing is viewed as a series of tasks which can be delegated to and carried out by untrained people. When so delegated, it is not even classified as health care, as it is the subject of co-payment. The profession argues for a return to the model for nursing homes where "a specialist gerontological nurse should be the lead clinical practitioner" (Royal College Physicians, Royal College of Nursing and British Geriatric Society 2000) – the original model for a nursing home, revived in the 1970s – as described in Chapter 4. Thus far, there has been no effective response to the Royal College of Physicians or the Royal College of Nursing proposals. In this area, for both professions, nursing and geriatric medicine, one of the defining characteristics of a profession, the ability to determine the content and terms of their own work (McKinley 1988), is compromised.

Legal and political attempts to reconstruct the resident as a patient

The NHS and Community Care Act of 1990, which shifted responsibility for long-term care from the NHS to local authorities, resulted in the

requirement for co-payment for costs of nursing homes care. As a result, the seeds for much discontent were sown. For as well as affecting fourth agers, co-payment compromised the capacity of families to transfer wealth between generations. It has brought into play the resident as family member rather than individual, with the potential for an alliance between third and fourth agers. This alliance has now mounted a series of legal and political challenges to the co-payment policies.

First, legal challenges to individual decisions about funding care have been mounted. These have resulted in two legal cases. The first is an appeal, R v North East Devon Health Authority *ex parte* Coughlan, which clarified the law about under which circumstances the NHS should be responsible for payment of nursing home fees. The second, more recent, case, in 2006, R (on the application of Grogan) v Bexley NHS Care Trust, re-inforced the Coughlan judgement.

Complaints by individuals and their relatives about reimbursement of nursing home fees as a result of the Coughlan judgement have kept the Health Service Ombudsman extremely busy, as in 2003 as she received over 4,000 complaints about this matter (Health Service Ombudsman 2004). Secondly, there has been a rise in consumer challenges to care homes. In particular, a "super complaint" brought by an alliance of voluntary organisations against unfair contracts in the care home sector (Guardian March 3rd 2004) was investigated by the Office of Fair Trading (2005). As yet, none of these challenges have resulted in a major change in government policy. Policy has been merely moulded to address the criticism without any fundamental change. The withdrawal of resources from fourth agers continues with very little check. However these developments are worth exploring further, as the nature of the arguments illuminate understanding of "the resident".

Attempts to reassert the citizen's rights to health care

The Royal Commission on the funding of long-term care, *With Respect to Old Age*, which reported in 1999, argued that it was fundamentally inequitable for some diseases such as cancer or heart disease to be seen as legitimately the province of the NHS whereas Alzheimer's disease or the effects of a stroke were not (Department of Health 1999a). This could not be justified. The emergence of diseases of old age means that it is difficult not to classify old people as sick and thus the grounds for excluding them from free health care were difficult to defend. The Commission also argued that costs were no grounds for the refusal to fund long-term care as there was no "demographic time bomb" and the costs of care were affordable. The key recommendation was that personal care should be funded. Personal care was defined as care that directly involves touching a person's body and therefore incorporated issues of intimacy, personal dignity and confidentiality. The Commission remarked that this type of care falls within the internationally recognised definition of nursing, but may be delivered by many people who are not nurses.

In the same year, before the government responded to the Royal Commission, the Court of Appeal decision in the Coughlan case (R v North East Devon Health Authority *ex parte* Coughlan) was announced. The judgement carefully avoided the issue of what should be defined as health or nursing care, instead concentrating on the division of responsibilities of the Secretary of State for Health as laid out in the 1977 NHS Act, and local authorities. The judgement concluded that the Secretary of State for Health was responsible for the provision of health care and that these responsibilities could not be shifted onto the local authority. When the primary need for nursing was a health need then the responsibility is that of the NHS, even when the individual has been placed in a home by the local authority. Whether the local authority can be expected to provide nursing services depends on the quantity and quality of these services. Local

authorities' responsibilities are limited to those which can be said to be "incidental and ancillary to the provision of accommodation" and which are such as "an authority whose primary responsibility is to provide social services can be expected to provide" (Loux et al 2000). The court recognised that this decision would have widespread and significant implications.

Although this lessened the scope for shifting the costs of nursing care to co-payment, it did not deem that all nursing care should be provided and funded by the NHS. Subsequent Department of Health guidance toned down the judgement by merely listing factors which health authorities should "bear in mind" or "pay attention to" when considering funding long-term care, rather than pointing out the authorities' legal duties (HSC 2001/15, LAC (2001) 18). The Health Service Ombudsman (2003), in a report of the investigation of a number of cases, notes that this guidance has been misapplied and misinterpreted by some Health Authorities, leading to injustice and hardship, and that the Department of Health was complicit in this. "It appears to me that some health authorities were reluctant to accept their responsibilities with regard to such patients and were not being pressed by the DH to do so" (para 22).

Instead, efforts have gone into developing limited arrangements for providing free nursing care, where nursing care means just care delivered or organised by a registered nurse as assessed by an NHS nurse. The maximum that the NHS will fund under this scheme was around £145 per week in 2003 for the highest category of residents, when the cost of nursing homes places is from £400 to £700 per week. The Ombudsman has pointed out that as this policy was not designed around the Coughlan judgement, many decisions taken using this policy are still unlawful. The Ombudsman concluded that the policy on funding of long-term care was not fair, logical or transparent. The Department of Health is criticised for not providing a clear national framework, with decisions about what criteria to use left to individual

Health Authorities and their application left to front-line staff without guidance. Again, local discretion has provided a convenient means to obscure inequitable treatment, the knowledge of which could be used to fuel public debate.

In the six weeks following the publication of her report in 2003, the Ombudsman received a further 1,300 complaints and is now recommending a review of all cases and a reimbursement. The cost is estimated to be in the order of £500m. It remains to be seen how fast the Primary Care Trusts (the successors to Health Authorities, which were abolished in 2003), will work to reassess residents and reimburse them or their estates. Even with the backing of an Appeal Court judgement, the Ombudsman and the interest of families in preserving their inheritance, it remains difficult to assert the view of residents as citizens with rights to health care free at the point of delivery or to reconstruct the resident as a patient (Henwood M and Waddington E 2005). Considerable power has been used to resist the attempts of these institutions to redefine the resident as a patient.

Attempts to reconstruct the resident as a consumer

The requirement for residents to contribute wholly or in part to the cost of their nursing home care has resulted in a new dimension in the politics of the long-term care – the relative and residents consumer alliance. At the end of life, the resident's assets come to be seen less in terms of the property of individuals but in terms of the claims of the successor generation of family members. Resistance is forming to the removal of this family wealth, particularly where the care is poor. For example, the Lynde House support group in the middle-class area of Richmond, Surrey, mounted a major campaign against the owner of Lynde House, Chai Patel. The majority of residents in Lynde House were privately funded, paying fees in excess of £700 a week. Their publicity succeeded in discrediting Chai Patel, owner of a chain of nursing homes, who was forced to resign as government advisor on

private health care (*A home unfit for heroes* and *Blair adviser quits in nursing home scandal* Guardian June 9th and September 22nd 2002) and was investigated by the General Medical Council for serious professional misconduct.

