

The Abuse of Older People in Private Sector Care Homes: Why does it occur? Why does it endure?

By

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ABSTRACT

Government policy has existed to protect adults who may be at risk of abuse since 1993. This policy was significantly revised in 2000 by '*No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*', that included specific guidance on responding to abuse in care homes. However, a catalogue of abuse of older people in care homes subsequent to 2000, some of which has recently been graphically recorded with the aid of concealable video cameras, confirms that abusive acts continue. This thesis examined the extent and nature of abuse in private sector care homes in England that now dominate the market of residential care provision, and has sought answers to the question of why it still occurs and endures.

The research has employed a mixed methods approach. An anonymously completed questionnaire was used to quantify and explore any *previous* experiences of abuse from newly appointed care staff in five newly opened care homes in three local authority areas. Concurrently, thirty-six semi-structured interviews were conducted with twelve care staff, twelve care managers and twelve care home proprietors, drawn from a sample of established homes in five local authority areas, exploring perceptions and experiences of the nature and causes of abuse.

A clear conclusion to be drawn from the findings is that action, driven by revised policy and legislation, is warranted at both societal and care home organisational levels to strengthen the prevention of abuse. Fundamental changes were found to be required both in how individuals and society as a whole perceive and value older

people and their care, in how care homes are regulated, and in how staff are recruited, supported and managed to minimise the potential for abusive behaviour.

DEDICATION

To all those people who believed in me over the past six years.

To all those people who in the future may experience a life free from abuse as a
result of this work.

ACKNOWLEDGEMENTS

My heartfelt thanks go to my wife who has supported and encouraged me to complete this work; it was an ambition that I once thought was perhaps beyond me, but with her help and tolerance this particular dream has been realised.

My profound gratitude to my academic supervisors Professor John Raine and Doctor Denise Tanner of the University of Birmingham; they unfailingly pulled and pushed me up the mountain, particularly the most treacherous parts. Now I can stand at the mountain's peak and gaze down at the path we have travelled together over the past six years. I thank them both for their invaluable insights and guidance.

Further thanks to Mike Marshall, my erstwhile manager who moved on elsewhere during the early stages of my research, but maintained an interest in this study and continued to send me pertinent information that he came across in the course of his consultancy work.

I must thank also the care staff, managers and proprietors of the care homes I engaged with directly, and all of those anonymous care staff who provided additional information. Some of us shared anguish during interviews; we all share a common desire to reduce the occurrence of abuse.

I thank also Dudley Metropolitan Borough Council for funding this research.

Finally, I thank my parents, both gone from this earth but still walking beside me; many years ago they planted the seeds that have finally borne fruit in the form of this academic achievement.

PROLOGUE

This research has proved immensely satisfying personally, but has also been disturbing. It proved at times difficult to conduct, partly because of the sometimes intense emotions displayed by respondents when relating their experiences to me during interviews, but in greater part as a result of the content of returned anonymous questionnaires. Though I worked in hospitals and private sector care homes as a registered nurse for fourteen years, mostly with older people, and encountered some abusive practices, I was unprepared for what was related to me within these questionnaires. Perversely, this is a testimony to the success of that particular research method.

Though I was able to share the upset with interviewees when it occurred, and offer them some words of comfort, words that were also reciprocated to me by them at times, I had to read through and analyse the total of 140 questionnaires, the majority of which depicted some form of abuse, alone. My academic supervisors of course supported me when we discussed what I found, and indeed they too I think shared some of my dismay, but essentially I carried, and still carry, what has become a great weight upon my conscience as a member of this society.

When I finally ceased nursing practice in 1997, I hoped I might leave behind the legacy of suffering I encountered because those experiences had an insidious negative effect upon me over time. It never did leave me however, and in part my recollections influenced my decision to conduct this research. Unfortunately, the lugubrious memories of my nursing experiences have been reanimated by what I

have found in the course of conducting the research for this thesis. Yet perhaps I should be grateful for those resurrected memories, many of which, though not all, were pervaded with human pain and anguish. Now, as a result of my research, I am more determined than ever to see changes made in how current safeguarding policy, often ineffective in terms of prevention, is applied in my own area and beyond to protect people from abuse.

That would be a start. And from such change other more profound change might begin to grow, and eventually the seeming pestilence of maltreatment of older people in some care homes, and probably elsewhere too, will be significantly reduced, if not eliminated.

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1. Introduction

1.1. Introduction

This chapter provides the background to this study, setting out the research questions, presenting an initial definition of abuse, and identifying who, within care homes, are included as potential perpetrators of abuse. It then considers the age and potential susceptibility to abuse of older people in care homes, and the importance of conceptualising care homes as complex institutions not generally open to public scrutiny. This is followed by recognition of a current lack of research into the causes of abuse in care homes, and of how conducting such enquiry may inform the formulation of future social policy. Finally, the impact of my dual role as a researcher and a local authority commissioner is considered.

1.2. Context of this Research

This research explores the circumstances under which the abuse of older adults occurs within English care homes operated as profit-making businesses that have come to constitute 91.4% of all care home provision (Livesley *et al.* 2011: 16). That such abuse endures, despite formal policy to combat it, is evident from continuing safeguarding¹ referrals to local authorities from within care homes in England (Health and Social Care Information Centre 2014), and from recent televised recorded images of abuse secured by covert filming within a number of private sector care homes during the period between 2011 and 2015.

¹ The term 'safeguarding' is the more contemporary term for 'adult protection'.

The research will address the overarching research question of:

Why do older people living in care homes continue to be abused despite national safeguarding policy in place since 2000?

In addressing this question the following sub-questions are also tackled:

What is the extent and nature of abuse of older people in contemporary care homes?

How do attitudes, relationships and behaviours within the care setting contribute to or prevent the occurrence of abuse?

What other aspects of the care provision process and the care home context contribute to or prevent the occurrence of abuse?

Drawing on both a range of existing definitions of abuse (Johnson 1986: 168; Department of Health 1993: 5; Williams and Keating 1999: 131; World Health Organisation 2002: 3), abuse, whether in care homes or elsewhere, may be defined as, *any action or omission by a person or persons toward another or others that causes some form of physical or psychological harm or financial detriment*. This research is concerned specifically with abuse occurring in care homes for older people, within the relationships between those who perpetrate abuse and those who are abused as carers and those requiring assistance with care needs, and where there is usually a relationship wherein the abused person depends upon the perpetrator of abuse for care needs to be met.

The perpetrators of abuse in the care home in which the older person lives are most likely to be the staff employed to care, and those who manage them, a view supported by the findings of Manthorpe and Martineau 2014 who found care home staff to be responsible for abuse in 78.6% of the Serious Case Reviews occurring between 2009 and 2011 that they studied. The people who own the care home business may also perpetrate abuse, either directly, or indirectly as a result of the degrees of control and influence they may exert over how the care home functions. Conversely, these same groups of people may prevent the occurrence or repetition of abuse. Staff of other agencies external to the care home who support the provision of care, including volunteers, those who receive care, and their relatives may also perpetrate or prevent abuse. However, they are beyond the focus of this research that concentrates upon those people that previous research has shown to be much more likely to carry out abuse within the care home (Cambridge *et al.* 2006; The NHS Information Centre 2014a).

1.3. Age and the Risk of Abuse to Older People in Care Homes

The thesis does not attempt to resolve the difficulties encountered in defining at what chronological point in their life a person becomes an 'older person' for the purpose of the research (Leeson *et al.* 2003). It is a universal characteristic of English care homes registered under current legislation to meet the needs of older people that those they accommodate are almost exclusively over the age of 65 years. Currently 59.2% of older people in care homes in England are over the age of 85 years (Office of National Statistics 2014), and this population will continue to grow with projected increases in this age group of 136% in the period 2010 to 2032 (Wittenberg *et al.*

2010). Irrespective of their precise age, many older care home residents are likely to be considered at risk of abuse. This risk often arises from psychological or physical frailty or illness that often accompanies increasing age (McCreadie 1994; 2002; Brooker *et al.* 2011), or may be as a result of isolation from anyone who may act as their advocate.

However, the risk of abuse to older people in care homes does not necessarily arise only because of the attributes of the individual residents *per se*, but may be a product of characteristics among those employed to provide their care, for example prejudice and discrimination, and of the circumstances under which care is provided. As Brown and Seden (2003: 34) assert, *everyone* is vulnerable [sic] when they "...surrender themselves to the care of others". In this vein the Safeguarding Vulnerable Groups Act (2006) defines 'vulnerability' purely by the situation in which the individual lives or the services they receive, including accommodation in care homes. However, despite these assertions not *all* older people can be considered at risk of abuse because of characteristics pertaining to them or to where they live, and it should be borne in mind that when abuse occurs it is the *abuser* that perpetrates it by their action or omission.

1.4. Care Homes as Institutions

This research conceptualises care homes as institutions comprised of both a physical environment and a social environment that influences the behaviours of the collective of individuals within it (Goffman 1961; Willcocks *et al.* 1987; Peace *et al.* 1997; Killett *et al.* 2013), including the organisational context in which the provision

of care takes place. The social environment encompasses the characteristics, conduct and interactions of those actors who manage and directly provide care, or are associated with the provision of care as the owners of the institutions as profit making businesses. The agentic phenomena under scrutiny are then, as Goffman asserts, not the exclusive property of the individual person or agent, but reside also within the patterns of social control and influence of the institution (Goffman 1961: 154).

The concept of the care home as an institution made up of the conglomeration of people who own, manage, work and live within it, and the organisational characteristics that consequently come into being, is important if we are to understand the complexity of interrelated features that may contribute to the occurrence of abuse. Further, the institution of the care home comprises not only the dynamics occurring among these groups, but also the influences upon them that may arise as a result of the place the organisation occupies within society.

The term 'institution', often imprecisely defined, is frequently linked in policy, practice guidance and academic literature with the subject of abuse (Commission for Social Care Inspection 2006a; Glasby 2007; World Health Organisation 2008; Centre for Policy on Ageing 2009; Froggatt *et al.* 2009; Dixon *et al.* 2009; Tadd *et al.* 2011a; Brooker *et al.* 2011; Care Quality Commission 2012a). However, it should be noted that the term 'institution' when used in this work has no intrinsic pejorative meaning of itself, though, as Jack (1998: 11) has pointed out, this negative perception seems to have become implicit in the use of the term in the language of both policy and practice.

1.5. The Semi-Public Nature of Care Homes

Care homes, in common with other institutions such as prisons and psychiatric hospitals, are not readily open to public scrutiny and there exists, to a degree, a “...barrier to social intercourse...” (Goffman 1961: 16). However, unlike the “total institutions” studied by Goffman, who depicted that barrier as largely absolute, the barrier characteristic of the contemporary care home is only partial as a natural consequence of involvement from relatives, friends and visiting professionals. Additionally, encouragement through both national good practice policies of maintaining links with communities (Department of Health 2006; National Care Homes Research and Development Forum 2007; Katz *et al.* 2011; Killett *et al.* 2011; Social Care Institute for Excellence 2012), and regulation that seeks to prescribe maintenance of social engagement (Care Quality Commission 2010; 2013), contribute to the permeability of the barrier. The degree of permeability is, however, mediated by the care manager, owner and to a lesser extent, the care providing staff, and also by the legitimate need for certain essential tasks relating to the caring function of the care home to be undertaken in private.

Similarly, the care home institution is not open on a regular basis, that is, other than once or twice a year routinely, to legally enforceable examination by the care home sector regulator. Even then the regulator will only occasionally formally examine degrees of social engagement facilitated by the care home. As the World Health Organisation (2008: 83) asserts, the institution impedes contacts between the older individual and the community. As such the care home is a semi-public institution and thus may be difficult to penetrate and subject to scrutiny.

1.6. The Dearth of Research on Abuse in Care Homes

These barriers to scrutiny may be the reason why only a small proportion of the published research has dealt specifically with abuse within care homes, particularly those accommodating older people (Killett *et al.* 2013: 15), and particularly those in the for-profit sector. In England there has been a preponderance of research into the quality of care within NHS hospitals, including some aspects tangentially related to abuse, for example the maintenance of dignity among patients (Tadd *et al.* 2011a), yet there has been surprisingly little rigorous research into abuse in care homes for older people. As Davies *et al.* (2009: 252) assert, a suspicion of outsiders on the part of care home staff has tended to render them hard for researchers to penetrate, particularly those in the for-profit sector. Harris and Benson (2006) found that research in such settings is made more difficult because potential participants are likely to be concerned that such studies might reveal information that reflects poorly upon them.

Yet the catalogue of accounts that have been reported in the media would seem to confirm the persistence of abuse of older adults within care homes. Proven occurrences of abuse at Aranmore Care Home in Manchester (1986), Nye Bevan Lodge in London (1987), Beech House in London (1999), The Maypole in Birmingham (2002), Laurel Bank Nursing Home in Yorkshire (2003), Parkfields in Somerset (2007), Hillcroft in Lancashire (2012), Merok Park in Banstead (2014), The Old Village School in Bedfordshire (2015) for example, are augmented by recent recorded footage of abuse following covert filming (technology not readily available in the 1980's and 1990's) at Winterbourne View in Bristol (2011), Ash Court in

Kentish Town (2011), Oban House in Croydon (2012), The Granary in Bristol (2012), The Old Deanery in Sussex (2012), Bethshan Nursing Home in Powys (2013), Orchid View in Essex (2013), Keldgate Manor in Yorkshire (2015) and an unnamed care home in south Devon² (2015). These occurrences, and the Serious Case Reviews that have followed some of those more recent, for example, Orchid View (West Sussex Adults Safeguarding Board 2014), provide immutable evidence of the abuse of older people, including physical violence, psychological torment and sexual abuse, within these institutions that exist purportedly to provide care. All of the occurrences listed above involved abuse of older people by multiple staff members, with the exception of Winterbourne View that involved the abuse of both younger and older people with a learning disability, and the unnamed care home that involved a single perpetrator.

These cases represent but a few of many occurrences of abuse identified over the past three decades and, as Benbow (2008: 9-10) remarked when considering the high profile abuse on Rowan Ward, an NHS hospital ward for older people rife with physical and psychological abuse and neglect in Withington Hospital, Manchester:

“A striking conclusion from studying the Rowan report and similar inquiries is that we have defiantly failed to learn lessons, problems are likely to continue. The response to the Rowan Report was to audit inpatient care [for older people with mental ill-health]. In contrast the residential and nursing home sector was not investigated and is highly likely to have

² This refers to a care home in Torquay that currently cannot be named for legal reasons. The care staff member was jailed for 10 years after conviction for three counts of sexual abuse.

similar and perhaps less overt problems. There are many potential Rowans and there is a need for continual vigilance”.

What this research has set out to provide is an exploration of private sector care homes as institutions that goes beyond what Lewin describes as the readily observable data or “symptoms” that are “...surface indications of some deeper-lying facts” (Lewin 1947: 10). It has sought to penetrate beneath what Schein (2004: 25) asserts are merely “artefacts” of organisations, for example, easily discernible behaviours, written procedures, and lists of espoused organisational values, to reveal the more fundamental factors that contribute to the occurrence of abuse and why it persists, the “...less overt problems...” suggested by Benbow above.

1.7. Informing Social Policy on Abuse in Care Homes

The continuing abuse of older people in care homes is morally wrong based on the tenet that all human beings warrant respect, care when they require it, and to be treated with humanity and kindness (Nahmiash 2002; Nordenfelt 2004; Tadd *et al.* 2011a; Flynn 2012), particularly during the later stages of life when assistance with physical and psychological functioning may be required. Similarly, abuse conflicts with the doctrines of Human Rights legislation³ (Human Rights Act 1998), the prescriptions of the statutory regulator of the care home market (Care Quality Commission 2014a) and with the principles of nationally prescribed care staff training

³ Human Rights legislation currently applies only to those people residing in private sector care homes that are functioning as public bodies by virtue of their contractual relationship, including the payment of fees, with a local authority.

(Skills for Care 2014a). In some cases, for example, physical assault, rape and theft, criminal offences are being committed. Indeed, as a number of scholars suggest, the term 'abuse' is often a euphemism for serious criminal acts and may, as a consequence, serve to lessen societal responses since abuse is not viewed as, or responded to, as a crime (Griffiths *et al.* 1997; Brown and Seden 2003; Fitzgerald *et al.* 2009).

The key objective of this research has been to examine and achieve an understanding of the dynamics and processes at work within care homes that create, sustain and conceal abuse. The thesis addresses, in part, the dearth of rich, in depth data required to inform effective policy and strategy, in the absence of legislation, in order to combat abuse in these facilities. It is founded on the view that the primary objective of social policy should not just be to respond collectively to abuse (in institutions and elsewhere) after it has occurred, as currently predominates, but also to prevent its occurrence in the first place. Of similar importance is determination of how to ensure effective scrutiny of the tense dynamic that is often present between the opposing forces of looking after older people well in a home-like environment and the generation of profit that is required if for-profit homes are to continue functioning.

1.8. Overcoming Barriers to Research

As a subject of research the perpetration of abuse presents particular problems because it is usually conducted covertly with perpetrators seeking to conceal their activities. When abusive or criminal behaviour is known to have occurred within the care home, the organisational actors who own, manage and work within it are

unlikely to perceive it to be in their best interests to reveal such behaviours. Importantly, such attention will also be unwelcome because it may reduce the ability of the private sector care home to generate profit.

Given the semi-public nature of care homes and the covert nature of abuse, I was well placed as a local authority commissioner of care home services both within my own authority and others across the country, particularly in the West Midlands, to conduct this research. It was envisaged that my commissioning role may be perceived by the organisational “gatekeepers” (O’Reilly 2009: 10), the proprietors and care managers who might either deny or facilitate access, as a mandate to conduct research legitimately into what was likely to be perceived as a sensitive area. However, my pre-existing professional relationship with care homes was always likely to attract some criticism, for example, in terms of possible lack of objectivity on my part, or as a result of providers wanting to portray to me a positive image of their homes. Nonetheless, this relationship would also hold the advantage of facilitating access to the semi-public environments otherwise difficult for researchers to penetrate, particularly when exploring the issue of abuse. Through a strategy of rigorously designed and carefully conducted research, my own view has been that the potential criticisms here were significantly outweighed by the expedient of gaining access to the research sites to further knowledge, and thereby develop and enhance understanding of the issues and so contribute to further development of adult protection policy. Further, the data secured by the research methods employed have subsequently cast care homes in a generally negative light, confirming the presence of frequent abuse. I maintain that this not only largely negates any criticism of my professional relationship with participating homes, but is

also a testimony to a shared recognition of the enduring problem of abuse, and a common desire to see it significantly reduced.

Moreover, my previous experience as a registered nurse and care home manager fulfilled the necessary conditions espoused by Mentes and Tripp-Reimer (2002) concerning the preparedness of investigators conducting research in care homes through compatibility with the care home setting and the ability to communicate effectively with staff therein. In addition, my professional experience in the sector was always likely to enhance 'sensitivity', or recognition and insight into relevant phenomena described by participants, and increase my ability to give meaning to them (Corbin and Strauss 2008: 32; 46). This is expressed by Dewing (2009: 237) as "...appreciation of the culture and context..." of the care home organisation as a prerequisite for effective research. In addition, by virtue of my previous experience in providing and managing care to older people, I would be (or so I thought) untroubled by the emotional demands of conducting research in care homes noted by others (Miller and Evans 1991; Higgins 1998; Dewing 2009).

1.9. Defining the Parameters of the Research

This research has been concerned with institutional abuse of older people, and specifically excluded their self-abuse and self-neglect. Though such abuse occurs within care homes, it was excluded because no caregiver is directly responsible for perpetrating such abuse. My research has focussed on the factors that give rise to abusive behaviour specifically by care providers, and thus abuse that is interactional in nature. Though the behaviours of care providers may indirectly lead to self-abuse

among older adults, the focus of this research was not upon the possibility of such occurrences.

1.10. Reviewing the Literature

The literature review was conducted initially using two primary sources of information.

a) Database searches using the following search engines:

EThOS-Beta.

SSCI.

CINAHL

ZETOC.

b) Internet searches using Boolean operators and truncation with the key terms of 'Abuse' AND 'Older People' AND 'Care Homes', 'Nursing homes', 'Dementia', 'Disability', 'Dependence', 'Care', 'Care Staff', 'Policy', 'Practice', 'Regulation', 'Inspection', 'Law', 'Prevalence', 'Incidence', 'Causes', 'Theories'.

Of the total number of 'hits' from each search, items were marked to include only English language sources and those from 1980 onwards⁴.

Once obtained, papers were read in full and critically giving consideration to:

⁴ In order to capture literature on the subject of the abuse of older people in care homes of which there is a limited amount.

- Provenance – Consideration of authors’ credentials and whether or not arguments were supported by evidence, for example, historical material, case studies, narratives, statistics, recent findings from empirical research.
- Methodology - Reviewing the techniques used to identify, gather, and analyze the data, the sampling methodology, and interpretations.
- Objectivity – Consideration of any known contrary data that was not included to prove the author's point, and reflection on any funding organization or affiliation that may introduce bias to reporting of findings.
- Persuasiveness – Judging which of the authors’ theses and/or recommendations were most or least convincing.
- Value – Consideration of the contribution made to enhanced understanding of the subject.

Evaluated evidence was extracted to align with preconceived and emerging themes pertinent to research questions and that would constitute the structure of the thesis, for example ‘current knowledge of the prevalence of the abuse of older people’ and ‘staff perceptions of residents in care homes’. Identifying these and other areas also aided the identification of the contribution to knowledge that the thesis would make (Hart 1998).

From papers identified in this way, additional sources of knowledge were noted from reference and reading lists where these were included in the original documents. These were obtained or accessed wherever possible and subjected to the same process of appraisal in order to supplement the breadth of the literature review.

1.11. Synopsis of Chapters

This chapter has provided a background to this study and is followed in Chapter 2 by an account of the development of safeguarding policy in response to incidents of abuse of older people in care homes. The parallel components of a developing market based approach to the provision of care in care homes that led to a significant growth in for-profit sector provision from the mid 1980's onwards, and to a consequent ambition to achieve more effective regulatory oversight, are then examined.

Chapter 3 reviews the published academic literature on the subject of abuse, commencing with issues pertinent to defining abuse specifically in care homes, to arrive at a definition of abuse for the purposes of my research. This is followed by consideration of the prevalence of abuse in care homes and contemporary efforts to address this. The review then explores the limited literature on theoretical models of abuse of older adults and concludes with a discussion of possible ageist influences upon its occurrence.

The design of this research and the adoption of a mixed methods approach to data collection are set out in Chapter 4, including detail of methods of data collection and analysis.

Chapters 5 and 6 present the findings from anonymous questionnaires and a series of semi-structured interviews that were conducted as the two empirical data gathering methods, the latter then analysed and interpreted through a grounded theory process.

Chapters 7 and 8 follow with discussion of the research findings, drawing on both the numerical data and free text responses to the anonymous questionnaires, and the concepts identified by the application of grounded theory to interview responses.

Chapter 9 both draws conclusions from the empirical evidence and offers theoretical perspectives on the causation of abuse in private sector care homes, before reflecting on the implications of the findings for the development of both policy and practice.

2. Social Policy, Marketisation and Regulation of Care Homes in England

2.1 Introduction

This chapter firstly reviews the slow development of social policy in England towards the abuse of older people, revealing the extent of definitional difficulties and how this contributed to continued under-recognition of abuse occurring in care homes. It then looks specifically at the development of a market based approach to care home provision that became dominated by for-profit providers whose motives were viewed by some as questionable. This is followed by an outline of care home regulation that subsequently emerged, initially largely as a result of the growing dominance of the private sector and a lack of trust among agencies of the provision of care to older people for pecuniary gain, though this was not extended to public sector provision until 2002 onwards.

2.2 Development of Social Policy on Abuse

2.2.1. Slow Recognition the Abuse of Older People as a Social Problem

The first identifiable references to abuse of older adults as a specific group arose in England in the 1970s (Baker 1975; Burston 1975). Recognising 'elder abuse' as a social issue requiring attention, both authors identified advanced age and concomitant frailty as predominant determinants of abuse perpetrated by people within familial relationships. However, use of the term "granny battering" as the title of both works tended to define abuse as physical abuse of older women by family

members, detracting attention from the existence of other forms of abuse inflicted upon both men and women in other environments, including, for example, care homes.

Regardless of the assertions of both Baker and Burston, and later conclusions of Cloke (1983) and Eastman (1984), as to the significance of abuse of older people as an urgent social problem, no immediate government policy response occurred. Biggs *et al.* (1995) and Glendenning (1999a) maintain that this was due to preoccupation with the then relatively recently emerged issues of child abuse and domestic violence toward women. Phillipson and Biggs (1995) have also suggested that the concept of older people being subject to abuse in their own homes was too damaging to the myth of the harmonious post-war family. Biggs (1996a) further suggests that even when recognition of 'elder abuse' was initially established, it was perhaps easier for society to think of abuse of older people as a secret within families, rather than an issue that exists where care is provided and overseen by 'professionals'. In this respect, Johnson (2011), for example, asserted that this tended to lead to a continuing de-emphasis on abuse occurring within institutions.

However, in 1990 amidst growing awareness of the abuse of older people as a societal issue, advice on managing incidents of abuse was produced in a document entitled '*Scream but Don't Abuse*' (British Geriatrics Society 1990), notably emanating from non-statutory organisations. Subsequently, in 1991, the then Social Services Inspectorate (SSI) commissioned a study within two London boroughs to gauge the extent of the occurrence of the 'elder' abuse (as it was then termed), but in domestic settings only. This small-scale exploration identified 64 cases of proven

abuse, and revealed that agency responses were fragmented and lacked clarity about what interventions were appropriate (Social Services Inspectorate 1992). In the same year the SSI commissioned a review of published research into the abuse of older people from the charitable organisation Age Concern Institute of Gerontology (McCreadie 1991).

Subsequently, and in large part due to high profile campaigning by the social work journal '*Community Care*' during 1993 to raise awareness of abuse of older people and, in parallel consideration of Ogg and Bennett's (1992) seminal research on prevalence of domestic abuse of older people in Britain, the Department of Health (1993) produced guidelines entitled '*No Longer Afraid: The Safeguard of Older People in Domestic Settings*'. This document again reflected contemporary emphasis on care provided within families as opposed to the institutional care of the time, and served to perpetuate the perception that abuse of older people was predominantly located within domestic circumstances.

Significantly, despite continuing emphasis on abuse within families, '*No Longer Afraid*', endorsed by government, gave all local authorities in England a mandate to develop their own responses to tackle the now increasingly recognised problem of the abuse of older people. Though no similar guidance was provided to either health authorities or the police (Ambache 1997: 210), '*No Longer Afraid*' did recommend an inter-agency approach. However, as Ambache (1997: 210) points out, this policy document was produced at a time when much of the focus of social services departments in England was upon the significant community care reforms being introduced as a result of the *National Health Service and Community Care Act 1990*.

Consequently, attention was detracted from abuse occurring in care homes that were viewed as an essential component, albeit perceived as not the first choice for many, contributing to the success of the *National Health Service and Community Care Act 1990*, by providing for those with the greatest needs among the older population (Peace et al. 1997: 12).

In stark contrast to the protection of children, no attempt was made to introduce specific adult protection legislation. Instead, the policy of '*No Longer Afraid*' relied upon existing legislation, including that concerning domestic violence and laws of tort, further supported by section 47⁵ of the *NHS and Community Care Act 1990*. This reliance upon existing laws may have been a result of the enduring view that adults, unlike children, whose protection had long been a concern of specific legislation, would be better able to protect themselves (Brown and Seden 2003; Wyandt 2004). Though some in the legal profession (Griffiths *et al.* 1990; Hoggett 1991), and some academics, (Biggs and Phillipson 1992; Pritchard 1992; Penhale 1992) had argued for specific abuse legislation to serve older people, this was not forthcoming. As a result of the absence of prescription or dedicated funding from government and a legislative vacuum, development of approaches to protect older people who might be at risk of abuse in England was variable between local authorities with an enduring focus on abuse in domestic environments.

⁵ Section 47 of the NHS and Community Care Act 1990 allowed the local authority to make urgent care provisions for people deemed to be at risk, without conducting a prior assessment of that person's needs, repealed by the Care Act 2014.

2.2.2. Definitional Difficulties

The formulation of effective policy to respond to the abuse of older people requires a definition that can be clearly understood by all responsible agencies. As a consequence of continued concerns about the abuse of older people by academics and practitioners, three broad classifications of abuse are generally recognised: domestic abuse occurring predominantly within the abused person's domicile; institutional abuse, within care homes for example; and self-abuse and self-neglect (McCreadie 1996; Stanley *et al.* 1999; Bonnie and Wallace 2002). Similarly, the literature suggests significant degrees of agreement on the major types of abuse, that is, physical, psychological, sexual, financial and neglect (Mowlam *et al.* 2007; Commission for Social Care Inspection 2008a; Her Majesty's Government 2010), but within this typology some complicating aspects need to be recognised. For example, sexual abuse may be regarded as a form of physical abuse (McDonald 1996; Ens 2001), neglect is not always recognised as a type of abuse of itself (Fulmer and Gould 1996; O'Keeffe 2007) and, where recognised, may be viewed by some scholars as further divisible into active or passive neglect (Baumhover and Beall 1996; Glendenning 1997a; Nerenberg 2006; Stevenson 2008).

Defining what is meant by abuse remains problematic and an agreed and universally applicable set of definitions continues to be elusive (House of Commons 2004; Penhale *et al.* 2007; Commission for Social Care Inspection 2008b; Krienert *et al.* 2009; Dixon *et al.* 2009; Manthorpe *et al.* 2011). Biggs *et al.* (1995) observe that the elusiveness of straightforward and all-encompassing definitions of abuse when applied to older people was another factor that hindered initial recognition of the

abuse of older people as a social problem. Yet defining abuse is important because it determines who is counted as abused, particularly significant given how little is currently known about the prevalence of abuse, notably that occurring in care homes. Similarly, defining abuse clarifies what is expected of care providers, and governs both whether, and precisely how, interventions in response to abuse are made. Further, the effectiveness of interventions may depend upon common understandings of abuse between different professional groups. Crucially, universality of definition would allow direct comparison between the outcomes of research into abuse, within and across national boundaries, to facilitate progress on addressing currently unresolved issues, not least of which are its prevalence and how it may be best prevented.

There are also differences between how health and social care organisations in England define abuse that may have a significant influence on what is reported, recorded and responded to as abuse in line with current national safeguarding policy. Health organisations have been found to be recording what may otherwise be identified as abuse, mostly within hospitals, as 'adverse incidents', 'clinical incidents', 'patient safety issues' and 'systems issues', thereby reducing the likelihood of accurate incidence data and consistent responses (Kodate and Dodds 2008: 2; Manthorpe *et al.* 2011: 60).

2.2.3. Inadequacy of Contemporary Policy Governing Responses to Abuse

Current social policy in England towards protecting adults at risk of abuse, including older people in care homes, was, as indicated, largely crystallised by the publication of *'No Secrets'* in 2000 (Department of Health 2000: 9) that defines abuse as:

"...a violation of an individual's human and civil rights by any other person or persons..."

This definition has been criticised for its very broad scope that permits inclusion of any kind of abusive behaviour (Dixon *et al.* 2010). Crucially however, and for the first time, *'No Secrets'* mandated local authorities as accountable lead agencies in the protection of "vulnerable adults" [sic], defining "vulnerable adults" as those who:

"...are or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation" (Department of Health 2000:8).

This therefore incorporates the contextual dimension specific to the "community care" practice it sought to influence.

Though this definition allowed the effect upon the abused individual to be considered in terms of the "...significant harm or exploitation..." (Department of Health 2000: 9), no attempt was made to define what, in operational terms, might constitute

“...significant harm...” Additionally, the definition tended to locate the cause of abuse with characteristics of the victim, along with the acts of others, and did not recognise that there might be features of the setting in which the person lived that might render them susceptible to abuse (Law Commission 2011: 114), for example, within a care home.

Further, not all people who are abused would be in receipt of ‘community care’, including care in care homes, and determining those who ‘...may be in need of community care services...’ was left by this definition to practitioner judgements (Commission for Social Care Inspection 2008b: 14). The problem was further confounded by the necessary application of criteria prescribed nationally, but applied locally by councils, to determine those individuals who might be eligible to access care services paid for by public funds⁶ (Department of Health 2002; National Audit Office 2014). As McCreadie (2002) also pointed out, this definition was based on a health and social care model of abuse and vulnerability to the risk of abuse, and assumed that those at risk were always in need of professional support. Moreover, abuse occurring within hospitals has been well documented (Kitchen 2002; House of Lords/House of Commons 2007a; Commission for Social Care Inspection 2008a; Department of Health 2010a), yet of those people abused within hospital settings, many were unlikely to be in need of community care services once discharged, though they might be at risk of abuse due to their age and effects of illness. Nonetheless the definition within ‘*No Secrets*’ remains the principle one guiding current adult protection practice.

⁶ Government plans that this will change during 2016 as the Care Act 2014 is implemented incrementally and thresholds of need to access care that is publically funded are more clearly defined nationally.

Furthermore, while, commendably 'No Secrets' included reference to the distinct category of 'institutional' abuse, it provided an overly simplistic and hardly helpful conceptualisation of the phenomenon, couching it in terms of abuse arising from:

"...poor care standards, lack of positive responses to complex needs, rigid routines, inadequate staffing and an insufficient knowledge base within the service" (Department of Health 2000: 12).

'No Secrets' also asserted that institutional abuse might be:

"Neglect or poor professional practice...This may take the form of isolated incidents of poor or unsatisfactory professional practice at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other. Repeated instances of poor care may be an indication of more serious problems and this is sometimes referred to as institutional abuse" (Department of Health 2000: 10).

As such, the effectiveness of current policy remains constrained because it gives little consideration to the complexities of the institution of the care home or to the values and deep assumptions held by organisational actors (Schein 2004: 25) that may (or may not) contribute to the origins and perpetuation of abusive behaviours. Such factors are likely to be potentially very significant if institutional abuse is to be overcome. Indeed, these factors, of organisational or agentic origin, may be the "...more serious problems..." referred to in the Department of Health definition above, but little research has yet been conducted on the fundamental and often

hidden dynamics operating within institutions that contribute to abuse occurring and enduring (Bennett and Kingston 1993; Edgar and O'Donnell 1997; Goldson 2006).

2.2.4. Recent Policy and Legislative Developments

The only *specific* legal responsibility placed upon any organisation or individual directly to safeguard adults at risk of abuse in support of 'No Secrets' arose from the *Mental Capacity Act 2005* that introduced the offences of 'ill-treatment' and 'wilful neglect', but applicable *only* to people who lack mental capacity. Notably, the first prosecution for ill-treatment was in a care home (London Borough of Newham 2009). Additionally certain Articles of the *Human Rights Act 1998* (Article 2 [right to life], Article 3 [prohibition of torture, inhuman and degrading treatment] and Article 5 [right to liberty]), that became applicable to publicly funded residents in private sector care homes from December 2008 (Her Majesty's Government 2008: 95), also provided some legislative protection and opportunity for redress to abused people, though these have not yet been tested in the courts in connection with abuse within care homes.

Consequently, some academics (Penhale *et al.* 2007: 97, 170; Spencer-Lane 2010: 45) continued to argue for legislation to establish a duty upon local authorities to make enquiries, and to take action in adult protection cases, because they regarded the existing mechanisms to be inadequate. The statutory regulator of care homes, the Commission for Social Care Inspection (CSCI) also pointed out that within the existing framework any legal redress or action with regard to adult protection was "...neither systematic nor co-ordinated, reflecting the sporadic development of safe-

guarding policy over the last 25 years” (CSCI 2008b: paragraph 2.1). The CSCI further suggested that legislation was required to create a “duty to investigate” and intervene in cases of abuse, and to lay a duty upon involved agencies to cooperate (CSCI 2008b: 14). The focus of many scholars and the regulator remained, however, on the response to reported occurrences of abuse, rather than on prevention. Any possible contributory factors within the organisational setting and that might have persisted to the detriment of other people at risk of abuse, were largely absent from these debates.

Continuing calls for more specific legislation for adult protection led to a national consultation to review safeguarding policy within *‘No Secrets’* during 2009. This was aimed at learning more about experiences of adult safeguarding and at informing decisions as to whether or not further policy change was necessary. The consultation also sought to examine any perceived need for specific legislation, to “...enable society to keep adults safe from abuse or harm” (Department of Health 2009: 9). As a result, some inchoate emphasis on prevention of abuse through empowerment emerged, though this was directed predominantly at care provided under the ‘personalisation’ agenda of central government, mostly addressed towards younger adults, with little consideration of the particular dynamics prevailing in care homes.

Following this consultation government confirmed that adult protection boards would become a statutory requirement to ensure clear lines of accountability, but no further legislative foundation for safeguarding adults was deemed necessary (Department of Health 2010b). Almost simultaneously respondents to a Law Commission

consultation on the legislative foundations of adult social care conducted in 2010 (Law Commission 2011) again supported the view that an express duty to investigate should be placed upon partners involved in adult protection responses, arguing that this would lend greater legitimacy to safeguarding enquiries (Law Commission 2011:110). The Law Commission itself supported that view, though their focus remained particularly upon establishing the facts and validity of individual allegations after the abuse had occurred (Law Commission 2011: 111).

Subsequently government issued confirmation that the then imminent draft *Care and Support Bill*⁷ would include a proposal for a duty upon local authorities to ‘make enquiries’ where safeguarding concerns existed, along with a duty upon local authorities, the police and health services to cooperate (Department of Health 2012: 2). Both Penhale *et al.* (2007) and Fitzgerald (2008) however, have recognised inconsistent involvement from agencies dependent upon organisational priorities and the goodwill of individuals, and it remains to be seen how effective the “duty to cooperate” introduced by the subsequent *Care Act 2014* will prove.

Simultaneously the Department of Health issued a public consultation on the need for new ‘powers of entry’, that would enable local authorities to speak to people with mental capacity where abuse or neglect was suspected (Department of Health 2012: 2). However, this consultation concluded that there was not a strong enough case to create a new law for this purpose.

⁷ The subsequent *Care Act 2014* included provision at Section 41(1)(2), compelling local authorities to “...make (or cause to be made) whatever enquiries it thinks necessary...” to determine whether action should be taken in cases where an adult is at risk of abuse and unable to protect themselves.

Towards the end of the completion of this thesis the provisions of the *Care Act 2014* began to come into force. As a result, local authorities are now required to lead a multi-agency safeguarding system, including the police and health commissioners. This system must seek to *prevent* abuse as well as stop it when it is detected, though it remains to be seen how preventative strategies will be applied to care homes (Social Care Institute for Excellence 2016). Further, the proposed statutory duty to establish adult safeguarding boards and a duty upon local authorities and their partners to make enquiries if an adult is thought to be at risk of abuse, have now been enacted. Additionally, local authorities also have the duty to arrange for an independent advocate to support people who are subject to a safeguarding enquiry. They must also carry out Safeguarding Adults Reviews (SARs)⁸ when a person with care and support needs dies, or is seriously injured as a consequence of abuse, in order to learn lessons and make improvements. Consequently, SARs are also intended to embody a preventative element, though the efficacy of this measure remains unknown at the time of writing.

The Care Act 2014 has also introduced several changes to the terminology of adult safeguarding originally embedded in the policy language of “*No Secrets*”, for example, ‘vulnerable adults’, are now to be referred to as ‘adults at risk, ‘institutional abuse’ as ‘organisational abuse, ‘safeguarding alerts as ‘safeguarding concerns’ and ‘investigations’ as ‘formal enquiries’. Additionally, several types of abuse have been recognised in addition to those within ‘*No Secrets*’, including ‘self-neglect’ and ‘modern slavery’.

⁸ Previously known as Serious Case Reviews.

What remains lacking is specific guidance on how the partners will achieve the prevention of abuse in care homes. Further, Section 42 of the *Care Act states* (in part):

(1) This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—

(a) has needs for care and support (whether or not the authority is meeting any of those needs),

(b) is experiencing, or is at risk of, abuse or neglect, and

(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

(2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

This section of the Act has created a distinction in practice between 'Section 42 enquiries' and 'Non-Section 42 enquiries', whereupon the latter can be scrutinised outside safeguarding processes. Consequently, non-section 42 enquiries may be undertaken by, for example, local authority or Clinical Commissioning Group contracting personnel exercising the conditions of the contract between the provider and the state. However, consideration of the knowledge and abilities of these personnel have not been considered in terms of their ability to recognise circumstance that constitute abuse of adults who may be at risk, particularly those that are deeply embedded within the care providing organisation.

2.2.5. Weaknesses of the Current Adult Protection Response

Though some improvements to current policy are likely in the future as a result of the consultations referred to under 2.2.4 above, to date, safeguarding responses remain predominantly reactive overall and primarily protective of *individual* older adults after abuse has taken place by formulating protective strategies (Phair and Heath 2010: 7). These can be considered as secondary or tertiary interventions or responses, offering remedy to the abused individual only after the event, as identified by Kalaga and Kingston (2007: 7), rather than as primary interventions to prevent the occurrence of abuse in the first place, for example, by identifying and tackling causal factors, including those that might be present in institutional settings.

Such is the current focus of policy in England to respond to abuse and to protect individuals already abused from further occurrences, that few, if any, cases of abuse are pursued to determine their underlying and fundamental causal factors. In part, this transpires because of lack or paucity of evidence, even where significant concerns remain (Brown 1999: 97), as well as in part because the mechanisms, skills and resources, and co-ordination required between agencies to secure such evidence retrospectively are lacking (Penhale *et al.* 2007: 73). Brown and Seden (2003: 243) have argued that the 'case conference' at the end of the safeguarding process should be an opportunity to launch active, preventative safeguarding strategies rather than simply close individual cases. Brown (2009: 309) has also expressed concern at the linear approach of most safeguarding responses that presuppose an error or failure in practice has occurred and that the problem can be

“contained”, whilst largely ignoring other potential contributory features of the organisation in which the abuse occurred.

Further, there is no clear evidence that current education, training and awareness-raising, often recommended as remedial actions following abuse, are effective in combating the abuse of older people (Faulkner 2012: 36), and, as the Commission for Social Care Inspection (2008a: 7) reported, only 38% of care home managers stated that they used their experience of adult abuse incidents to improve practice subsequently. Kalaga and Kingston (2007: 7) also concluded that, following the occurrence of abuse, the “...evidence base for the effectiveness of current therapeutic or legal interventions is sparse”, for example, raising awareness of abusive practice and providing training, and invocation of laws of tort respectively, a view shared by other academics more than a decade and a half previously (McDonald *et al.* 1991).

2.3 The Development of a Market Based Approach to Care

2.3.1 Origins of a Competitive ‘Mixed Economy’ of Care Provision

The *National Assistance Act 1948* first required local authorities to provide residential accommodation for citizens who, as a result of age or infirmity, were in need of care not otherwise available to them. The resulting establishment of older people’s residential homes by local authorities was the response. The *National Assistance Act* thereby sought to end the existence of Public Assistance Institutions, which were

essentially Victorian era workhouses, supposedly abolished by the *Local Government Act 1929*, but in reality often simply renamed.

The changes to residential care provision envisaged by the *National Assistance Act 1948* were generally received with enthusiasm by local authorities, politicians and the press (Means 1986), and visions of hotel like accommodation caring for 25-30 older people as 'guests' emerged to replace the archaic provision of the Public Assistance Institutions. Townsend (1962) however, demonstrated the illusory nature of these aspirations almost fifteen years later, pointing out that at the time of his research, over half of older people's residential provision was in the former Public Assistance Institutions, often perpetuating austere and oppressive regimes. Although Townsend acknowledged some improved environments in refurbished buildings and a small number of new build facilities within a few local authorities, he confirmed the common occurrence of continuing isolation, under occupation, lack of privacy, dignity and identity, and loss of powers of self-determination for the older people within these institutions.

However, monolithic public sector residential provision continued to expand until the inception of the Conservative Government in 1979 that heralded an increasingly market-like approach to providing both health and social care. The National Health Service consequently saw newly separated internal provider and commissioner roles, creating a quasi-market therein from 1989 onwards (Department of Health 1989a; Le Grand 1991; Means and Smith 1998; Rao 2000; Glasby 2007), and leading to a concentration on acute, rather than long term care previously provided for older people on "long-stay" wards in NHS hospitals (Audit Commission 1997;

Clough 1998; Hardy and Wistow 2000). Almost simultaneously, local authorities were required to undertake compulsory competitive tendering (Elcock 1989), and thereafter 'Best Value' reviews (DETR 1998; Davies 2000; Stewart 2000), subjecting their directly provided services to external competition from alternative providers, with the aim of reducing their monopolistic provider role and stimulating private sector supply (for all services). Government espoused a 'mixed economy' of care providers including public, for-profit and non-profit making organisations, with people making use of services, including care homes, increasingly conceptualised as 'consumers' in a market like economy of care (Department of Health and Social Security 1981; Department of Health 1989b; Leeson *et al.* 2003).

2.3.2. The 'Perverse Incentive' of Non-Assessed Social Care Needs in Creating a Private Sector Dominated Market

To facilitate their long-term policy of encouraging this market based approach, in 1983 the same Conservative Government introduced a system of social security financing that allowed those in receipt of social security benefits to enter private sector care homes, that were subject at the time to minimal regulatory oversight. In the absence of either sufficient alternatives, and particularly given the closure of NHS "long-stay" wards hospitals (Audit Commission 1997; Clough 1998; Hardy and Wistow 2000), or any similar funding arrangements for domiciliary care, vast numbers of older people took the only option available to them when faced with age-related frailty and inadequate family supports, and entered private sector care homes (Walker 1997; Glendenning 1997b; Clough 1998; Laing and Saper: 1999). Consequently, numbers of places in care homes increased by 242% between 1983 and 1986, the majority of which were for-profit businesses (Netten *et al.* 2001: 1). In

the same period the number of places in local authority residential homes declined by 43% (Audit Commission 1997: 10). By 1988 the ratio of publicly-provided to privately-provided residential care in England had changed from a pre-1983 ratio of five to one to almost one to one (Peace *et al.* 1997:15), and from 1989, private sector provision became an ever-increasing majority (Hardy and Wistow 2000: 46), accelerated in many local authorities by the outsourcing that followed the “Best Value” reviews mentioned above.

In 1986, following criticism from the Audit Commission (1986) identifying the impact of social security payments directly to individuals introduced in 1983 on the growth of private sector institutional care at the expense of other community care options, the Conservative government declared an urgent need to review the way in which this ever-increasing proportion of public funds was being consumed, ostensibly to support community care policy (Glasby 2007: 19). The review, which was undertaken by Sir Roy Griffiths, subsequently recommending that the practice of making social security payments to individuals for funding residential care should be rescinded (Griffiths 1988). These payments, Griffiths concluded, acted as a “perverse incentive” undermining government’s espoused commitment to advancing other forms of community based care, and excessively consuming financial resources that could otherwise be directed to support people in their own homes (Wistow *et al.* 1994: 4).

Subsequently, as a consequence of the *NHS and Community Care Act 1990*, responsibility for assessing the *need* of individuals for residential care and the *control* of funding to finance it, transferred from the Department of Health and Social

Security to local authorities. Care provision was to be sourced from the 'mixed economy' to be further encouraged by local authorities acting as planners, and commissioners of services by contract. Sir Roy Griffiths also argued that local authorities should no longer continue as "...monopolistic providers..." (Griffiths 1988: paragraph 3.4) but instead they should "...review the extent to which they need to maintain homes of their own..." and "...promote the development of a flourishing independent sector..." (Department of Health 1989b: paragraph 1.11).

Many local authorities evinced concern at the time about the morality of the private provision of care for monetary reward. They also argued that more comprehensive monitoring of the quality of service provision would be necessary in an increasingly competitive market-like environment of care where the pursuit of profit would become a principle motive (Wistow *et al.* 1994), particularly given increasing reports of abuse in private sector care homes at the time (Counsel and Care 1991; Chambers 1991). However, to encourage adherence to central government policy direction, for the first three years after the introduction of the 1990 Act local authorities were compelled to spend 85% of the transitional grant⁹ within the private sector. Again, in the absence of any significant alternatives, much of this money was spent on the purchase of long-term places in care homes. Consequently, by 1996 77% of residential care was provided within the private sector (Knapp *et al.* 2001: 11).

⁹ A sum of money allocated to each local authority by central government to ease the financial demands of introducing the change.

Increased utilisation of the private sector, initially enforced by policy, contributed to continued reductions in public sector provision and further concurrent growth in the independent sector, particularly in for-profit operations. Although transitional arrangements have long since ceased, by 2010 91.4% of residential care for older people in England was located in the private sector (Livesley *et al.* 2011: 16). Jack (1998: 17) describes this dramatic reduction of public sector residential provision as “...a haemorrhage of social wealth...” with Holman (1993: 45) suggesting the promotion of market forces and competition in care provision led to ‘selfishness and greed’ among providers.

2.3.3 Continued Dominance of Private For-profit Care Home Provision

The election of a Labour government in 1997 hardly changed the prevailing situation of social care provision though the incoming administration asserted that the ‘market model’ had not delivered. Instead, it professed a ‘third way of what counts is what works’, and advocated a new emphasis on partnership and collaboration (Department of Health 1997: 11; Department of Health 1998: paragraph 1.7). Despite the new emphasis on collaboration rather than competition, and on combining the strengths of both market based and collaborative approaches, the dominance of the market, particularly for the provision of care homes continued (Henwood and Wistow 1999: 17; Jones and Tucker 2000 11; Rao 2000: 38; Hudson 2000: 222; Knapp *et al.* 2001: 283).

The notion of achieving plurality of care provision in a market like environment continued to be espoused by a subsequent Coalition Conservative/Liberal Democrat

Government from 2010 (Department of Health 2010c: 21; Galpin 2012: 231), reflected in the policy assertions that ‘any qualified provider’ could enter the health and social care market (Care Quality Commission 2012a: 9). As a result, the private sector care home market continues to be dominated by for-profit provision for all client groups. As Galpin (2012: 232) claims, a minimalist approach to regulation has led to a transfer of power away from government, previously mandated to ensure robust provision of residential care for all those who needed it, to a private sector market that must ensure profit is generated to survive.

2.4 Regulation of the Market

2.4.1. Recognition of the Need for Stronger Regulation

Prior to the development of a market-based approach to care, conduct of the relatively few private and voluntary sector homes was governed by minimalist regulation, as set out in ‘*Statutory Instrument 1962 No. 2000*’. The significant growth of private sector care homes in the early 1980s gave rise to a realisation that more robust regulation was required to assure some degree of quality and protection for residents in this rapidly expanding market (Holmes and Johnson 1988: 2; Walker 1997: 209). This view was reinforced by a number of scandals involving the mistreatment of residents in care homes at the time (Peace 1993: 192; Glendenning 1997b: 152), though recognition of the paucity and inadequacy of regulation specific to care homes had existed since Townsend’s critique of institutional care in 1962 (Peace *et al.* 1997: 19). Ever increasing volumes of predominantly for-profit sector provision, beyond direct public accountability, led both academics and practitioners

to express concern about the risks posed to many 'consumers'. These concerns largely reflected the often limited capacity of residents to act like consumers in the 'market', by securing and processing information and making informed choices, and by moving from unsatisfactory 'suppliers' of services to alternative providers (Wistow *et al.* 1996: 28). The motivations of the rising number of for-profit care home entrepreneurs were also increasingly called into question, as was the quality of much of the provision (Peace *et al.* 1997: 99). Consequently, in an attempt to ensure good standards, the *Registered Homes Act 1984* set out procedures for the registration and regulation of independent sector care homes, though did not extend to the equivalent public sector facilities.

However, the Act did not specify standards of care to be provided by registered care homes, leaving them to be established by newly created inspection and registration units, located 'at arm's length' within local authorities (Department of Health 1995; Manthorpe 1997:165), although a code of practice was produced by the Centre for Policy on Ageing (Centre for Policy on Ageing 1984). Consequently, there emerged across the country a disparate range of requirements seeking to ensure appropriate standards of care that were not well defined and often inadequate (Day *et al.* 1996: 11; Peace *et al.* 1997: 101). As pointed out in the area of physical abuse in care homes, intriguingly, there appeared to be no apparent relationship between standards of care, as measured by various characteristics identified by regulators, and the occurrence of physical abuse (Gilleard 1994: 101; Cambridge *et al.* 2006: 22).

The regime of regulation and inspection, however, did serve to focus attentions and raise public awareness of poor standards and instances of abuse and neglect in a significant number of care homes, contributing to public awareness of a range of particularly significant examples of abuse and neglect. As a result, government commissioned an independent review of residential care that became known as the *Wagner Report* (National Institute of Social Work 1988) that sought to improve the profile and public perception of residential care, emphasising its worth and how it could "...respond effectively to changing social trends..." (National Institute of Social Work 1988: 1).

2.4.2. Establishment of National Minimum Standards for Care Homes

However, criticism of the regulatory function established by the *Registered Homes Act 1984* continued, largely based upon the absence of nationally prescribed standards and protracted mechanisms of corrective enforcement actions (Davies 2000: 302; Hudson 2000: 220). In response, the Department of Health issued a consultation document in 1995 (Department of Health and Welsh Office 1995) to review the extant regulatory system, described by Nazarko (1997) as fragmented, outdated and incomplete. Intentions arising from the consultation included the establishment of nationally prescribed standards of care and a national regulatory organisation (Department of Health 1998; Department of Health 1999).

Subsequently, regulation of private sector care homes (and other registered services) was reformed in 2000 by the *Care Standards Act 2000*, creating a new national regulator, the National Care Standards Commission (NCSC). The NCSC

took over the regulatory functions of all local and health authorities in England in 2002, introducing an inspection regime based upon unprecedented National Minimum Standards (NMS), encompassing for the first time public sector operated care homes. Thirty-eight NMS were to be met by care homes, and Regulation 13(6) attendant to the Act required providers to "...make arrangements, by training staff or by other measures, to prevent service users being harmed or suffering abuse or being placed at risk of harm or abuse" (Her Majesty's Government 2001: 10). However, this consolidation of regulation was hardly welcomed by care home representative groups, which felt it amounted to increased central controls and bureaucracy without ensuring improvements in quality (Gumerson 2004). Moreover, just two weeks after the creation of the NCSC the Government announced proposals to rationalise health and social care regulation, by creating the Commission for Social Care Inspection (CSCI), to regulate *all* social care provision, into which the infant NCSC was subsumed.

2.4.3. Identifying Staff Who Perpetrate Abuse

The *Care Standards Act of 2000* also laid the foundation for the inception of the Protection of Vulnerable Adults (POVA) list in July 2004, designed to support the effectiveness of multi-agency responses to safeguarding adults, prescribed by '*No Secrets*' (Department of Health 2000), and to augment Criminal Records Bureau (CRB) checks, to prevent staff with histories of abuse securing care work. Although the CRB process had been created some years earlier under the *Police Act 1997*, and has demonstrably improved recruitment decision making and thereby possibly prevented the occurrence of some abuse (Mustafa 2008), this new mechanism was

designed to identify people with *any* conviction or caution for *any* crime. As a result, employers of care workers were required to check all prospective recruits for work with “vulnerable adults” to ensure they were not on this list. Further, employers (or the regulator) were required to refer care workers to the POVA list if they had, or were believed to have, abused an adult at risk, the latter category resulting in a ‘provisional’ listing until abuse was proven or otherwise. If a person was confirmed to be on the POVA list, they were not permitted to work with “vulnerable adults” (Department of Health 2004).

Subsequently, following the Soham murders (of two children by the caretaker at their school), the *Bichard Inquiry* (Bichard 2004) led to the *Safeguarding Vulnerable Groups Act 2006* that strengthened processes for checking on people employed in health, social care and education. Among other matters the Act established the Independent Safeguarding Authority (ISA) that replaced the POVA and CRB lists, with the aim of preventing employment of people who might be a risk to adults or children. The new mechanism that was introduced now required a single decision to be made to place a person’s name on the list, rather than the two stage ‘provisional’ and ‘confirmed’ status of the previous POVA list. However, as with that approach, the ISA list would continue to rely upon the diligence of employers to refer offenders, and tended to focus simply on the individual perpetrator, irrespective of any deeper, more pervasive, institutional factors that might perhaps have contributed to the abuses that occurred. Further, as Penhale *et al.* (2007: 148) assert of such checks, the mechanisms would only identify those people who had been caught and convicted of their crimes.

2.4.4. The Shift to Risk-Based Inspections Based

In 2004 the Government announced a review of the National Minimum Standards and supporting regulations, subsequently couched in terms of "...ensuring inspection can have the maximum impact on service improvement and deliver real value for money" (Department of Health 2006: 1). Some commentators, however, asserted that this review was a result of realisation in Government that the country could not after all afford the regulatory function that had been previously devised (United Kingdom Parliament 2007: Column 47WH). Following this consultation, the frequency of inspections was changed from a minimum of two each year for care homes, to a variable frequency of up to only one inspection every three years, based upon assessment of risk (using a range of indicators, including provider-generated self-assessments). This approach, initially used as an internal management tool by the CSCI from 1st April 2006, was later developed into a quality rating system and placed in the public domain from 2008 onwards. Reducing the frequency of inspections was justified by the regulator in terms of efficiency and proportionality, rather than as a means of conserving scarce financial resources at a time when the national budget for regulation had been significantly reduced, with many inspectors and support staff being made redundant, and administrative functions centralised.

2.4.5. Failures of Care Homes to Meet the Prescribed National Minimum Standards

Notwithstanding these changes, at the end of the first year of the new inspection regime, only 26% of care homes were assessed as meeting the National Minimum Standards, and at the end of the second year, 2004, only 48% were assessed as doing so (Her Majesty's Government 2005: 61). In 2005, after three years of revised

regulation, 20% of care home providers were deemed to have failed to meet the prescribed standards (Commission for Social Care Inspection 2005: paragraph 8.24). Perhaps significantly the CSCI noted that non-profit sector care homes consistently performed at a higher level of compliance when compared to those in the for-profit sector (Commission for Social Care Inspection 2005: paragraph 8.105). In 2006 21% of care home providers were still failing to meet NMS (Commission for Social Care Inspection 2006c: 140) and, in the 2009 annual report (produced by the Care Quality Commission as successor to the CSCI), 17% of care homes still failed to meet all of the National *Minimum* Standards (Care Quality Commission 2009: 62).

Despite such failures, Gumerson *et al.* (2004) maintain from their research that the revised regulatory regime has at least removed some poor care providers from the market, and has generally driven standards upwards. As a result, they suggested that some abuse was likely to have been prevented. However, a study of care homes in Kent and Medway local authorities (Cambridge *et al.* 2006: 22) found no association between performance in relation to National Minimum Standards and the protection of adults who might be at risk of abuse among the forty-five care homes where adult protection alerts had been raised.

2.4.6. Weakness of the Current Regulatory Regime

As a result of the regulatory review process commenced in 2004, and referred to above (Department of Health 2006: 1), a significantly revised system of regulation came into being in 2010 by virtue of the *Health and Social Care Act 2008*. This Act created the current regulatory body, the Care Quality Commission (CQC), to perform

the national regulatory function and to embrace a far wider range of both health and social care providers required to comply with newly prescribed 'essential standards of quality and safety' (Care Quality Commission 2010). The new 'essential standards' included 'Outcome 7' again detailing specific requirements for safeguarding people receiving services from abuse, though all of the CQC 'outcomes' were fundamental to protecting against abuse in its various forms.

Notably, the creation of the new regulator saw abandonment of the publicly accessible quality rating system, a loss that was largely lamented at the time by the sector that had come to recognise its usefulness in a competitive market (Killett *et al.* 2013:43). Furthermore, the new regulator received significant criticism of its failure to maintain effective inspection processes whilst registering providers under the new legislation (National Audit Office 2011; Health Select Committee 2011). Both the CQC and the Department of Health subsequently acknowledged that they had underestimated the task of establishing the new regulatory system (Care Quality Commission 2012b: 16) during which period the number of inspections of care homes fell by 65% between 2009-2010 and 2010-2011 (Health Select Committee 2011: paragraph 11).

Such criticisms of the effectiveness of the inspection regime were largely catalysed by disturbing revelations of severe physical and psychological abuse at Winterbourne View in 2011, captured by covert filming (as referred to in Chapter 1 of this thesis). However, since 2012 the stated intention of the regulator has been to conduct a maximum of one planned inspection of each care home in any twelve-month period, based upon assessments of risk. The CQC acknowledged that the

effectiveness of this approach was unknown, given the revelations at Winterbourne View (Care Quality Commission 2012b: 27). A review of other options was consequently conducted by means of a national consultation, including that of reintroducing a quality rating system and placing the findings in the public domain (Care Quality Commission 2013).

Each such annual inspection, as currently conducted, routinely focuses on between five and eight¹⁰ of sixteen 'essential standards of quality and safety', unless specific deficiencies in care practices are drawn to the attention of the regulator by routes other than inspection processes, for example, adult safeguarding referrals. Though the numbers of providers inspected has been increasing since January 2011, particularly following Winterbourne View, the regulator is, as yet, unable to publish information on how many care homes are meeting *all* of the sixteen '*essential*' standards. Against such a background, Killett *et al.* (2013: 45) have talked of a crisis of confidence in the regulatory function and questioned the return being provided for the considerable resources involved.

In such a context, it is therefore difficult to see how current regulation, particularly taking account of the frequency of inspections, could be expected to reliably identify the subtler, often concealed institutional practices that give rise to abuse in care homes. As Kingston *et al.* (2003: 27) have argued, a key element of preventing abuse of people who might be at risk of abuse in the care sector is stringent regulation and inspection, yet the CQC (2011: 12) determined in its first overview of

¹⁰ Generally, of the 16 'essential' standards five are scrutinised routinely in residential care homes and eight in care homes that provide nursing care.

the care market, that 'Outcome 4, effective, safe and appropriate care', was one of three outcomes generating the most enforcement actions, even though a supposedly enhanced inspection regime had been operational since 2002. Further, Killett *et al.* (2013: 131) concluded from their study of organisational cultures in ten care homes, that an inspection report indicating compliance with prescribed standards did not necessarily mean that care was of a good standard. Moreover, this echoes the research findings of Gilleard (1994: 101) and Cambridge *et al.* (2006: 22) who similarly found no correlation between compliance with prescribed standards and evidence relating to abuse.

A more recent market report issued by the CQC (2012c: 12-13) revealed that, of the essential standards inspected in care homes, between 12% and 16% of homes were still not meeting the requirements. It is difficult to reconcile the low proportion of the total of sixteen prescribed essential standards inspected, and the proportions of care homes not meeting those standards that *are* scrutinised, with the CQC assertion that they will "...maintain a relentless focus on providers' requirements to comply with essential standards..." (Care Quality Commission 2011: 5), within an espoused role of "...protecting and promoting the health, safety and welfare of people who use services" (Health and Social Care Act 2008). Following the recent *Francis Report* (Francis 2013) into occurrences of widespread and entrenched abuse at Mid-Staffordshire NHS Foundation Trust, the CQC was again instructed develop a range of new care standards against which they could assess and monitor the performance of health and social care providers, including care homes. Announcement of the revised standards, of which there are now only five, was accompanied by intentions to reinstate a publicly available assessment of quality of all providers' services, at the

time of writing, to be implemented from October 2014 for care homes (Care Quality Commission 2014a).

2.5. Conclusions

This chapter has reviewed the development of policy towards the abuse of older people in England. Though improvements to policy have been made as a result of 'No Secrets' (Department of Health 2000), there remain limitations to its effectiveness, particularly with regard to abuse in care homes, which remains inadequately defined. Yet Government-led marketisation of social care provision has contributed to the domination of residential care by for-profit providers, and concerns about quality of care have led to consequent successive developments of the regulatory approach. However, there is evidence to demonstrate the ineffectiveness of regulatory regimes, and their limited impact on the promotion of good, non-abusive care.

The next chapter presents a review of the literature on abuse, with a focus particularly on that occurring within care homes, and establishes an operational definition of abuse in such settings. Finally, the current, limited, knowledge of the prevalence and incidence of abuse in care homes is then reviewed, followed by exploration of relevant theory on the causes of such abuse.

3. Research Insights and Theoretical Perspectives on the Abuse of Older People

3.1 Introduction

This chapter reviews the literature on abuse of older people, commencing with contexts in which abuse within care homes may be defined, including the particular issues of trust and duty of care, intent, frequency and levels of harm, that set it apart from other forms of abuse. Examining these factors allows a specific definition of institutional abuse that underpins this research to be constructed. This is followed by consideration of the current limited knowledge of the prevalence and incidence of abuse, and contemporary efforts to address this limitation. How care home staff perceive residents, and existing proposed theoretical models of why abuse occurs are then appraised, including the literature concerning impacts of ageism upon the occurrence of abuse at both personal and societal levels.

3.2 Care Home Institutions as Sites of Abuse

3.2.1 Difficulties of Conceptualising Institutional Abuse

The concept of institutional abuse with which this research is concerned is particularly variable, though two poles are identifiable in the literature. The first aligns with Spencer's definition (1994: 6), as "...any act or omission directed at a resident in an institution that causes harm..." giving rise to a tendency to focus upon isolated perpetrators within the institution and any pathology associated to them, for example, alcohol dependency. This view accords with the 'bad apple' approach identified by

Biggs *et al.* (1995) and Carter (1999), and is better described as ‘abuse carried out within the institution’ rather than institutional abuse. The second embraces the possibility that the institution itself may become abusive, where embedded institutional practices, rules, customs and actions of staff are direct and indirect causes of abuse (Schneider *et al.* 2010; Tadd *et al.* 2011b). Both Decalmer (1997:59) and Peace *et al.* (1997:67) suggest that institutional abuse of this kind is probably the most common form, though the extent, causes and nature of such abusive regimes are currently unknown.

It is important to note however that institutional care is not a synonym for poor care, a tendency pointed out by Jack (1998) and Hussein *et al.* (2007), and that can be seen as prevalent in contemporary public policy and media scrutiny, both of which influence societal perceptions at macro- and micro-levels. Contemporary public policy tends to offer institutional care as a last resort for those people in most need within society, and media attention often becomes frenzied and widespread when abhorrent practices are identified within care homes.

3.2.2. Current Restricted Policy Focus Upon Institutional Abuse

The current adult protection policy of ‘No Secrets’ (Department of Health 2000) cited earlier only identifies a limited number of what it considers to be indicative features of institutional abuse, that is: “...*poor care standards, lack of positive responses to complex needs, rigid routines, inadequate staffing and an insufficient knowledge base within the service*” (Department of Health 2000: 12) perpetuating an overly simplistic conceptualisation of this type of abuse and its causes, without examining *why* these features may be present.

Pertinent to conceptualising abuse specifically in care homes is that multiple types of abuse are often perpetrated by care givers over time (Post *et al.* 2010; Cambridge *et al.* 2006; 2011). Such abuse is usually categorised as physical, psychological, sexual, financial or neglect in accord with the definitions within ‘No Secrets’ (Department of Health 2000: 9), as a result of deliberate action or omission, or action or omission because of lack of knowledge, including lack of knowledge that allows the abusive practices of others to go unchallenged (Cambridge *et al.* 2011: 241). However, as Brown and Seden (2003: 227) assert, though helpful in describing types of abuse, discrete categorisations through such prescriptive definition conveys a fragmented picture of abuse, again grounding it in terms of isolated incidents, when it is known that multiple abuses often occur in care homes over time (Age Concern 2006a; Post *et al.* 2010; Cambridge *et al.* 2006; 2011), and can involve multiple perpetrators (Cooper *et al.* 2006). Consequently, though categorising acts of abuse through policy has some utility, it is more important to recognise and include within guiding policy the prevailing human dynamics, interactions and influences of the environment associated with the occurrence of institutional abuse. Though there are benefits to establishing consistent definitions to capture the *types* of abuse that may occur in care homes, it is likely that any definition of institutional abuse requires significant extension to encompass reasons *why* it occurs in the particular social context of the institution that is the private sector care home.

However, there is virtually no extant research to reliably inform policy that explains the fundamental causes of deliberate abusive actions or omissions within care homes that should be sites of safety and care. Further, the training of staff in the care home sector is well developed and extensive, exceeding that in other “...low

paid, low skill...” sectors (Joseph Rowntree Foundation 2014: 32). Additionally, the controls of regulation, compulsory vetting of staff, and purchase of services under monitored contracts are now ubiquitous. Consequently, the assertion that abusive acts or omissions occur as a result of lack of training becomes less tenable, and suggests other, as yet unknown, factors may be operating as contributory causes of abuse.

3.2.3. Issues of Trust and Duty of Care

Though it is known that both deliberate and potentially unintended acts of abuse occur in care homes, there is an expectation of trust that is objectively unequivocal because of the duty of care placed by law upon those responsible for providing care in such circumstances (Sentencing Guidelines Council 2004). This duty of care arises from the physical ‘proximity’ of the caregiver to the person receiving care, and a general duty of care incumbent upon the caregiver. In accord with physical proximity and the general duty of care, Lord Aitkin set the precedent in English law that the carer must,

“...take reasonable care to avoid acts or omissions that can be reasonably foreseen as likely to injure their neighbours...those people who are so directly affected by their act that they ought reasonably have them in contemplation” (Lord Aitkin 1932).

Further, in a private sector care home there is created between the person receiving care and the proprietor and staff a legal ‘proximity’, creating a legal duty of care, by

virtue of the contractual relationships facilitating care provision. This is as a result of both private and public law, governing self-funded and publicly funded care recipients respectively. As Fulmer and Gould (1996) point out, legal proximity in the domestic setting is often difficult to establish in terms of which family members have such accountability, but legal proximity is clear within care homes.

3.2.4. Issues of Intent, Frequency and Levels of Harm

As Mowlam *et al.* (2007: 18) found in domestic settings where care is provided by family members or friends, it may be difficult to separate what is intentional abuse from what may be "...normal levels and expressions of conflict and discord in adult relationships". In care homes however, staff are in paid employment and receive training in the conduct of their duties, so any question of intent to harm becomes secondary to the fact that abuse has occurred. This, and the duty of care already incumbent upon care home staff as a result of legal and physical proximity, leaves no margin for behaviour arising from 'conflict and discord' as identified by Mowlam *et al.* (2007). Conflict and discord will probably arise, particularly when caring for people with severe physical or cognitive illness, but this has to be managed in both the personal and organisational sense. Otherwise the entire purpose of providing care in a home like environment is undermined.

Furthermore, the methodology employed by O'Keefe *et al.* (2007: 14-16) in their study of abuse in domestic settings defined physical, sexual and financial abuse in terms of one occurrence, yet defined both psychological abuse and neglect as recordable only when reaching a threshold of ten or more occurrences in the

preceding year. Again, though such an operational definition of psychological abuse and neglect might be legitimate in domestic settings, perhaps to account for the 'normal levels of conflict and discord' cited by Mowlam *et al.* (2007) above, it cannot be applied to care homes. This is because paid care staff have a duty of care to those in need of care, as a result of physical and legal proximity, and where even single episodes of psychological abuse or neglect breach that duty.

However, Brown (1999: 89) advocates caution to avoid "...sensationalising relatively minor occurrences, insults and injuries..." that may be classified as abusive within care homes. Nonetheless, Brown and Stein (1998: 374) determined in Kent and East Sussex, that it is the threshold above which "harm" is caused that professionals find most difficult to identify as the point at which they should report their concerns. Collins (2010: 5) supports this view, confirming from Serious Case Reviews that staff fail to report what are perceived as 'smaller' concerns, often identified at a later date to be significant indicators of abusive situations.

3.2.5. The Operational Definition Used in This Research

McCreadie (1994: 4) offers that a single, all-encompassing definition of abuse is unattainable, and that clarity through definition of who is abused, the relevance of their age, the place where abuse occurs, the perpetrator(s) and the type of abuse, is the best that can be achieved so "...at least people know what they are talking about with some degree of precision". The research presented in this thesis accords with McCreadie's assertions above, through exploration to achieve specific understanding of abuse of older people that may be perpetrated by staff, managers and owners

within private sector care homes. Moreover, this research seeks to clarify the dynamics involved in causing abuse, particularly as no definition has yet been formulated that captures the motivations and intentions of the abuser in the care home setting, symptomatic of what little is known about why staff in care homes perpetrate abuse.