Another consumer campaign was mounted by the Consumer Association (2003) and 28 other charities (*Government agency announces care homes inquiry* Guardian March 3rd 2004). The alliance had requested that the Office of Fair Trading investigate potential subsidisation by the private payers or co-payers of the under-funding of nursing homes by local authorities and central government. The Alliance claimed that there were significant distortions in the market for care homes. The Office of Fair Trading declined to investigate this subject but instead launched an investigation into one of the Alliance's other complaints, the adequacy of price information for potential care home residents and their representatives. This found that two thirds of contracts which fee-paying residents signed were unfair or unclear. As a result of their investigation, the Office of Fair Trading took enforcement action against unfair terms in ten care home operators contracts covering 800 homes and around 50,000 places – about one quarter of the market (OFT press release March 21st 2005). Examples of the unfair terms included terms which let the care home make frequent or arbitrary increases in residents' fees and imposed unfair penalties, restrictions or obligations on the resident.

The lack of any standardised information about the performance of nursing homes, identified above, is difficult to justify to a public which has been encouraged to use performance indicators as part of a political debate on the public sector. This "informal super complaint" to the Office of Fair Trading suggests that the family is emerging as a consumer in the care home industry.

The family definition of the resident as person

From a small number of studies (Dupuis and Norris 2001; Krause, Grant and Long 1999; Foner 1995; Davies and Nolan 2003) of relatives' perception of nursing homes, there is evidence that family members attempt to maintain the resident as "person" even though the institution and its staff member operate as though this were not the case. However, at some point nearly all families with a relative in a home will relinquish their relative to the institution, with its different view of "the relative". In a study of daughters of Canadian nursing home residents, Dupuis and Norris (2001) found that a major aspect of the daughters' role was described in terms of trying to maintain as much of the parent as possible – their parent's physical appearance, mental function, and the parent's sense of who they are – even though little of their former self remained. But the maintenance of this status of person is a struggle against the institution. Relatives experienced stress in trying to persuade staff to relate to their parent as a person, as considerable effort was required (Krause, Grant and Long, 1999). These attempts to maintain the classification of their parent as a person carried on as long as adult children received affection from their parents. When it became impossible for the parent to reciprocate, it was likely that the adult child would cease in their attempts to maintain this classification and relinquish the parent to the institution. This would suggest that near relatives perceive the essence of being a person as emotional reciprocity. Staff in nursing homes resent the active involvement of relatives, as adult children's attempts to maintain their relative as a person cut across the requirements to get through the work (Foner 1995). It was seen as pressure on the job. Staff are unlikely to be able to build up such emotional relationships with residents as they will have no shared history, and the impaired residents will have little capacity for emotional exchange.

The re-emergence of the person as the point of reference

I have suggested that major cultural factors rooted in the status of old people explain the difficulties in categorising "the resident". As the rules are vague, based on provision of "adequate" care for the condition of residents, there are major difficulties in determining the point of reference. Yet despite the fact that nursing homes are structurally precluded from providing health care, when there is a scandal in a nursing home, they will be judged by the health care experts, using expert knowledge. Any other point of reference would raise difficult questions about diminished status of residents.

To illustrate, I use the only two publicly available inquiries conducted by independent assessors. Both these inquiries received major publicity. The first resulted in a further inquiry by the Ombudsman and a Health Select Committee (1997), and the second in the resignation of one the government's key advisors on the private health care sector. The first report, which is also drawn on for Chapter 6, was written in 1996 by Brian Livesley, a Professor in the Care of the Elderly, and Sue Ellington, a Director of Nursing in the NHS. Livesley and Ellington (1996) analysed care in a particular nursing home, in terms of Livesley's experience of managing facilities providing care for very old people in the NHS. That is to say, they provide an expert account of the institutional arrangements that would be required to manage the residents of this type as "patients". Judged by this standard – the standard expected of contemporary health care, the nursing home failed. Expert vignettes describing the problems of "the patients" in the idiom of a specialist in the requirements of this type of care are provided. Three of some forty in the report are given below. Livesley and Ellington then identify how the institutional arrangements, in particular the staffing resources, would make it impossible to provide appropriate care for such "patients":

> This elderly blind, demented, diabetic patient was aged 86 and known to be confused, disoriented and physically aggressive with a tendency to undress in public. Within

> a week of admission to the Home the patient had a fall and three weeks later, after a separate incident, was found on the floor complaining of a great deal of pain. (para 4.20.)
>
> This patient was aged over 70 and described as elderly mentally infirm with Alzheimer's disease and epilepsy resulting in total dependency and an inability to communicate effectively. This patients was admitted with pressure sore which had caused problems since January 1994. (para 4.26.)
>
> This patient was aged 69 and had: diabetes mellitus, breathing difficulties requiring oxygen at times, several drugs requiring repeated administration through the day and dressing needed for weepy and swollen legs. This patient – who was just able to stand and could walk with a shuffle but normally slept in a chair at night – was described as having good understanding of both the spoken and written word and an excellent psychological state. (para 4.22.)

There were around 130 similar "patients" in this home. The staff employed to care for these "patients", could neither produce such expertly coded vignettes nor could they possibly translate such vignettes into appropriate actions to manage their problems. There were too few qualified staff who could understand the meaning or practical implications of these reduced codes. The staff consists of 82 unqualified care assistants and 25 qualified nurses to provide 24-hour cover. Medical care was from a GP practice who were contracted for five hours a week to provide a service to 130 highly dependent residents as well as coping with the several thousand other patients on their list. Of the qualified nursing staff, only one had a qualification in care of the elderly, and a further six had experience of work in caring for the elderly. Data from the RCN survey of nurses in the independent sector (Royal College of Nursing 2003b) undertaken in 2001/02 would suggest that these staffing arrangements are not atypical. There was no requirement for a medical assessment of residents before admission. So, pressure to fill the beds for economic reasons meant residents were admitted with needs beyond the capacity of the nursing staff and the limited time of the GPs. In this

case, the medical and nursing work escalated beyond the capacity of the staff to manage and many of the residents were subsequently admitted to hospital in a poor condition.