The parameters of the specific definition used for the purposes of the research consequently align with the call for multiple definitions of abuse to fulfil certain purposes (Bennett and Kingston 1993; Wyandt 2004; Dixon *et al.* 2010), that is:

- Legal definitions to guide decision making as to what abusive acts justify intervention supported by legislation.
- Case management definitions to guide practice decisions about eligibility for services and establish a baseline against which services are evaluated.
- Research definitions to guide rigorous research.

For the purpose of the research I have adopted an *a priori* research definition suitable to the unique context of the care home (Pillemer 1988: 227; Bonnie and Wallace 2003: 47). That is, the abuse by action or omission, within the recognised categories of physical, psychological, sexual, financial abuse and neglect, perpetrated directly or indirectly by care staff, managers or owners in for profit care homes, upon whom there is an expectation of trust [in a social context of providing care and protection], against older people who require assistance with care.

3.3 Prevalence, Extent and Incidence of Abuse of Older People in Care Homes

To avoid the possibility of semantic confusion, in the review below 'prevalence' of abuse means the number of occurrences of abuse existing in a population at a given point in time, and 'incidence' means the number of new cases of abuse occurring over a given time period (McDonald and Collins 2000:13; Bonnie and Wallace 2002: 72).

3.3.1. Current Limitations of Evidence of Prevalence of Abuse from Reliable Research

There are a number of methodologically sound studies of the prevalence of abuse of older people that have been conducted in the United States and Europe and that used probability samples and, according to Cooper *et al.* (2008), reliable measures. These studies however, were confined to older people living at home, and excluded people who had illnesses that reduce their cognitive functioning. The findings of these studies indicated that abuse in domestic environments ranged from 2% to 5.6% of their research populations (Pillemer and Finkelhor 1988; Podneiks 1992; Ogg, and Bennett 1992; Wetzels and Greve 1996; Comjjs *et al.* 1998). However, results were not comparable between studies because of differing operational definitions of abuse, the types of abuse about which researchers asked, timescales during which abuse might have occurred, and differing age ranges and cultural norms of research subject populations.

The studies outlined above are also now dated, and following growing recognition of the absence of reliable prevalence data concerning abuse of older people across the United Kingdom, O'Keeffe and colleagues conducted the *UK Study of Abuse and*

Neglect of Older People in 2007 (O’Keeffe *et al.* 2007). Using a random probability sample of 1,784 older people living at home, this study concluded that 2.6% of people aged over 66 experienced sexual, financial, physical and psychological abuse and neglect in the previous year.

3.3.2. Exclusion of People with Cognitive Dysfunction and Those Living in Care Homes

However, the estimates of prevalence above are likely to be conservative in terms of whole populations due to exclusion of both people with reduced cognitive functions *and* those living in care homes from the empirical studies. This is because there is research that suggests disproportionate numbers of older people with cognitive impairments are subject to abuse from paid carers in both domestic and institutional settings (Dyer *et al.* 2000; Milne *et al.* 2001; Lachs and Pillemer 2004; Pillemer 2005; Cooper *et al.* 2006; Social Care Institute of Excellence 2006; Cambridge *et al.* 2006, 2011; Post *et al.* 2010). As a result, samples were not accurate representations of *overall* older populations of the respective countries in which the research was conducted (Mowlam *et al.* 2007; Stevenson 2008). It is suggested that people with cognitive impairment, as a result of their demanding behaviours and inability to advocate for themselves, are more likely to be the victims of abuse (Lachs and Pillemer 2004; Goergen 2004; Pillemer 2005; House of Lords/House of Commons 2007b; Benbow 2008; Social Care Institute for Excellence 2012). Similarly, they may be far less able to perceive given behaviours as abusive (Commission for Social Care Inspection 2008a). Further, within care homes for older people excluded from these studies, significant numbers of people were likely to be experiencing such cognitive difficulties, with estimates of dementia present either on admission or

among existing residents varying between 31% and 75% (Bebbington *et al.* 2001: 28; Macdonald *et al.* 2002: 60; Mathews and Denning 2002: 225; Gilmour *et al.* 2003: 254; Bowman *et al.* 2004: 565; National Audit Office 2007: 44; Alzheimer's Society 2007:11). Cambridge *et al.* (2006: 63) for example, found that care homes accounted for 63.8% of all abuse referrals for older people with dementia, and 51.9% for older people without dementia, though their research was confined to Kent and Medway local authorities.

3.3.3. Confounding Variables

Additionally, underreporting, postulated by some to be as few as one in every four or five cases of elder abuse reported (Wolf 2000:7; Bonnie and Wallace 2003:9; Cooper *et al.* 2008: 1), or as few as one in every 15 cases (World Health Organisation 2008: 1), may occur as a result of a range of factors, confounding studies that seek to quantify prevalence of abuse. Some scholars assert that only the most severe and visible occurrences of abuse in all settings are reported to the authorities, and many incidents remain unreported or hidden (Health Select Committee 2004; Buri *et al.* 2006) and may, in some cases, not even be identified as abuse (Choi 2000; Bergeron 2001; Tadd *et al.* 2011b). Specifically within institutions, intimidation of the abused into silence by the abuser (Ramsey-Klawnsnik 1996), fear of eviction (Alzheimer's Society 2004; House of Lords/House of Commons 2007b), fear of reprisals from institutional care staff (Gibbs and Mosqueda 2004; Harris and Benson 2006; Alzheimer's Society 2007; Collins and Walford 2008; Wells 2009; Dixon *et al.* 2009; Owen *et al.* 2012; Flynn 2015), and fear of isolation (World

Health Organisation 2008), have been determined as reasons for preventing reports of abuse .

However, as Stevenson (1989: 22) pointed out prior to most of the studies described above, there is little point in wasting research time on the prevalence of the abuse of older people as to do so may lead to a "...spurious precision..." in which figures are cited that will not withstand scrutiny. Biggs and Kingston (1995: 40) assert however, that prevalence studies do confirm the reality of abuse in the lives of significant numbers of people.

3.3.4. Limited Knowledge of the Extent of Abuse in Care Homes

The data available on abuse occurring in care homes is both limited and problematic, an issue that this study aims to address in part. However, the research that does exist suggests that abuse of older adults can be a common part of life rather than an exceptional occurrence within these institutions whose primary purpose should be to provide care (Pillemer and Moore 1989; Pillemer and Hudson 1993; Joint Committee on Human Rights 2007; Cooper *et al.* 2008; Cambridge *et al.* 2011). Though Pillemer and Moore (1989) did not attempt to quantify the abuse they found in terms of its prevalence among the older people in the thirty-two care homes they studied, they found that in the one year immediately preceding their study, 36% of the 577 nursing and care staff participating in telephone interviews had witnessed physical abuse and 10% admitted perpetrating it. Similarly, 81% of staff had witnessed psychological abuse and 40% had perpetrated it. A similar study conducted by Pillemer and Hudson (1993) found that among 221 randomly selected care staff in

care homes, 2% had slapped a resident, 10% had pushed or grabbed a resident, 17% had excessively restrained a resident, and 8% had threatened to hit a resident in the preceding month. Further, 23% admitted to have insulted or sworn at a resident and 51% that they had shouted at residents in anger during the same period.

Research conducted by the College of Nurses of Ontario (1993) determined that of the 1608 nursing and care staff participating in equal proportions, almost 50% had witnessed abuse of older residents, of which 32% had witnessed physical abuse and 37% verbal abuse, though no time period was specified. Not all respondents in this research, however, were employed in care homes, though 36% did identify abuse as occurring in such facilities. Saveman *et al.* (1999) found that when exploring abuse of older people reported in domestic, sheltered housing, group homes and nursing homes in Sweden, 11% of the 499 participating staff providing care knew of at least one occurrence of abuse in the preceding year. Two percent of these staff admitted to perpetrating abuse themselves. Goergen (2001: 11/12) determined that 79% of eighty nursing staff in eight German nursing homes reported personal involvement in abuse, and 66% reported witnessing abuse perpetrated by a colleague. Respondents reported psychological abuse far more frequently than physical abuse. Those reporting personal involvement reported the abuse they had perpetrated to be of low to moderate severity and often non-intentional or impulsive, whilst those reporting that they had witnessed abuse described the abuse they had seen as severe, repeated, committed collectively by groups of staff, and claimed that some occurrences were 'covered up' by staff. Goergen (2004: 20) also later determined

that in a second sample of eight nursing homes, 71.5% of respondents reported personally committing abuse, and 71.2% to witnessing it.

It is interesting to note that all of the studies outlined above exploring abuse in care homes change the unit of analysis from the potentially abused person, as used in the studies of abuse in domestic settings cited earlier (Pillemer and Finkelhor 1988; Podneiks 1992; Ogg, and Bennett 1992; Wetzels and Greve 1996; Comjij *et al.* 1998; O’Keeffe *et al.* 2007) to the potential perpetrator of abuse, preventing direct comparisons. Nonetheless, a systematic review by Cooper *et al.* (2008) determined from a meta-analysis of all available studies that 16% of long-term care staff had admitted to committing psychological abuse, 10% to committing physical abuse, and 80% of staff reported that they had witnessed others committing abuse, in the care home in which they were employed.

In consideration of a long history of public enquiries and care home regulatory tribunals, Glendenning (1997a: 15) asserted, “There is chilling evidence that elderly people [in care homes] are more likely to be at risk [of abuse] than the 91-95% who live in the community”. Garner and Evans (2000: 6) similarly maintain that, “Abuse does not only occur in rare, well publicised incidents; it is a common part of institutional life”. Further evidence to support this view was determined by Jenkins *et al.* (2000: 10) upon analysis of calls made to the Action on Elder Abuse helpline between 1997 and 1999 who found almost 30% of calls related to abuse in care homes or hospitals, yet only 4-5% of those over retirement age reside in such settings at any one time (Office for National Statistics 1999). Jenkins *et al.* (2000: 15) also found that 29% of abusers identified in calls to the helpline were paid care

workers, and 362 reported abuse in formal care settings, compared to 148 in the abused people's homes. Action on Elder Abuse (2006: 15) itself later determined a similar proportion of 29.4% of alerts emanating solely from care homes within nine local authority areas during a six-month period in 2005. In a study of abuse occurring in a number of forms of long-term care, Post *et al.* (2010: 339) attributed "significant levels" of abuse determined in their research into a range of long-term care facilities to the inclusion of care homes in their sample.

3.3.5. Minimal Knowledge of the Incidence of Abuse

Some of the studies described above are now dated, but provide evidence of the prevalence of abuse of older people in institutional care. This research explores prevalence of abuse in contemporary care homes and augments current levels of knowledge, yet there is no existing data on incidence of abuse in any setting. Though Bonnie and Wallace (2003: 9) and Glendenning (1997a: 14) assert that the prevalence of abuse is unlikely to change significantly over time, but that incidence will increase worldwide as a function of an increasing population of older people, this cannot be certain in the absence of reliable incidence data. Neither Bonnie and Wallace (2003) nor Glendenning (1997a) give reasons for their assertions, and it is possible that despite populations of increasing age and dependency in care homes that may lead to increased risk of abuse (Fossey and James 2008; Royal College of Nursing 2010), effective preventative interventions, for example, may reduce incidence and consequently, in the longer term, prevalence. Yet whether or not this is occurring currently remains unknown.

There is no doubt that the global populations of older people in both developed and developing countries is rapidly increasing (Post *et al.* 2006; Lutz *et al.* 2008) and the higher risk groups of older, old people and those with dementia is also increasing (Cooper *et al.* 2008). These phenomena are likely to influence the incidence of abuse globally and might, through increased competition for resources at both a macro- and micro-level also increase prevalence. Both incidence and prevalence data, were they available, may be utilised in conjunction with population projections to determine how much abuse might be anticipated in the future, though changing levels of social awareness and developing definitions and thresholds of abuse might also influence any such determination.

3.3.6. Persistence of Abuse in Care Homes

Pillemer *et al.* (2001: 5) maintain that, "...abuse, although often not detected or reported, in fact, existed in every facility [that included care homes] we have ever surveyed. It is a serious problem." From their studies in nursing homes Pillemer *et al.* (2001) concluded that abuse may be reduced but could never be eliminated. Glendenning (1999b: 174) and Cambridge *et al.* (2006: 56; 2011: 245) similarly assert from studies of occurrences of abuse, specifically in institutions and in all settings respectively, that there is evidence that older people living in institutions are more likely to be at risk than those that live in the community. Cambridge *et al.* (2006: 57) found, for example, that 51.9% of all reported abuse of older people occurred within care homes, compared to 42.2% occurring in peoples' own homes. For those older people with mental health problems, 63.8% of abuse occurred within care homes compared to 27.9% in their own homes. Interestingly only 0.2% of alerts

(both older and younger adults) from within care homes were classed as institutional abuse within data from Kent and Medway where the research was conducted (Cambridge *et al.* 2006: 23). Fyson and Kitson (2012: 100) also determined that 52% of all adult abuse allegations they analysed from one English local authority (both older and younger adults), came from within care homes.

There may be other, as yet unknown variables influencing these figures, for example, higher levels of reporting from within care homes because of greater scrutiny and supervision of staff activities. However, covertly obtained and televised video footage of abuse previously referred to in nine care homes between 2011 and 2015, and recent reports of abuse in the press, for example at Merok Park in Barnstead during 2014, confirm that abuse does still occur in care homes in this early part of the 21st Century.

3.3.7. Contemporary Efforts to Address the Lack of Prevalence and Incidence Data

Ogg and Munn-Giddings pointed out as early as 1993 that there is no single source in the United Kingdom where referrals of abuse of older people in any setting are recorded (Ogg and Munn-Giddings 1993: 401), a view reiterated more recently by Sumner (2004: 10). The statutory regulator of care homes in England has confirmed that during 2008 referrals relating to the protection of adults at risk in care homes and those receiving domiciliary care rose by between 10% and 150% when compared to the previous year, with an average rise of 36% across English local authorities (CSCI 2008a: 22). Similarly, the National Audit Office (2014: 9) found that safeguarding referrals recorded by local authorities concerning older victims in

all settings increased by 13% between 2010/11 and 2012/13. It remains unclear, however, whether such an increase is due to increasing incidence of abuse or increased awareness and ease of reporting abuse following the establishment and application of national adult protection policy '*No Secrets*' (2000). The latter possibility, however, seems unlikely given that 14 years had elapsed since the implementation of '*No Secrets*' at the time of the report from the National Audit Office. Further, reported figures were simply of referrals, with no data available as to outcomes in terms of substantiation of alleged abuse or otherwise.

In 2011/2012 the NHS Information Centre conducted a national survey of all English councils (The NHS Information Centre 2012), achieving 100% response, though with some data quality issues. The data collection pro-forma sought information about who is being abused, in what way, where and by whom. From a definitional perspective, the data collection instrument recognised physical, psychological, financial and sexual abuse, and neglect, and included institutional abuse as a discrete category (The NHS Information Centre 2012: 27). In the guidelines appended to the data collection instrument the NHS Information Centre employed the definition of institutional abuse given by '*No Secrets*' quoted earlier, though this may have been interpreted differently by the local authorities submitting the original data.

The data subsequently presented in the final report (The NHS Information Centre 2013) determined that 4% of adult protection referrals concerned institutional abuse (all ages) (The NHS Information Centre 2013: 27). However, data is then presented to show that 34% of referrals concerned abuse that was alleged to have occurred

within care homes (all ages) (The NHS Information Centre 2013: 30). This same data collection exercise revealed identical results in subsequent surveys when repeated during 2012-2013 and 2013-2014 (The NHS Information Centre 2014a; 2014b), chiming with the findings of Cambridge *et al.* (2006: 57) referred to above who determined only 0.2% of all referrals from care homes were classed as institutional abuse, though they accounted for over 50% of all referrals.

No further comment is made within the reports of the NHS Information Centre on the low figure for institutional abuse despite the high number of reports of abuse from care homes. This suggests a failure to acknowledge a lack of sophistication within the health and social care economy, and among its analytical personnel, that enables such a straightforward and uncontested delineation between pervasive institutional abuse, and what are recorded as isolated acts of abuse within the care home, to be presented. This is symptomatic of a continuing tendency to treat abuse occurring within care homes as isolated events attributable to individual perpetrators, rather than a potential reflection of a pervasive and embedded institutional *mêlée* that may itself be responsible for the origins of abuse.

Presentation of figures in this manner also assumes that the mechanisms and skills exist within the agencies involved in exploring adult protection allegations that inform the subsequent data to determine whether or not reported abuse that presents as isolated incidents *within* institutions are indicative of ingrained and pervasive ill-treatment that is institutional abuse. These mechanisms and skills are not currently widespread within the limited operational abilities of local authorities and their partner

agencies, some evidence of which was determined by Penhale *et al.* (2007: 73) and suggested by Killett *et al.* (2011: 91).

Further, the data collection fields within the document include outcome domains shown in table 3.1 below and, though this data collection process is a major step forward in measuring prevalence of abuse, it can be seen that outcome options identify intervention possibilities that, where applied to care homes, focus again upon superficial organisational features.

Table 3.1: Categories of Outcomes of Safeguarding Referrals for Reporting by Councils with Social Services Responsibilities to the NHS Information Centre.

Criminal Prosecution/Formal Caution
Police Action
Community Care Assessment
Removal from Property or Service
Management of Access to the Vulnerable Adult
Referral to POVA/ISA List
Referral to Registration Body
Disciplinary Action
Enforcement Action by Care Quality Commission
Continued Monitoring
Counselling/Training/Treatment
Referral to Court Mandated Treatment
Referral to Multi Agency Public Protection Arrangements
Action Under Mental Health Act
Action by Contract Compliance
Exoneration
No Further Action

Collection of this national data may provide a valuable longitudinal perspective on the occurrence of abuse, particularly if it becomes more sophisticated. However, in the absence of reliable data to date, policy makers do not know if the prevalence or incidence of abuse of adults at risk of abuse is increasing or otherwise. From a social

policy formulation perspective, it would be advantageous to know whether intervention strategies are leading to a decline in the incidence and prevalence of abuse in care homes (and elsewhere). Achieving this is perhaps particularly important as the World Health Organisation (2008: 4) predicts an increase in both the occurrence and severity of abuse in the coming decades as a result of an ageing population worldwide and changes in care giving responsibilities, family structures and relationships.

3.4 Staff Attitudes and Theoretical Models of Abuse of Older Adults at Risk of Abuse

3.4.1. The Challenge of Caring Relationships

Providing care to other people is often viewed uncritically as rewarding and unproblematic (Brechin 2000: 141), but caring relationships present a challenge in that they must take account of the expectations, needs and ambitions of the person receiving care, in addition to ensuring any physical needs are met. For some people needing care, a detached form of assistance with physical needs may be what is wanted, but for others, emotional warmth, understanding and psychological support to meet their needs themselves may be what is desired. Providing 'care' is therefore often a question of being respectful and sensitive to a person's wishes and needs, supportive and enabling where this is appropriate, but helping directly where it is warranted. This is a balance between providing task-based care and emotion-based care (Davies 1995; Society for Disability Studies 2015), the "caring for" and "caring about" dichotomy described by Graham (1983: 15) and Peace *et al.* (1997: 43). Caring therefore involves "...attending physically, mentally and emotionally to the

needs of another *and* giving a commitment to the nurturance, growth and healing of that other” (Davies 1995: 18).

People with long-term illnesses and disabilities, and those with long-term mental illness, tend to be particularly exposed to the power imbalance that often exists between the person; requiring support and the care giver, experiencing more task based and pragmatic, rather than emotional and psychological support (Brechin 2000: 143). Braye and Preston-Shoot (1996: 96) suggest that the care provider must attend to three conflicting drives that need to be kept in balance with respect to each individual receiving care; thus the enhancement of autonomy must be balanced with empowerment to achieve autonomy, which in turn must be in balance with protection where people may be at risk of abuse. Though circumstances continue to improve for many with a long-term disability (Davies 1995; Society for Disability Studies 2015), this is less evident among older people living in care homes (Commission for Social Care Inspection 2008b).

Kitwood (1997: 119) questioned the particular prevalence of primarily physical and protective care provided to people with dementia, maintaining that such physically focussed care prevented staff from being “psychologically available” to the person with dementia. This, in part, denied people with dementia their “personhood”, their “...standing or status, bestowed upon one human being, by others, in the context of relationship and social being” (Kitwood 1997: 8). The purpose of care to people with dementia must, therefore, recognise ‘personhood’, treating them with respect for their individual choices and preferences, and respect for their dignity, privacy and feelings. However, a number of Serious Case Reviews of the abuse of older people

with dementia in care homes suggests that the concept of personhood is still not always applied in practice (Manthorpe and Martineau 2014), for example, Elm View in Calderdale 2011; Purbeck Care Home in Dorset 2012 and Orchid View in West Sussex in 2014.

3.4.2. Staff Perceptions of Residents in Care Homes

Much of the extant research conducted in care homes and hospitals tends to focus on the levels of dependency of residents or patients, including the presence of dementia, as a factor that may lead to poor quality or disrespectful care (Killett *et al.* 2011:27). There is very little research concerning the personality attributes of residents, whether 'real' or perceived, that may affect how staff engage with them and how the nature of subsequent relationships is central to the quality of life of those receiving care. However, in the single privately owned care home she studied Lee-Treweek (1996: 125) tells of the care staff classification of the residents as 'the lovelies', 'the disliked' and 'the confused', and of how 'the disliked' were perceived, once identified as such, in "...fixed, one dimensional terms..." such as 'cold', 'mean', 'unkind', 'thoughtless', 'vicious' and 'evil'. Consequently, though care staff generally undertook the necessary physical care tasks for 'the disliked' they denied them any emotional support (Lee-Treweek 1996: 127), behaviour that would be construed in contemporary idiom as psychological abuse or neglect. These assertions echo the earlier work of Evers (1981: 124) who identified care staff classification of some elderly female residents on NHS long-stay geriatric hospital wards of the day as "awkward Alices" who received neglectful and indifferent treatment as a result. Goergen (2001: 19) similarly found staff in care homes labelled residents as

'difficult', 'mentally disturbed' and 'aggressive', whilst both Tomita (1990: 174) and DeHart *et al.* (2009: 364) determined that residents were characterised by some care staff as 'disgruntled', 'unreasonable', 'demanding' or 'full of self-pity' and who were treated unkindly as a result. More recently Schneider *et al.* (2010: 70) found that some care staff in hospital settings believed that older patients with dementia deliberately and selfishly thwarted their efforts to undertake physical care tasks, and acted in a generally antisocial manner, without the staff considering how the effects of residents' dementia may be influencing their behaviour. Schneider's findings are remarkable given the contemporary extent of training on caring for people with dementia. Maben *et al.* (2012:90) have also determined how acutely ill, but cognitively intact older people in hospitals are labelled by staff as either 'poppets' (a term of endearment]) or 'parcels' (a pejorative term for 'awkward', 'demanding' or 'unfriendly' patients), and are treated either with care and affection, or in a "dehumanising" way respectively as a result.

3.4.3. Training of Care Staff

Training for staff in care homes has been frequently offered as a solution to poor quality care and abuse (Tadd *et al.* 2011b; Faulkner and Sweeney 2011; Faulkner 2012; Cavendish 2013), including, amongst other subject areas, respecting those who require care, treating them with dignity and respect, self-awareness and managing stress (Skills for Care 2014a). For over twenty years extensive training in the form of National Vocational Qualifications has been available for care staff in England. Attainment of these skill-based certifications of practical competence is

significant with some 45.5% of direct care staff in England holding an NVQ at levels two, three or four (Skills for Care 2012: 47). In many local authorities this figure is in the region of 80% because fees paid to care homes have been positively titrated with reference to higher levels of NVQ certification amongst care staff (Laing and Buisson 2014: 321). In addition, care staff in English care homes are all required to undertake 'Common Induction' training, prescribed by Skills for Care, including a module specifically on safeguarding adults from abuse (Skills for Care 2014a: 7).

Furthermore, by means of sector regulation and purchase of services from care homes under contracts, minimum levels of training, and specific policies and procedures to, for example, foster respect and the positive evaluation and protection of residents, are stipulated by regulators and commissioners. These mechanisms have been in use with ever increasing sophistication, particularly since the extensive 'marketisation' of the care home sector that followed the *National Health Service and Community Care Act 1990* described earlier. Consequently, care providing organisations are more likely to provide training than are organisations in other industry sectors (Joseph Rowntree Foundation 2014: 32). However, occurrences of abuse identified in the introduction to this thesis, including some recorded on film, and continuing adult protection referrals to local authorities indicate that abuse still occurs (The NHS Information Centre 2013; 2014a; 2014b). Though it may not be possible to abuse from care homes entirely, the frequency with which it has been recorded in recent years, suggests that increased efforts by some means must be made to reduce it.

3.4.4 Theories of Abuse

Normative perceptions of care staff and residents in care homes tend to ignore the forced social relationships that often exist between care giver and care receiver, and the effect that personalities may have upon their consequent interactions (Zimmerman *et al.* 2005). Instead, the literature concerning abuse tends to identify potential risk factors that may contribute to abuse, and offer them as theoretical explanations of why it occurs, such as carer stress, for example. However, such isolated factors may in turn be subsumed within a small number of theoretical models that seek to build fundamental explanations for abuse from interrelationships among risk factors and their psychological bases. In the arena of adult abuse there are four theoretical models ‘imported’ from other disciplines, usually encountered in application to abuse in domestic settings, that have potential application to understanding the occurrence of abuse in care homes.

3.4.5. Situational Theory

Perhaps the most commonly cited theory in the abuse literature, situational theory, derived from child abuse and domestic violence perspectives (McDonald *et al.* 1991; Penhale and Parker 2008), locates causes of abuse in the situational variables in which the carer – older person relationship exists. Situational theory identifies factors located with the carer, such as misuse of alcohol or drugs, mental illness and exhaustion, along with the economic circumstances of both carer and the person who require care, for example, employment status, income, and issues relating to the environment in which care is provided. In the context of older people, the older

person is often viewed as a source of stress upon the carer as a result of behaviours and dependency attributable to old age and attendant physical and psychological decline.

Situational theory has been criticised for its inability to explain why some carers abuse and some do not when experiencing comparable circumstances, particularly those likely to cause stress (Bennett and Kingston 1993). However, Montgomery (1989 cited in Biggs *et al.* 1995: 68) offers that the distinction between objective stress factors and the subjective experience of stress is relevant, in that different stressors have different degrees of impact upon different carers. Montgomery (1989) also criticises the frequent assumption that the nature of the caring task is negative and deleterious, offering that for some carers it can be positive and rewarding. Though Pittaway and Westhues (1993) determined some support for situational theory applied to domestic circumstances by means of secondary data analysis, Pillemer (2005) points to a paucity of convincing evidence yielded by rigorous case comparison studies to demonstrate a causal relationship between stress and the occurrence of abuse.

Further, situational theory may be criticised in some circumstances for the emphasis placed upon the abused person as a cause of their own abuse through their behaviours (Biggs *et al.* 1995: 67), many of which, for the older person, may be beyond conscious control, particularly in the presence of cognitive decline. However, though not specifically presented in situational theoretic terms, the behavioural characteristics of older people, particularly those with cognitive illnesses, have been identified as factors that introduce increased stress into the situation of care,

including that prevailing in care homes (Payne and Cikovic 1995; Lachs and Pillemer 2004; Joshi and Flaherty 2005; Post *et al.* 2010).

3.4.6. Social Exchange Theory

Social exchange theory is built upon the precept that "...social interaction involves an exchange of rewards and punishments between at least two people, and that all people seek to maximise rewards and minimise punishments." (Phillipson and Biggs 1995: 194; McDonald and Collins 2000: 28). The theory holds that in most relationships there is a difference in the degree to which people can access resources, and in their abilities to provide some benefit (or punishment) to others (Boudreau 1993: 145). To sustain continued interaction there must be a perception among participants within a relationship that there is an acceptable balance between rewards and punishments of any exchange. Failure to achieve positive consequences or rewards will lead to either avoidance or conflict. Applying this theory to the care home, resources may be food and fluids, warmth, and equipment to alleviate the effects of disability or illness; benefits may be the ability to provide assistance with physical care or to provide psychological support. These resources and benefits are those that are predominantly under the control of care home staff. As a result, there is likely to be an imbalance of exchange between the person who needs care and the caregiver, where one is dependent upon the other, and the dependent person has little or no access to resources. Within the older persons care home environment the person requiring care likely has little to offer other than gratitude and emotional warmth if they have the cognitive ability to do so.

In the context of social exchange theory, it may be argued that as some people become older, their power, when viewed as access to resources and ability to give benefits to others, diminishes. As a consequence, they may become more reliant on others and more susceptible to abuses. Critics of this model however, point out that not all older people who are abused will experience such a diminution of power, and to assume that they do is an ageist presumption (McDonald and Collins 2000). Further, it is conceivable that the relationship between the person receiving care and the care giver may generate feelings of personal satisfaction for some care givers, the praise of others, and could perhaps lead to recognition and promotion for those in employment as care staff, therefore providing 'rewards' by other means.

Gouldner (1960) and George (1986) also assert that the norms of reciprocity and solidarity present within longstanding relationships, particularly those that are familial, also cast doubt upon the usefulness of social exchange theory. Yet in the context of the care home the norms of reciprocity and solidarity are less likely to prevail between care staff and the person receiving care, many of who are likely to have significant cognitive and physical problems, further diminishing their ability to reciprocate within relationships. Furthermore, many older people remain in the care home until their death, and, at some point, as a result of physical and/or cognitive decline, will almost inevitably experience a period of powerlessness for a greater or lesser time that renders them more at risk in the context of the resultant power imbalance.

Exceptions to such a prospect are sudden death or admission to hospital in the earlier, rather than later, stages of physical and cognitive decline, though there is

evidence to suggest abuse is also common within hospitals (Kitchen 2002; Sawbridge and Hewison 2011).

3.4.7. Symbolic Interaction Theory

Symbolic interaction theory holds that the way social life is organised and how people act toward things is based on the subjective meaning those things have for them (McCall and Simmons 1966; Blumer 1969; Denzin 2004). These meanings arise from the symbols used in communication and interaction, modified through individual interpretation.

As Blumer offers (1969: 180):

“Symbolic interaction refers...to the peculiar and distinctive character of interaction as it takes place in human beings. The peculiarity consists in the fact that human beings interpret or define each other’s actions instead of merely reacting to each other’s reactions. Their response is not made directly to the actions of one another but instead is based on the meaning which they attach to such actions. Thus, human interaction is mediated by the use of symbols, by interpretation, or by ascertaining the meaning of one another’s actions. This mediation is equivalent to inserting a process of interpretation between stimulus and response in the case of human behaviour.”

Abusive behaviour may therefore be viewed as a consequence of interactions and interpretations within families and institutions (Emerson 1962; Phillipson 1997; Nolan 1997). This theory is concerned with both the behaviours of the abused person and perpetrator of abuse, and each person's mediating symbolic interpretations of those behaviours and the meanings attributed to them. In the context of the abuse of older people, the theory predicts that processes arising from biological and social ageing may change role definitions in the social context in which those people live (Phillipson 1997: 111). These alterations may then change previously established identities, such as parent-child, precipitating stress within social relationships that may, in some instances, lead to abuse. In some circumstances revised symbolic identities may emerge within the relationship, such as a reversal of previous parent-child identities, but in others, forms of abuse, particularly psychological abuse, may occur (Biggs and Phillipson 1994: 218; Phillipson 1997: 112).

Symbolic interaction theory might be useful in offering some explanation of how the ageing process care staff observe in the older people they care for affects them at a personal level. Given that the majority of staff are not likely to have experienced poor health and dependency to the extent of those they look after, caring for them may remind them of the inevitability of their own ageing, further confirmed by dominant, largely negative, social stereotypes of ageing, both of which may be construed as symbolic interpretations (Kitwood 1997; Fiske *et al.* 2002; Abrams and Houston 2006). If care staff have a negative and stigmatised perception of the older people they work with, they are more likely to exhibit less tolerance in the face of, for example, challenging behaviours, and have a greater expectation of conformity.

Featherstone and Hepworth (1991: 376) assert that the loss of bodily functions and controls sometimes experienced by older people impairs their ability to interact, and symbolises a loss of power through decline that may induce others to treat them as less than a full adult. As Nolan (1997: 201) maintains, where the behaviours of the older person are not congruent with the symbolism of the care staff, they are more likely to adopt a punitive approach that could lead to abuse. Consequently, both the personal decline of the older person, and embedded social influences, contribute to symbolism and meaning at the micro-level (Hewstone 1989; Kitwood 1997; McGlone and Fitzgerald 2005), and may be instrumental in creating the conditions where abuse is more likely to occur.

3.4.8. Feminist Theory

Early research located the abuse of older people predominantly within family relationships, thereby explaining the greater proportion of abuse in terms of spousal abuse and domestic violence, often in situational theoretic terms. This situational theory has proved to be resilient and only limited research has been conducted to provide further theoretical explanation of the abuse of older women by their partners (Aronson *et al.* 1995; McDonald and Wigdor 1995). Spouse abuse in old age is unlikely to be first time abuse (Knight 1994; Neysmith 1995; Eckley and Vilakazi 1995), and the lasting view has been that the abuse of an elderly spouse is simply domestic abuse grown old. Consequently, feminist scholars have explained it as a product of family patriarchy, long identified as one of the primary sources of violence against women in western society (Vinton 1991; Jack 1994; Pittaway and Gallagher 1995).

However, Whittaker (1995) and Neysmith (1995) point out that women may also abuse older male spouses or parents, contradicting an understanding of abuse nested solely within gender-based power inequalities. Similarly, research into abuse occurring in gay and lesbian domestic situations has cast doubt upon gender-based theories of domestic abuse (Coleman 1994; Letellier 1994), as has research concluding that increasing numbers of women are using violence against men (Gelles and Loseke 1993; Johnson 1998). Again, the cardinal issue in such circumstances offered by some scholars is the imbalance of power between the abused and the abuser within the domestic relationship which is not necessarily directly related to gender (Jack 1994; Miller 1994; Payne 2005).

Particularly pertinent to care homes for older people is that an estimated 95% of caring staff are female (Manthorpe *et al.* 2004; Cambridge *et al.* 2006; Dening and Milne 2008; Skills for Care 2014b) and the majority of residents in care homes, some 72%-78%, are also female (Lievesley *et al.* 2011: 20; Laing and Buisson 2012:48). Further, in England 88.2% of care managers and 74% of senior managers, including proprietors where they fulfil these functions, are female (Skills for Care 2014b). Therefore, the care home may be construed as a matriarchal institution to which current feminist theory of abuse may be difficult to apply.

3.4.9. Complementary Explanatory Frameworks

These four theoretical models are conceived neither as mutually exclusive, nor inevitable. All of them perhaps have a degree of explanatory power in different

circumstances, and must therefore be considered in the particular contexts of those that perpetrate abuse and those who are abused. These models may be supplemented by what are often offered in the literature as the ecological model (Schroder-Butterfill and Marianti 2006; Schiamberg *et al.* 2011), and the political economy model (Biggs 1996b; Wolf 2000; Ramsey-Klawnsnik 2000).

Ecological models consider the origins of abuse in terms of socio-cultural and social factors, and relationships between agent and environment (Nahmiash 2002: 23). Schroder-Butterfill and Marianti (2006:17) offer a specific ecological model that disaggregates the likelihood of abuse into the domains of exposure, threats, coping capacities and outcomes, including, for example, living environment, relationships, access to resources and cognitive abilities. The four domains are then utilised to focus attention on aspects of the risks of various forms of abuse occurring.

The political economy model refers to macro-level system marginalisation of older people and perpetuation of ageist tendencies towards them within societies that create an ideology of economic and political exclusion (Wolf 2000; Ramsey-Klawnsnik 2000). The political economy model suggests ideological images of older people as dependent upon society for support. Older people may then be viewed as responsible for ever increasing welfare benefit and healthcare costs, creating a future demographic crisis, with unsustainable pressures on health, social care and pension structures. This perspective locates abuse within a macro-system socio-political context and considers the structural factors of poverty, gender, power, inequality and age prejudicial attitudes in abuse (Hughes 1995). This echoes Townsend's (1986) concept of structured dependency of older people. If some older

people are prone to abuse because of physical and psychological dependency, the likelihood of abuse may be increased through social forces that discriminate against both older people and those employed to care for them, who in turn may be considered as abused by the wider social system of which they are part.

However, these two models are sense making frameworks rather than stand-alone explanatory theories that may be subsumed within the situational and social exchange theories respectively. Additionally, these models may be considered to reflect the assertions of the Social Model of Disability (Oliver 1983; 1990; 2013; Lang 2007; Society for Disability Studies 2015) that moves away from the functional, physiological and cognitive difficulties of the person that labels individuals as “vulnerable” or “at risk”, the “medical model” of disability (Stout and Schwartz 2014), to consideration of the importance of politics, empowerment, citizenship and choice, and the tendency of many societies to systematically discriminate against and oppress ‘disabled’ people. The Social Model of Disability asserts that people with a disability consequently often experience negative attitudes from society that undermine their personhood and their status as full citizens because of negative perceptions and disadvantage (Charlton 1998). This often leads to dismissals of individuality and depersonalisation (Brisenden 1986; Society for Disability Studies 2015), that in turn may give rise to unfavourable treatment, sometimes amounting to abuse. It is by altering these dimensions of the perceptions of disabled people by society that they can enjoy the status of full and active citizens.

Charlton (1998) asserts that many disabled people have internalised the oppression they have experienced from society, a view echoed by other scholars with regard to

older people (Harris and Benson 2006; Ray, Sharp and Abrams 2006; Vanlaere and Gastmans 2007), leading to individuals believing that they are less capable than others, increasing their 'vulnerability' and risk of abuse.

There have been government policy led moves to ensuring disabled people live in community settings where care is provided to them in their own homes over the past twenty years, moving away from perceptions of them as 'vulnerable' to perceptions of them as people who can be enabled by their environments, income and work opportunities, for example (Priestly 1999; Lang 2007). However, this has been far less prevalent for older people who may experience a range of functional and cognitive disabilities and are, beyond a certain point of need, consequently consigned to care homes. That this would not be the choice for many is confirmed by research (Poole 2006; Yeandle 2009; Department of Health 2009), suggesting their presence in care homes to be another example of political and social influences based on cost containment, and failures to empower, through denials of full citizenship and choice.

3.4.10. The Role of Power Imbalance

Williams and Keating (1999: 131) define abuse as, "...the use of power to serve self-interest or group interest...", whilst Penhale (1999: 4) similarly asserts that "...power relations are central to all abusive situations". The imbalance of power between those providing care and the recipients of care have been recognised elsewhere in the literature as a causal factor of abuse (Ticoll 1994; Charlton 1998; Marsland et al 2007), whilst Whittaker (1997) maintains that abuse can *only* occur between two

people in *any* relationship when a power imbalance exists between them; one person perceives and is perceived by the other as more powerful, and the other perceives and is perceived by the other as less powerful.

Power dependence theory, that has many similarities to social exchange theory (Emerson 1962; Blau 1964) states that the power of person A over person B is directly proportional to the degree of dependence of person A upon person B. Emerson (1962:32) states that a person's power resides in the others dependency, and extends the concept of power created in this way to communities and societies, further echoing the Social Model of Disability and particularly relevant to older people residing in care homes as discussed previously. The current tendency towards increasing needs among older people being admitted to care homes in both physical and psychological terms (Cooper et al. 2008) renders them particularly frail and relatively powerless in terms of power-dependence theory. They are therefore particularly reliant upon those employed to care for them, and their only other sources of advocacy are usually relatives whose degrees of contact and awareness of life in the care home may be limited.

In many circumstances of the admission of older people to care homes it is often unclear as to whose interests are being served, particularly given research previously cited has indicated overwhelmingly that care homes would not be the choice of many older people (Poole 2006; Yeandle 2009; Department of Health 2009). The very act of placing older people in care homes may thus be considered an abuse of power, whether facilitated by professionals acting on society's behalf, or family and friends, again constituting a manifestation of a denial of their 'personhood'

(Kitwood 1997: 8) and continued dominance of the 'medical model' of disability (Stout and Schwartz 2014). As Minichiello (2002) *et al.* determined, it is not uncommon for older people to accept their fate with resignation to an inability to act and prevent what is happening to them, compounding the power imbalance between those receiving care and those providing it.

Some research has indicated, however, that in terms of power-dependence within abusive relationships the dependence may not necessarily be located with the abused person. A number of studies have shown that it may be the perpetrator of abuse who is dependent on the person they abuse, and it is the abuser's feelings of powerlessness that generate the abusive behaviour, for example, dependency of the abuser upon the abused for housing and money (Pillemer and Wolf 1986; Pillemer and Suitor 1992). However, the known research in this area has been conducted within family relationships and domestic environments and it is unlikely that care staff in care homes are directly dependent upon the older people in their care in terms of power-dependence within social exchanges, though they may be considered to be indirectly dependent in the sense that they are paid for the care tasks they perform.

There is currently no single explanatory theory for abuse of adults at risk of abuse in general, and certainly no such theory for those accommodated in for-profit care homes in particular. Some scholars have questioned the continuing search for an all-encompassing theory of adult abuse that is likely an unattainable objective (Hudson 1992; Pillemer and Hudson 1993; Ansello 1996), and, as Kelman (1973: 38) asserts, it is perhaps that the focus of enquiry should not be on specific causes and motives

of abuse, but on the conditions in which the usual moral inhibitions that prevent it are weakened or negated.

3.5 Aspects of the Care Provision Process and Care Home Context that Contribute to the Occurrence of Abuse

3.5.1. The Nature of the Work of Care in Care Homes

Much has been written about the imbalance between insufficient time available to staff to complete required tasks in institutional care settings. This work has been conducted primarily in hospitals, predominantly in relation to the care of older people (Lawler 1999; Walsh and Kowando 2002; Wilkinson *et al.* 2009; Haak 2009; Schneider *et al.* 2010; Tadd *et al.* 2011a), but also includes care homes for older people (Willcocks *et al.* 1987; Pillemer 1988; Bright 1999; Stanley 2009; Wild *et al.* 2010a; Killett *et al.* 2011; Tadd *et al.* 2011a; 2011b).

Though these studies were not linked directly to the occurrence of abuse, but to quality of care and maintenance of dignity, Tadd *et al.* (2011a: 246; 2011b: 78) asserts that pressures on staff time when caring for older people are critical to the adoption of a reactive, task oriented approach to patients among care staff in both NHS hospitals and care homes. In circumstances where insufficient time was available to staff to complete tasks required of them, quality of care and dignity of those requiring care were found to be compromised. Schneider *et al.* (2010:67) similarly determined that care staff in hospitals chose *against* applying the principles of person centred care on dementia wards in the interests of fulfilling required daily

routines designed to maximise available time for task completion, a phenomenon termed a “pragmatic relationship”, characterised by a paucity of interaction and communication between staff and patients.

Research in institutional care settings has also frequently raised the presence of significant stress upon staff as a result of undertaking care tasks within limited time, (Glendenning 1997b: 155), linked in some circumstances to shortages of staff and material resources (Glendenning 1997b: 157; Baillon *et al.* 1996: 223; Wiener and Kayser-Jones 1990: 95), redolent of the situational theory of abuse described above. Sources of stress upon staff have been found to include demanding behaviours, illness, suffering and death among those in need of care (Schneider *et al.* 2010: 43; Tadd *et al.* 2012b: 177), and the ever increasing morbidity and dependency of older people in care homes has been acknowledged in the literature (Bowman *et al.* 2004; British Geriatrics Society 2007; Wild *et al.* 2010a; Killett *et al.* 2013). Lievesley *et al.* (2011: 31) found that residents with cognitive limitations due to dementia living in care homes were two and a half times more likely to exhibit behaviour that challenges the provision of care than those without such illness, an attribute likely to place higher levels of stress upon care staff. Some studies have confirmed that staff members who perpetrate physical and psychological abuse in care homes were both physically exhausted and ‘burned out’ (Pillemer and Moore 1990; Pillemer and Bachman-Prehn 1991; Saveman *et al.* 1999; Todd and Watts 2005; Duffy *et al.* 2009; Tadd *et al.* 2011b), with Duffy *et al.* (2009) detecting ‘burnout’ to be present among 68.6% of care staff in care homes for older people with dementia. Macpherson *et al.* (1994) and Mozely *et al.* (2004) similarly found levels of significant

psychological distress in 15.7% and 25.1% of their sample populations of a range of care providing staff respectively.

Stress has also been found to be a contributory factor to circumstances in which the individuality of those receiving care in hospitals can “become obscured” (Schneider *et al.* 2010: 10), and, in both hospitals and care homes, where “desensitisation” and “depersonalisation” leading to a lack of emotional responses from care staff may occur (Maben *et al.* 2007: 104; Schneider *et al.* 2010: 43; Tadd *et al.* 2011b: 9). Badger (2005) and Brodaty *et al.* (2005) both determined that physical isolation and emotional withdrawal from the people receiving care, and sometimes anger towards them (amongst other emotions), was an adaptive strategy among staff working in the stressful environments of hospital intensive care wards and care homes respectively. Schneider *et al.* (2010) similarly concluded that the desensitisation among the care staff they studied in hospital settings was a protective mechanism to negate the stressful, distressing sights, sounds and smells of the work, minimise the fear of verbal and physical attacks upon them, and lessen the emotional impact of the deaths they encountered. These phenomena seem to be consistent with the work of Menzies Lyth (1988: 46) who suggested that care work in hospitals requiring close contact with dependency, pain and death would inevitably give rise to anxieties within the care giving staff. Consequently, Menzies Lyth asserts, a social system arises to defend staff against these unpleasant, anxiety provoking experiences that in turn leads to failures to acknowledge the humanity and individuality of those receiving care.

3.5.2. The Contribution of Stereotypes, Prejudice, Stigmatisation and Ageism to the Occurrence of Abuse

Butler (1969: 243) identified processes where the individuality of older people came to be ignored within society, leading to "...systematic stereotyping, prejudicial attitudes and discrimination against people because of their chronological age". Stereotyping of older people, that can occur at both the level of individual perception and that of societies, places them within a distinct social group, ignoring individuality and defining expectations of how they will behave and relate to others, usually, but not exclusively, in negative terms (Nelson 2002; Fiske *et al.* 2002; Abrams and Houston 2006; Kennedy 2014). Older people may then be perceived as a separate, homogenous group (Fiske 2002: 878) of, for example, frail, dependent [sic], unimaginative and non-productive people (Fine and Glendinning 2005: 602). Consequently, there is a tendency for all older people to receive different and discriminatory responses from both other people who are not old and from wider society (Bagley *et al.* 2011; Commission for Healthcare Audit and Inspection 2007). As a result of stereotyping, older people may be viewed as dependent [sic] (Stevenson 2008; Commission for Social Care Inspection 2006b; Age Concern 2006b; Her Majesty's Government 2005) and passive recipients of societal assistance (Calman *et al.* 2003; Bowers *et al.* 2011), consequently marginalized within society, affecting their status as citizens (Biggs and Phillipson 1994; Biggs *et al.* 1995; Penhale and Kingston 1995; Peace *et al.* 1997; Commission for Social Care Inspection 2006b). This response discriminates on the basis of age, manifest as behaviour that treats older people unequally or unfairly because of their age at both macro- and micro-levels (Ray, Sharp and Abrams 2006; Glasby 2007; Local Government Association 2011). However, ageism is often more than just age

discrimination, and may be characterised by deep-seated, negative beliefs about the process of ageing and of people who are older (Angus and Reeve 2006; Department of Health 2007; Brown Wilson *et al.* 2009; World Health Organisation 2011). Such beliefs are socially generated and reinforced, embedded as they are in rules and mechanisms of everyday life and its institutions (Bytheway 2001; Bowers *et al.* 2009), particularly through the contemporary media of television and newspapers (Abrams and Houston 2006; Stevenson 2008). Such ageist stereotypes exaggerate negative characteristics, usually based on false assumptions unsupported by fact, and any positive characteristics of older people tend to be ignored (Carp 2000; Harbison 2000; Harris and Benson 2006).

Prejudicial attitudes, that is, entrenched attitudes that are typically negative or hostile directed toward a particular social group, are usually based on stereotypes and stigmatisation. Neuberg *et al.* (2003) describes stigmatisation as one end of a continuum of the process of assigning positive or negative labels to people or groups and valuing or devaluing them in accord with these labels. Prejudicial attitudes arising as a consequence may lead to hurtful or insulting behaviour toward older people, whilst the most severe form may give rise to active and serious abuse (Hayes 1993; Quinn and Tomita 1997).

The commonly held beliefs about older people, and the generally negative value judgements attributed to them that constitute an ageist view, may create and reinforce fear and denigration of the ageing process among individuals (Faculty of Old Age Psychiatry 2006; Carruthers and Ormondroyd 2009), leading to a belief that older people lack competence and are in need of protection (Stratton and Tadd

2005). They may consequently be labelled as “vulnerable”, argued by Brown and Seden (2003) to be counterproductive in that it implies that abuse arises out of the person’s age and associated impairments rather than the characteristics of the abuser or the society in which they are embedded.

3.5.3. Tentative Theories on Ageist Views

There is a range of theories why ageism occurs at individual and societal levels, exerting powerful influences upon beliefs, value formation and thereby attitudes and behaviour. For example, some scholars offer that Western society positively values and emphasises youth, beauty, sexuality, health, economic productivity, wealth and prosperity, while older people are portrayed negatively or largely subordinated and ignored (Shemmings 1998: 157; Fahey 2003: 38; Featherstone and Hepworth 2005: 356). The popular perception is that older people no longer possess these attributes that are positively valued by society. As Kosberg (1998) offers, personal hedonism is a contributory factor to the occurrence of abuse of older people. Whilst children and younger people are viewed as integral to the future of society, older people are viewed as a burden upon it (Thane 2000; Eastman and Harris 2004; Stevenson 2008). Mathew and Russell (2005) assert that once older people are seen as a burden upon society it is easy to exclude ‘them’ from the circle of people about whom ‘we’ should care, and this serves to further diminish their humanity. Neuberger *et al.* (2003: 37) maintain that these negative views form, in part, as a result of the biologically based need amongst all human beings to live in effective groups, and that less able and competent people, such as the old, are stigmatised as non-contributors to the general good of society.

Similarly, potential vulnerability and need often accompanying old age are often actively perceived as weaknesses that are viewed with mockery and hatred (Terry 1997; Phelan 2008; Galpin 2012). As Thomas (1977: 273) noted,

“...there is hostility towards those who have opted out [as it may be perceived] of the economic process and a reluctance to devote much of society’s resources to their maintenance.”.

These stereotypical views of older people as unproductive and burdensome among society are also noted by Glendenning (1997c: 6), Biggs (1997:77) and Ambache (1997: 216) as particularly relevant to formal modes of care provision. It has been suggested that older people in long-term care represent the ultimate insult through their constant presence as a reminder of inevitable dependency and decline into vulnerability and death that we must all face, and this may give rise to avoidance and marginalisation of them (Mollon 2000; Lafontaine 2009).

As Butler (1969: 243) offers:

“Ageism reflects a deep seated uneasiness on the part of the young and middle-aged, a personal revulsion to and distaste for growing old, disease, disability; and a fear of powerlessness, ‘uselessness’, and death”.

Notable to the context of private sector care homes where 38.4% of care staff are aged between 18 and 29 (Skills for Care 2012: 19), are the assertions of Butler and

Lewis (1987), supported by Traxler (1980), that ageism allows younger people to see older people as different from themselves.

3.5.4. Enduring Negative Views of Ageing

Disquiet about the potential 'burden' of an ageing population is a long-standing phenomenon, identifiable in England in the seventeenth century (Thomas 1977: 242), and manifest in post Second World War Britain (Royal Commission on Population 1949:121). There is certainly evidence that age discrimination is still present, widespread and entrenched within the health and social care system of England (Department of Health 2007; Centre for Policy on Ageing 2009; Carruthers and Ormondroyd 2009: 6; Wild *et al.* 2010a: 27). Bowers *et al.* (2009: 7) have also confirmed from their research that ageism and stigma associated with old age and a consequent perceived need for support also remain rife in the perceptions of older people themselves.

Governmental policy has also continued to emphasise a growing older population of the United Kingdom as a social problem requiring action as a result of an increasing demand upon health, social and financial institutions, leading to 'far reaching consequences', 'unsustainable dependency ratios' and a 'silver tsunami' (Department of Health 2001; Wanless *et al.* 2006; Department of Works and Pensions 2008; Bagley *et al.* 2011; Commission on Funding of Care and Support 2011; Davies 2010). Expression of such views ostensibly at national, governmental level may serve to influence the beliefs, value formation, attitudes and subsequent behaviours among those who are not old, though they may not always be conscious

of them; for example, though only two percent of a representative sample in research conducted by Abrams and Houston (2006: 34) expressed negative feelings about people aged over 70, 26% of the same sample who were over 70 reported they were victims of discrimination on the basis of their age. Gilkeard and Higgs (2013) argue that perceptions of 'old age' [sic] based upon chronological age are altering, and older people are no longer so widely perceived as dependent upon society and viewed with prejudice. However, Gilkeard and Higgs (2013) also point out that these changing perceptions have led to a conceptualisation of a 'fourth age' of life, relating to the *very old*, characterised by the dependency and illness previously associated with older people in general. It is these 'older old' people who make up a significant and ever increasing proportion of older people in care homes (Wittenberg *et al.* 2010). Therefore, the moral dilemma about the costs and practicalities of caring for an increasing population of older people in England is likely to focus more intensively on the 'oldest old', generating conditions that allow ageism to persist, as suggested by Thane (2000), and abuse to occur and remain unchallenged.

3.5.5. The Continuing Discourse on Ageing

The 'oldest old' proportion of the population, those over the age of eighty years, is the fastest growing (Kinsella 2005). Life expectancy continues to increase and is currently predicted to reach 120 years by 2050 as a result of medical and socioeconomic changes (Freund *et al.* 2009). Older people are living longer as a result of changes in their lifestyles largely occurring in the late twentieth and early years of the twenty first century, with greater emphasis being placed on dietary modifications, exercise, and positive social activities (Depp *et al.* 2010). Rowe and Kahn (1998), for example, determined from a ten-year longitudinal study that lifestyle

influences how people age both physically and mentally, and that decline in old age is not necessarily inevitable, particularly given the many opportunities and freedoms it can bring. Marmot *et al.* (2003) further point out from the English Longitudinal Study of Ageing (ELSA) a marked variability in older peoples physical and mental functioning, and their health, social and economic circumstances as they age. Marmot and Breeze (2008) subsequently illustrate the myth that older people are uniformly characterised by decline and increased dependency, referring again to evidence from their longitudinal research that revealed many vigorous and active old and very old people. Schaie (1990: 302) similarly found empirical evidence from a longitudinal study that cognitive decline among older people, a characteristic that leads many to reside in care homes where they may be at risk of abuse, is not always inevitable, and when it has occurred it is largely reversible in around 40% of cases.

Some scholars also criticise the view of ageism as all pervasive within society, arguing that people who are not old are generally kind and helpful toward older people and do not necessarily hold negative attitudes and stereotypical views toward them (Cole 1992; Abrams and Houston 2006). Abrams and Houston (2006:27) argue that there is nothing morally wrong, for example, with those that are not old disliking the physical and cognitive declines accompanying old age, or with regretting the death of a younger person more than that of an older person. Brown and Draper (2003) suggest that most examples of age discriminatory behaviour are matters of thoughtlessness and incorrect assumptions about older people, reflecting those of wider society. Such a view perhaps contradicts the belief that ageism is a deeply rooted and intractable prejudice, but it remains that care organisations and their staff

may be behaving in ways that they do not recognise as discriminatory and are perpetrating abuse as a consequence.

Earlier scholars of age related fields have also identified that increased dependency and consequent burdensomeness are not inevitable consequences of advanced age (Townsend: 1981; Phillipson 1982; Walker 1986). Townsend in particular (1981; 1986) developed the view that dependency of older people is socially constructed. Townsend identifies the denial of rights to self-determination through institutionalised ageism, and the consequent structured dependency that arises as a result of institutional care, along with other major factors, such as forced retirement, that cement the dependent [sic] status of older people within society. Biggs (1997: 79) offers that social policy focuses predominantly upon the dependencies and vulnerabilities of a minority, and that though this focus is valid for some, the minority comes to represent the experiences of the majority of the ageing population to influence both policy formulation and public attitudes.

Some academics argue that these negative perceptions of older people may be internalised and adopted by older people themselves, resulting in lowered expectations, self-esteem, shame and depression (Harbison 2000; Harris and Benson 2006; Ray, Sharp and Abrams 2006; Vanlaere and Gastmans 2007), and feelings of helplessness, oppression and powerlessness (Bytheway 1990; Scourfield 2007). In turn, older people may be actually encouraged to embrace dependency (Sargeant 1999; Langer 2009) exacerbated by professional-client relationships of care that are dependency creating as undue power is vested with the professional (Oliver 1990; 2013). These processes of internalisation may be further fostered

among older people through their political representation as burdens upon society (Walker 1990; Bowers et al 2011). As such the label of 'vulnerability' conceivably diverts attention from the perpetrators of abuse, whether as individuals or within institutions, in a society that oppresses, exploits and objectifies its older population as a result of pervasive ageist assumptions (Biggs 1997: 75).

Biggs et al (1995: 84) maintain that "Beginning to see elders as objects rather than human is the foundation on which a continuum of petty slights and abuses build into active mistreatment" and that the older person is placed symbolically outside normal "...categories of belonging..." that otherwise dictate normal social behaviour (Biggs et al 1995: 30). Others assert that as a consequence staff who are employed to care may unconsciously bring with them to their work these negative images of older people and of old age (Evans 1998; Garner and Ardern 1998), subsequently regarding them as "other", separated from them by time, failing to see the common humanity between them (Falconer and O'Neill 2007).

Ageing is, however, increasingly viewed by many as a period of development and activity rather than decline (Commission for Healthcare Audit and Inspection 2006; Blood 2010) when older people share similar aspirations to younger people in (retaining) autonomy and independence, choice and control, irrespective of poor health or limited mobility (Harding 1999: 43, 44; Her Majesty's Government 2005: 3). Harbison (2000: 293) points out that ageing is being reconstructed to "...remove the legitimisation of dependency for older people" and Latimer et al (2011: 13/14) offer that ageing is now viewed as a "...treatable pathology..." that is not necessarily inevitable or intractable. Bowers et al (2011: 20) have determined through action

research that older people themselves, including those with high care needs, desire to continue to contribute to society and be seen as active citizens with rights, roles and responsibilities. Government (Her Majesty's Government 2009) similarly determined that the majority of older people would like to continue working in some capacity beyond attainment of state pensionable age and, ironically, there is research to suggest that retiring later in life may delay the onset of dementia (Lupton et al 2010). Macnicol (2015), however, challenges the objectivity of governments assertions, suggesting that they represent an ideology of neoliberalisation of old age and retirement, removing there 'protected' stages of life and encouraging (or forcing) people to work later in life.

Nonetheless, the changes that occur in the capabilities, physical and mental health, and cognitive functioning in older age are variable, with some remaining active in the tenth decade of life, with others frail at seventy (Munk 2010). However, the tendency towards smaller family sizes, increases in family break ups and divorce, and greater social mobility amongst the young, for example, to secure particular employment or educational opportunities, suggest that older people are more likely to experience isolation, depression and an increased reliance upon paid care providers for help with physical and psychological needs (Gray 2009; Terrion and Lagace 2008). As a consequence, those people who become the 'oldest old' within society and experience more complex and multiple, chronic physical and psychological illnesses are more likely to be admitted to care homes (Hillman and Stricker 2002).

Though perceptions of old age are altering, the term 'old age' has, and continues to be, socially constructed through interactions, language and media influences upon

the population (Burr 2003; Degnen 2007). As Warren (1998: 297) puts it, "...the ageing body is seen as a cultural icon of decline and helplessness" and discourses that portray the bodily changes of old age are socially constructed in mostly negative terms in western societies (Warren 1998; Twigg 2004). This iconology however, continues to change and old age is increasingly coming to be conceptualised as an enjoyable period of activity and creativity with opportunities for self-actualisation; opportunities that were perhaps unattainable in earlier years that were dominated by childcare and career aspirations, and perhaps caring for ageing parents (Katz 2000).

3.6. Conclusions

This chapter has reviewed the literature concerning the particular definitional issues applicable to abuse in care homes, and specific considerations that need to be taken into account when defining and responding to abuse in these settings. However, it is clear that inadequate conceptualisations of abuse in care homes continue to constrain understanding of its causes. What little is known about the prevalence and incidence of abuse in care homes, again in part because of inconsistencies around defining abuse, has then been presented. The review has shown that though there have been recent attempts to address a lack of prevalence data on abuse in care homes (and elsewhere) to gauge the extent of the problem, there remains a lack of clarity about what constitutes 'abuse carried out in a care home' and what constitutes embedded 'institutional abuse'. This restricts the effectiveness of current adult protection responses.

The inadequacies of any single current theoretical explanations for why abuse occurs, particularly in care homes, have been discussed, confirming a need for more

complex, multi-dimensional understanding and explanations of abuse in these establishments. The literature reviewed suggests that staff perceptions of older residents and the potential ineffectiveness of staff training may contribute to the occurrence of abuse. The nature of the work of caring for older people in care homes and its role as an additional contributory factor in abuse has been visited, as have the potential implications of stereotypes, prejudice and stigma towards older people for the occurrence of abuse.

The next chapter describes research design, methods used, and principles of data analysis.

4. Research Design and Methods

4.1. Introduction

This chapter presents the rationale for research design and the research questions it addresses, determining the choice of cross-sectional design over longitudinal design. It also sets out all elements of the research method, including the underlying principle for adopting a mixed-methods approach to secure both qualitative and quantitative data to provide a more comprehensive account of the area of enquiry by virtue of the mutual explanatory powers of methods used.

4.2. Research Rationale

The literature review suggests that the causes of abuse of older people, wherever it occurs, are complex, arising from the individual, social and, if applicable, organisational circumstances of the person who is abused, and of the perpetrator of abuse. The literature has identified how the difficulty in developing definitions of abuse has contributed to limited knowledge of the prevalence and incidence of abuse in care homes. It has also emerged that existing theoretical explanations of abuse have only limited capacity to explicate this form of abuse, though the review reveals that staffs' perceptions of residents and the apparent limited effectiveness of extensive training, potentially coloured by stereotypes and prejudice among individual staff members and within society, are possible contributory factors. Among these factors can be found characteristics that resonate with the range of theoretical models of abuse described in the preceding chapter, but no wholly adequate

theoretical explanation for this kind of abuse has yet been identified. It is also apparent from the literature that current approaches to adult protection and regulation applied to care homes are ineffective as they are failing to address the conditions that permit abuse to occur.

Post *et al.* (2010) assert that to understand and therefore help counter the causes of abuse in both domestic and institutional settings, a considerable strengthening of the research effort is required, specifically to inform subsequent policy development. As identified in the literature review, scholars have recognized a dearth of research into the origins of abuse exclusively within institutions, including care homes, (Bennett and Kingston 1993: 126; Glendenning 1997a: 40; Glendenning 1999b: 186; Ambache 1997: 218; Bonnie and Wallace 2003: 4; Manthorpe *et al.* 2005: 20; Cambridge *et al.* 2006: 4), and this is reflected in the absence of satisfactory theoretical explanations of why abuse occurs in these facilities. As both Lee Treweek (1996: 116) and Bowers *et al.* (2009: 10) suggest following their own research experiences, the paucity of research in care homes reflects difficulties experienced when attempting to engage with the industry as a result of suspicions around the motives and outcomes of research among care home owners and managers.

As a result, there is limited knowledge and understanding of the nature and extent of the underlying causes of abuse, reflected in both current policy and practice. This is arguably especially true of the abuse of older people who live in care homes where very little empirical research has been conducted, particularly within the for-profit sector. The aim of the research is to achieve a greater depth of understanding of both agentic and organisational determinants of abuse within these homes.

Accordingly, the overarching research question is:

Why do older people living in care homes continue to be abused despite national safeguarding policy in place since 2000?

This enquiry also addresses the following three sub-questions:

What is the extent and nature of abuse of older people in contemporary care homes?

How do attitudes, relationships and behaviours within the care setting contribute to or prevent the occurrence of abuse?

What other aspects of the care provision process and the care home context contribute to or prevent the occurrence of abuse?

4.3. Philosophical Orientation

In designing research to address these questions, I adopted a pragmatic paradigm that is the overarching framework for the mixed-methods approach I used (Tashakkori and Teddlie 2003; Creswell 2003; Denscombe 2010). The pragmatic paradigm linked my choice of research methods directly to the purpose of my intended research questions in a way that offered the best chance of obtaining useful answers, rather than as a result of a particular philosophical epistemological allegiance to either positivism (quantitative) or interpretivism (qualitative) (Creswell 2003; Johnson and Onwuegbuzie 2004; Becker and Bryman 2004; Wooley 2009;

Denscombe 2010). As Darlington and Scott (2002) suggest, a greater number of decisions on whether to take a qualitative or quantitative approach to research are based not on particular philosophical beliefs, but on the design and methodology identified to be best suited to the purpose of the research. My research consequently collected data simultaneously using instruments drawn from both qualitative and quantitative traditions to inform the stated research questions, and rejected a need for a forced choice between paradigms. As Teddlie and Tashakkori assert (2003: 19) "...the incompatibility thesis [between qualitative and quantitative philosophies] has now been largely discredited..." and Bryman (2006a: 114), has determined evidence that the relevance of philosophical paradigm positions among practising researchers using mixed methods is minimal.

Tashakkori and Teddlie (2003) and Hesse-Biber and Leavy (2008) have also asserted that mixed methods approaches hold advantage over mono-method approaches in that they can answer simultaneously exploratory and confirmatory questions, and provide stronger data through depth and breadth of responses about complex social phenomena. My research was both in part exploratory and confirmatory, seeking to explore agentic and organisational features to construct substantive theory regarding what factors contribute to abuse, and establish confirmation in numerical terms of its current extent, in private sector care homes. Further, Bryman (2006b: 106) suggests that mixed methods offer the facets of "completeness" and "explanation" to research (among other dimensions), giving a more comprehensive account of the area of enquiry by virtue of the mutual explanatory powers of methods used. Additionally, Gorard and Taylor (2004: 7) maintain of a mixed method approach that because "...figures can be very

persuasive to policy-makers whereas stories are more easily remembered and repeated by them for illustrative purposes”, they often have a greater impact. Jewell and Bero (2008: 190) support this assertion, commenting upon the “power of anecdotes”, particularly pertinent given the intended policy influencing nature of my research, and supported by the assertions of other scholars of the view that there is a growing acknowledgement that complex social problems can be usefully understood by scrutiny of them by both qualitative and quantitative means (Rossman and Wilson 1994: 315; Morgan 2007: 49).

Consequently, the combined methods of a predominantly quantitative data gathering anonymous, postal questionnaire, and a qualitative data gathering semi-structured interview, were designed to be “... mutually illuminating, producing findings greater than the sum of the parts” (Wooley 2009: 7). As Wooley (2009: 8) asserts, though mixed methods are not necessarily mutually validatory, they are certainly “complementary”, combining the strengths of each method to address different aspects of the research enquiry. They thereby reduce the impacts of weaknesses of both methods when used in isolation (Johnson and Onwuegbuzie 2004: 14), increasing the amount of evidence available to the researcher (Gorard and Taylor 2004: 9). Each method I used sought to gather data on aspects of the same substantive issue, combating, to a degree, the possible charge of anecdotalism often directed toward qualitative methods as a result of limited quantification (Bryman 2004: 448).

4.4. Research Design

The purpose of this research was to inform future policy development by exploring why the abuse of older people in care homes endures from the largely previously unexplored perspectives of the people involved in providing care in private sector care homes. It was therefore envisaged primarily as theory building or inductive in nature, in that research would be conducted without preconceptions of existing theory, which is in any case severely limited with regard to the factors that may lead to abuse of older people in care homes. From the data collected it would be possible to generate concepts and subsequently new substantive theory, that is theory applicable to a specific delimited area (Becker and Bryman 2004; Corbin and Strauss 2008; O'Reilly 2009; de Vaus 2010; Denscombe 2010), as to why abuse occurs in care homes. In turn, this theory would contribute to improving the efficacy of current English safeguarding policy, particularly with the aim of achieving a preventative focus. The research was therefore considered to be “policy research” concerned with establishing knowledge primarily for action and improvement (Hakim 2000: 4; Becker and Bryman 2004: 14) by focussing attention upon pertinent individuals and the organisation in which they work as units of analysis (Hakim 2000: 113), and determining factors that contribute to the occurrence of abuse (de Vaus: 2010: 19).

The principal consideration when identifying research design was necessarily practicality, given I would be conducting the research as sole researcher on a part-time basis whilst in full-time employment. Though a qualitative longitudinal design was considered particularly suitable to achieve understanding of

“...individual/collective agency and structural determinants” (Holland *et al.* 2006: 19) this was discarded because of impracticality in terms of the time required to conduct the research over a protracted period.

Subsequently, a qualitative cross-sectional design was identified as achievable. Having no time dimension, such a design would yield results that are a reflection of any characteristics among research participants at a given point in time, rather than of change over time or causal direction as might be achieved using a longitudinal design (Bryman 2004: 45; deVaus 2010: 176). Similarly, trajectories of participants, for example, staff who perpetrate abuse, would more likely be elucidated by virtue of protracted engagement with them when using a longitudinal design (Thomson and Holland 2003). Nonetheless, the cross-sectional design would be able identify differences in both dependent and independent variables at one point in time, in this case, for example, attitudes and behaviours of staff (an independent variable) and their role in contributing to the occurrence of abuse (a dependent variable), should they elect to reveal these during interviews or when responding to questionnaires (Bryman 2004: 41). Further, because concepts and substantive theory would emerge inductively from the data, there was likely to be good correspondence between data and concepts conferring internal validity to my study (Bryman and Becker 2004: 250).

Though limitations of lack of temporal order and causal direction arising from an absence of a temporal dimension can be overcome to a degree by repeated cross-sectional studies (de Vaus 2010:173), this was not a realistic option for my research given time and resource constraints. Further, a general mobility among care staff

moving between homes, and in and out of the sector, for example (Skills for Care 2012), would likely prevent in many cases the same actors from being subjects of repeated cross-sectional studies.

4.5. Research Method: Semi-structured Interviews

Within care homes older people have daily contact with the care staff employed to care for them directly. They are also likely to have contact, though probably to a lesser degree, with the care manager of the home. Again, to an even lesser extent, older people may have some contact with the owner of the home, unless the owner also fulfils the role of care manager, as may be the case in some smaller homes. Owners and care managers will also influence the conduct of all other people within the care home, for example, cleaning and catering staff, and visitors, through their presence, methods of management, and the content and implementation of organisational policies and procedures. Consequently, these three groups of people, care home owners, managers and care staff, will have degrees of influence and control over the daily lives (including throughout the night), of the older people in their care, and be a rich source of data concerning agency and ecology within the care home to inform my research. These groups of participants were therefore chosen for their ability to “...contribute to evolving theory...” (Creswell 1998: 118). As Hughes and Wearing suggest (2007), in order to understand organisational practices different sources of knowledge and levels of experience must be considered, and as Dewing (2009: 227) points out, there is in particular a notable dearth of research within care homes that represents the perspectives of care staff.

There is no doubt that the residents in care homes could also have been a source of data that may have similarly informed research objectives. However, discussion with university supervisors and local government officers responsible for granting ethical approval (the latter organisation being my employer)¹¹, concluded that doing so presented challenges that were difficult to overcome given the time and resources available to me. These challenges were centred around possible distress that might be caused to residents, some of who may be considered at risk of abuse, the dilemma that may arise upon disclosure of abuse experienced by a respondent, and the significant issues of reliably assessing cognitive abilities of residents who might participate. Issues of securing informed consent from older people who may have cognitive difficulties were also salient and prohibitive in the context of this study conducted by me as a lone doctoral researcher. However, hearing the voices of older residents in care homes is a valuable means of further understanding the causes of abuse, and this does need to be the focus of future research.