The Livesley and Ellington report also highlights problems between the NHS and the nursing homes sector in categorisation of different types of care. In the NHS, the terms "Elderly Mentally Infirm", "Palliative Care" and "Terminal Care" have specific meanings which define a level and type of service provision. However, they had no meaning in the Registered Homes Act where a nursing home provides undifferentiated nursing care. So there was no requirement for the nursing home to provide anything else, even though these labels were attached to residents. That is to say, the NHS expected its own standards and definitions to apply and they did not. Livesley recommended that the Health Authority should publish clear definitions of the categories of patients for which nursing homes may be registered and state the resources, equipment, skills and experience that will be required. However, as described in Chapter 6, any authority that did this would have some difficulties finding a legal justification, if a nursing home appealed. Livesley and Ellington concluded that the Health Authority should urgently consider whether the nursing home was "fit".

The second inquiry, into Lynde House, was written in 2002 (Kingston and Richmond Health Authority 2002) by a nurse manager. She considered that the registered person was unfit because they had allowed insufficient levels of staff to meet the high level of residents' need, had allowed inadequately trained staff to undertake the care tasks and procedures, such as administration of medicines and ear syringing, and had allowed nursing staff to continue to undertake poor practice, for example, wound care. The report also argues that the care failed to be "safe" and "adequate" for the following reasons: failure to undertake comprehensive pre-admission assessments, residents presenting with acute clinical signs and symptoms were not

referred promptly to the GP, there was no complete set of nursing records that reflected the changing needs of each resident including absence of care planning in some critical situations, for example diabetes, chest infections, pressure sores, lack of fluid and hydration records and so on. In short, this was judged as health care.

CONCLUSION

Vincent (2003, 2006) suggests that in modern societies the problems of old age and death are constructed typically as a medical problem with a scientific solution. In the fourth age, older people lose control of their bodies to the medical profession. This medicalisation of old age structures people's perceptions and stifles the possibility of creative cultural activity around old age. Locating the meaning of death in striving for an even longer life span denies the possibility of old age as a valued part of the life course. The evidence presented in this chapter stands in sharp contrast to Vincent's argument. I suggest that the residents of nursing homes are not medicalised. They are bereft of medical resources. Yet this has not led to the burgeoning of cultural understanding or valuing of the lives of nursing home residents.

Instead, borrowing from Cohen (1994), I have suggested that the removal of resources, professional, economic and symbolic, dissociates residents from the social body and they occupy a transitional category between full person and death. Thus nursing home residents are deprived of the characteristics deemed appropriate for the "sick person" or "dying people". But this is contested. Institutions in the regulatory space of nursing homes — medicine, public and consumer law and the family — have attempted to redefine the resident. Thus the resident as "sick" or "dying" person forms part of the background debate around nursing homes. As the *raison d'être* of regulation is to protect residents, the

resident's contested status, person or non-person, raises difficult issues as to what counts as a legitimate interpretation of regulatory rules. Nursing homes are structurally incapable of providing the care deemed appropriate to "sick" or dying people but such images re-emerge as the points of reference for the interpretation of rules when there is a public scandal. For what other point of reference could be used without calling into question the resident's status as a person? If residents cannot be classified as sick people, what are they? Given this situation, nursing homes and their regulators must maintain considerable defences against the articulation of this paradox. With hindsight, the difficulties in obtaining access to inspection units described in Chapter 2, might be attributable to this, at least in part.

Chapter 8

NURSING HOMES REGULATION: A MORAL OR POLITICAL TALE?

Impaired both physically and cognitively, the residents of nursing homes are in a poor state. In any one year, one quarter of them will die. Such people were referred to by an eminent geriatrician as living in the "Stone Age" of old age, where body and spirit are rock (Isaacs 1981 p451). These "fourth agers" constitute a particular group of individuals who are not just old but at the very end of their lives. When "fourth agers" are the residents of nursing homes, they are afforded special legal protection in the form of nursing home regulation. The *raison d'être* of regulation of nursing homes is the protection of nursing home residents.

Where regulation is conceived as legal rules backed by some form of sanction then two "ideal" approaches predominate in the literature – a "co-operative" or "compliance" approach and a "deterrence" or "punitive" model (Baldwin 2004, Tombs 2002). Developed as theoretical ideals from empirical studies of regulation in practice, each is based on particular premises about the best ways of achieving social control of corporations and individuals. Thus both are underpinned by particular views of states, firms, corporate actors, law, and "protected".

The "co-operative" approach comes in many guises. Compliance may be seen simply as negotiated between the regulator and regulatee (Hutter 1997), or the aim may be more sophisticated – to proactively stimulate corporate self-regulation as in "enforced self-regulation", "responsive regulation" (Ayes and Braithwaite 1992) or "meta regulation" (Gunningham and Grabosky 1998; Coglianese and Lazer 2002; Parker 2002). The "co-operative" approach is based on the premise that there is or can be general agreement about social goals and that industry is or can be persuaded to be a moral actor and will

be co-operative in ensuring that social harms are minimised (Tombs 2002). In this approach regulatory rules are viewed with a degree of moral ambiguity (Hawkins 1984, 2002). Thus the untoward actions of industry are referred to as "social harms" rather than "crimes". In order to facilitate a co-operative approach, a regulatory design based on broad rules or standards which promote dialogue is required (Black 1995). As dialogue and mutual understanding are the key, rules need to be accompanied by administrative rather than legal sanctions, as enforcement through the courts can often cut across the regulators' intentions (Black 1995; Scott 2001). Ideas vary as to who should be involved in establishing the meaning of such broad rules. Black (1997; 1999b) favours an "interpretive community" – a closed system where all regulatory actors – the rule maker, regulator and regulatee – share a common understanding of the meaning of the rule. In "responsive regulation", "the protected" and public interest groups should be also involved (Ayres and Braithwaite 1992), while in Parker's (2002) version, "meta regulation", corporate management should be open to a broad range of stakeholder deliberations facilitated and enforced by legal regulation.

Tombs (2002) is critical, describing the co-operative approach to regulation as consensus politics – naïve to the inherent nature of power relations between industry, regulators and the public. Baldwin (2004) also has reservations in that he suggests corporate players may not see the world in the same way regulators view it, to the extent that effective dialogue may not be possible. For example, they may be more interested in maximising shareholder returns than in responding to ethical prescriptions of regulators.

In the "deterrence" or "punitive" model, the most effective way of achieving the social ends of regulation is by "punishment" rather than "persuasion" (Baldwin 2004). Punitive policing strategies with stronger enforcement and prosecution, and overall tougher criminal legislation, are recommended (Tombs 2002; Gray 2006). Thus the

formal legal system is seen as the essential element in the crime inhibition process (Simpson 2002). For some proponents of this approach (Pearce and Tombs 1991), there is no moral ambiguity associated with regulatory law, the state or the nature of capital. "Right" and "wrong" are clear and the untoward actions of industry or individual corporate managers are regarded as "crimes" which should be treated no differently from any other crime. The force of the law should be used to shame and punish this morally wrong conduct. The implication is that the state through legislation should protect the public interest against the excesses or social costs of private capital. In this model, law – not only regulatory law but, increasingly, fundamental human rights law – has a major role in ensuring justice, by standing up for those who have been wronged by the actions of industry. In practice, neither model exists in a pure form. Empirical research suggests that even where regulatory regimes appear accommodative or co-operative, sanctions including prosecutions are used but used selectively (Hutter 2001). This is the case for nursing home regulation where, in the main, regulation appears accommodative or co-operative but when this ceases to be tenable the registration of homes is withdrawn.

Another way of viewing regulation is to see it as the outcome of competition or negotiations between private and public actors and institutions in a bounded space (Scott 2001; Hancher and Moran 1989 ch10). Recently, however, the boundary has become ill defined and regulation is now conceptualised as a decentred or fragmented activity (Black 2001; Scott 2001) – that is, no longer inevitably connected to powers of a central sovereign state but instead operating through norms employed by non-state actors.

The empirical exploration of a system conceived in terms of "regulatory space" is a complex methodological problem. One approach has been to focus one key symbolic event or object and use it as a means to explore particular regulatory systems. For example,

Hawkins (2002) focuses on the decision to prosecute, separating the regulatory space into the broad setting of economic, political and social circumstances – the surround, the legal and organisational setting in which the decisions are made, which is referred to as the field – and the way individual decision makers frame the decision – the frame. Thus as well as providing information about the decision, such an analysis provides insight into the relative importance of particular elements which are part of "the context" for the decision. This thesis is similar, in that I have chosen a specific point of focus – not a specific decision, but a key symbolic object central to both nursing home rules and the *raison d'être* of the regulatory system – "the resident". The social construction of this key symbolic object by different self-referential groups and communities has been explored.

Until the new regulatory framework for nursing home regulation came into force in 2002, the state had the dominant voice in this "regulatory space". In order to control the tensions between public expenditure and the state's role in providing support for this vulnerable group, the 'command and control' regulatory framework of the Registered Homes Act 1984 was nested within an overarching framework of indirect state control. A framework of state normative and fiscal policies driven by social policies with respect to this particular social group, precluded certain interpretations of regulatory rules and ensured that some rules remain ill-defined or unstable. That is to say rather than de-centred, regulation in this area was "centred". Where the regulated market concerns providing services funded by government as part of the traditional welfare state, there may be reasons for regulation to remain very "centred".

NURSING HOME REGULATION AND THE COMPLIANCE MODEL OF REGULATION

Nursing home regulation as outlined in this thesis has many of the characteristics of the traditional "compliance" model. Broad standards are accompanied primarily by administrative sanctions with few prosecutions and there is a closed interpretive community. Yet there are problems with the operation of the traditional compliance approach, as many rules rest on an ill-defined construct, "the resident", whose further definition is actively disrupted.

Ways of fixing standards

As a construct within the normative framework for regulation, people who live in nursing homes are the point of reference for many of the key regulatory rules. Rules in nursing home regulation may be specific but the rules governing the care of residents/patients tend to be framed broadly, using evaluative words – for example, the staffing and facilities of nursing homes must be "suitable" and "adequate" to the "condition" of "patients".

As Galligan (1986b) notes, irrespective of whether rules are broad or specific, there is always considerable discretion inherent in their application. Empirical studies of regulation suggest that non-legal factors are of considerable importance in understanding how discretion is exercised. Organisational factors (Galligan 1986), public pressure (Hawkins 1984, Hutter 1988), as well as the size of the regulated company (Pearce and Tombs 1998) may all play a part. Rules may be interpreted interactionally (Hutter 1997), or used in discursive negotiations about the proper conduct of matter under discussion (Black 1999b), in which case they may become part of rhetorical resources deployed by different groups in an assertion of

authority. Meaning may be moulded to provide strategic advantage in such interactions. Galligan (1986) summarises the factors which influence such discretionary decisions as the effective and efficient ways of executing the task, the economic, political and social environment, the moral background both of the community and the deciding official, and the organisational structure of the regulatory agency. With so many contextual, contingent and emergent factors involved, how is coherence achieved and the norm stabilised?

The starting point for nursing home regulation is that the particular framing of rules described above evokes a particular type of question: Suitable for whom? Adequate for what purposes? For such rules to have meaning, a mental representation or image of the point of reference for such rules must be invoked – or, in a legal frame of reference, "an image of the protected". Thus "the protected" is a construct created and maintained by social processes whose function is to make actions in nursing home regulation meaningful. By representing "the protected" in one particular way rather than another certain types of actions are relevant and others are unthinkable. Or to put it another way an image has similarity with what is understood within phenomenology as "a frame". Images frame problems and thus enable action to be planned, steered and justified (Dingwall and Strong 1997). Thus "image" is understood as the way that nursing home work and the regulation of nursing homes are held together. In the broadest sense, it is one of the key constructs which allows the governance of the activity. What are the origins of such images? What resources were available to fashion such images? How are such collective images stabilised?

Investigating "images of the protected" – that is, situating the image in a legal frame – means identifying the sites of production within the regulatory system and gathering information from them. At the time of the fieldwork, there was no central nursing home regulatory agency – regulation was undertaken by some 100 separate Health Authorities

– therefore two other potential sites of production were considered. First, in the interaction between field level officials and regulatee, and secondly, the Registered Homes Tribunal – the appeal system for nursing home owners. Both became the subject of empirical investigation, the former through an observational study of the work of two groups of nursing home inspectors from different Health Authorities and the latter through an analysis of Tribunal decisions. The next issue was where to look for an adequate contextual explanation for the images encountered. What types of discourses or resources are available to inspectors to fashion such images? As described in Chapter 5, the different types of images used by the two groups of inspectors could be explained simply by their different backgrounds.

However, in this thesis, explanations have been sought in the macrosocial environment as well as in resources immediately available to inspectors from their individual backgrounds or from the local organisational culture. What is being asserted here is that the local culture is not the only context for understanding collective ideas of the protected. As Wodak and Meyer (2001 p21) note, social actors do not exclusively make use of their individual experience and strategies; they also rely upon collective frames of perception.

Two major frames in the macrosocial environment were considered. First, health care professions, in particular nursing and medicine, and secondly, the state. As inspectors and nursing home managers are members of the same profession, one of the major cultural resources available to nursing home inspectors is nursing. An investigation of how elderly residents and, more generally, how old people at the end of their lives were viewed within the occupation of nursing was undertaken through an analysis of the nursing literature. That is, both the sociological literature on nursing and the literature written by and directed towards nurses were examined to establish what types of images were stabilised within nursing. A similar investigation was

undertaken using the literature of the specialist medicine of old age. Second, a preliminary analysis suggested that the state had a significant control over a number of key aspects of nursing home regulation apart from the regulatory legislation. For example, the state is also the main purchaser of nursing home care. Therefore the policy intent towards residents or, more generally, towards elderly people at the end of their lives, was considered as a cultural resource for the production of images of the residents. To understand how such old people were viewed in health and social policy, an investigation of the resources and institutions which historically have been available for old people at the end of their lives was compared with resources and institutions available to "sick people".