My research therefore sought to gather data from the point of view of care staff, their managers, and the owners of care homes; an exploration of this semi-public world from their perspectives, using the cross-sectional design identified above. Consequently, a qualitative, semi-structured, face-to face interview method was considered to be appropriate to determine interviewees' unique and multiple perspectives (Bryman 2004: 319; Corbin and Strauss 2008: 8). Though the use of focus groups or group interviews was also considered, I believed that these were not the most appropriate methods to encourage participants to talk of their own beliefs

¹¹ It was later determined that ethical approval was not required from the local authority as my employer because people who resided in care homes were not participating in the research.

and experiences relating to the emotive subject of abuse, particularly any they had witnessed, or even perhaps perpetrated. Though these methods have the advantage of saving time, and could perhaps stimulate useful discussion between participants to yield valuable perspectives (Bryman 2004: 346), I was concerned that they might constrain honesty and frankness among respondents. Further, participation by care home proprietors in particular in focus groups or group interviews may have been more difficult to secure given that they are competitors in the same market.

Interviews with each of the three categories of respondent followed a schedule of very similar open-ended questions, with a small number of differences arising as a result of perceived differences in organisational roles (see appendices 1, 2 and 3). Both the questions employed and the perceived differences applicable to each interviewee type were based, in part, upon my personal perceptions, though these perceptions arose from 30 years of experience working on and managing hospital wards and for-profit nursing homes (as a qualified nurse), and in commissioning care home services for local government. Further insights to contribute to question formulation arose from fifteen years of participation in local authority safeguarding responses to allegations of abuse in care homes. Research questions were also influenced to a degree by the additional knowledge yielded by the literature review, and were intended to act as initial probes to ensure that the same broad topic areas were explored with all respondents.

Participants were given choice as to where they would prefer their interviews to be conducted, but were advised that privacy and the absence of disturbance would ideally be required; all but one participant opted to be interviewed in the care home

they owned or in which they worked. The one exception elected to be interviewed in my office. Participants were made aware prior to and immediately before the interview commenced that their involvement was voluntary and they could decline to answer any question or could end the interview at any time. They were also advised that their identity would be kept anonymous during recording, analysis and reporting. Each participant was given an information sheet prior to the interview to explain this, and the purpose of the research and its potential positive contribution to preventing abuse in care homes (see appendix 4). All participants were asked to sign their affirmation of consent to participating in this research (see appendix 5).

Interviews were conducted between December 2011 and July 2013, lasting on average one hour and ten minutes.; in total over 42 hours of interviews were conducted with 36 participants. With respondents' consent, dialogues were recorded in full using a digital voice recorder, allowing intonation and emphasis within verbal responses to be considered during transcription (Bryman 2004; Denscombe 2010). This method also allowed me to concentrate particularly upon the interview dynamic itself rather than on the manual recording of responses, and facilitated later transcription. Digitally stored responses were rendered anonymous at the time of recording by entering an alpha-numeric code to identify each participant prior to commencement of the interview. That code was used to identify subsequent transcriptions, segments of data, and verbatim responses presented in data analysis and discussion.

4.6. Research Method: Anonymous Postal Questionnaires

However, as confirmed by both the literature review and my own experience, the abuse of older people in care homes is often covert, remaining hidden or obscured within the partially closed care home environment. Admitting knowledge of abuse during a research interview might be construed as a reflection of both personal and organisational failings that amount to admissions of complicity or guilt. In some cases, such admissions may also confirm commission of, or complicity with criminal acts. Even in cases where abuse may be inadvertent, there remains a barrier to veracity, as to admit awareness of inadequate knowledge or skill, or the occurrence of errors, remains an admission of shortcomings on the part of individuals and, in some instances, the organisation.

Consequently, it was possible that research subjects, and perhaps care staff in particular (in this research) as they delivered the majority of hands-on personal care, might provide unreliable, misleading information concerning any abuse of which they might be aware. They might tell me what they believed I wanted to hear (Mitchell and Jolley 2009: 213), or what they thought I ought to hear (Becker 1970:104; Murphy *et al.* 1998:18), termed “socially desirable responding” by Booth-Kewley *et al.* (2007: 465). This they might do to avoid conveying a negative image of their work performance and the organisation that employed them. That is, respondents might differ on the variable of whether or not they offer ‘real’ or ‘false’ responses, and this variable would influence research outcomes (Anderton *et al.* 1980; Pearl 2000). A confounding variable would thus be potentially introduced, though Bennett and

Kingston (1993: 135) have suggested that admitting to abuse can actually be a beneficial cathartic experience.

To mitigate the effect of this potentially confounding variable I devised a self-completion questionnaire, requiring responses that could be predominantly quantified, to assemble data from the care staff of newly opened care homes for older people (see appendix 6). The questionnaire was designed, however, also to provide additional qualitative data based upon the experiences of those completing it. As a social care commissioner I anticipated knowledge of where these new care home developments might occur within the West Midlands during the period of my research.

A unique feature of this method was that I constructed the questionnaire to be completed by newly appointed care staff in the period immediately prior to their active duty commencing, or during induction with their new employer. Many of these newly employed care staff were likely to have been working as care staff in their previous posts, and the questionnaire sought responses about their experiences whilst working in their previous care homes. Moreover, respondents were asked to complete the questionnaire anonymously, with neither personal details nor details of previous employing care home required, and to return it directly by post to me using a postage paid envelope supplied. An explanatory information sheet about the purposes of the research, including the categorisation of types of abuse, was appended to each questionnaire (see appendix 7). This method was intended to overcome any fear of consequences that might otherwise be present among care staff who were aware of abuse in the homes in which they had worked, and that may

contribute to under-reporting. These consequences have been found to include victimisation, intimidation, ostracism, and reprisal from peers or superordinates, including loss of employment (Biggs *et al.* 1995; Heath 1996; Hudson Keller 1996; Eastman 1998; Jenkins *et al.* 2000; Garner and Evans 2000; Kitchen 2002; Taylor and Dodd 2003; Carvel 2009).

The anonymity of respondents also reduced the possibility that disgruntled staff might conceptualise completion of the questionnaire using spurious or exaggerated responses as a means of retribution against a former employer, manager or colleague who they found unsatisfactory. Similarly, anonymity of respondents was intended to allay any suspicion that may otherwise arise among the owners and managers that were asked to distribute and facilitate completion of questionnaires by their newly appointed staff. Care managers and proprietors who consented to the questionnaire being used among their staff were assured that it was not any practice within *their* care home that was under scrutiny. Further, by this method the anonymous questionnaire responses would not be influenced by any incidental interpersonal dynamics, the 'interviewer effect' (Holstein and Gubrium 2004; Gillham 2005), unlike the face-to-face interview method, and were considered to be less susceptible to the likelihood of respondent fatigue than the semi-structured interviews (Bryman 2004).

4.7. Facilitating Triangulation

The use of two methods also ensured a means of triangulation of research evidence, defined as facilitating comparison of two or more sets of data secured concurrently by different methods from different, but related sources, to gain a more complete understanding (Webb *et al.* 1966; Denzin 1970; Mays and Pope 2000; Bryman 2004; Hoffman 2007; Denscombe 2010). Both Bryman (2006b) and Creswell and Plano Clark (2007) maintain that triangulation may itself be considered a design type of mixed methods research, characterised by concurrent collection of qualitative and quantitative data, with equal weight given to each and integrated during analysis and interpretation stages.

As Firestone (1987: 20) asserts:

“Used separately, qualitative and quantitative studies provide different kinds of information. When focussed on the same issue, qualitative and quantitative studies can triangulate – that is, use different methods to assess the robustness or stability of findings”

However, because my research drew upon the knowledge and experiences of a significant number of interview respondents (n=36) from the three groups comprising care home proprietors, managers and care staff, each having different experiences and perceptions, and employed grounded theory techniques of data analysis to construct theory grounded in the data, I maintain that bias was in any case reduced. Nonetheless, I envisaged that triangulation would confer enhanced validity and

reliability upon my research, whilst reducing any bias that might have arisen from the subjective nature of interview responses (Gorard and Taylor 2004: 43; Bryman 2006b: 106; Denscombe 2010: 141). Such responses might otherwise be considered to inform my research only from "...someone's point of view..." (Becker 1967: 245) and might exhibit, according to Weber (1949: 90), "...one sided accentuation of aspects of reality..." as a result of each respondent's own experiences and interpretations of those experiences. I anticipated that the occurrence of such bias might arise as a result of the sensitive nature of the abuse of older people that would be discussed during interviews.

Greene *et al.* (1989: 259) also support the triangulatory and complementary nature of mixed method designs, and add that they may also function not only by "expansion", extending the breadth and range of enquiry, but also by "initiation", in discovering paradox and contradiction, new perspectives, and the "...recasting of questions or results from one method with questions or results from the other method". As Sechrest and Sedani (1995: 4) claim, "...methodological pluralism is an absolutely necessary strategy in the face of overwhelming cognitive limitations and biases inherent in human mental processing and responding". In my research, I intended to achieve an unprecedented exploration and understanding of individuals' perspectives and experiences of abuse, and the interplay between structural and organisational factors and agency of the care home that led to its occurrence (after Wooley 2009).

4.8. Ethical Considerations

The research engaged respondents in enquiry about the subject of abuse of older people that may affect them by generating powerful emotions during recall and discussion when interviewed. There was consequently potential for participants to suffer some detriment as a result of participation, yet this was balanced against the possible benefits in that findings might inform policy to prevent and respond to the abuse of older people in care homes.

In considering this ethical dilemma, I adopted a principle based approach to ethical conduct in accord with that espoused by Beauchamp and Childless (2001), giving consideration to the following principles:

- Respect for Autonomy: Participants must be free to make their own informed decisions about engaging in the research process, particularly with respect to consent and confidentiality.
- Non-maleficence: Research must not cause harm.
- Beneficence: Research should benefit others.

To ensure respect for autonomy potential interview participants were provided with an information sheet explaining the subject of, and reasons for research enquiry, that their participation was voluntary, and that they could withdraw from the interview process at any time without giving a reason, and without fear of any consequences.

To inform consideration of consent the information sheet assured potential participants that their responses would be kept anonymous in the resulting thesis, and any subsequent publications arising from the research, and that any data provided would always be treated confidentially. Respondents were able to choose whether their responses were digitally recorded or written down, but were assured that in either mode their identity would be protected by assigning to their responses an alpha-numeric code. I was present to provide additional explanation if required at the point formal consent was secured, and contact details of both I and my academic supervisors were also provided should any potential or actual participant require additional information.

However, because of the nature of this research, participants were also advised that should they reveal abuse of any individuals who could be identified, then this information would need to be referred to the appropriate public agency for scrutiny. Each participant was required to sign affirmation of their understanding of the nature of the research, their anonymity, and confidentiality of recorded and transcribed data, and thereby give consent prior to each interview commencing.

The subject of abuse of older people is one that might raise distressing issues and possibly recollections and experiences that respondents might find upsetting. Yet the principle of non-maleficence requires that research does not cause harm to those that participate in it. The right to withdraw consent at any time during the interview process stated above accorded with this principle, and, in addition, participants were advised that I could provide access to professional counselling if that was required. If

participants became perceptibly distressed during the interview process, the interview was stopped and they were given the opportunity to end the dialogue.

The principle of beneficence asserts that the research should benefit others and this principle is the foundation for my research. Potential respondents were advised in the information they received when considering their consent that although no tangible personal reward would result from participation, benefits would likely arise for society and the care home industry. These potential benefits were couched in terms of positive changes to existing social policy towards preventing abuse of older people as a consequence of the research to which they had contributed. Ethical approval for this research was granted by the University of Birmingham on 4th August 2011(Appendix 8).

4.9. Designing Research Questions

As Lofland and Lofland (1995: 78) suggest, when devising research questions the researcher must ask, “Just what about this thing is puzzling you?” The cardinal question for the genesis of this study being, why, after twenty-one years of formal government policy ostensibly to address the abuse of older people, over thirty years of regulation prescribed by statute (in respect of care homes), and twenty-one years of degrees of control exerted over care homes by local authorities by means of contracts, does the abuse of older people in care homes persist? The questions within the semi-structured interview questionnaire and anonymous postal questionnaire were intended to explore this overarching enquiry.

Scholars suggest that research analyses of organisational practices and cultures may occur at three levels of human experience: the micro-, meso- and macro-levels (Brueggemann 1996; Wodarski and Dziegielewski 2002; Hughes and Wearing 2007). The micro-level refers to characteristics and behaviours of the agent or groups of agents, the meso-level to the features and processes existing and utilised to achieve identified organisational outcomes, and the macro-level to the organisational purpose that guide practice at both meso- and micro- levels. Though the policy driven, regulated and contractual, market based nature of the for-profit care homes' environment, in theory, effectively prescribes meso- and macro-level activity to a significant degree, owners, managers and care staff would be likely to provide responses located within the boundaries of these three levels of analysis. The questions devised for my research therefore sought to elucidate individual perceptions, beliefs, behaviours and experiences influencing everyday working practice at micro-level that might serve to prevent or precipitate abuse, whilst also exploring meso- and macro-level influences upon agentic behaviour.

Questions were designed to encourage participants to express how they experienced and perceived both their complex social world and its influences upon them as people who are paid to provide care to others, and, in particular, that part of it in which they worked, engaging with the people entrusted to their care. There was thus an acknowledgement that during the interview component of the research there might be significant departures from the question schedule, but this could well be desirable in exploring facets of experience, and perceptions not previously considered by me. As Hand (2003: 17) asserts, this leads the interview itself to become a site of knowledge construction.

Questions I devised for the interviews were consequently open questions, avoiding leading questions and allowing responses to be generated by the interview subject (Dunne *et al.* 2005: 32) to "...reveal the full richness and complexity..." (Denscombe 2010: 165), of respondents' perceptions, and elucidating subjective meanings relevant to research enquiry (Holstein and Gubrium 2004: 144). The intention of the question formulation was to establish general areas of enquiry to elicit responses, while I might also stimulate and explore particular veins of interest relevant to the purpose of my research overall. Similarly, it was anticipated that respondents were likely to direct the course of the interview to a greater degree, moving into unanticipated areas of exploration, and that this would increase the depth of data collected (Denzin and Lincoln 2000).

The semi-structured interview design was intended to facilitate a more "active interview" approach wherein respondents would have opportunities to explore and explain what they perceive to be important to them (Holstein and Gubrium 2004: 140; Charmaz 2006: 29; Corbin and Strauss 2008:153). The interviews were viewed as a social interaction, a two way "sense and meaning making" process, rather than a mechanical, detached means of extracting information, viewing the respondent simply as a "...vessel of answers..." (Holstein and Gubrium 2004: 144). The interview would then, "...seek qualitative knowledge of specific situations...and open, nuanced descriptions of the subjects' experience..." (Kvale 1996: 30), avoiding otherwise "...sterile description of organisational characteristics as categories of abstract variables instead of flesh and blood processes" (Minzberg 1979: 585). It was also considered that the semi-structured nature of the interviews might convey greater power to participants in terms of their influence on the direction in which the

interview proceeded (Mills *et al.* 2006; O'Connor 2001), thereby encouraging them to talk more liberally about what can be a sensitive subject.

4.10. Access to Research Sites

In order to carry out the selected research methodologies, access was needed to care homes that have been previously described in this work as semi-public environments, not necessarily amenable to external scrutiny. As a social care commissioner of twenty years standing I was able to negotiate access and entry to the settings I intended to research, which may be described as otherwise private and closed (Hammersley and Atkinson 1995; Lofland and Lofland 1995). An additional advantage was that by virtue of my experience working in health, social care and independent sector nursing homes, I was able to recognize the organisational mores of the people contributing to my research, understand the language and technical jargon of the industry, and could base findings upon comprehensive knowledge of cultural factors present within care homes (Garson 2008).

4.11: The Sample

The sample of care homes within which I conducted the qualitative interviews was drawn from private sector care homes located within four local authority areas with boundaries co-terminus to those of my 'home' local authority, and were determined because of geographical accessibility, given the interview research method. Using the GMIS (Getting Management Information Simply) satellite mapping system, care homes within a six-mile notional radius beyond the irregular boundary of the 'home'

authority were identified. Within this area 16 care homes in area 1, 8 in area 2, 8 in area 3 and 14 in area 4, along with the 58 care homes within the 'home' authority area, were identified. A letter was sent to all of these care homes explaining the nature and purpose of the research and requesting expressions of interest in participation. Twenty-eight care homes subsequently offered to take part, from which twelve homes were randomly selected ensuring representation from each local authority, two in each of areas 1 to 4, and four in the 'home' local authority area.

The sample of care homes in which the anonymous questionnaire was administered was determined by the chance opening of new care homes within any of the five local authority areas included in the study that became known to me during the period of the project. Consequently, the questionnaire was distributed to one new care home in area 1, two new care homes in area 4, and two in my 'home' authority area. Each home was initially contacted by telephone to determine their willingness to participate and subsequently visited in person by me to explain my research objectives and method, and deliver questionnaires, each having a participant information sheet providing rationale for the research appended to it.

The samples were then non-probability, purposive samples (Bryman 2004: 333), rather than random or probability samples, often held as the ideal sampling method (Verdugo 1998: 12; Becker 1998: 67; Bryman 2004: 87) wherein each unit of the population has an equal or known chance of being selected (Bryman 2004: 90; deVaus 2010: 79), and to which statistical analysis techniques may be reliably applied allowing findings to be generalised to entire populations (Brewer 2000: 7; deVaus 2010: 188). However, given an overall population of some 14,500 for-profit

care homes for older people dispersed throughout England, research enquiry based upon a probability sampling method was beyond the resources of my project. Nonetheless, the purposive samples I used were intended to ensure correspondence between research objectives and securing data from those people relevant to the research enquiry in a small range of care homes within the resources constraints of a lone researcher.

Moreover, the concept of generalisability as applied to quantitative research may be replaced with the concept of transferability in qualitative research (Borrego *et al.* 2009: 57). My research thus sought to generalise by depiction and analysis of specific context, placing the onus of identifying appropriate circumstances for transferability upon the reader (Freeman *et al.* 2009). It is the rich, “thick” description (Geertz 1973 cited in Charmaz 2006: 140) from the experiences of my research participants that ensures the trustworthiness of findings and their transferability to other contexts. As Gomm *et al.* (2000:99) maintain, it is quite legitimate for qualitative researchers to “...use part of something to stand for the whole.” Further, as Glaser and Strauss (1967) assert, multiple comparison groups, in this research, proprietors, managers and care staff, also lend credibility to the research. This view is supported by Corbin and Strauss (2008: 308) who maintain that if research findings are credible, in that they are plausible, applicable, and can readily be used because they provide insight, understanding, and work with diverse situations to bring about desired change, then the allied concepts of reliability and validity are superfluous philosophical debate because the researcher is not trying to *control* variables but to *discover* them.

In addition to 'transferability' Lincoln and Guba (1985) suggest 'credibility' as an alternative criterion to assess the quality of qualitative research. Lincoln and Guba maintain that credibility is whether a set of findings are believable, and cite triangulation of data from more than one sources, as in this research, as a means of achieving this.

4.12. Piloting the Research Instruments

The semi structured interview method was piloted with three care homes, and the anonymous questionnaire with one home, in accordance with the assertion of Bell (2006: 147) who states,

“All data gathering instruments should be piloted to test how long it takes recipients to complete them, to check that all questions and instructions are clear and to enable removal of any items which do not yield useable data”

I consequently determined a tendency among interviewees in response to the first question to provide lengthy and very detailed histories of how they came to be care home owners, care managers or, though to a lesser extent, care staff. However, this question was retained as it did yield some insights, particularly into relevant motivational factors and sources of stress within the care home, and perhaps more importantly, also appeared to enable respondents to relax during the initial stage of the interview process. As both Yow (2005: 87) and Corbin and Strauss (2008: 28) confirm, such introductory questions can help participants to relax, stimulate memory and encourage spontaneity. Similarly, by using this initial opportunity to engage with

respondents I was able to foster a degree of reciprocity and trust, improving the likelihood of securing reliable, telling data about a subject that is sometimes difficult and distressing for respondents to discuss. Nonetheless, I became aware of a potential need to constrain lengthy responses to this initial question by diplomatically urging the respondent to move on to the next question once the fundamental reasons for career histories and motivations were established.

Further, the pilot demonstrated that respondents' experiences of input from the police into allegations and occurrences of abuse were minimal (question 7 for proprietors, question 5 for care managers and care staff), though they reported engagement with other agencies, notably from a range of Primary Care Trust staff. Consequently, the question that was intended to explore this area was changed to include the Primary Care Trust, statutory care home regulator, the police or any other agency as possible sources of input, apart from the local authority that was the subject of the preceding question because of its role as lead, co-ordinating agency.

As Thomas (2005) notes, piloting questionnaires is particularly important given the researcher will not have a physical presence during the data gathering process. Accordingly, the anonymous questionnaire was piloted in a newly opened care home within my 'home' area during August 2010. Of thirty-five questionnaires issued to the care home, given the expected recruitment of this number of care staff, an "acceptable" return rate of 24(68.6%) questionnaires were achieved (Mangione 1995: 60). Returned questionnaires had been completed as expected and appeared to yield the intended information with a wealth of examples of abuse either witnessed or suspected by respondents.

4.13. Analysis of Questionnaire Data

Numerical data from the anonymous questionnaire are presented in Tables 5.1 to 5.8 of Chapter 5 as a univariate descriptive analysis expressing whole numbers or percentages of respondents describing or experiencing particular phenomena elucidated by the questions asked of them. Some examples of thematically grouped or isolated free text responses from the questionnaire are also provided in the analysis as illustrative of particular characteristics of staff experiences, attitudes and behaviours.

4.14. Analysis of Interview Data

Analysis of the face to face interview transcripts used some of the techniques characteristic of constructivist grounded theory methodology applicable to inductive research, and particularly suited to the analysis of qualitative interviewing (Charmaz 2006: 28; Charmaz 2009: 138). Using selected elements of grounded theory methodology has been stated to be legitimate by Charmaz (2006: 9), Corbin and Strauss (2008: 303) and Birks and Mills (2011: 29). Employing grounded theory methods allowed my research findings to surpass description and exploration, moving beyond concrete statements taken from the data to make analytic interpretations and develop theory (McNabb 2002: 302; Denscombe 2010: 280), in this research, theory to explain why older people in care homes are abused. Further, given the potential policy influencing nature of my research as iterated previously, grounded theory was deemed particularly effective to achieve "... a meaningful guide to action" (Strauss and Corbin 1998: 12).

It could not be claimed, however, that my research constituted a grounded theory study *per se* because it did not employ throughout the grounded theory techniques of theoretical sampling following the initial purposive sample (though the sample was preconceived as comprising three different groups of key actors), significant concurrent data collection and analysis (until toward the end of the fieldwork phase of the research project), or the extensive use of memos (though memos were used to order phenomena occurring within transcribed data and to re-order them during continuing analysis) (Charmaz 2006; Corbin and Strauss 2008; Birks and Mills 2011). However, it was considered to align with the emergent nature of grounded theory and the fluid and flexible characteristics of grounded theory methods used in data analysis (Strauss and Corbin 1998: xi; Charmaz 2006: 178; Morse 2009: 14) to allow the construction of substantive theory (see page 106). As a consequence, I maintain that this work might be regarded as the initial phase of what could become a larger grounded theory study, with the theory arising from it subject to future modification and enhancement in the light of, for example, additional data collection based on theoretical sampling techniques, leading ultimately to theoretical saturation (Charmaz 2006: 12; Corbin 2009: 48). Theoretical sampling is based upon the premise that the researcher cannot know the initial sample frame required to answer all identified research questions fully (Charmaz 2006: 100). As became apparent in time during this research, professionals involved in the investigation of allegations of abuse might also contribute data that would likely inform research questions. Theoretical saturation follows theoretical sampling and occurs when the activity of gathering new data ceases to create new components of theoretical categories that have arisen from open and axial coding practices (Charmaz 2006: 113).

As has been advocated by a number of scholars who have promoted the use of grounded theory methods (Strauss and Corbin 1998; Charmaz 2006; Corbin and Strauss 2008; Birks and Mills 2011), the technique of open coding was applied to interview transcripts. Open coding is the technique of examining, comparing and categorising data (Strauss and Corbin 1998: 61), in this research, respondents' phrases, and thereby the characteristics, experiences, explanations and phenomena associated with the work of providing care within the care home environment (Pandit 1996: 1; Strauss and Corbin 1998: 77). Open coding is one of the most central processes of grounded theory (Bryman 2004: 402) and required transcripts of interviews to be reviewed, and component parts of text that seemed to have theoretical significance to be labelled with codes that allowed them to be subsequently grouped into potential concepts. Phrases taken from interview transcripts of responses given in answer to, and subsequent discussion of interview questions were consequently grouped manually by virtue of their thematic similarities and conceptual reoccurrences, to bring what Corbin and Strauss (2008: 55) describe as 'conceptual order' to the data. Examples of many of these phrases that are the segments of coded data grouped under conceptual headings are given in the subsequent Chapter six.

The concepts so derived from the coded segments of responses in turn provided the data for subsequent review as the initial analysis progressed. Charmaz (2006: 57) describes this process as 'focused coding' wherein significant and/or frequently occurring initial codes are grouped to form emerging concepts. As Strauss (1987: 25) asserts, "...behaviours and actions are examined comparatively by the analyst

who then codes them, naming them as indicators of a class of events and behaviours". In this way the analysis began to reveal how and why the three groups of respondents constructed, perceived and acted on their respective realities within the care home, and how respondents' beliefs and behaviours might be interacting, aligning with Corbin and Strauss's (2008: 89) later depiction below of data analysis by this means:

- 1) There are conditions – why, where, how and what happens.
- 2) There are inter/actions and emotions – the responses made by individuals or groups to situations, problems, happenings and events.
- 3) There are consequences – the outcomes of inter/actions and emotions.

For example, all three groups of respondents, care home proprietors, care managers and care staff, commented on how physically and emotionally difficult the job of caring for older people in care homes could be, often because of the dependency and behaviours of the people being looked after, and frequently because of time constraints (the conditions). In turn they asserted that these 'conditions' generated stress, fatigue, dislike of some residents and frustration in some circumstances (the emotions and interactions), which in turn resulted in the level and nature of care provided being less good than it might ideally have been, perhaps even abusive in nature (the consequences).

Concepts representing relevant phenomena were subsequently scrutinised and grouped to form two core organising 'categories' (Corbin and Strauss 2008: 159), the 'Micro-environment of the care home' and the 'Macro-social context within which the care home operates' (depicted in Figures 6.1 and 6.2 of Chapter 6). Each code, concept and subsequent category arose from, and were therefore grounded directly within the interview data, and the subsequent analytical process that was undertaken built levels of abstraction from the data, with the aim of developing substantive theory, that is theory applicable to a specific delimited area, but theory grounded in the source data (Charmaz 2006: 8). In accordance with the assertions of Charmaz (2006) and Corbin and Strauss (2008) this was found to be a non-linear process with some of the initial codes appearing to support more than one concept, and as meaning emerged from responses and subsequent open coding, initial codes were moved from their original conceptual groups to others where they seemed more applicable.

As the analysis progressed and I compiled and scrutinised diagrammatic representations of the identified concepts and connections between them, 'axial' relationships between some concepts emerged (Corbin and Strauss 2008: 198; Charmaz 2006: 60; Birks and Mills 201: 12). Consequently, some concepts became sub-concepts of higher order concepts to capture their fundamental interdependencies. This identification of axial relationships has been described by Strauss and Corbin (1998: 125) as bringing the data that has been initially fractured by the process of open coding back together to form a coherent whole, lending a fuller understanding of the "studied experience".

For example, respondents identified the dependency of residents, the presence of dementia, the power imbalance between care staff and those requiring care, the fact that they were caring for 'strangers', and the sometimes unpleasant personal characteristics of residents as features of the relationships they had with those they looked after. These concepts, cited as contributing to the occurrence of abuse, became axially related sub-concepts grouped under the overall concept of 'Dimensions of the Care Staff/Resident Relationship'. As a further example, respondents also described the formation of 'Factions and Cliques' between care staff, and how this could lead to the occurrence and concealment of abusive behaviour. They also described how relationships between care staff and residents, and between care staff groups could be influenced by having 'The Right Manager' of the home, again influencing the likelihood of abuse occurring and enduring. These concepts of 'Factions and Cliques' and 'The Right Manager' were in turn viewed as axially related to 'Dimensions of the Care Staff/Resident Relationship' and were subsequently grouped under the higher order concept of 'Divisions, Alliances and Relationships', within the organising category of 'The Micro-environment of the Care Home' (see Figure 6.1 on page 156).

Identifying axial relationships sought to confirm likely interactions between sub-concepts, concepts and higher order concepts that were revealed by the data as conditions that are interdependent and related to each other. When coded data was assembled into concepts, all but four of the twenty-seven identified concepts and sub-concepts included perceptions and insights derived from responses from all three groups of interview participants. This outcome indicated a significant degree of commonality in perceptions of the identified phenomena, confirming the credibility of

my research and suggesting significant explanatory power in the context of my research questions (Birks and Mills 2011: 113).

4.15. Conclusions

This chapter has set out the rationale for the design of this research, eschewing adoption of an exclusively positivist or interpretivist epistemology and adopting a mixed-method approach to data collection that necessarily embodies both positivist and interpretive traditions to answer stated research questions. Purposive sampling strategies for both the anonymous questionnaire and semi-structured interview methods have been detailed as achievable by a lone researcher with limited resources. The piloting of research instruments and ethical considerations have also been described. The use of a univariate descriptive analysis of quantitative data and a grounded theory approach to the analysis of qualitative data from interviews has been presented as a means of developing substantive theory of the abuse of older people in care homes.

The next two chapters present the research findings. Chapter 5 reports the data obtained from the anonymous questionnaire issued to five newly opened care homes, and Chapter 6 presents the data from the semi-structured interviews conducted with proprietors, care managers and care staff of the twelve participating homes.

5. Analysis of Anonymous Questionnaires

5.1. Introduction

This chapter presents the data, both numerical and textual, from the anonymous questionnaire issued to five newly opened care homes for completion and return by staff employed to provide care to older people.

5.2. Analysis

Table 5.1 below (page 136) shows the total number of anonymous questionnaires returned from each of the five care homes to which they were issued, whether abuse had been witnessed or suspected or not, the sex, median age and years of care experience, and ethnic origins of the care staff who completed them.

Return rates were in the range of 66.6% to 77.5% across the five homes based on estimated numbers of care staff to be recruited by each home. Using Mangione's (1995: 60) classification, this represents an "acceptable" to "very good" number of returns. The majority of returns were completed by women (93.6%) with only nine returned by men (6.4%), reflecting the predominantly female workforce in the care home sector. Median values for years of experience in care work among those returning questionnaires were between four and nine years across the five homes, with median ages of respondents in the range 26 to 34 years, reflective of the 38.4% of care staff between the ages of 18 to 29 years known to be working in the care home sector (Skills for Care 2012: 19).

A significant majority of 89.3% of returns indicated that respondents had witnessed and/or suspected abuse in their previous homes, with only 10.7% stating that no abuse had either been witnessed or was suspected.

The majority of respondents identified themselves as 'White British' in the range 58.6% to 86.4% across the five care homes, with the next most predominant ethnic group identified as 'Black and Black British' in the range 12.5% to 25.8% across the five homes. Representation of other ethnic groups was significantly lower.

Table 5.1: Number of Returns and Socio-demographic Characteristics of All Anonymous Questionnaire Respondents.

Care Home Identifier	N	LTC	B	R	HM	Total %
Date Opened	2011	2012	2012	2013	2013	
Estimated Initial Intake Care Staff	40	45	38	36	30	189
Questionnaires Returned: Abuse not Witnessed/Suspected	2	3	5	2	3	10.7%
Questionnaires Returned: Abuse Witnessed/Suspected	29	31	24	22	19	89.3%
% Returns	77.5%	75.6%	76.3%	66.6%	73.3%	74.1%
Females	29	32	28	21	21	93.6%
Males	2	2	1	3	1	6.4%
Median Years Experience in Paid Care Role	6	8	9	8	4	8
Median Age	26	26	30	31	34	30
White British	64.5%	78.8%	58.6%	66.7%	86.4%	71%
White and Black Caribbean	0	9.1%	0	0	0	1.8%
White and Black African	0	0	17.2%	0	0	3.4%
Indian	9.7%	0	0	20.8%	0	6.1%
Bangladeshi	0	0	10.3%	0	0	2.1%
Black & Black British (Caribbean)	25.8%	12.1%	13.8%	12.5%	13.6%	15.6%

Table 5.2 below (page 139) identifies the work histories of respondents who stated they had witnessed or suspected abuse, the numbers who had received training on abuse at basic and higher levels, and numbers who had received training in care to National Vocational Qualification (NVQ) levels 2 and 3.

In all but one care home the majority of respondents had moved to their 'new' care home from a care home in the same local authority area (75.2% overall). The exception to this was one care home (care home LTC) where the majority of newly employed staff had crossed the border (in terms of where they worked) from care homes in another local authority (74.2% in this home). It is likely this had occurred because this particular care home had opened within an approximate 1.5-mile linear distance from the boundary of an adjacent local authority.

The majority of respondents identified themselves as care staff in their previous homes (97.6%), with one stating they had previously been employed as a 'senior carer' (0.8%), and two as 'other' (1.6%), though one of these had noted on the questionnaire that she had previously worked as a cook.

A significant majority of 88% of these predominantly care staff had previously worked in homes for older people who had dementia. Only 10.4% had recorded their previous care home as a home for older people, and just 1.6% of respondents had worked in care homes for 'other' client groups. This is perhaps in accord with the increasing number of care homes in the sector that are targeting the ever growing numbers of older people who are entering care homes with a dementia (Laing and Buisson 2014).

The median values for the number of years respondents had worked in their previous homes were either 2 years (one care home) or 3 years (4 care homes), with modal values of 2 and 3 years respectively, suggesting a care staff work force that is relatively transient.

Training on abuse had been undertaken at a basic level by 92% of respondents, with 13.6% of respondents stating they had received training at a 'higher level' (sum exceeds 100% because some staff stated they received training at both basic awareness and higher levels). Only 4.8% of respondents stated they had not received any training on the abuse of adults at risk.

A high proportion of 84% of all respondents stated they held qualifications at either NVQ Level 2 or 3, with only 16% stating they did not hold a qualification of any kind in care. This level of NVQ training at levels 2 and 3 among respondents significantly exceeds the level of 42.4% recorded for England among direct care staff (all settings) by Skills for Care (2012: 47).

Table 5.2: Care Work History and Training of All Anonymous Questionnaire Respondents who had Witnessed or Suspected Abuse.

Care Home Identifier	N	LTC	B	R	HM	Total %
To New Care Home from a Home in Same Council Area	24	8	24	20	18	75.2%
To New Home from a Home in Different Area	5	23	0	2	1	24.8%
Role in Prev':						
Senior Care	1	0	0	0	0	0.8%
Care Staff	27	30	24	22	19	97.6%
Other	1	1	0	0	0	1.6%
Previous Home=Older People	3	4	2	4	0	10.4%
Previous Home=Older People with Dementia	25	27	22	17	19	88%
Previous Home=Other	1	0	0	1	0	1.6%
Median Years in Previous Home	3	2	3	3	3	
Training on Abuse at Basic Awareness Level	24	29	22	21	19	92%
Training on Abuse at Higher Level	4	6	4	1	2	13.6%
No Abuse Training	5	0	1	0	0	4.8%
NVQ Level 2 or 3	21	28	20	18	18	84%
No Care Qualification	8	3	4	4	1	16%

5.3 below (page 141) below shows the numbers of respondents who reported witnessing or who suspected abuse in their former care homes. In the cases of abuse witnessed by respondents, table 5.3 shows the type and frequencies of abuse, and whether the abuse occurred during the day or night, and how long ago.

High numbers of care staff completing the questionnaire from all five care homes reported witnessing abuse, between 72.4% to 83.3% of respondents confirming they had done so across the five homes. Similarly, significant numbers of respondents from all five homes, between 45.2% and 66.7%, also suspected abuse had taken place, though they had not witnessed it. A significant majority of respondents had both witnessed *and* suspected that abuse had occurred.

Of all identified *types* of abuse witnessed by care staff, psychological abuse was most common (46.9%), followed by neglect (31.6%) and then physical abuse (20.3%). Only one respondent reported knowledge of financial abuse and one of sexual abuse. Respondents had in many cases witnessed more than one type of abuse, and a significant majority had witnessed abuse occurring 'repeatedly' (83.1%) rather than on just one occasion (16.8%). The majority of abuse was reported as witnessed during the daytime hours.

Of all respondents who had witnessed abuse in the previous care home in which they had worked, 75.5% had done so during the 12-month period prior to questionnaire completion, and 39.4% had witnessed abuse in the period of one to three years prior to questionnaire completion. Five respondents (5.3%) reported

witnessing abuse more than three years previously (sum exceeds 100% because respondents had witnessed occurrences of abuse across the range of timescales offered in the questionnaire).

Table 5.3: Frequency and Characteristics of Abuse Witnessed by Anonymous Questionnaire Respondents

Care Home Identifier	N	LTC	B	R	HM	Total %
Care Staff Who Witnessed Abuse	21(72.4%)	23(74.2%)	20(83.3%)	16(72.7%)	14(73.7%)	75.2%
Care Staff Who Suspected Abuse	19(65.5%)	14(45.2%)	16(66.7%)	14(63.6%)	10(52.6%)	58.4%
Types of Witnessed Abuse:						
Physical	7	11	8	5	5	20.3%
Psychological	20	20	18	14	11	46.9%
Financial	1	0	0	0	0	0.6%
Neglect	17	14	8	8	9	31.6%
Sexual	0	0	0	1	0	0.6%
Other	0	0	0	0	0	
How Often Was Abuse Witnessed:						
Once	2	3	3	5	4	16.8%
Repeatedly	21	22	17	13	11	83.1%
Abuse Witnessed During Day or Night:						
Day	18	17	16	14	11	85.4%
Night	1	6	2	1	3	14.6%
Abuse Witnessed Within:						
Past 12 Months	17	14	17	11	12	75.5%
12 Months to 3 Years	8	11	5	7	6	39.4%
More than 3 Years Ago	0	2	0	1	2	5.3%

Table 5.4 (page 143) below shows patterns of reporting of witnessed abuse, consequent actions, and involvement of agencies external to the care home in which the abuse occurred.

Of all respondents who had witnessed abuse a majority of 91.4% stated that incidents of abuse had been reported to the proprietor or manager of the care home, though 8.5% stated that incidents had not been reported. Significantly, 29.8% of respondents had also indicated that not *all* incidents of abuse had been reported (sum exceeds 100% because some staff were aware of multiple incidents, some of which had been reported and some not, or not always).

Following reports of abuse to proprietors and care managers, 73% of care staff who had witnessed abuse confirmed that action had been taken by the proprietor or manager, but 22.3% stated that action had not been taken, 16% that action was not always taken, and 3.2% stated that they did not know if action had been taken (sum exceeds 100% because of multiple incidents).

The involvement of external agencies in investigating abuse was confirmed by 64.9% of respondents, though 25.5% also reported that external agencies had not been involved in subsequent investigations. Some 29.8% of respondents also stated that external agencies were not always involved in investigations of alleged abuse (sum exceeds 100% because of multiple incidents).

Table 5.4: Reporting and Action Undertaken Following Abuse as Reported by Anonymous Questionnaire Respondents who had Witnessed Abuse

Care Home Identifier	N	LTC	B	R	HM	Total %
Abuse Reported to Owner/Manager	17	22	20	15	12	91.4%
Abuse Not Reported to Owner Manager	4	1	0	1	2	8.5%
Abuse Not Always Reported to Owner /Manager	8	6	4	6	4	29.8%
Don't Know	0	0	0	0	0	0
Action Taken Following Report	14	20	12	11	12	73%
Action Not Taken Following Report	5	2	7	5	2	22.3%
Action Not Always Taken Following Report	4	5	1	5	0	16%
Don't Know	1	0	1	1	0	3.2%
External Agency Involved in Investigating Abuse	12	17	12	8	12	64.9%
No External Agency Involved in Investigating Abuse	6	4	6	6	2	25.5%
External Agency Not Always Involved in Investigating Abuse	7	8	4	7	2	29.8%
Don't Know	0	0	0	0	0	0
Deliberate Non-reporting of Abuse to External Agency	12	10	9	10	4	47.9%

Table 5.4 above also shows that a significant 47.9% of respondents who had witnessed abuse stated that they were aware that abuse had deliberately not been reported to external agencies beyond the confines of the care home in some instances (question 21).

Table 5.5 below shows the methods described by respondents that were used to conceal abuse (question 22).

Table 5.5: Methods Used to Conceal Abuse Reported by Care Staff who had Witnessed Abuse

Method of Concealment of Abuse	Number of Respondents
No one external to the home was told of the abuse.	12
Staff were told that the abuse did not need to be reported because it was not serious enough.	12
Staff were told to keep quiet about the abuse if they wanted to keep their jobs.	9
Lies were told to relatives.	6
Records were completed to say that injuries were accidental though they were not; they were caused by care staff.	5

Revealing insights into the micro level organisation of the care home were given by respondents when asked in the questionnaire to describe the type and nature of abuse they had witnessed (questions 12 and 13). Though some respondents had reported witnessing more than one type of abuse, they did not always describe examples of all types they claimed to have witnessed. The most predominant form of abuse of which examples were given was psychological abuse, followed closely by neglect and then physical abuse. Table 5.6 (page 145) below lists the abuse

witnessed by respondents, with the numbers of respondents referring to each example given in brackets.

Table 5.6: Examples of Abuse Witnessed by Respondents

Type of Abuse Witnessed	Examples
Psychological [71 examples]	Ignoring residents (11), denying choice (7), name calling (12), threatening with physical abuse (11), tormenting verbally [not specified] (5), threats of eviction from the care home (4), withholding affection (7), taunting about a physical disability or loss of bodily function (8), taunting about sexual needs (2), threats of catheterisation (2), denying residents choice (2).
Neglect [69 examples]	Leaving residents in wet pads (8) or wet beds (6), not washing residents (5), not attending to oral hygiene (4), not giving drinks (11), not giving food (8), falsification of food and fluid intake records (4), falsification of skin bundle ¹² records (2), leaving residents sat in wheelchairs (5), leaving residents in a state of undress (6), leaving and forgetting residents on the toilet (3), placing the call button out of reach (3), rough handling (4).
Physical [49 examples]	Slapping on the face (3), slapping on arms or legs (4), punching on arms and legs (2), punching in the chest (2), pinching (4), pulling hair (4), physical restraint (8), concealed physical restraint [2 examples of female residents tied into chairs with 'tights'] (6), forcing residents to get up when they did not want to (6), rushing with feeding (3), illegal lifting methods (3), giving un-prescribed medication (1), over medication at night (2), over medication [time not specified] (1).

Respondents described some specific occurrences of abuse that provide a unique, though disturbing insight into the semi-public microcosm, often existing beyond ready scrutiny, of the care homes in which they had previously worked. One respondent told of a technique used by care staff:

¹² 'Skin Bundles' are a means of assessing and determining treatment and progress towards healing of decubitus ulcers [pressure sores].

'They did this thing they called snagging which meant hooking the vest of the person with dementia over the ends of the bolts that held the toilet seat on. This stopped them getting up and wandering off instead of using the toilet and the carer could go and do someone else at the same time to save time.'

Two additional care staff, newly appointed in different homes, also described very similar techniques of restraint, one also using the term 'snagging', the other using the term 'hooking'.

Two respondents, each from a different care home, described the 'cocoon', another means of restraint used by night staff, one stating:

'The night staff regularly wound the resident in a bed sheet tightly first then pinned them to the bed with a draw sheet or Kylie®¹³ across them tucked under the mattress and another sheet on top with their arms lying on top tucked tightly under the mattress. This stopped them messing in their incontinence pad and making a mess that someone would have to clean up and no one could see it. They call it a cocoon. But it's restraint.'

Three respondents told of how care staff would engage in 'speed feeding' suggesting this as a method to save time, one telling:

¹³ Kylie®: a thick, square incontinence absorbing pad with long non-absorbent 'wing's that can be tucked under a mattress.

'They had to feed three residents at a time, so it was quickly from one to the other around the table, using a spoon and pushing it into their mouths. They called it speed feeding, one after the other in a half circle and somebody got that job every time.'

Two respondents also told of how no one would bother to feed 'the biters', residents with dementia who would try and bite the hand of the person feeding them.

One respondent described how a member of night staff would bring to the home an over the counter cold remedy that contained a mild sedative to give to residents to 'help' them sleep, asserting that this was done so that night staff would not be disturbed.

Another told of how a man was tied to a radiator to stop him walking around during the night and hitting staff, asserting that this was done so that staff could sleep undisturbed through the night.

There were also a number of examples of abuse that did not fit unquestionably into any of the categories of abuse usually employed in the policy and practice literature, for example:

'The senior carer and her cronies took delight in the senior carer cleaning this man's toenails with a fork then putting it on the dinner table to watch another resident eat their dinner with it.'

'The carer stuck her hand down her own trousers, rubbed herself and pushed her hand in the man's face saying "I'd bet you would like some of this you dirty bastard".'

'One carer got the man's soiled underwear and rubbed it in his face and told him he was a "dirty bastard".'

'A resident who shouted all morning was punished by being given his dinner after everyone else had eaten...it [the meal] was quite cold by then.'

'The night staff get a lot of residents up at about five [in the morning] for the day staff and put their day clothes on. Then they put their dressing gowns on over the top so anyone looking won't see they are already dressed.'

'This senior actually came round and copped me changing a pad and bed sheets and she went absolutely apeshit at me 'you can't do this, you can't do the other', and she was the one in charge, she said 'you've used two packs of pads tonight', I said they pay for them and I'm not leaving someone in a wet or messy pad and she says 'they have one pad on all night regardless of the state of the pad or state of the bed. They are changed when they get up in the morning, one pad, each resident, all night.'

Question 20 of the anonymous questionnaire asked respondents to suggest why they thought the abuse they had *witnessed* had taken place, generating the responses in table 5.7 (page 149) below:

Table 5.7: Reasons Suggested for the Occurrence of Abuse by Respondents who had Witnessed Abuse

Suggested Reasons for Abuse	Number of Respondents
'Weak' care manager	4
Managers that did not 'care'	2
Manager that did not spend much or no time 'on the floor'	7
'Bad' care staff	4
Care staff that did not care	8
Care homes 'take on anybody'	4
Volume of work/limited time	14
Stress of the job	7
Care staff talking to each other and not working	6
Chances of being caught very small	8
Abuse easily done 'behind closed doors'	7
Care staff ignoring the training they have received ⁷	7
Residents were very 'demanding', 'trying', 'dependent', or 'aggressive'	8
Care work is 'hard', difficult' or 'demanding'	6
Old people not treated as 'people' or as 'human'	4

Not all respondents who stated they had witnessed abuse answered this question, but some respondents offered several reasons for the occurrence of the abuse they had witnessed.

Some respondents also offered revealing insights from their experiences when asked at question 25 for any other comments or information they might wish to provide. One care staff member related for example:

'Yes, my second experience in care they had four staff on duty for 20 dependent residents but one was permanently in the kitchen because the staff were struggling they were hoisting alone they all ganged up on me one day and said "We know it's wrong but we have to do it" and said "could you

not just do it too?" I refused and said "No I'd rather leave here." I was in tears because I'd not been taught this way and felt isolated. I did leave as this place caused me to be off with depression.'

A second revealed:

'The care manager and the owner called me into the office [after I had reported the abuse] and the owner asked me if I had a mortgage. I said I did and he said "If you don't shut up about what happened I'll have your house off you." I was scared he might so I said nothing.'

Responses to questions 12 and 13 of the anonymous questionnaire (above in table 5.6 on page 145) were frequently reflected in responses to questions 23 and 24 that asked respondents to indicate the types and nature of abuse they *suspected* or *were aware of*, but had not actually witnessed. Table 5.8 below summarises those responses.

Table 5.8: Examples of Abuse Suspected by Respondents

Type of Abuse Suspected	Examples
Psychological [20]	Name calling (9), threatening with physical abuse (4), taunting about a physical disability or loss of bodily function (3), taunting [not specified] (4)
Neglect [68]	Leaving residents in wet pads (4), or wet beds (8), not washing residents (7), not attending to oral hygiene (12), not giving drinks (14), not giving food (8), falsification of food and fluid intake records (8), , leaving residents sat in wheelchairs (1), leaving residents in a state of undress (2), leaving and forgetting residents on the toilet (2), placing the call button out of reach (2).
Physical [39]	Physical blows to the body (6), pinching (4), drag lifting (7), physical restraint (6), forcing residents to get up when they did not want to (14), rushing with feeding (2).

The predominant form of abuse of which respondents claimed to be aware or that they suspected was neglect, followed by physical abuse and then psychological abuse.

5.3. Conclusions

This chapter has presented the results of the anonymous questionnaire to provide limited quantification of the occurrence of abuse in the five participating care homes as reported by care staff. Data analysis has revealed significant occurrences of witnessed abuse in all of the care homes in which respondents worked, the nature of that abuse, and evidence that not all abuse is reported and acted upon. Uniquely it has also revealed examples of abusive acts and associated behaviours in the care home that have been witnessed and encountered by respondents, and that despite guiding national safeguarding policy, not all occurrences of abuse are reported to the appropriate authorities.

The next chapter summarises the data gathered from semi structured interviews conducted with care home owners, managers and care staff, which was analysed using the grounded theory techniques of open coding and conceptual ordering.

6. Analysis of Semi-structured Interview Responses.

6.1. Introduction

This chapter presents the findings following the application of grounded theory analytical techniques described in chapter 4, to elucidate and organise data from the responses to the thirty-six semi-structured interviews conducted with proprietors, care managers and care staff, the socio-demographic characteristics of whom are shown in table 6.1 below (page 153).

Table 6.1: Socio-demographic Characteristics of Interview Respondents

Identifier	Male/Female	Age	Years Exp' in Paid Care	Stated Ethnicity
PA	F	51	25	Indian
PB	F	51	29	White British
PC	F	53	20	White British
PD	M	47	11	Indian
PE	F	63	Not Stated	White British
PF	M	40	21	White British
PG	M	37	6	Black British Caribbean
PH	F	48	24	White British
PI	F	55	34	White British
PJ	F	Not Stated	5	Indian
PK	F	51	10	White British
PL	F	42	24	White British
MA	F	43	Not Stated	White Irish
MB	F	57	37	White British
MC	F	35	Not Stated	White British
MD	F	57	23	White British
ME	F	44	20	White British
MF	F	36	14	Indian
MG	F	43	19	White British
MH	F	44	25	White British
MI	F	47	29	White British
MJ	F	53	35	White British
MK	F	39	14	White British
ML	F	36	9	White British
CA	F	49	14	White British
CB	F	59	Not Stated	White British
CC	F	37	21	White British
CD	F	32	6	Pakistani
CE	F	58	15	White British
CF	M	27	10	White British
CG	F	40	23	White British
CH	F	48	30	White British
CI	F	44	25	White British
CJ	F	43	Not Stated	White British
CK	F	39	21	White British
CL	F	46	25	Indian

6.2. Grounded Theory Analysis

As stated in Chapter 4 the application of grounded theory analysis identified two core organising categories: 'The micro environment of the care home' and 'The macro-social context within which the care home operates'. Each of the organising categories are comprised of concepts and sub-concepts derived from the data, and represent the dynamic interactions that occur between individual agents within the care home environment and factors located within the wider societal context (Schiamberg *et al.* 2011).

Figures 6.1 and 6.2 (pages 156 and 157) below illustrate these two core organising categories that broadly align with the view of research within organisations suggested by Brueggemann (1996), Wodarski and Dziegielewski (2002) and Hughes and Wearing (2007) on page 120 preceding, but in this research confined to macro-social contexts and micro-environmental characteristics operating upon and within the care home. The subsequent discussion illustrates how the values, beliefs, attitudes and behaviours of those involved in providing care at the micro-level of the care home are perhaps inseparable from influences of aspects of the macro-level social context in which both perpetrators and victims of abuse are embedded.

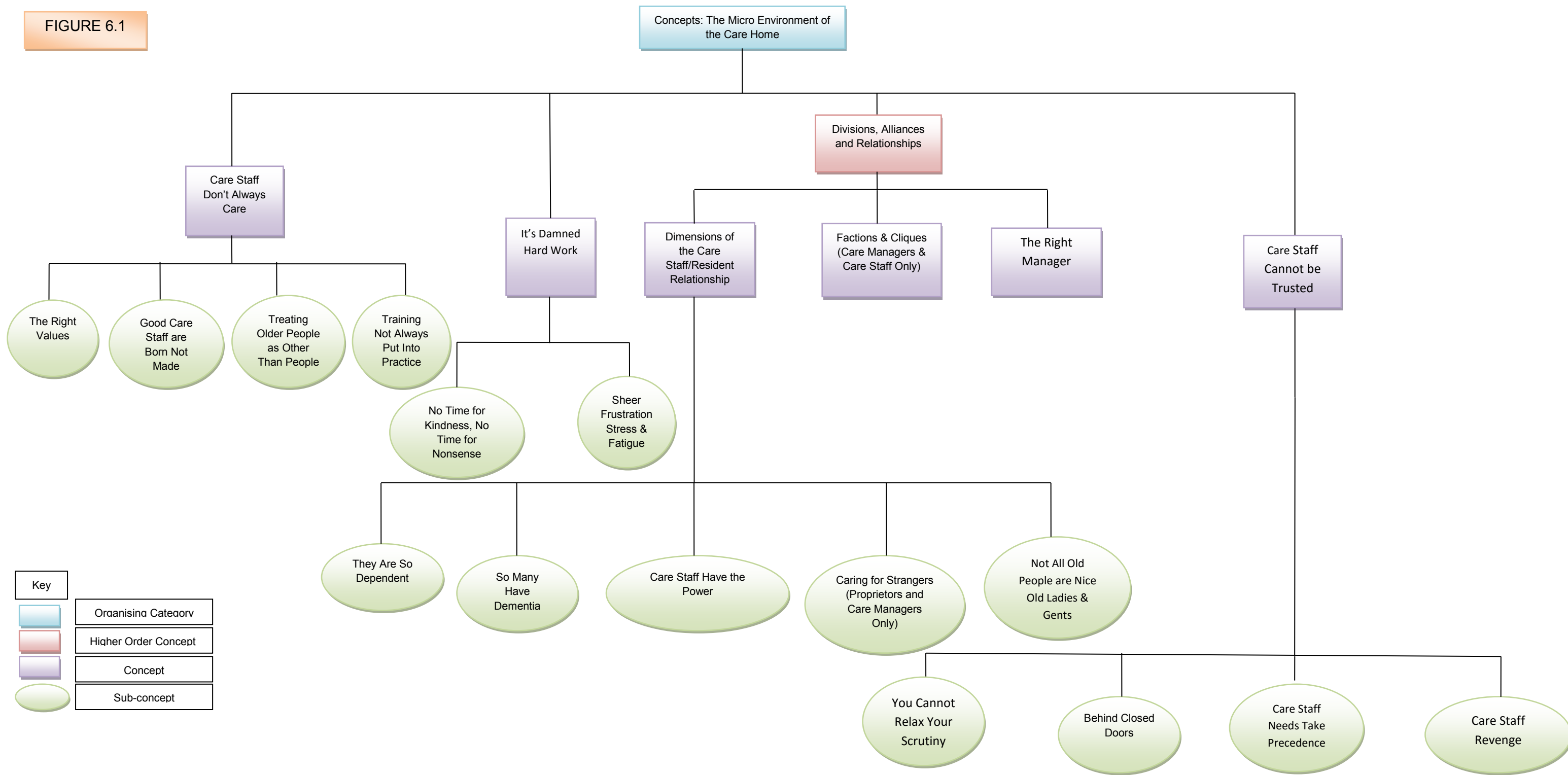
Figures 6.1 and 6.2, particularly Figure 6.1, show how some concepts are comprised of a number of originally identified axially related sub-concepts arising from the open coding stage of analysis (Charmaz 2006: 61). For example, the concept 'Care Staff Don't Always Care', is comprised of the axially related sub-concepts of 'The Right

Values', 'Good Care Staff Are Born Not Made', Treating Older People as Other Than People' and 'Training Not Always Put into Practice'.

It should be noted that Figures 6.1 and 6.2 are representations of very complex phenomena. The figures depict the verbalisations of respondents that were coded and grouped to represent concepts using grounded theory techniques in order to capture respondents' experiences, observations and beliefs. However, the representations are simplifications that embody my interpretation of the data, and the concepts and sub-concepts appearing in figures 6.1 and 6.2 are my groupings of those that I determined to be axially related to each other. Theoretically, they could be further reduced, but the reliability of the findings based on larger numbers of concepts might be diluted as a result.

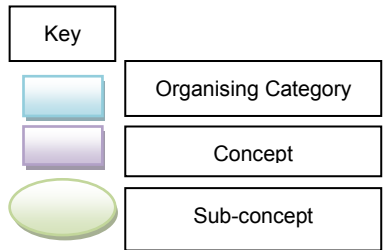
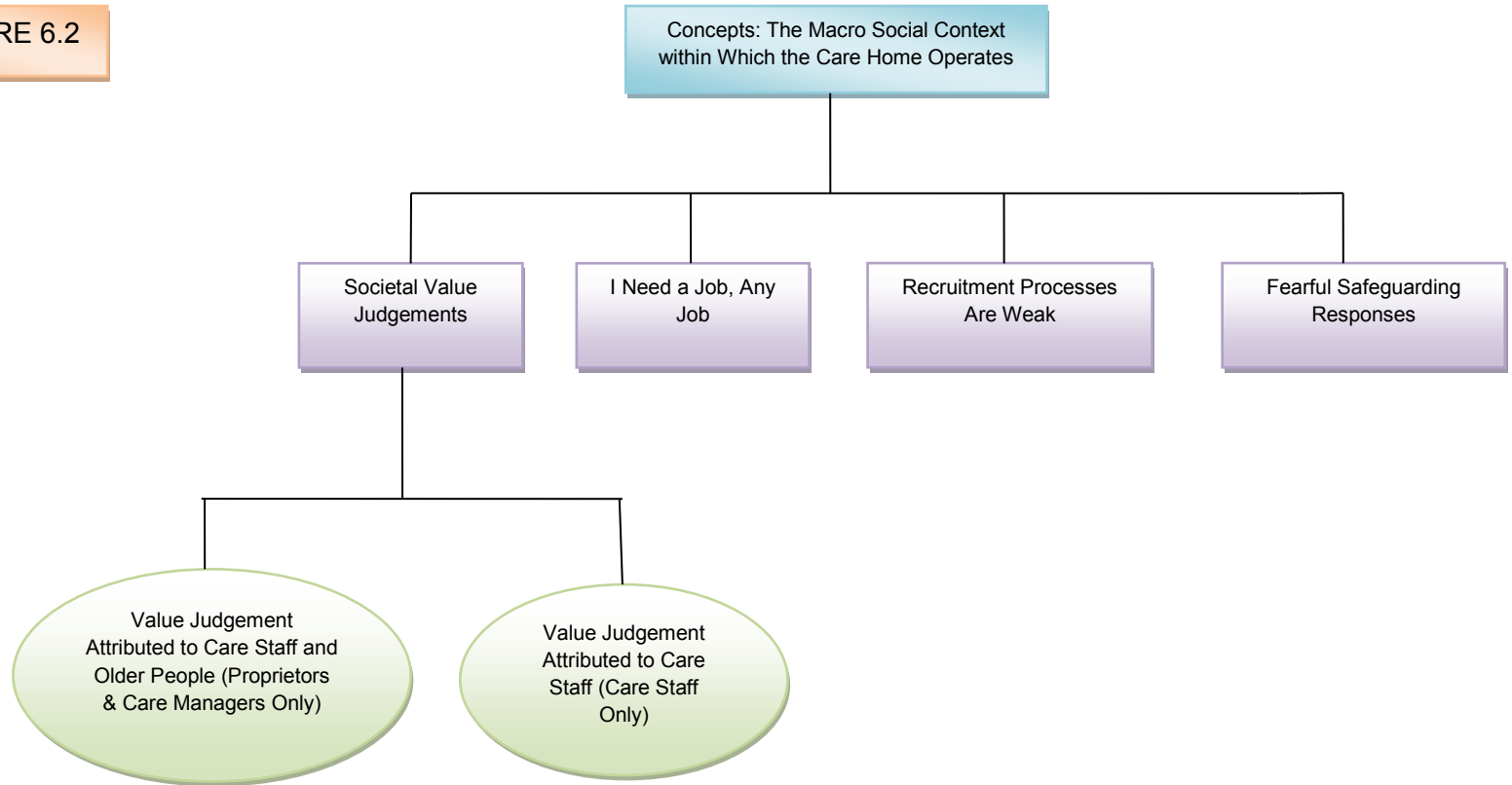
The subsequent presentation of findings on page 158 onwards includes examples of participants' responses under each identified concept heading. These verbatim responses are the segments of coded data that were grouped during analysis to form sub-concepts, concepts and the two organising categories that are depicted in figures 6.1 and 6.2. To preserve anonymity, the verbatim responses that are the coded data are identified by two letters in brackets. The first letter, either 'P', 'M' or 'C' indicates it is from a Proprietor, Care Manager or Care Staff member respectively, the second letter 'A' through to 'L' identifies from which of the twelve care homes whose staff participated in the research that particular respondent originates. Participants' verbatim responses are printed in italics, and underlined words within verbatim responses indicate emphasis attributable to the respondent.

FIGURE 6.1



Key	
	Organising Category
	Higher Order Concept
	Concept
	Sub-concept

FIGURE 6.2



6.3. The Micro-Environment of the Care Home: Concepts

6.3.1. Care Staff Don't Always Care

Four axially related sub-concepts were identified from data to form this higher order concept.

The Right Values

Proprietors, care managers and care staff expressed recognition that care staff working in their care homes did not always value positively the older people they are employed to care for, and may abuse them as a result. Some proprietors and care managers were explicit in expressing that many care staff they encountered did not treat the older people they were expected to care for with respect or dignity¹⁴, and that some often behaved in a manner that suggested they did not believe that the older person should have a voice in their care, indicative of the value placed upon them. One care manager asserted that:

“A lot of people come for care jobs and they don't see older people of deserving of respect and dignity...It's not about staff numbers, it's the right staff who care, with the right values to make a difference.” (ME)

¹⁴ For an insightful discussion of the concept of dignity see Nordenfelt 2004. The 'dignity' referred to be respondents was not further analysed during interviews and has been taken to mean the universal dignity attributed by one human being to another as a result of being human, termed 'mensenwurde' by Nordenfelt.

Other care managers also talked specifically of the values held by care staff and their consequent attitudes towards older people in their care, one manager asserted for example:

“...you’ve [the care staff] gotta have the right attitude there to actually want to do something for that person [the person needing care] and sometimes it’s smelly and dirty what you have to do. Sometimes it’s an unpleasant and difficult job and you’ve got to think that person is actually worth something...you can’t change people’s values...it doesn’t matter whether they’ve got NVQ 2 or 3 or dementia training, it comes down to attitude and values and if they haven’t got that you can do whatever training you like but it won’t make a jot of difference.” (ML)

This statement indicated recognition of the link between care staff valuing the people they are employed to look after, regarding them as having ‘worth’, and consequently being more likely to have an appropriate attitude to their care and therefore less likely to perpetrate abuse.

Reference to values and attitudes held by care staff as often incongruous with caring about older people was a recurring motif among proprietors and care managers, but care staff also seemed to recognise implicitly the sometimes incompatible values held by their colleagues, one carer offered, for example:

“...carers also have that problem making the connection with older people, you’ve got to have that caring nature to make a connection...I stand and

watch and listen and they don't speak to the old people, ask them how they are, did they enjoy their breakfast, it's like they aren't worthy of communication..." (CB)

Again, perception of the 'worth' of the older person featured in this response. Other carers also iterated that they encountered colleagues who appeared not to care about or value the people they were supposed to look after, having little interest in them as individuals, often linking this attitude to perceptions of the cognitive ability and prognosis of older residents, for example one carer suggested that:

"...well in truth most of these old people don't know what's going on anyway, so they don't know whether they are clean or not do they?" (CF)

Another that:

"...some carers see it all as a bit futile really so they don't bother. Futile because they are going to die soon." (CH)

These perceptions among care staff of the lack of awareness among those they looked after as to *"...whether they are clean or not..."* because of cognitive difficulties, and the futility of providing care to older people because they *"...are going to die soon..."* seemed to reflect value judgements made by carers about the older person and their perceived worth. These value judgements were then having an influence on the attitudes and subsequent actions of individual care staff members.

Good Care Staff Are Born, Not Made

The perception that many staff coming into care were not suited to undertake the caring role was common among proprietors, care managers and care staff, though noticeably more frequently asserted by care managers. All three groups suggested that abuse often arose as a result of carers not caring about the people they were supposed to be looking after. Though no explicit reference was made to the values held by care staff in direct conjunction with the frequent assertions that 'good carers are born, not made', there were numerous references to care staff attitudes to those in their care, clearly illustrating a lack of a caring disposition among many care staff in the perceptions of respondents.

One proprietor asserted that:

"...kindness is a non-quantifiable commodity but arguably the most essential commodity an individual needs to give empathetic care. You can train a carer but you cannot train caring. You can train kind acts but you cannot train kindness. There aren't enough caring and kind people who are born that way to go around." (PI)

In a similar vein responses typical of care managers included:

"I believe good carers are born not made. I think much of what a carer must do is intuitive. You can enhance somebody's skills but if it isn't there to start with I don't think that can be changed". (MK)

and

“You can shape carers, but you’ve either got it or you haven’t. You can see the care in some people and maybe you can mould it in a direction...but you can’t train people to care if it’s not there in the first place...” (ML)

Other care managers talked of striving to recruit care staff with the ‘right attitude’ to care and of how difficult this was. A small number of these managers did not necessarily believe that carers were born to care but that, if they had the right attitude, they could possibly be nurtured to care. Yet care managers were ubiquitously of the opinion that training alone could not produce good carers. The limitation of the efficacy of training is discussed later as a sub-concept in its own right.

Care staff also frequently espoused that there was some innate characteristic in a person’s character or nature that would make them a good carer. One experienced carer offered that:

“In my eyes you can’t teach somebody how to be a good carer, you can’t train them to be a good carer, you’ve either got it or you haven’t. You can’t make someone be a good carer, it’s born in them...Not all the training, policies, supervision in the world will stop abuse and it will always be happening because you get the wrong people in the wrong jobs and I don’t think it will ever stop.” (CB)

Another carer suggested:

“...just as you can’t make someone love somebody, you can’t make somebody care, all the training in the world, all the money, unless you care you are not going to change it.” (CH)

Again both of these utterances reflect, as did a number of other care staffs perceptions, along with those of both proprietors and care managers, the limitations of training in terms of its ability to alter the fundamental propensity of an individual to care.

Treating Older People as Other Than People

Though all three groups of respondents spoke of how, in their experience, some care staff had a tendency to treat the older people in their care as “other than” as or “less than people”, only one proprietor offered such a perception, stating that:

“...carers seem to view the elderly as something that inconveniences them, not people, not people who are deserving of their kindness, compassion and warmth...” (PE)

Care managers however were particularly voluble on this perceived phenomenon, telling of how some care staff treated older people as “cargo”, “materials”, “objects”, “lumps of meat” or “work pieces” and of how this could contribute to the occurrence of abusive practices:

“I became disillusioned with people [residents] being treated as they were like cargo or materials, part of a production line...” (MH)

“It’s my mission for them [care staff] to understand that clients are not objects but I have to keep reminding them.” (MG)

“...they [older people] were literally seen as lumps of meat” (ML)

“We do have a syndrome where care staff treat the residents as a work piece to be washed, dressed, powdered and peppered and sat in the lounge nicely presented as if they can say ‘I’ve made this today’, but they are not human beings in those chairs. As time goes on it becomes a job by rote, they [the residents] look immaculate but when they were got up in the morning, no one spoke to them!” (MI)

Managers also related how care staff would treat those in their care as if they were all “the same”, or as if they were not “real people”, and “mechanistically” within what one care manager described as a “conveyor belt system” (a term also used by a care staff member), and as if they were an “inconvenience” and just a “finished product” after necessary care tasks had been completed.

One care manager suggested:

“...there is something about doing the job well enough mechanistically, but without any emotional involvement...any actual caring about the person.”

(MF)

Another that:

“It’s as if they see them [the residents] as an inconvenience” (MB)

Several care managers stated their belief that this behaviour among care staff was also a result of their perception that they needed to complete a defined number of tasks within a given time.

Care managers, however, also indicated that residents were perceived by care staff as a different “group” of people, separate from the staff within the home.

“The staff are one group and the residents the other. The staff do unto the residents, do what they need to do but don’t engage with them as they would probably engage with anyone else...” (MH)

“It’s as if the staff see the residents as a different group, a group of not real people.” (MJ)

“You do get the us and them syndrome, the staff and the residents, they never quite match up, they are too different and here for different reasons...just thrown together...” (MG)

Care staff echoed the perceptions of care managers about the attitude of some care staff towards residents:

“It’s like a conveyor belt, no care taken over what they [care staff colleagues] are doing, they don’t treat the old people like they deserve respect...” (CA)

“Carers can be brutal it’s as if they are looking after a thing not a person, they are looking at them very selfishly. It’s like they go into automatic...they just don’t see what they are dealing with...it’s as if there is no life in the thing they are looking after...” (CB)

Some care staff also suggested, in accord with the perceptions of some care managers, that limited time was partly responsible for this apparent attitude of care staff; another care staff member offered an alternative explanation:

“...but they [care staff] forget what they are actually dealing with and that’s a human being. Why do they forget? The frustrations of life, the way the world is coming to now, everything is greed and self, all about me.” (CF)

It may be of significance that care staff respondents used the third person *'they'* referring to their colleagues when describing their experiences that defined this concept, and not *'I'*.

Training Not Always Put into Practice

There was clear recognition among all three groups of respondents that training provided to care staff, though often extensive, was not always subsequently put into practice by them when attending to the care needs of residents, and that abusive practices could consequently arise.

Carers in particular recognised that training alone could not substitute for the vital 'propensity to care' that was an intrinsic characteristic of good carers, one care staff member for example iterated that:

"...training doesn't make someone care, the qualification is irrelevant, to me it's how much does the person care...Lovely certificates don't count for much, you can't trust certificates, you need people who care...certificates can come later..." (CG)

Proprietors were also explicit in asserting that the more important characteristic of a care staff member that contributed to the provision of good care and an absence of abuse was that persons 'attitude' rather than training. Proprietors also referred to the 'mind-set' and 'culture' of the care staff they employed as seemingly synonymous with attitude, and were clear that it was not so much training that was important, but

these attitudinal characteristics of care staff, and, again, their ‘valuing’ of older people that was necessary to secure good care. Care managers spoke more implicitly of the importance of a certain ‘way of thinking...’ (MI) and ‘...what goes on in someone’s heart...’ (MH) and that caring was ‘...in the blood...’ (MB) and how such characteristics remained unaltered by training provided in its current form, comments that resonate with the sub-concepts ‘The Right Values’ and ‘Good Care Staff Are Born Not Made’.

Care managers and care staff were particularly vociferous in decrying the effectiveness of training asserting that despite the extensive training provided to care staff in the sector, those staff would then *choose* whether or not to put this training into practice when ostensibly attending to the needs of the older people in their care.

As one care manager asserted:

“...you can’t train people to care...” (ML)

A number of proprietors and care managers spoke of the need for trust to be placed in care staff in the sense that they needed to be trusted to practice what they had been specifically trained to do when working beyond the scrutiny of managers or peers. Additional specific dimensions of ‘trust’ attributable to care staff are discussed later in the concept ‘Care Staff Cannot Be Trusted’.

One proprietor remarked:

“Training is OK but its attitude and valuing people that counts. As I said before you can have all the training in the world but some of these care staff they don’t put the training into practice, especially when I’m not here, you can’t trust them, they know what they should do but then they do it another way to save time.” (PA)

One care manager referred specifically to the fact that carers often worked alone with residents behind a closed door and that this is where the choice whether or not to adhere to training would be made by the carer. Another care manager cited specifically the pressure of limited time to undertake the required work of the carer as a deciding factor governing whether or not training was actually put into practice.