CONSTRUCTING THE RESIDENT

The resident as a "sick person"

While the resident is described as "a person" in primary legislation, in the secondary legislation which is concerned with the conduct of care, residents are described as "patients". But the image of the resident as a "sick" person or "patient" is difficult to sustain as specialist doctors have been excluded from nursing homes and the version of nursing enacted in nursing homes is largely divorced from the profession.

Chapter 7 presented evidence that specialist medicine for elderly people was founded just before the inception of the welfare state on the idea that the decline in health of significant numbers of old people in long-stay institutions could be arrested or reversed. That is to say, it was the role of specialist medicine to engage in heroic acts of taking very old people off the path of inevitable decline to death and restore their function. But historically as well as contemporarily, few benefited from these redemptive acts (Thane 2000). Major

structural factors ensure that this type of reclassification is limited. Thus the Registered Homes Act 1984 placed no requirement on nursing homes to employ doctors, either generalist or specialist. Having specialist doctors sift through the institutionalised population looking for those to apply the expensive specialist skills of modern medicine does not fit with the policies of cost constraint required for the contemporary welfare state. Excluding doctors sends a very clear message that residents should not be treated or given the rights to care as the sick. Similarly, Chapter 7 presents evidence that it is difficult to classify residents as "dying", as they are not afforded the same care as the terminally ill. Instead, in the Registered Homes Act 1984, residents are deemed as having undifferentiated nursing needs where nursing is operationalised as an activity carried out by untrained staff.

Despite the increasing construction of old age in terms of diseases such as dementia, the Registered Homes Act 1984 continued to be interpreted in a way which denied that residents had a need for specialist care. Residents were required to compete for medical care, both specialist and general, with the rest of the population. In 1999, in an effort to influence the implementation of the Care Standards Act 2000, the successor to the Registered Homes Act 1984, the Royal College of Nursing, the Royal College of Physicians and the British Geriatric Society (2000) co-operated in producing recommendations aimed at increasing the specialised nursing and medical input into nursing homes. Thus the professions have attempted to reclaim the resident as sick. Yet, these proposals were not incorporated in the new Act, under which the nursing homes were abolished as a legal category, moving even further away from the health care sector. With this move, the image of the resident as a sick person is even more difficult to sustain.

Images of residents in professional nursing

As indicated in Chapter 7, from about the 1930s there has been a professional interest in halting or reversing the decline of body and mind in old age and promoting "rehabilitation". As the predominant concept of self is based on autonomy and independence, the aims of "rehabilitation" are often inappropriate to the characteristics of nursing home residents. But recent work undertaken by the professional association for nurses, the Royal College of Nursing, working with psychologists interested in old age, has explored ways of relating to residents more appropriate to their characteristics. A range of sociological and psychological theories – for example, symbolic interactionism, phenomenology and psychoanalysis – have been pressed into use to develop more sympathetic models of care. For example, interventions based on this so-called "humanistic gerontology" (Estes and Linkin 2000), have been devised which draw on life histories or emotions[1]. Yet, as Chapter 4 concluded, such models have only recently entered the discourse of professional nursing of old age, and work to transmit these images throughout the nursing profession – or specifically to the nursing home sector – is being developed. A further problem is that these models require a sophisticated interpersonal relationship between the nurse and the client – a relationship which is difficult to realise with an untrained workforce. The characteristics of the labour force within nursing homes, the structure of nursing as an occupation, the use of unqualified nurses, the poor opportunities in the sector for specialist training and the absence of specialist doctors from the sector mean that there are considerable difficulties in undertaking this translation work.

Chapter 4 noted that nursing is a segmented occupation. Qualified nurses and care staff in nursing homes have little connection with professional and academic nurses responsible for developing these

[1] eg Kitwood T (1993) *Towards a Theory of Dementia Care: the interpersonal process.*

professional resources specifically related to old age. As Dingwall and colleagues (1988) noted, they are in effect enacting different versions of the same occupation, each with its own culture and objectives. With no requirement for such nurses to have professional qualifications in the care of the elderly, or to show professional leadership, owners or managers of nursing homes who are qualified nurses may be drawn towards the "tradeswoman" version of nursing. That is, managing a nursing home, whether as an employee or as the owner, is not seen as a profession or a calling, but as a business. Proprietors and private sector nurse managers may be less concerned with promoting the profession, education or writing – very few articles in journals are authored by nurses working in nursing homes. This makes it difficult to stabilise or transmit any images produced by this culture. Instead of the traditional professional interests, nurse proprietors or private sector nurse managers are more concerned with adopting practices which promote financial viability, given the straitened circumstances for funding nursing homes.

The lack of the "professional" segment of nursing in nursing homes is compounded by the fact that much nursing in nursing homes is carried out with unqualified staff who are paid very low wages, with few training or educational opportunities for learning sophisticated ways of relating to very old people. Therefore, although cultural resources may be available, an invisible wall exists between professional nursing and staff, qualified and unqualified, in nursing homes. Communicating different practices from academic nursing to nursing practice in nursing homes takes place in an *ad hoc* manner and is reliant on the initiative of a few academic departments engaged in trying to improve the learning experience of student nurses.

The problem of developing a stable coherent image of the resident is compounded by the fact that they are excluded from commonly legitimated roles of being sick or terminally ill. For example, although in the initial regulations and guidance people who live in

nursing homes were referred to as "patients", care is not offered on the same terms as the rest of the sick population, by experts and free at the point of delivery (eg Glendinning et al 2002). Instead, care is subject to co-payment and given in the main by untrained staff. When people are considered sick or disabled, one of the functions of health care professionals is to produce coherent images of such people which form the basis for morality of conduct or an ethics of practice towards that subject. But the symbolic resources required to standardise and describe an image of sickness or disability tailored to this group are either denied, or, where they have been developed, the stabilisation and transmission has been disrupted. Given that it is difficult to embed an image of "the protected" as "a patient", what other general cultural resources are available to produce such images?

Resources for producing images of very old people

Much writing on nursing homes is normative, concerned with issues such as how life in a nursing home could be "made better" (eg Weiner and Kayser-Jones 1990; Davies 2003). In this respect, it echoes the literature on old age, which Cohen (1994) describes as being dominated by a "language of conversion" and "a trope of anger". That is, the reader is invited to feel shame at conditions under which old people live and is invited to join a movement to improve things. Yet, as I conclude in Chapters 1 and 7, there are considerable difficulties in understanding what a "good enough" life might be for an old person at the end of their life who is severely physically and cognitively impaired. Vincent (2003, 2006) argues that the search for immortality through science and medicine has impoverished thought in this area – there is a paucity of cultural resources with which to produce a coherent image of a very old person.