6.3.2. It’s Damned Hard Work

Proprietors, care managers and care staff provided a range of revealing and often passionate responses during interviews when exploring the hard, demanding nature of the caring task, and how this might contribute to the occurrence of abuse, some examples of which are rendered below:

“We expect care staff to do a very difficult job and we don’t pay them a lot or regard them as highly as we should, we expect the world and give them very

little...We don't value care staff and the work that they do, if staff were valued you wouldn't get the horrible things...terrible..." (PJ).

"Doing the physical care for older people is bad enough, unpleasant to say the least, but when they [older residents] are fighting and kicking and screaming abuse it makes it worse...it shocks and frightens them [care staff] and that is when they sometimes retaliate." (MF).

"...it is actually down there doing the physical and personal care and its damned hard work and people forget that. It is as much about the emotional toll it takes on care staff." (MJ).

"...endless, demanding repetitive work with no real point I suppose...I mean there's just no point, they will get worse and eventually die." (CC).

The physically and emotionally demanding nature of basic care work was woven into many responses. All three groups of respondents also spoke of how this could lead care staff to distance themselves from those they were required to assist with, or perform for, intimate caring tasks, remaining "disconnected" (PK) from them, and becoming "hardened" (ML) towards them, despite the intimate and personally invasive tasks they were often required to undertake. Care manager 'ML' offered that she thought this hardening may be a protective process, linked to the carer's awareness that the person they were providing care to was likely to die in the shorter rather than the longer term. This assertion echoed the words of care staff member 'CC' above, and the futility of the caring task because of the resident's imminent

death evinced earlier by carer 'CH' in the sub-concept 'The Right Values'. A number of other carers also spoke of the inevitability of the death of some of those people they looked after and one carer 'CK' spoke of the 'grief' and 'pain' they must then deal with. This same carer revealed her consequent belief that it was best "...not to get too close to them, not to care for them too much..."

Two further sub-concepts were identified as axially related to this concept 'Its Damned Hard Work'.

No Time for Kindness-No Time for Any Nonsense

Both care managers and care staff commented extensively on the limited time available for the necessary tasks of care to be undertaken. Care staff and their managers referred to the tasks of getting older people up in the morning, 'putting' them to bed at night, washing them, including those that were no longer in control of bladder and bowel functions, 'feeding' and 'toileting'. One care manager also cited the insufficiency of time for adequate fluids to be given to those being looked after.

Another care manager opined from her experience in a home in which she had previously worked:

"...it was a case of we've [the care staff] got jobs to do and sometimes residents get in the way. No matter what, I could not change that. It's just a job, something we have to do and that is where the focus on tasks comes from." (MJ).

Care managers and care staff talked specifically of the constant tension between limited time available and the number of tasks to be completed in that time. This was couched as either to 'get the job done' before a break was due to them, or before their shift ended, and how this led to shortcuts being taken that were essentially abusive in terms of circumventing proper care provision, denying choice, abrogating opportunities for any communication with those in their care, and sometimes resulting in rough handling.

For example, one care staff member described her experience:

"But we've all got the training these days but the problem is care staff don't do what the training says we must do. It's about shortcuts to get the work done because it's got to be done before they can have their break. When one carer has ten old people to get up in the morning it's got to be a rush job and there is no time for any nonsense from any residents." (CA)

And in response to the interviewer's subsequent question as to what the respondent meant by '*...no time for any nonsense...*':

"Well, y'know care staff can be a bit abrupt a bit insistent and rough...to get the job done."

Another member of care staff told of two particular 'shortcuts' routinely taken by care staff colleagues to save time:

“...I know some carers here don’t bother washing people properly but spray them with deodorant to make them smell as if they have. Same with brushing teeth...give them some mouthwash...trouble is they might swallow it.” (CK)

Care staff (CC) also told of how residents were sometimes sprayed with deodorant or sprinkled with talcum powder to create the appearance that they had been washed when assisted by care staff to get up in the morning, and that this was done to save time.

Some care staff were also explicit about the ‘tradition’ within their homes of day staff putting so many people to bed so that the night staff would reciprocate the next day by getting a similar number of people up in the morning, irrespective of whether these people wanted to arise or retire at these times:

“Time, time and money and if you don’t put so many to bed for the night staff, the night staff won’t get so many up for us and so our lives will be harder.”
(CB)

Another care staff member seemed to be shifting the responsibility for the constraints imposed by limited time elsewhere:

“We as care staff are just told what we have to do so we do it. But there is no time for kindness, no time to really care, what do you expect?” (CK)

Several care managers commented on how ubiquitous this phenomenon of care staff focussing on task completion to imaginary deadlines at the expense of residents' dignity and wellbeing was, how it often led to abuse, and how resistant to change they found it to be.

One care manager explained that:

"...staff don't adhere to policies and procedures, they know what they should do then they behave differently and abuse by rushing people, not letting them have choice and being too rough. They get used to concentrating on tasks; they don't see the needs and wants of a person. You get this syndrome where so many people have to be got up in the morning at say 5 a.m. and they are just sitting there without even a drink and they do it so the night staff will put so many to bed for the day staff, irrespective of whether they want to go or not." (MB)

Perhaps significantly only one proprietor identified a perceived tension between the need for care tasks to be undertaken and the amount of time available to care staff in their employ to do so:

"There's no doubt that as clients become more poorly and care needs increase there is going to be an increasing pressure on time, we only have a certain amount of time..." (PH)

The dearth of comment from proprietors on the time required to complete necessary tasks by a given number of care staff might have been indicative of their awareness that in order to allow care staff to devote more time to both physical tasks and non-task based work, more care staff would need to be employed on each shift. To do this would lead to an almost inevitable reduction in profit for the care home business, particularly given the staffing establishment in care homes consumes the greatest portion of income from fees; as a consequence, most private sector care homes operate on care staffing levels that are the bare minimum to avoid criticism from regulators.

Sheer Frustration Stress and Fatigue.

Responses were also frequently littered with specific references to the stressful nature of the industry of caring for older people, and the fatigue that frontline carers in particular often experience. Proprietors cited sources of personal stress as those of running a business and meeting the requirements of statutory regulator and commissioners of services. Not surprisingly perhaps, care managers identified the source of their *own* stress as the tasks of managing the care home, including both the demands placed upon them by proprietors and regulators, and of managing care staff. The task of managing care staff included the range of behaviours they were reported by managers to exhibit that were likely to lead to poor care, neglect and abuse, in their daily round of looking after people. Some of these behaviours are identified in several of the concepts and sub-concepts of this analysis, primarily within the concept 'Care Staff Cannot Be Trusted' that follows.

Both care managers and care staff themselves attributed the stress and fatigue experienced by *care staff* primarily to the nature of the work that they do and the time available to them in which to do it. Depictions of the nature of care work included the frequently demanding behaviours, in both physical and psychological terms, of the older people in need of care, often as a result of a predominance of those with dementia, and ever increasing physical dependence¹⁵, both on admission and with inevitable progressive morbidity. Several care managers asserted that care staff needed significant ‘mental strength’ to undertake the work of providing care to older people.

One care manager stated:

‘...I have seen it [abuse] arise through sheer frustration, stress and fatigue on the part of the person abusing. I know sometimes residents will hit out and your first thought when somebody hits you is to hit back isn’t it?’ (MF)

Another care manager told passionately of how:

“...carers aren’t looking after relatives, they are doing a nasty, dirty, sometimes dangerous job for minimum wage and no recognition and the client group needs more help than ever now as they are more dependent...What do we expect of people? Tender loving care every day? When somebody has

¹⁵ The term ‘dependent’ is used in this chapter frequently because the word was used frequently by respondents to describe their beliefs and experiences.

been doubly incontinent and they are trying to hit them [care staff] as they clean them up and when they [residents] keep asking you the same question every five minutes it's like 'Oh my God' that's a stressful experience!" (MH)

A female care staff member told of how:

"...I find doing intimate care for these people makes me anxious, I don't think I should be doing it really, especially for the men, that makes me really anxious...but somebody has to do it I suppose...it's hard." (CH)

Another carer asserted:

"We have to do some really dirty, nasty things, what's the word? Excrement, that's it! Shit! Sorry, urine, blood, vomit and we are paid just a basic wage. It's a difficult, stressful job for minimum wage so why the horror when abuse is found out? (CG)

One proprietor and several respondents among both care managers and care staff also identified factors external to the care home as sources of stress upon carers, one carer suggesting:

"...if someone has had a bad night before their shift you can bet some old dear is gonna cop it!" (CA)

Respondents cited family worries, marital and childcare problems, personal illness and financial difficulties as sources of stress that might be 'carried into' the care home as a place of work. Some respondents articulated their belief that this external stress could lead to abusive behaviour from care staff toward often demanding residents.

6.3.3. Divisions, Alliances and Relationships

All three groups of respondents spoke of how the characteristics of the older people requiring care could impact upon care staff, thereby contributing to circumstances in which they engaged in abuse. Respondents among care managers and care staff only, also described aspects of the relationships among care staff as a discrete group in terms of factions and cliques among them, and all respondents cited characteristics of relationships with care home management that may also lead to the occurrence and endurance of abuse. These three concepts were grouped under the higher order concept of 'Divisions, Alliances and Relationships'.

6.3.3.1 Dimensions of the Care Staff/Resident Relationship

Five axially related sub-concepts were identified from responses relating to the divisions and alliances sometimes existing within relationships between care staff and the older people receiving care:

They Are So Dependent

All three groups of respondents spoke of how the older people they looked after were becoming more physically “dependent” over time, specifically upon admission, one proprietor remarking:

“They [the care staff] are dealing with people who come to us in a very poorly condition and they know they won’t be with us for very long...you don’t often get the opportunity to see people come to us and perhaps improve and live a good quality life.” (PH)

Proprietors and care managers spoke of how this increasing physical dependency, frequently linked to the presence of dementia, led to increased vulnerability to abuse by care staff. Both proprietors and care managers linked increased dependency to the increasing age of those residing in care homes, one proprietor (PH) asserting that extreme dependency among residents changed the environment of the care home “completely” and how, as a consequence, it was difficult to make the work of care staff “enjoyable”.

Care staff also recognised this increasing dependency and how older people were more “demanding” of them as a result, one care staff member describing how:

“Four or five years ago everybody in this home could do things for themselves, but not anymore they need a lot of care, some of these would have been nursing cases five years ago, they’re half dead some of them!”
(CB)

A second carer related how:

“They [the residents] are so dependent, so demanding and I’m so tired. They hit you, kick you. I’ve been spat on, for no reason. Yes, I’ve struck back, just on impulse, only once mind...and I shouldn’t have done that.” (CI)

Other care staff also spoke of “dependent” and “demanding” behaviours exhibited by residents, and how their behaviours rendered their jobs as carers more difficult and stressful, citing aggressive behaviour, the frequency of accidents, attempts by residents to leave the care home when they were not safe to do so, repetitive speech, destructive behaviour and behaviour that was “Just like a baby” (CI). Care staff frequently attributed these ‘demanding behaviours’ predominantly to the presence of dementia, both implicitly and explicitly.

So Many Have Dementia

Interwoven with accounts of increased dependency, as indicated by the final paragraph above, were accounts from all three groups of respondents of how significant numbers of residents with dementia had a tendency to increase the prevalence of risks to abuse, and could lead to abuse by care staff because of their consequent behaviours and inability to advocate for themselves. One care manager (MA) spoke of how, in her experience, residents with dementia had been specifically targeted for abuse by a group of care staff because of they were unable to speak out about the abuse they were experiencing due to cognitive decline as a result of their illness.

Though care home proprietors referred to the presence of dementia the least as a progenitor of abuse, one proprietor made the concerning statement:

“What’s the point in treating someone with dementia if there is no outcome? Yes, feed them, accommodate them, cloth them, fine, beyond that leave them.” (PD)

Care managers were the group of respondents to most frequently cite dementia as a factor contributing to the occurrence of abuse, asserting that, for example:

“Those with dementia are particularly demanding and require compassion and patience, but few care staff seem to have that for them.” (ME)

and

“Dementia care creates more abuse because people [residents] can’t tell you what has actually happened [to them]...Dementias are also more vulnerable because they are more challenging, not in terms of their behaviour most of the time, it’s down to communication issues; the fact that you have a tired member of staff and the person with dementia is getting on their nerves.”
(MJ)

It is interesting that (MJ) subordinates the behaviour of the person with dementia to the communication issues that may be encountered by care staff when providing care to people with dementia. (MJ) also notes, as did other respondents, the fact that

people with dementia, at least in some instances, are unable to report to others what they may be experiencing whilst residing in the care home.

Proprietors and care managers also referred to their perceptions that ignorance and fear of people with dementia persisted among care staff. Care managers in particular spoke of how care staff seemed to 'see' the dementia and associated behaviours, rather than the older person who was experiencing dementia, and of particular difficulties care staff had with dealing with aggressive behaviour directed toward them.

Though there was nothing explicit in care staff responses to directly support proprietors' and care managers' perceptions of fear and ignorance of people with dementia among them, one carer did remark that:

"We have to exert some control over them [residents] as well as provide care.

The dementeds require most control, they don't know what they are doing."

(CC)

Though it is not possible to determine what form or level of 'control' this particular care staff member believed to be appropriate, it is a reflection perhaps of the power care staff possess in their relationship with some of the people they are employed to care for. The use of the term 'dementeds' by this carer appears to be a pejorative term for the people with dementia in her care.

Care Staff Have the Power

Aligning perhaps with the response of (MJ) above *“Dementia care creates more abuse because people [residents] can’t tell you what has actually happened [to them] ...”* was the concerning insight offered by one care manager that:

“Often fear of abuse, or making people fear abuse rather, is sufficient to control residents’ behaviour by care staff, including reporting of abuse by victims because there is no hard evidence.” (MB)

Another care manager spoke of her perceptions:

“There is a type of person that comes into this job, almost as a type of control, a power factor, looking after people who are vulnerable and here is a safe place to do it. To exercise control and be nasty to them [residents]. If you have the role of ‘carer’ people won’t really question what you are doing because you are in the role supposedly. If you want to abuse people it’s a good way to do it because you are there [in the care home] four to five times a week so there are lots of good opportunities to do it.” (MF)

Proprietor (PD) also spoke of how the inability of people who had dementia to speak for themselves could render them more likely victims of abuse. This proprietor also cited frailty and confusion as preventing residents from speaking out about abuse, and told of the fear of care staff that residents sometimes experienced, further suggestive of the power held by care staff as perceived by residents.

One care manager commented that:

“I think the elderly are an easy target and some old people won’t speak up. Old people think that if they say something they might not get fed or looked after” (MG)

These responses are indicative of the power that care staff have in their relationship with the older people entrusted to their care. In these examples power to instil fear, to control, and power, or perceived power, over resources available.

One care manager (ML) offered that in order to endure the extreme physical and emotional demands of caring for older people with significant needs, carers would use the power they have over residents in order to cope with doing a job that was “not pretty” for low pay. In this context, ‘ML’ asserted that the power that care staff possess manifests in the choice of whether or not to engage with those they are caring for, and is reinforced by virtue of the fact that many of those they were looking after may be unable to ask that carers engage with them at a personal level. Manager ‘ML’ believed this to be because of cognitive difficulties, or a reluctance to attempt to engage on the part of the resident for fear of the response, given they were aware their carers might be very busy.

Care staff also made some tangential references to the power they were able to exercise over residents:

“We have to exert some control over them [residents] as well as provide care. The dementeds require most control, they don’t know what they are doing.”

(CC)

Another care staff member revealing:

People do know what is right from what is wrong, but it’s like power, like a power thing they’ve got, it’s like ‘you [the resident] can’t do anything about it’, do you know what I mean?” (CH)

A third stating:

“...we are the lowest paid and we have no authority so we feel powerless...I suppose we have more power than the residents though...” (CJ)

These remarks suggest that care staff implicitly recognise the power they hold over those in their care.

Caring for Strangers (Proprietors and Care Managers Only)

Both proprietors and care managers pointed out the frequently demanding and disagreeable nature of care tasks undertaken for people who were ‘strangers’ to the care staff involved, and that this could create the conditions under which abuse was more likely:

“You’re caring for strangers, it’s an unpleasant job much of the time dealing with bodily substances and we had one of our service users whack one of our staff the other day”. (PB)

Care managers also raised their perception of tensions in this relationship of caring for strangers, one care manager suggesting that:

“I think some affection is important [from carer to resident] but that can be difficult when you are supposed to be looking after someone with who there is no bond” (ML)

A second commented that:

“They might not abuse if it was their mom or dad, but it isn’t, it’s somebody you don’t really know! Caring for people who are not family is very difficult, you might do things for them but you don’t really care about them.” (MJ)

Another care manager suggesting:

“Working with older people is rewarding, but it can be difficult, I find it best not to form emotional attachments” (MC)

Other care managers and care staff also spoke of how they believed it unwise to form emotional attachments to residents, predominantly because they were going to die whilst in the care home. However, there seems to be an incongruence between

the expressed pointlessness of forming emotional bonds with residents because their death was inevitable, and the dangers of doing so because of the emotional pain then experienced following their death. Nevertheless, this expressed belief perhaps militates against providing care with compassion, factors that may lead to abuse.

As care manager 'MH', previously cited, asserts:

"...carers aren't looking after relatives, they are doing a nasty, dirty, sometimes dangerous job for minimum wage and no recognition and the client group needs more help than ever now as they are more dependent...What do we expect of people? Tender loving care every day?"

Not All Old People Are Nice Old Ladies and Gents

Respondents from all three groups also pointed out that the older people in their care were not always pleasant people to provide care to, and that this may precipitate abusive behaviours. One proprietor summed up a recurring perception among respondents in that:

"Just because somebody is older and vulnerable doesn't necessarily make them a nice person...there seems to be a perception out there that as soon as somebody is eighty or ninety or whatever and a grandmother or grandfather and come into a care home it's as if they've already got wings on their back and it's not always the case. They can be quite...abusive is not

really the term, but perhaps generally not a nice person to look after. Some staff deal with it better than others...sometimes that can lead to it [abuse from care staff] as well.” (PF)

A second proprietor maintaining:

“You’ve also got little old ladies, ain’t always lovely little old ladies, they can tell a lot of lies about care staff” (PD)

One care manager also suggested:

“...staff do have a lot to put up with, they do get abused so it’s no wonder they sometimes get their own back” (MA)

A second care manager described how:

“Residents know how to push your buttons, you can see staff starting to get worked up, no wonder really they sometimes retaliate...” (MG)

A third maintained:

“...care staff can’t help not liking some of the old people they look after and not all old people are nice old ladies and gents...some can be terrible and abusive and violent themselves...so care staff can retaliate” (MK)

Though less likely to cite the personal characteristics and behaviours of residents as precipitating abuse, care staff also described how older residents were often “nasty” and “rude” to them as carers, and of how personalities of carers and residents could “clash” on occasion and lead to unkindness and neglect from care staff.

One carer stated:

“There is so much to do yes, so when they [residents] get nasty, and they do, they [care staff] get nasty too” (CD)

The comments made by respondents about the personality attributes and behaviours of older residents also seemed to carry the implicit suggestion that residents who behaved in certain ways were themselves responsible for the abusive consequences at the hands of the care staff employed to look after them.

One carer offered her insight:

“It’s not human nature to get on with everyone all the time, but when it’s your job you have to despite how difficult it is and if you can’t hack it you should bog off. People do know what is right from what is wrong, but it’s like power, like a power thing they’ve got, it’s like ‘you [the resident] can’t do anything about it’, do you know what I mean?” (CH)

Care staff member 'CH' again reiterates the potential power held by care staff, suggesting how it may be exercised at least in some circumstances where residents are not 'liked'.

6.3.3.2. Factions and Cliques (Care Managers and Care Staff Only)

Both care managers and care staff spoke extensively about the phenomenon of the care staff complement within their care homes forming sub-groups among their number, often employing the terms 'cliques' and 'factions' in their descriptions. The comments about sub-group formation from both cadres of respondents included those that came into being in general terms, and specifically to those resulting from the peculiar separation between care staff working during the daytime and those working during the night. Some care managers also related their perceptions of the negative effect that the established staff group could have upon newly appointed staff.

Care managers were particularly voluble about the phenomenon of sub-group formation among care staff and how it could lead to abuse; one care manager spoke of how:

"You do get factions amongst staff, can be independent individuals, but also groups of staff who don't relate to each other particularly well...and these mates working with mates leads to factions and staff doing what they want to make their work life more bearable rather than for the good of the clients"

that's when neglect occurs...and psychological abuse, for a bit of entertainment...y'know taunting and the like.” (MD)

Another manager related her experience:

“There was a culture at my previous home where there was a core of rotten apples...some staff I recruited were perfect for the job but got sucked in by the rotten apples, and that is how it carries on and grows because they look after each other, each other's backs and you can't actually trip them up. Though you know residents are being abused and neglected, you struggle to identify the ring leaders.” (MJ)

A third manager told of how she had encountered:

“...systematic abuse ...by small cliques of care staff including physical abuse yes, but more often psychological abuse.” (ME)

A fourth related:

“...there are groups of staff who defend one another and how they treat the residents, saying it is in their best interests, like restraint for example...restraint was wrong and not in peoples' best interests, more for the staff to have a peaceful time.” (MF)

Other care managers spoke of how sub-groups or 'cliques' would 'play each other off', blaming each other for abuse, particularly neglectful behaviours when important tasks, for example feeding, washing, and wound care, were left undone. Some care managers told of a code of loyalties among care staff that prohibited reporting of abuse carried out by another member of the 'sub-group', others spoke of how care staff would 'watch each other's backs' whilst allowing abusive practices to continue. In the experiences of respondents this 'watching of backs' included both failing to report abuse and lying to refute allegations that were made by others. Some care managers described how care staff would 'close-ranks' to defend a member of a particular sub-group, and how fear appeared to be sometimes a factor, fear of retaliation from other members of the sub-group. One care manager pointed out how some care staff would have more dominant personalities and would exert influence over more timid, subservient care staff members. Care managers also spoke of how care staff were ever mindful of the fact that they must continue to work alongside the people who they might otherwise report for having perpetrated abuse. Another care manager explicitly identified how the cohesiveness of the sub-group among the staff was a manifestation of the power care staff could exercise within the organisation of the care home. One care manager offered that the reason for the formation of sub-groups among care staff was to allow sub-group members to:

"...focus on their own needs...like having breaks together with no one left to look after the people, having a laugh, often at the expense of residents especially those with dementia...it's all about them...that's what it becomes...all about the staff." (MI)

Care staff also described the formation of sub-groups or 'cliques' among their peers, though to a lesser extent than care managers. One care staff member described how:

"... there are cliques of staff and sometimes they conflict and you get bad cliques and good cliques of staff and loyalties, so staff won't tell on the people they work with who are in their group." (CC)

Another care staff member reflecting:

"When staff work together they have loyalties and if they see abuse they are likely to turn a blind eye...I know that happens here. In care homes they are like a little group and you know this group have got a clique and they don't respect anyone who doesn't fit that clique and do as they do at work..." (CG)

Both care managers and care staff respondents also frequently described a divide between care staff working during the day and those working during the night:

"...we have had, y'know, day girls and night girls and they should be doing this and they should be doing that and in the end nobody does what should be done and residents are neglected." (MK)

"The biggest group behaviour I see among staff is days and nights and that's because they never, ever work together so they can afford to be 'Oh it's the night staff' or 'it's the day staff' and they play against each other and that can

lead to abuse, particularly neglect because no one takes responsibility for things that are not...the care that is given.” (MD)

“You get a friction between day staff and night staff in every home, one lot saying that’s not our job to do and in the end no one does the job and people suffer and are abused by neglect as a result. I find that common with the day staff night staff divide. That’s when it gets to be them and us...” (CI)

“The day staff, night staff divide is notorious, across the board wherever I’ve worked it’s always been us and them, two different groups of people with ways of doing things and loyalties to each other. But as a result it’s more than neglect...when somebody is lying in their own urine and faeces for hours on end because the night staff haven’t done what they should and try and say then it’s because the day staff were late getting them up its physical abuse that is.” (CK)

It is interesting to compare these perceptions with the earlier reports of care staff who told of a seeming co-operation between day and night staff, wherein each group either put to bed or got up an equivalent number of residents, irrespective of residents wishes, to make the respective working lives of each group of staff easier.

Care staff working exclusively during the day or exclusively during the night is common practice in private sector care homes, occasional exceptions being when overtime is worked to cover a shift during either period which is not the staffs’ usual working pattern. Only one proprietor (PG) among respondents described how he had

introduced limited internal rotation¹⁶ to combat this phenomenon of the divide between day staff and night staff.

Care managers also spoke of how longer serving staff who had adopted 'shortcuts', 'bad habits' and an attitude of complacency, influenced and 'contaminated' new staff who came to work in the care homes they managed. Care managers spoke of bullying and intimidation toward new staff, who were usually in any case isolated because in most instances they would be the only new employee and not a part of any established group or sub-group. This bullying was undertaken in the opinion of care managers, to secure compliance with established abusive practices. Care managers spoke predominantly of neglect in this context, but also of cases of psychological abuse.

One care manager related her extreme experience at a previous home:

"She [long serving member of care staff] was the main culprit. She was the ringleader. I've always...and I'll still say it to this day, the two [newly recruited staff] that were working alongside her, if it hadn't been for her they would not at any time have done what they did, they were bullied into it, pure and simple because they were petrified of this member of staff. No that's no excuse, but through pure intimidation the two members of staff were victims as well but the main culprit got away with it..." (MA)

¹⁶ 'Internal rotation' involves all staff working both days and nights, alternating from one to the other usually every four weeks.

This care manager described how these three staff had tormented a resident who had severe dementia by taking from her a teddy bear that the resident thought was her child and would carry and cuddle much of the time, and had kicked it across the floor, verbally taunting the resident as they did so, with such jibes as “Look, look at your baby...”. The care manager also described how residents with dementia who needed wheelchairs were ‘raced’ by these staff who allowed their wheelchairs and occupants to ‘freewheel’ down an incline within the care home.

Another care manager offered that:

“A lot of bad practice is inherited, they’ve been doing it for so long, anyone new comes along they just carry on and its accepted as the norm, but it’s because of peer pressure and a fear in the new person because they want to keep their job and get on.” (MG)

A care staff member also remarked tellingly that:

“...and the bad carers affect the good carers. Abuse is like poison, it spreads...”

6.3.3.3. The Right Manager

Respondents from all three groups spoke of characteristics of care managers and the relationships they developed, predominantly with care staff, that they perceived as necessary to deter and prevent abusive behaviours.

Proprietors asserted that the care managers they employed needed to be able to be 'vigilant' over, and 'control' and 'supervise' care staff who would otherwise 'backslide' into unsatisfactory behaviours. They spoke of how care managers must 'constantly manage' care staff and must lead by "...example, dialogue and experience..." (PI). Care home proprietors also suggested that care managers must value the staff that they managed and convey to them "...what type of home we want and where we want to go..." (PJ). Two proprietors offered that care managers must recognise and manage the particular stresses that care staff experienced in their everyday work to reduce the likelihood of abuse. Proprietors couched their views in terms of the effect that allegations of abuse could have a negative impact upon reputation and thereby income generated by the care home business.

One proprietor spoke of how, when they had taken over ownership of their care home, it was being 'run' by the care staff because the care manager was ineffective in her relationship with care staff, and had become "one with them (the care staff)" (PJ). Others spoke of how care staff had a propensity to dictate the way a care home operated if they were not effectively managed and supervised. Another proprietor described the care staff group as a "wolf pack" preying on weaker care staff members and residents alike when he had taken over the care home, and that this was because the previous manager had "lost control" of the care staff group (PF).

Care managers also recognised explicitly that they and their peers needed to be diligent in their oversight of care staff behaviours to prevent "backsliding" into abusive practice, and spoke of how care staff could not always be trusted to care properly for the people in their care. They cited "strength of management" as

necessary, but also that care managers themselves should be caring toward both residents and care staff. Care managers identified that leadership was also important to engender appropriate behaviours and “happiness” among care staff, and that this would lead to care staff treating residents well, because they, as care staff, were treated well. Care managers echoed the belief of some proprietors that without effective management it would be the care staff who “ran”, and therefore dictated in large part, the functioning of the care home by “managing the manager” (MH).

Two care managers also spoke of the strength required of care managers to manage their sometimes tense relationship with proprietors, which, in the circumstances related by these respondents, concerned proprietors urging savings to be made at the expense of the calibre of care provided. Care managers spoke of their belief that “interest” and “appropriate attitudes and behaviours” from proprietors’ also engendered positive behaviours from care staff.

One care manager asserted:

“...a lot is also about how staff are treated by their managers and I always say you should treat staff how you want the staff to treat the residents. I do believe that homes have cultures that you can see and that does come from managers. I do believe you can have the best care staff team but if you have the wrong manager that care staff team is restricted and contaminated by how the manager works and of course the manager holds a lot of power being able to influence holidays and overtime and things...You get proprietors who aren’t particularly interested in the staff, don’t give two hoots

about the manager...so staff feel devalued and in time they don't value the people they look after..." (MF)

The assertion of this care manager spoke of the importance of the care manager in shaping how the care home operates and also suggested a three-way interdependence between care manager, care staff and proprietor that influences the subsequent 'culture' of the care home. A second manager interviewed, speaking of the characteristics of proprietors that they had experienced, similarly offered that "...abuse starts from the top..." (MJ).

Care staff also talked, though to a lesser extent, of the characteristics of the management they experienced.

One care staff member reiterated the beliefs of proprietors and care managers in that:

"...managers have constantly got to check what people [care staff] are doing, but they don't...or can't because they can't see what carers are doing when the door is closed...or they are too busy anyway." (CC)

Another recounted her experiences working in previous homes:

"I have worked in homes where I have just been left to get on with it because managers' focus is somewhere else so if it was my intention to abuse I can." (CD)

A third care staff member spoke of how:

“...abuse is tainted so it’s ignored by the manager because it makes people at the top look bad, so brush it under the carpet it will go away, lets pretend we are doing a good job.” (CE)

Another care staff member supported this view from her experience:

“I’ve reported people to management level [for abusive behaviour] and they’ve said ‘We didn’t expect that of you.’...they didn’t want to know what I said, they wouldn’t act.... they made me feel as if I was in the wrong.” (CF)

Other care staff told of how they had reported abuse but that no action was taken, offering that this attitude was because they were at the bottom of the care home hierarchy, “at the bottom of the pile”, and that they meant “nothing” to the manager

One carer suggested that:

“They [care staff] are supposed to care within the job role, but they don’t care and if the manager doesn’t spot the issues, or ignores the issues they [care staff] just carry on and gradually get worse if nothing happens as a result of their neglecting and harmful ways...” (CJ)

The comments and observations of some of the care staff respondents during interviews suggested that not all care managers were as vigilant or responsive to reports of abuse as may be required.

6.3.4. Care Staff Cannot be Trusted

Proprietors, care managers and care staff all recounted their perceptions and experiences of some notable behaviour among care staff within their care homes, suggesting that these staff cannot be trusted. Their responses were organised into four intersecting sub-concepts, labelled as 'You Cannot Relax Your Scrutiny', 'Behind Closed Doors', 'Residents Staff Needs Take Precedence' and 'Care Staff Revenge'. These sub-concepts provide revealing insights into the microcosm of the care home that may lead to abusive practices.

You Cannot Relax Your Scrutiny

Care home proprietors were effusive in their responses that spoke of how they perceived care staff as often not deserving of their trust, or that of their care managers, because if they were not subject to constant scrutiny they would engage in behaviours that were abusive. One proprietor pointed out how necessary it is for care staff to be worthy of trust given that in care homes "...human beings are your method of delivery of service..." (PD)

Another proprietor asserted:

“You cannot relax your scrutiny because as soon as you do these strange things, like staff taking cigarette breaks leaving residents unsupervised, creep back in. Why? Why? Because you are not behind them all the time, you just don’t loosen your scrutiny. Even though I know we have a fantastic staff team you don’t loosen your vigilance. What is it in human nature as soon as you take your eye off the ball, there is no authority, they relax, then they take shortcuts and that easily becomes abusive.” (PJ)

though there seems to be a contradiction embedded in this proprietor’s response, given she refers to a ‘...fantastic staff team...’ over whom she must ‘...not relax her vigilance.’

A second proprietor offered that:

“...staff like to be left to be doing their own thing, things weren’t getting done properly, so obviously they weren’t doing their job properly and residents were being abused. The care staff were running the home, they will run the home if they get the chance so you have to demonstrate who is the person to be listened to, who is running the home. They [care staff] can’t be left to do their own thing, just turning up for work and doing the very basics, so people were neglected and abused.” (PK)

Care managers were similarly unreserved in their experiences and observations of the need for constant scrutiny of their care staff:

“...they [care staff] know what should be done, they know the right attitude, they know the philosophies, but what happens after you’ve got no real control of really and that’s the frightening part for me because they do revert back. You have to keep control over care staff otherwise they just do as they please...” (MB)

“You have to monitor and supervise [the care staff] all the time to make sure they are good and deliver the care that is required. They can’t be trusted to do so otherwise.” (MJ)

“That relieves my stress because if I know I told them that this morning they will do it for me today. But they won’t necessarily do it tomorrow or the next day or next week. Because they don’t, if they can get away with half a job then many of them will. It’s quicker and they can have more time doing things that don’t involve residents, like the social aspects of being at work in the care home.” (MC)

“They [care staff] will do what they have to do, what must be done and that’s it. And as I say at weekends when I am not around they will do less or do things in a rush, amounting to neglect and psychological abuse, so they can sit with their friends and chat. It seems the residents are not particularly important to them.” (MD)

Both proprietors and care managers also spoke of how care staff might respond positively when they were reprimanded for poor care, but would still “backslide” without constant supervision. Both groups of respondents told of the need to constantly check care staff performance, and how difficult this could be during night shifts and at weekends when, as proprietors and managers, they would not usually be present at the care home.

Care staff also provided some interesting insights that tended to confirm the perceptions of proprietors and care managers:

“No, no, you can’t trust carers [spoken very quietly] believe me, you need to be on your toes, these people are carers, but you need to be looking and listening all the time.” (CI)

“Well when relatives are around, and you usually know...you get to know when they are here, some [carers] behave differently. They’ll hold May’s [resident] hand because she’s got her head down, looks...well depressed. But when there is no one around...her hand doesn’t get held.” (CA)

“Oh everyone gets a drink when there are visitors here. But when they are not, some, the difficult ones that need help to drink, don’t get one.” (CE)

“You see, filling in turn charts...they get filled in but it doesn’t mean the person has been turned. Well as long as they are on the side they are

supposed to be on at the end of the shift you're OK...who can know if you see what I mean?" (CF)

"Residents are often blamed for their own injuries, and who is to know? It has happened here, yes (lowers voice) one resident had two injuries to her legs and the carers blamed it on her banging her legs on the cot sides...but she can't even move her legs." (CL)

"Some care staff [working on nights] get some residents up here at five in the morning...they don't want to get up but if they do that then the day staff will put the same number to bed before they go off shift. They [the residents] might not want to go to bed at half past six but they still have to go..." (CG)

Behind Closed Doors

All three groups of respondents identified the giving of intimate personal care in bedrooms, bathrooms and toilets as a phenomenon particular to care homes that contributed to the occurrence and concealment, and therefore perpetuation, of abuse.

One proprietor told of her own experience:

"...some [care staff] will appear to take on board what you tell them to do but don't really mean it and don't practice what they should when no one is watching." (PC)

Care managers, however, commented on this particular characteristic of care work in care homes with significantly greater frequency than the other two groups of respondents:

“...a member of staff may raise something to you regarding a colleague, something minor, but it’s what they have witnessed. What else is going on? Behind closed doors?”