Theories of the self, whether legal, sociological or developmental, fit poorly the attributes or characteristics of old people at the end of life. Generally, as described in Chapters 1 and 4, such theories

presume a capacity for rationality, independence, competence and self-reflection. Moreover, theories of self which emphasise autonomy and independence are on the ascendancy in law and in contemporary culture in general. The work of Agich (1993) explored in Chapter 4 suggests that physical or mental decline in old age is not incorporated into contemporary cultural understandings of the self. Leaving aside these theoretical ideals, the lived experience of old age is considered to be a neglected area within gerontology (Estes and Linkin 2000). But there are particular difficulties in understanding the "lived" experience of nursing home residents. Recent work in anthropology suggests that the body is important to maintaining the integrity of self (Lawton 2000), yet the resident's sense of self is challenged by bodily decay. Similarly, cognitive impairment limits the capacity for articulate self-reflection of the experience. As Cohen (1994) notes, old age presents an extreme existential crisis. Given the lack of coherent image to fix the question, suitable for whom?, on what do nursing home inspectors base their judgement about compliance?

Nursing home inspectors and images of residents

The analysis of the fieldwork presented in Chapter 5 was based on the proposition that images of residents could be inferred from the different inspection methodologies employed by the two different groups of inspectors. One inspection unit placed a heavy emphasis on "risk" – particularly legal risk. The legal risk to the nursing home was from the burgeoning web of regulation in which nursing homes are embedded, not just the Registered Homes Act 1984. The risk of litigation was "talked up". The main threat was portrayed as arising from a failure of the home to have systems and practices in place which adequately protect the resident, specifically the resident's body. Elderly residents were like very delicate china which could easily be chipped or broken! The systems required to protect residents were conceived not only in terms of the state of the buildings and equipment but in terms of the systems of care, including

staff employment and training. For this unit, there was no need to ask residents for their views or experiences of the home. The failure or absence of routines, procedures and systems was written on the resident's bodies. The inspectors' job was portrayed to the home manager as "to protect you from the law". Inspectors would attempt to form an alliance with the home manager to inculcate systems and practices which would become everyday. In this way, the home would be protected from a harsh and threatening legal environment. The formal reports issued contained bare statements about whether the home had met the standard or not. They contained little other information to help readers or service users flesh out what this meant in terms of the quality of a home. In effect inspectors were protecting the resident as a body – an object – and the home as a business.

For the other inspection unit, the inspection methodology employed involved a professional discussion with the nursing home manager about "the needs" of residents and interviews with residents to find out their experience of care. Nursing homes were thus expected to respond to residents' needs either as professionally defined or as articulated by the residents themselves. The relationship that inspectors attempted to portray with nursing managers was that they were holding them to account professionally. The resident was constructed as a person with agency whose needs were professionally defined. However, neither professionally defined needs nor views of residents appeared to carry much persuasive force. It was too easy for nursing home managers to discredit residents as very difficult or confused. Unfortunately, as described below, the decisions of the Tribunal analysed in Chapter 6 suggest that in this regulatory system, professionally defined needs generally carry little weight against economic constraints imposed by the state on the nursing home sector. However, the inspectors from this group issued very forceful public reports which spelt out very clearly a home's deficiencies. In these reports, homes were publicly shamed. Or, from a professional

point of view, their colleagues in nursing homes were shown up as letting the profession down. Inspectors might be seen as more concerned with the effect on the profession, not the effect on individual businesses. However, for the reasons identified below, resting an inspector's authority on the nursing profession may carry very little weight. In contrast, when the state of the resident's body and systems used to protect it are used as evidence of compliance then it is possible to draw authority from more powerful regulatory frameworks concerned with the environment such as the Health and Safety at Work Act.

Like all models, the key features of these inspection models have been heightened for analytic purposes. They have been described as "ideal types". However, the first model has been reported in other empirical studies of nursing homes. Davies (2004) found three models or communities of care in nursing homes she studied: "the cosmetic community", where the objectives were "customer satisfaction" and where relationships were "cordial but superficial"; the "complete community", where the aims were growth and development and relationships were spontaneous and reciprocal – a "community of equals"; the "controlled community", where the objectives were minimising risk and relationships were distant and combative. Davies's "controlled community" fits well the risk model that the first group of inspectors were trying to inculcate into nursing homes. It is also a model which fits contemporary ideas about the governance of organisations (Power 2004). However, the model does not find favour with Braithwaite (1993), who saw similar models in operation in nursing homes in the USA, or with Davies. Speaking from the perspective of an academic nurse, Davies (2003 p233) notes that "the views and preferences of service users are secondary to the institutional view of how life and care are best ordered".

The approaches to compliance used by the different inspection units can be understood as an appeal to the two different versions of

nursing outlined above – an appeal to the business person and an appeal to the professional nurse. The inspectors who were part of a private consultancy were in effect business women themselves and were enacting that model with managers. They were encouraging managers to engage in practices which they perceived would lessen the risk to their business. The other group, whose background was as NHS nurse managers, adopted a professional model which emphasised the resident as independent autonomous subject – a model of the patient which was prevalent in professional nursing in general. The analysis also suggests that strategies of compliance which appeal to a shared authority within the profession of nursing are likely to have limited effect with the business-women working in nursing homes. The premise that there is a shared *professional* nursing culture between the inspector and the nursing home manager is questionable. If nursing is construed as professional nursing then for the reasons outlined above nursing is arguably part of the context, not a constituent part of nursing homes or their regulation. Or to put it another way, professional nursing is not part of the interpretive community for nursing home rules and the profession may only have weak control over qualified nurses in nursing homes. Whether or not there is a shared culture between nurses in nursing homes and nurse inspectors or the professional sectors of the occupation about what would constitute the proper conduct of a nursing home or the proper relationship towards a very old person, clearly warrants more detailed empirical investigation. It was not possible to explore the views and images of residents developed and promoted by private sector managers in this thesis.

THE STATE - A THE DOMINANT ACTOR IN THE REGULATORY SPACE

The interpretive community for images of the protected

Black (1995) suggests that an interpretive community is one in which there is shared understanding of interpretation of rules. Professions are excluded from being part of the interpretive community of nursing home regulation, except insofar as they are members of the inspectorate. Similarly, patients or their representatives have no voice in this community either. Thus the interpretive community of nursing home regulation consists of inspection units, regulatees and the Registered Homes Tribunal.

"Appropriate to the condition of residents" could mean a high standard of care. However, there is a patterned attempt to ensure that standards are not interpreted in this way. As professional expertise is excluded, other models must be pressed into service as a basis of, and justification for, action. Some models identified from the fieldwork can be a useful aid to compliance, for example when the resident is conceptualised as a delicate body in need of protection. But such models can also be out of step with the characteristics of residents. For example, nurse inspectors may use a methodology which involves interviewing clients about their views when they are aware that very few residents can provide a coherent response. Bathrooms may be built and approved which are not suitable to the physical needs of residents because they fit a business model which presumed both that the relatives are the main decision makers about the choice of homes and that relatives expect private bathroom facilities.

Other voices are now attempting to enter the interpretive arena. They have contested the accepted view of the resident and there have been efforts to reconstruct the resident as "sick person" and "consumer". The Health Ombudsman (2004) is now supporting campaigns to reinstate health care free at the point of delivery and is recommending a national assessment tool underpinned by a

multidisciplinary assessment, not just a nursing assessment. Both these development take place against considerable resistance from the Department of Health. Similarly, the lack of information about nursing homes has compromised the image of the resident as "consumer" to such an extent that the Office of Fair Trading (2005) has recently conducted an inquiry into availability of information about nursing homes.

However, there does seem to be some shared understanding within the traditional closed community that care "appropriate" to the condition of residents is of a lower standard than that afforded to the sick. This view is supported through the decisions of the Registered Homes Tribunal described below.

Images from the Registered Home TribunalThe Registered Homes Tribunal was set up to allow nursing home owners a right of appeal against the arbitrary administrative decisions of inspectors or Health Authorities. As such the resident or the residents' representative had no voice in the Tribunal. The Tribunal is part of the regulatory system but, although in theory independent from government, in its operation it is arguably very much under the control of the state, specifically the Department of Health. As demonstrated in Chapter 6, the Tribunal always seems to have an eye on the Department's legislative and policy intent in its decision making.

Earlier reviews of the Tribunal's work (Harman and Harman 1989 and Brooke Ross 1989) concluded that the Tribunal did little to improve the rights of residents. The conclusion of this thesis is similar. The cumulative effects of a series of Tribunal decisions was not to raise standards, but to ensure that home owners were not adversely penalised for working within economic constraints set centrally by the state through the reimbursement rates. Inspectors who required a specific standard of care based on their professional judgement of the "condition" of residents were dismissed as "over enthusiastic". Residents were fitted into buildings rather than a requirement to

make buildings fit for the specific "condition" of residents. Similarly, the Tribunal ruled that there was no requirement to employ specialist staff to care for people with dementia. This was not the state's intent. In another case, one major provider was allowed to determine its own staffing levels, with the Tribunal arguing that risk of loss of reputation and market forces would prevent care falling to a low level. Thus the Tribunal reinforced the view that, unlike other areas of health care where professional provider pressure is a powerful influence on level of service provision, professionals have little authority in nursing home regulation and the resident can only expect a standard of care solely set within economic constraints imposed by the state. However, the Tribunal had a bottom line below which standards must not fall. So, while residents do not have rights to care on the same terms as sick people, they do have some minimal rights. As noted in Chapter 3, nursing homes appear to operate with a "social licence" (Gunningham, Kagan and Thornton 2004). In cases of cruelty, abuse, neglect or dishonesty, a home owner would be declared unfit and the home closed. Any care above this level is acceptable.

While residents do not have the same rights as others to health care, human rights legislation has been used in a way which appears to confound the regulatory intent to protect residents from poor quality care. In a recent decision (RHT 457), the Tribunal ruled that the Health Authority's evidence about the state of health of the residents was inadmissible because the authority had not obtained consent from all residents to be examined. The majority of residents were so cognitively impaired that they could not give consent, but the Health Authority's failure to get such consent from either residents or relatives violated the residents' human rights. The Health Authority lost the case, and the nursing home where conditions were bad carried on operating. The irony is that, with the emphasis of human rights residents' right to privacy is exerted over their rights to a standard of care, irrespective of their capacity to exercise or comprehend or enjoy their privacy.

The effect of the Tribunal decisions is to obscure state policy and render it incomprehensible when judged by the requirements of services offered to the sick. When the economics of the industry and residents' needs conflict then the Tribunal only enforces needs at a very basic level. Thus care is "adequate" and "suitable" for a person with fewer rights than someone who is sick. But the state's influence over the operation of the Tribunal extended beyond reference to state's legal and policy intent. The state, specifically the Department of Health, controlled the Tribunal's procedural rules. Despite protests from the Council on Tribunals, for over two decades, the Department of Health allowed the Tribunal to operate with no formal rules regarding the filing of evidence and the negotiation of hearing dates. As a result the Tribunal's activities were hampered by frequent cancellations and requests for adjournments. The protracted hearings allowed nursing home owners considerable advantage and generated a reluctance on the part of Health Authorities and inspectors to take actions which might result in appeals.

Other state instruments and relationships of control

The analysis above suggests that interpretation of regulatory rules or regulation in this sector cannot be fully understood from within the legal system circumscribed by the Registered Homes Act 1984. Moreover, the Act is not the only, or necessarily the most important, mechanism of control in this system. The state, one of the major defining forces in this regulatory space, has inculcated values through mechanisms which lie both inside and outside the framework of the 1984 Act.

As described in Chapter 7, the development of the nursing home sector has enabled the NHS to withdraw from the responsibility of caring for frail, old people at the end of life who can no longer live independently. The Department of Health manages the market in nursing home places to broadly fit with government policies for this

client group. The evidence from Chapter 7 suggests that one of the major planks of this policy is severe cost constraint. With two thirds of nursing home places subsidised by the state (Laing and Buisson 2000), the state is in effect the main purchaser of nursing home places. Mechanisms are in place to control the prices that the care home may charge to publicly funded residents. Thus the Department, through subsidies and other financial measures, has control over the supply of nursing homes places and the economics of the sector. In effect, the Department of Health is the economic regulator for the sector. There is now considerable evidence that these financial policies have created a marginal industry (Netten 2005) where large providers are favoured (Holden 2002) and residents' needs must be made to fit within cost constraints. In such industries, there are tendencies to "cut corners" and the difficulties of regulating marginal industries are well known (Kagan 1994).

In terms of the legal framework, the Secretary of State for Health was responsible for drafting the nursing home regulations, and Health Authorities, accountable through the NHS to the Department of Health, were responsible for inspecting nursing homes and enforcing the 1984 Act. The Secretary of State also has powers in the 1984 Act to define the nature of the labour force in the sector and has not required doctors or other members of the modern health care team to be employed. Nursing homes are required to be in the charge of a "qualified" nurse and employ "qualified nurses", but the 1984 Act gives the Secretary of State the power to define the qualifications required for a "qualified nurse" (c25 (2)). And as noted above, the state has chosen not to construct "qualified" as someone who has expertise in care of the elderly.

It is difficult to classify residents as "sick" or "dying", because the resources generally available to such people in terms of professional relationships and expert knowledge are absent from nursing homes. Co-payment for nursing home care also provides a clear signal to the

public that nursing homes are not part of the health care system which remains free at the point of delivery to the sick. Chapter 7 also outlined how nursing home residents are largely excluded from the collection of population statistics about health, with little medical research in general on the problems of extreme old age. Information on which to base a comparison of the performance of homes is lacking. Although this lack of information could be explained by the contingencies of data collection and funding, the same is not true of implementation of the assessment for funding nursing care in nursing homes. This has been implemented with no requirement for standardised assessment tools. This suggests an intent to ensure that comparative information which might fuel a public debate about levels of care or geographical or other inequities cannot be produced. The general impoverishment of symbolic resources disrupts attempts by skilled actors to produce, elaborate and transmit a coherent image of the resident. Thus skilled actors cannot consolidate a site of power within the sector.

This thesis began with the assumption that the key actors, instruments, relationships and processes in nursing home regulation flow from the Registered Homes Act 1984. That is, the system of regulation consisted of the primary legislation and the relevant regulations, the enforcement system, the appeal system and the nursing homes themselves. The interpretive community for nursing home rules consisted of these elements. Following from this, images of the protected would be generated from within these traditional boundaries. However, the analysis above leads to the conclusion that on close inspection nursing home regulation is a "centred" activity. But it is one in which the responsibilities between industry, regulators and state become very blurred, obscuring the operations of power to the extent that informed debated becomes impoverished.

THE MORAL AND POLITICAL STATUS OF THE RESIDENT

So-called "participative regulation" is one way in which "the protected" are increasingly being given a focus and a voice within regulation. Although the term has been given new impetus in environmental regulation and in consumer protection, its roots go back to the Health and Safety at Work etc Act 1974. This Act was designed as a tripartite structure to fully involve the workers whom the legislation partly aimed to protect in the regulatory process (Hutter 2001). Rothstein (2004) suggests a number of reasons for the current vogue for participative regulation: providing a broader assessment of risk; ensuring the legitimacy of regulatory processes; and increasing public trust in the regulator. Clearly, there are a number of different ways of involving the public or the protected in regulatory processes. Rowe and Frewer (2005) suggest that there are three basic concepts for public involvement in general based on the flow of information: public communication, which consists of providing the public with information; public consultation, where information is communicated from the public to the regulator; and public participation, where there is a two-way dialogue or negotiation between the public and the regulator which aims to transfer the opinions of both. Compared with the regulatory regimes concerned with occupational health and safety, environment or food safety, nursing home regulation under the 1984 Act was a very closed system with little public involvement. However, the new Commission for Social Care Inspection which took over in 2004 is more concerned with public involvement. The reports of inspection visits are available from its website, occasional reports about the compliance of the sector are also published, consultation processes have been mounted and the Commission is planning to pilot new ways of involving the public in inspection processes. All these processes may make the regulation of care homes more transparent and hence more legitimate. But little public information is available about the sanctioning of care homes, for example, enforcement notices,

withdrawals of registration or prosecutions. Given that information about the enforcement actions by the Health and Safety Executive against individual care homes is available, this seems a little odd. As Rothstein (2004) notes, there is always a need to balance stakeholder interests in participative regulation and one of the most powerful stakeholders in nursing home regulation is the state.

The category or image of "the patient" has been the subject of centuries of historical, social and cultural elaboration. This has produced an image, stabilised within any particular historic period, which governs the moral conduct of the health care professions and of people in general towards patients. Much of the training for health care professionals and their continued professional development is concerned with the further elaboration of this image and the professional's relationship to it (Good 1995). In contrast, the image of "the resident" remains unstable – unanchored by any fitting cultural definition. This precludes the expression of a clear ethical mandate towards this group. The lack of stable image means that the conduct of nursing homes and their regulation exist in a state of moral ambiguity. On the one hand, if residents are full people with all relevant citizens' rights, then care should be provided on the same terms as the rest of the population – that is, in line with professionally defined needs. Indeed, when scandals about nursing homes erupt, then experts – doctors and nurses – are brought in to judge the nursing homes' deficiencies. Such judgements inevitably use the frame of expert health care with the resident framed as a sick person (see Livesley and Ellington 1996; Kingston and Richmond Health Authority 2002) as there is no other frame which can be openly justified. But through financial constraints and other mechanisms other values are insinuated. A lesser form of care is expected and the appropriation of resources, both financial and symbolic, from this group is acceptable. As a consequence, both inspector and managers must work with this ambiguous image, sharing a guilty secret. They cannot operate openly with this devalued image. For in doing so, they

would place themselves outside the moral community which declares that all people are equal – that old people – our parents and elderly relatives – have the same rights as the rest of the population, that they should be treated as individuals according to their needs. Residents and the conduct of nursing homes can thus be read from different and conflicting frames of reference – one ethical, the other with an unsettling moral provenance. Inspectors and nursing homes are reluctant to expose their work to the outside world for fear that external observers may read what they see in the wrong frame. This may account for the difficulties I had in getting access. A further consequence of this moral ambiguity is that it is difficult for staff to understand how the proper conduct of a nursing home should be organised and how, ethically, they should relate to residents. Where the framing of the resident is contested and morally incoherent then neglect and general poor standards can be negated by an alternative framing.

Both models of regulation outlined at the beginning of this chapter can be viewed as moral enterprises. In the compliance approach, there is expectation of understanding of the aims of regulation as socially desirable goals. Either firms operate according to a "social licence" based on what is tolerated by wider society, or the aim of regulation must be to persuade them to do so (Scott 2003). In the deterrence model, the aim is justice achieved through a formal legal system. However, the expression of the purpose of regulation in terms of moral goals becomes very vexed in relation to nursing home regulation as "the protected" have a very ambiguous social status.

Cohen (1994), writing from an anthropological perspective, suggests that the relationship between old people and other groups is best understood by acknowledging the nature of generational politics. A central dynamic is the challenge posed to the continuity of the social body by the degeneration of each successive generation. In an act of intergenerational violence, individuals in the generation close to

death who show the ominous symptoms of decay are symbolically separated from the social body by being denied access to the resources, economic and symbolic, that are attributed to full people – that is, they are symbolically put to death. Cohen argues that social policy and much scholarship on old age avoids facing the true nature of this conflict and disguises the violence involved. There is a sense in which nursing home residents are separated from the social body and have their resources appropriated. Morality in this case cannot be construed as ensuring equality between nursing home residents and other groups. To be sure, the major inequalities between very elderly people and the rest of the population raise issues of social justice. Thus an appeal to legal empowerment or political action might seem appropriate. But such solutions, advocated for other disadvantaged groups, hardly seem appropriate for old people approaching death. There may be reasons why the articulation of the social goals of regulation may be difficult. Societies may have darker non-consensual ends.

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