...I’ve found more sinister things going on. Systematic abuse for one by small cliques of care staff including physical abuse yes, but more often psychological abuse, taunts, ridicule, that sort of thing...” (MG)

“Some staff pick up others bad habits. I know all the shortcuts, all the corners that can be cut, but proving someone is doing it can be hard, especially when most of the care happens in private.” (MJ)

“In care homes you can only see a piece of care home life and lots goes on behind closed doors, in bedrooms and toilets...you see residents being taken out of the lounge for attention and the they come back, but you don’t know what has gone on in between and people with dementia can’t say what has happened to them...you only generally see the main lounge areas. Maybe CCTV [closed circuit television]?” (MH)

Other proprietors and managers also suggested that closed circuit television might be the answer to preventing abuse that occurred ‘behind closed doors’, but all

appreciated the ethical dilemma surrounding the use of such technology, particularly to scrutinise the giving of intimate care, wherever that might be undertaken.

Care staff also recognised the significance of much of their work being carried out 'behind closed doors', one care staff member recognising that:

"I have worked in homes where I have just been left to get on with it so if my intention is to abuse I can. Nine times out of ten there is nobody with me to see...it's a hard job, dirty sometimes and you have to trust what people are doing especially as a lot of care is given in bedrooms..." (CD)

Proprietors, care managers and care staff all spoke of how, given intimate care was frequently provided in the privacy of bedrooms, toilets and bathrooms, trust had to be placed in care staff. These respondents, however, maintained that such trust was not always well placed. The importance of the ability to trust the care staff providing direct and often intimate care in private spaces away from scrutiny is implicit within the need for such care to be undertaken in privacy 'behind a closed door'.

Care Staff Needs Take Precedence

Respondents also spoke of how care staff viewed the care home as their place of work and/or as some form of social gathering with their peers, rather than as the home of residents, and how residents within the home were disregarded, or at best viewed by care staff as a secondary consideration, contributing to the occurrence of abuse.

One proprietor spoke at length on this perceived phenomenon:

“Abuse occurs because the home is their [the care staff] workplace and they see it as the thing to do, forgetting that these [residents] are people to be looked after in what is their home. Staff constantly go for as many cigarettes as they wish as if it was part of their working day, and leave the residents unsupervised, like it’s an entitlement. We have had accidents and falls and residents assaulting other residents as a result of this but they [care staff] still see coming to work as a bit of a social event and cigarette breaks and a chat are an entitlement. You have to remind the staff they are not here to meet their own needs.” (PJ)

Care managers also told of how:

“You also get carers who think they are here for their own convenience and that the residents are just a nuisance and so their needs are neglected or they are abused because they get in the way of what the staff want to do...” (MH)

“Staff...want to do things how they want to do things and that is to save time so they can socialise with each other, that’s why jobs are rushed and people don’t get drinks, or food, or they don’t get washed or looked after” (MF)

“You also get carers who don’t understand what the role is about. They seem to think they are here for their own convenience, to meet their needs and happy to get paid for it.” (ME)

“This is the residents home not the staffs home and those with dementia will be pottering about and the staff will tell them to ‘sit down, sit down’ or even shove them back into a chair, but this is their home so as long as they are not at risk they don’t have to sit down just because it’s causing disruption or inconvenience to the staff. So it’s about staff seeing it as a workplace first and the residents’ home second and it’s easy done in the daily grind. It can become a social club for staff and looking after the people is a secondary thing, they’ve [the staff] got to have their smoke break, their tea break and residents get neglected as a result. I forever have to remind [care staff] they should be engaging with residents, they [the residents] are not an inconvenience.” (MD)

Care manager ‘MD’ also spoke of the phenomenon of “...mates working with mates...”, and how this could also lead to the social needs of care staff taking precedence as well as the formation of sub-groups within the staff complement, previously identified under ‘Factions and Cliques’.

Care staff themselves seemed to confirm the perceptions of proprietors and care managers, though their narratives were always in the third person:

“Some [care staff newly recruited and at the end of their probationary period] even try to change things in the home, how staff...how they work, for the worse. It’s not for a positive way but to make it easier for them so the needs of the staff are met first primarily and residents come second.” (CC)

“...carers are always clock watching because they have got their own needs, tea breaks, smoke breaks, lunchtime, finishing time, they can’t be bothered ‘Oh I’ll do it later, I’ll do it some other time,’ and that time never comes and residents needs are neglected and it doesn’t get done and who is going to know? Much of the abuse here happens behind closed doors...” (CB)

“Sometimes people [care staff] forget they are in the workplace I think, they are here to do a job they’re getting paid for, but its ‘let’s get ‘em to bed so we can watch the telly’ and woe betide any resident who gets in the way of that!” (CJ)

“Everything that is done for the older person should be done for the older person, not for the staff, not because it takes less time and effort and not because you don’t like them. But it doesn’t work like that in reality it’s mostly done for the staffs’ convenience so they can have an easier work life and that’s where a lot of abuse comes from, that’s why they [residents] don’t get fed properly or get a drink...” (CK)

Care Staff Revenge

All three groups of respondents described two behaviours they had encountered that were grouped into this sub-concept. These behaviours were again suggestive of how care staff may not always behave as might be expected.

Respondents described how care staff would take advantage of the system that exists for reporting allegations of abuse in the knowledge that the authorities have a responsibility to investigate *all* such allegations.

One proprietor told of how:

“...the reporting of abuse has become a ‘bitchline’ for disgruntled members of staff...disgruntled members of staff who want to get their own back because they’ve been performance managed. It’s frightening the power these care staff can exercise.” (PI)

A second proprietor maintained:

“...I know staff make anonymous allegations to hit back at their manager because otherwise they have no power...” (PB)

A number of care managers also spoke of their belief that, in their experience, some of the anonymous allegations that had instigated safeguarding enquiries had been made spuriously by members of care staff employed at their homes. They cited such

occurrences as care staff seeking retribution following, for example, instigation of disciplinary action, not granting requested leave at Christmas, and general antagonism between care managers and members of care staff.

Proprietors and care managers also related how care staff would threaten colleagues with whom they did not 'get on', with allegations that "would get the names on the POVA¹⁷ list..." (MH). Care staff confirmed this behaviour in some of their responses:

"...and the senior care here actually said to me 'If you don't like how the manager treats you, you can always make that call and tell the authorities she allows abuse and neglect here'...she didn't like the manager that's for sure." (CK)

"...and I know the senior carer has told other staff that her and her cronies will get them listed on the POVA list if they don't work as she wants them to work which means abusing residents. By not washing them, by not taking the time to help them eat, not cleaning them properly y'know..." (CL)

Though 'Care Staff Revenge' is not a factor that causes abuse, it may be a factor that helps to perpetuate it when exacting 'revenge' is used as a lever to engender

¹⁷ The Protection of Vulnerable Adults (POVA) list includes the names of any staff deemed to be unsuitable to work with vulnerable adults. The POVA list was replaced by the ISA [Independent Safeguarding Authority] list implemented from 2009, again replaced in 2012 by the Disclosure and Barring Service (DBS) list that combines POVA and Criminal Records Bureau (CRB) records.

behaviours in staff that may be abusive, as in the example above from care staff 'CL'.

6.4. The Macro-Social Environment within which the Care Home Operates: Concepts

6.4.1. Societal Value Judgements

Though all three groups of respondents shared their perceptions of how societal value judgements related to aspects of the care industry perhaps contributed to the creation of circumstances where abuse of older people in care homes might occur and be perpetuated, perspectives elucidated in this study were somewhat different among the three groups.

Proprietors and care managers spoke of the societal judgements in terms of the low value attributed to both care staff *and* older people, whereas care staff related their perception of how *they* were perceived by society, their managers and proprietors as having low value in terms of the job that they do, but did not speak of the value that might be attributed by society to the people in their care. These perceptions were isolated as axially related sub-concepts.

Value Judgement Attributed to Care Staff and Older People (Proprietors and Care Managers Only)

Proprietors cited the low pay of care staff as indicative of the view society generally holds of those who undertake care work and of the people they care for. Several proprietors spoke of how increasing the pay rates for care staff would reduce the

occurrence of abuse because higher rates of pay would compensate for the difficult and stressful nature of the job of caring for older people with significant care needs. Some proprietors also believed that if pay rates were increased care staff would not need to work additional hours to earn more, given that, in their opinion, tiredness among care staff could also contribute to the likelihood of abuse. They suggested, however, that to increase pay rates to care staff would require higher fees to be paid to support their businesses and this, in turn, would require an increase in the rate of general taxation. Proprietors believed this would not occur due to unpopularity with an electorate that did not value older people positively enough to pay for an increase in the hourly pay rates of care staff through higher rates of income tax.

Other proprietors suggested that placing older people in care homes was probably not the best option, stating that ideally they would be given care in their own homes, but to do so would be far too expensive for the country to bear. One care home proprietor opined paradoxically, whilst indicating the care home environment around her in which the interview was being conducted that:

“...there is something fundamentally wrong with a society that allows the very people who fought for our right to speak out should be treated like this at the end of their days.” (PI)

Care managers also confirmed that care staff were poorly paid in their opinion, mostly receiving only the national minimum wage for a very demanding job, and that this reflected the low value placed by society on care staff and the job that they do. Care managers supported the view that society does not value older people,

suggesting that society's positive evaluations were attributed to aspects other than how older people should be looked after:

"...a lot of people don't care about the elderly. It's just society values that have changed over the years. People don't seem to be family orientated these days. We worship other Gods than our seniors." (MF)

"It's a lot to do with the media, their input is about glamour, stars and reality TV...it's down to what is instilled at a young age about the elderly. I think younger people are losing respect for the elderly that's why abuse is going on...it's societies fault." (MJ)

"I think it's down to human nature and society, that the able and well and unimpaired dominate society as one group, they are listened to and have more power." (MH)

"You get the likes of Winterbourne¹⁸ and you get the shock factor and then it goes quiet and nobody notices, nobody cares. If you could see what goes on behind closed doors you'd be shocked. It's as if everyone has got used to abuse...accepts a level of abuse will occur. It's something in human nature and generations are changing. Though some do I suppose, the majority of younger people don't respect their elders. It's the way they are brought up by

¹⁸ A high profile occurrence of abuse in a community hospital for people of all ages with learning difficulties where incidents of abuse captured on film and televised in 2011

their parents. That has a massive impact on the way younger people are today and their attitudes to older people. And the elderly are living longer and need more care that just isn't there because the younger people, many carers just don't care... respect for older people is disappearing." (MD)

Value Judgement Attributed to Care Staff (Care Staff Only)

Care staff also spoke frequently about the low pay they received, often referring to being paid the national minimum wage for a very difficult job. Care staff saw this as indicative that they were at "...the bottom of the pile..." (CJ), in the view of society. Some carers believed they did a very important job in looking after older people in care homes, and a small number overtly spoke of their pride at being carers, but many also recognised they experienced low status in society because of how they earned a living. One told of a social encounter with a person they had not previously met:

"[she said] 'Oh you wipe arses for a living?' I [the carer] said 'Yes, yes I do and I'm very proud of it because it takes a certain type of person to be able to do that', but you could see she was looking down her nose at me" (CA)

Another care staff member asserted:

"I think we've got a hell of a big problem because it's a non-caring society don't you think? No one has much regard for the people who do the caring for those that need it in society...more money won't solve it...but valuing the

people who do the job might help, seeing carers as a very important job in society.” (CB)

One carer perhaps summed up:

“I think the way of life...everybody is angry, everybody is out for something, everybody wants something for nothing these days, there is no respect and I think frustration...to a lot of people...and obviously, no offence, it shouldn't be frustration all about money...people are just angrier now...but now I don't feel like...people look at people who have got something and its more of a jealousy factor, no 'Oh well done for them' its 'bloody hell why ain't that happening to me...because I'm just a carer?' and they take out that anger and frustration on the people they should be looking after...because they can...they are helpless.’ (CD)

Care staff also spoke of their perception that they were at the 'bottom of the pile' not only from a societal perspective but also within the hierarchical structure of the care home, where they were looked down upon by care managers and care home proprietors; “you are nothing to them”, one care staff member 'CB' asserted. Other care staff spoke of a lack of support and interest in them, especially from care home proprietors, and of respect, affirming how this often led to care staff resenting the managers and the owners of the care homes in which they worked.

One care staff member offered that:

“...we are the lowest paid and we have no authority so we feel powerless...I suppose we have more power than the residents though...” (CJ)

6.4.2. I Need a Job, Any Job

Proprietors, care managers and care staff all identified that the need for a job, any job that provided an income, was instrumental in bringing unsuitable people into contact with older people within the care home environment. They perceived this phenomenon as a contributory factor in the occurrence of abuse because recruited care staff were often found to be incompatible with the work involved that demands respect for, and significant patience with, the older people in need of care.

Care home proprietors and care managers told of the high frequency of unsolicited telephone calls from people of both sexes and all ages seeking employment as care staff. They also related how common it was for people to knock on the doors of their care homes seeking employment. They told of how caring was a last resort for many people seeking employment, and also of how the job of carer, though generally known to be low paid, was believed to be an easy job to do by those who had no previous experience of care work.¹⁹

¹⁹ During the period of this research unemployment rates were falling among the general population, but were still relatively high.

Care managers spoke of how people, for example, “come into care because there is nothing else” (MG) and of how “this [caring] is the only job they can get and they [carers] couldn’t care less...they have no interest in the job really...that’s where abuse comes from” (ME)

One care manager summed up the beliefs evinced by many of her counterparts:

“But carers are always needed, people come into care because it’s a job, it’s a job for life, but they’ve got to want to come into care, got to be the right sort of person to like the elderly. But people come into care just to provide household income, or a second household income, not because they want to care. Without other industries left care is one of the few available, I’ve certainly had more men apply in recent times...it’s a job. Care work is easy access and some people have no other opportunities but to do this work so the pay can stay low. So carers get an income that is better than no income at all, but carers have low status in society” (MD)

Other care managers spoke of a noticeable increase in the number of enquiries they received since unemployment in the general population had increased in recent years.

Carers similarly identified that it was not uncommon for people to take jobs in care because they were unable to secure anything else as a result of their capabilities or because levels of unemployment were high. Carers identified a link between people

entering care jobs in care homes just for the sake of securing employment and the occurrence of abuse:

“A lot of carers don’t come into this to give...they come into it because they get paid. Though you are paid paltry for the job. What do we expect as a society from carers when they are paid the minimum wage? Is it surprising they give some old dear a poke or a pinch or a slap from time to time? Imagine trying to clean somebody who has...y’know...been heavily incontinent and they are trying to bite you or punch you, is it surprising it happens?” (CH)

“And carers think ‘I’m only getting paid such and such so I’ll go in and do the bare minimum, chat with my friends instead of meeting peoples’ needs’, that’s where neglect comes from. Caring for someone, maybe very old, maybe with dementia, maybe aggressive, it’s one hell of a job, so why are we paid the minimum wage.... not valued by society?” (CG)

“Let’s be honest about this, you’ve got more people that don’t care, more are here just for a job to pay the rent, the mortgage, but they haven’t got the brains to do anything else...they are here just to get the money.” (CB)

Another care staff member was frank, recounting:

“If I’m honest it was basically I needed a second job. I never had the desire to work in care if I’m honest, I didn’t know what the job entailed y’know, but I needed the income...” (CA)

Notably, of the twelve care staff interviewed during this research none had purposefully aimed to work in care. All care staff respondents had drifted into the work because they needed to work to generate income, and either nothing else was available to them or they believed they were not capable of anything other than care because of their personal limitations. Only one former care staff member who was interviewed as a care manager had intentionally prepared for a ‘career’ in care whilst in secondary education. Though she had intended to study nursing, she had failed the entrance test and had consequently worked as a carer in the same home she now managed, having spent twenty-five years with the same employer.

6.4.3. Recruitment Processes Are Weak

Proprietors, care managers and care staff all highlighted a number of perceived weaknesses inherent to current interviewing and selection practices within the care home sector and how this increased the risk of abuse occurring.

All three groups explained their beliefs that the interview process was weak in that candidates for care staff jobs seemed able to answer questions and say the ‘right’ things at interview, but that this was not reflected in their conduct once employment

had been secured. Proprietors and care managers spoke of how very difficult it was during an interview to determine the true values and attitudes held by care staff job candidates towards the older people they would be caring for.

A care manager described:

“Sometimes you think yeah they have got the passion, sometimes you can see it pour out at interview but once they are in the door its completely a different scenario. The passion was a falsehood and once they’re through the door you think ‘where’s it gone?’ or at the end of the probationary period they’re crap but at the interview they shined.” (MJ)

Other respondents also recounted how newly recruited care staff would work and behave as was required during their probationary period²⁰, but that when that period came to an end their behaviour would sometimes change, including abusive and neglectful practices.

One proprietor reported:

“You can’t ever know you have recruited appropriate staff, I follow the regulations, we get references and they come in on a probationary period, they seem fine and then they abuse...how can you prevent it?” (PB)

²⁰ The probationary period in the private sector care home sector for care staff is usually 3 months.

A care staff member described her experience as follows:

“...we do get those that interview well and are fine until the end of their probationary period and then all hell breaks loose and they become abusive and neglecting in their practice and even try to change things in the home, how staff...how they work, for the worse” (CC)

One proprietor described ‘sophisticated’ care job applicants who would perform well at interview because, she believed, they had been prepared by the ‘Job Centre’, acting as intermediary between the job candidate and the prospective care home employer. She spoke of how it was impossible to “drill down and get to the person” (PH) in an interview lasting around one hour.

A second proprietor told how:

“We’ve interviewed some people sometimes and thought they are going to be fantastic and they haven’t been as good as you think and have neglected and psychologically abused residents as we have found out later...” (PC)

Some care staff members gave substance to this perception in their responses:

“I mean I can go in an interview and speak the best garbage, say you know I’m the best and I’m this and I’m that and I might be nothing if you know what I mean.” (CD)

“The recruitment process is not fool-proof, you can say anything to get a job and once you’re in, you’re in.” (CK)

Proprietors, care managers and care staff also expressed their belief that the current Protection of Vulnerable Adults (POVA) list checks with the Independent Safeguarding Authority (ISA) had limitations to its effectiveness.

A care staff member summed up perceptions of respondents:

“...and POVA list checks are only any good if you’ve been caught. I could have been up to all sorts of things but never caught, I could have been abusing for twenty years, just not caught [laughs]. They are only worth anything, CRBs, if you have been caught doing abuse.” (CF)

One care manager also pointed out that only those staff committing more severe forms of abuse were recorded on the POVA list, and that this was a limit to its effectiveness because abuse was common at lower “everyday” levels (MJ), redolent of other respondents’ assertions that “psychological abuse leaves no marks”.

All three groups of respondents also believed that the current practice of potential care home employers securing two written references prior to employing new care staff was flawed. Proprietors told of how they had recruited care staff with positive references but that on some occasions these staff had gone on to abuse those in their care. There was a belief among proprietors and care staff that positive references were sometimes given for care staff by former employers as a

mechanism to 'get rid' of care staff who were not wanted by their employers. It was these staff, they believed, who were likely to be those that might go on to abuse.

6.4.4. Fearful Safeguarding Responses

All three groups of respondents asserted that the nature of the safeguarding response from local authorities was “negative”, “intimidating” and “awful”, and generated feelings of “fear” and “terror” among those care managers and proprietors who were required to attend multi-agency meetings. Care managers and proprietors spoke from personal experiences in greater part, whilst care staff perceptions were formed from what they had heard from their managers or surmised in general. Proprietors, care managers and care staff also spoke of their belief that the nature of the safeguarding response had a strong tendency to presume guilt before it was proven.

Proprietors and care managers expressed their belief that these two characteristics of the response was a deterrent to incidents of abuse being reported and was serving to perpetuate abuse by driving it further “underground”. In turn, proprietors and care managers asserted this phenomenon was leading to non-disclosure and either a “blind eye” being turned when abuse occurred, or to attempts being made to deal with cases of abuse “in-house” without the involvement of external agencies.

Remarks of respondents included:

"I've been to safeguarding...I was terrified...that process is upsetting and frightening...a horrendous experience. I was petrified. You expect us to bare all and then you give us a hard time. To be honest I would only report something that was serious" (PB)

"...it's an awful thing for a registered manager and owner to go through...awful...it's really not nice...it's very stressful...more likely to drive evidence of abuse further underground...an awful experience. This is very much a deterrent to care home staff reporting and being open about abuse" (PF)

"Absolutely there is a temptation not to report...the providers are the ones who are made to feel guilty and this stifles openness in the culture of the care home. If providers were not assumed to be guilty before they were proven innocent there would be a lot more openness" (PI)

"It's a destructive not proactive process when that [the safeguarding response from authorities] it's counter-productive because the process is so geared to being guilty before you can prove your innocence it invites non-disclosure [of abuse]" (PK)

"You feel like you are the accused, even when nothing is proven, small wonder some staff, managers especially, are reluctant to report, turn a blind eye. I know it goes on from other managers of homes in this group" (MC)

“I often used to have a knot in my stomach when having to make a safeguarding referral. It is a deterrent to reporting. I have colleagues who have not reported because of this fear. The whole process is demoralising...daunting” (MG)

“I know I’m not the only one, you are terrified, you go into absolute panic and it shouldn’t be like that. I know a manager who was reduced to tears and that is going to stop, to stop reporting from homes. People won’t be open when it’s like this.” (MH)

“It’s very hard for homes to admit to abuse because of the treatment they then receive, I believe it drives it [abuse] underground...” (MB)

“...you are made to feel guilty before you are proven to be...” (CA)

“It’s very daunting to go...It is very daunting, bloody horrible I would say. You must feel you are in a court of law and you have done something wrong, you are made to feel guilty.” (CG)

All twelve care managers who were interviewed raised the nature of the safeguarding response from authorities as being a deterrent to disclosing abuse. Though unlikely to be a cause of abuse, such a widely recognised characteristic within care homes may contribute to the concealment and perpetuation of abuse as a consequence of abusive practices remaining unchallenged, certainly by external agencies.

6.5. Conclusions

This chapter has presented themes derived from grounded theory analysis of the data, illustrating these with verbatim examples of responses. It has shown how these coded responses were grouped into the organising categories at micro-care home environment and macro-societal context levels as represented in Figures 6.1. and 6.2. (on pages 156 and 157), to depict the myriad potential factors that may create the conditions wherein abuse may be perpetrated.

The following chapter discusses findings arising from analysis of interview responses and from numerical and free text responses to the anonymous questionnaire in relation to the first two of my original research questions:

‘What is the extent and nature of abuse of older people in contemporary care homes?’

‘How do attitudes, relationships and behaviours within the care setting contribute to or prevent the occurrence of abuse?’

7. Explaining Abuse: Attitudes, Relationships and Behaviours.

7.1. Introduction

The aim of this study was to inform future policy that will contribute to overcoming the abuse of older people in care homes by developing substantive theory of why it occurs.

This, and the subsequent chapter, discuss key issues arising from analysis of responses to the primarily quantitative anonymous questionnaire, and from the grounded theory analysis of interview data. Numbers in square brackets indicate specific numbers of anonymous questionnaire respondents who indicated particular knowledge or experience of the identified factor contributing to the discussion.

Throughout the discussion findings are integrated with theoretical concepts from other fields of research to begin the construction of an unprecedented theoretical explanation of why abuse occurs within care homes.

This first chapter discusses the role of staff attitudes and behaviours, and of their relationships within the care home that might contribute to abuse.

7.2. The Extent of Abusive Practices in Contemporary Care Homes

It is clear from qualitative interviews with care home proprietors, managers and care staff, and particularly from anonymous questionnaire responses from care staff, that abuse of older people in contemporary care homes continues to occur. This is reflected by a significant majority of 89.3% of the total number of questionnaire respondents (n=140) confirming that they had either witnessed or suspected abuse in the homes in which they had previously worked, with only 10.7% stating they had neither witnessed nor suspected abuse. As shown in table 5.3 on page 141, of those questionnaire respondents who had witnessed or suspected abuse (n=125) between 72.4% and 83.3% in each of the five homes reported witnessing it, whilst between 45.2% and 66.7% suspected abuse to have occurred. The proportions of staff witnessing abuse are similar to the findings of Pillemer and Moore (1989) and Goergen (2001; 2004) cited in the literature review. Of those who had witnessed abuse (n=94), 89.4% stated it had occurred repeatedly rather than as single occurrences.

Questionnaire respondents who had witnessed abuse described psychological abuse most commonly (46.9%), followed by neglect (39.4%) and physical abuse (20.3%), and provided examples of how these abuses had taken form as depicted in table 5.6 on page 145. Interview and questionnaire respondents described a range of particular practices they had witnessed, identifying, for example, the practices of the 'cocoon', 'hooking' or 'snagging' and 'speed feeding'.

Though interview respondents were often imprecise about the timescales in their reports of the abusive behaviours they had witnessed, 75.5% of questionnaire respondents stated the abuse seen had occurred during the previous 12 months. Further, 39.4% had stated the abuse occurred between one and three years prior to questionnaire completion, and 5.3% more than 3 years prior to questionnaire completion. Given that questionnaires were administered to the five participating care homes during the period 2011 to 2013, these reports were of abuse occurring relatively recently.

This research has consequently determined that physical and psychological abuse and neglect in for-profit care homes remains a common occurrence according to the reports of the care staff interviewed, and those who had previously worked in other private care homes. Responses also illustrated the many forms it may take within the broader categories of physical and psychological abuse, and neglect, though reports of financial and direct sexual abuse were largely absent²¹. Analysis of interview data in particular also elucidated the complex interplay between factors among care staff, those requiring care, the care home organisation, and the society in which it is embedded, that may create conditions where abuse is more likely to occur.

The anonymous questionnaire methodology proved effective in revealing particular abusive practices occurring in more than one care home. It has also confirmed that abuse was not always reported at the time it occurred and that deliberate strategies

²¹ One respondent to the anonymous questionnaire indicated they had witnessed financial abuse, one sexual abuse, but no details of either were provided. Other anonymous questionnaire responses indicated a small number of examples of psychological abuse with some sexualised content; there were no specific examples of direct sexual abuse reported during research interviews.

were sometimes adopted within care homes to conceal abuse. Such specific aspects of behaviour have not previously been documented on this scale as a result of research, and it appears that the anonymity of both identities of respondents and the care homes in which they previously worked supported frank and honest disclosure of much hitherto unreported abuse.

7.3. Value Judgements, Relationships and Behaviours Among staff that Contribute to the Occurrence of Abuse

7.3.1. Value Judgements and Attitudes

Attributing a positive value to older people requiring care, and having a munificent attitude towards them, is of cardinal importance given that care staff are the instruments whereby care is directly provided. Care staff are the principal arbiters of the nature of that care and of whether or not abuse occurs. However, as all groups of interview respondents confirmed, not all care staff *do* value positively those they are employed to care for, and this sometimes manifests in their attitude and consequent abusive behaviour towards them. Interview respondents identified lack of respect, a failure to treat older people with dignity, or to attribute to them the same 'worth' as other people, perceptions that suggest the presence of negative, prejudicial views operating among some care staff. Frequent references were also made to the reduced cognitive abilities, awareness, and perceived short life expectancy of residents following admission, and were used by some care staff to legitimise ageist presumptions that compound unfavourable perceptions of the older people they engaged with. For example, the assertion of carer 'CH' that "*...most of these old people don't know what's going on anyway, so they don't know whether they are*

clean or not do they?" Similarly, anonymous questionnaire responses not only revealed the disturbing frequency of the occurrence of abuse in care homes, but also gave some unique insights into the range of abusive behaviour care staff had encountered. The reported behaviours suggest a continuum of abuse ranging from widespread neglectful omissions, to examples of seriously harmful, sometimes pre-meditated acts that further suggest that older people in care may not be positively valued or attributed much worth by staff employed to care for them.

Though the research raises multiple factors that may contribute to the occurrence of abuse, for example stress experienced by staff, understanding the role of individual staff members' value judgements and attitudes that may lay the foundations for abuse can be enhanced by identification of three distinct, though interrelated components of age related prejudice, applicable at both individual and societal levels (Butler 1969; Baron and Byrne 2002):

- A cognitive component (beliefs and stereotypes about older people)
- An affective component (prejudicial attitudes towards older people)
- A behavioural component (direct and indirect discriminatory practice towards older people),

To these propositions this research adds a 'value judgement component', as suggested by all groups of interview respondents, situated between the non-evaluative "cognitive component" and the "affective component" above. It is this

value judgement *formed by the individual* as a result of the myriad of influences within their society that generates either a positive *or* negative affect²². The subsequent affect is the progenitor of attitudes that may in turn produce abusive behaviour.

Individual Value Judgements

Much of the literature exploring human values is concerned with “what people value” in their lives and to what they might personally aspire to achieve self-fulfilment, the “means” [instrumental] and “ends” [terminal] values respectively (Rokeach 1973). For example, self-direction, stimulation, and power (Schwartz *et al.* 2000; Schwartz *et al.* 2001; Schwartz and Rubel 2005). These instrumental and terminal values to which people may aspire to or covet, are also treated in terms of how *positively* they are valued, rather than whether or not they are evaluated in *negative* terms (Schwartz and Rubel 2005).

However, the development of individual value judgements considered here relates to the sense of both what and *who* is good, desirable, valuable and worthwhile, or what and *who* is not good, undesirable and without worth, in terms of evaluations based upon societal and individual, personal *consequence or effect* terms (Santrock 2007). As Bruun (1972: 88 in Morrison 1995: 270) offers, “A person who is living is, by definition, value oriented in the sense that they are judging and evaluating their

²² The word ‘affect’ is used here as a noun denoting a feeling, emotion or mood associated with an idea or action, or its external expression (Encarta Dictionary of English).

surrounding world and its inhabitants". In turn, value orientations and subsequent judgements affect the perceived utility derived from potential interpersonal relations with those upon whom the value judgement has been conferred. The combination of non-evaluative beliefs and the subsequent positive or negative evaluation attributed to these beliefs, form attitudes (Fitzsimmons and Barr 1997; Mansell *et al.* 2007). Attitudes subsequently give rise to a predisposition to think and behave in a certain way in response to specific stimuli (Fitzsimmons and Barr 1997; Albarracin *et al.* 2005; Jimenez 2009; Bowers *et al.* 2009). So, if older people are valued positively by care staff in these depictions, a positive, non-prejudicial affective component may well be manifest. Conversely, if they are not valued positively, a negative, prejudicial affective component may be evident. This affective component influences subsequent behaviours; in this way value orientation affects human action (Weber 1949 in Morrison 1995: 347; Schwartz 1992: 6). As this research confirms, there were many examples of abusive behaviours in care homes as experienced by staff who completed the anonymous questionnaire in particular. Such abusive behaviours in care homes would be unexpected by normative standards.

These theories from the disciplines of sociology and psychology may be applied to the level of the individual agent working in the care home. For example, the care staff member who believes that old people demand greater resources than younger people may ascribe to them a negative value judgement, perceiving that older peoples' needs may reduce their own access to resources, increase their tax liabilities and consequently limit income. In turn they perceive that this affects their abilities to provide for their children. Consequently, the care worker develops a negative attitude towards older people and their worth, manifest as rough handling

behaviour, compounded perhaps by the stimulus of verbal abuse from the older person arising from their cognitive dysfunction. Conversely, the care worker may hold the belief that older people, having contributed to society throughout their lives, now deserve significant resources for their care in their later years, attributing to them a positive value. This value judgement engenders an attitude of disregard for any increased tax burden that may occur as a result, and caring, tolerant and respectful conduct towards older people, maintained even in the face of behaviour that challenges the application of this attitude to care.

For example, during one research interview a carer asserted that:

“These old men fought in the war to give us our freedom, they may be old but they deserve the best care....” (CB).

Whilst conversely a second asserted:

“...they have had their lives, they are so dependent and what in truth can we do for them, they will die soon anyway...” (CG).

The presence of negative value judgements about older people among care staff will probably reduce the likelihood of them facilitating circumstances where older people, especially those with dementia, can experience interaction and creative activity through meaningful relationships recognising the ‘personhood’ of the individual, the use of familiar and comforting routines, and the provision of care that is personalised to individual needs (Kitwood 1997; Killick 2012; Downs 2013).

Individuals' Value Judgements and Their Significance to Policy

It was not possible to demonstrate from this research a direct causal link between the presence of negative value judgements of older people as identified by interview respondents, and abuse. Further, the existence of negative value judgements about older people does not necessarily mean that those providing their care will engage, or always engage, in abusive behaviour. However, the significance of value judgements among staff that are congruent with caring for older people becomes apparent when applied to espoused government policy and supporting research. Such policy is replete with calls for care providing organisations to hold appropriate “values” with respect to the people for whom they provide care (Tadd *et al.* 2011a; Cavendish 2013; Killett *et al.* 2013; 2014c), yet this policy led approach to modifying behaviour at the micro-level of the care home fails to recognise two fundamental flaws in its approach:

1) What are often quoted in policy as ‘values’ are *not* values in the sense that ‘to value’ [as a verb] is a judgement of the ‘worth’, ‘degree of usefulness or desirability’ or ‘merit’ of something or somebody. Instead they are espoused desired principles of care [‘value’ used as a noun, and often erroneously] for what is seen to be good practice among care providers, including those that operate care homes. For example, Skills for Care (2013: 1) cites the ‘values’ of ‘courage’ and ‘imagination’ as desirable among care staff, but these are personal attributes that may be applied to principles of care rather than evaluations of the people who are to be require care.

2) It is, in any case the *individual* agent who applies their own evaluative process of judgement to any espoused organisational principles or desirable personal attributes, and perhaps more crucially to the people to whom those principles are supposed to apply, and their 'worth', 'usefulness or desirability' or 'merit'. These value judgements give rise to consequent attitudes that in turn influence their behaviour and approach toward providing care. Though this evaluative process will be influenced by many factors, such as upbringing, personal relationships, educational experiences and wider society, it remains a judgement formed and exercised by the *individual*.

Confusing Value Judgements with Principles of Care

Though some scholars have previously raised the consideration of 'aptitude' or 'suitability to care' in consideration of family and domiciliary care provision, this has been treated very briefly without explanation (Biggs *et al.* 1995: 71; Froggatt *et al.* 2009:18). Only recently has government policy in the form of The Cavendish Review (Cavendish 2013), when discussing the recruitment of care staff in all sectors, tentatively recognised the importance of "...testing values, and aptitude attitudes [of potential staff] at the recruitment stage" (Cavendish 2013: 56). Unfortunately, however, the Cavendish Review mentions value orientated recruitment just once and offers no guidance on how this might be achieved. Further, what are presented as 'values' by Cavendish are better described as 'principles of care', and there is a failure to conceptualise that it is the individual who, in any case, subsequently confers a value judgement upon these principles, and, consequently, whether or not to adhere to them. Similarly, there is some recent acknowledgement of the importance of the "...values demonstrated in practice..." by care home

organisations, in the sense that they may be in conflict with the values that the organisation publicly articulates (Killett *et al.* 2013: 6). However, the research of Killett *et al.* (2013) refers to the values of the care home organisation, rather than the value judgements made by the individuals within it, and also assumes that organisational values as stated will be readily adopted by the collective group of staff, when this may not be the case (Jimenez 2009). Again Killett *et al.* employ the term 'values' as synonymous with 'principles of care and practice' and personal attributes of staff, citing for instance "leading by example" as a value (Killett *et al.* 2013: 99), and, like Cavendish, omit consideration of the *value judgements* that will be inevitably conferred by individual staff members upon these principles of practice. As Schein (2004: 25) maintains when considering organisational cultures in general, "Values are open to discussion and people can agree to disagree about them", a characteristic perhaps reflected within NHS organisations, for example, by a report from the Health Service Ombudsman (2011: 7) who highlights the "...gulf between the principles and values of the NHS Constitution and the felt reality of being an older person in the care of the NHS..." suggesting that the values of NHS staff directly providing care may not be congruent with idealised, espoused organisational values.

It clearly cannot be assumed that care staff who enter the care home workforce will have necessarily developed value judgements that are compatible with the demanding work of caring for older people who require assistance to meet their needs, many of whom will have cognitive difficulties rendering them particularly reliant upon those staff around them. During the interviews, several care staff themselves acknowledged the incompatibility of the value judgements held by some

of their peers with the work they were undertaking. Similarly, twelve anonymous questionnaire respondents also suggested that 'bad' care staff, (or care staff who simply 'did not care') were responsible for the abuse they had witnessed. Fundamentally, value judgement frameworks congruent with the work of providing care cannot simply be 'given', conferred, or forced upon care staff. As has been revealed by the concepts of 'I Need a Job' and 'Recruitment Processes are Weak' emerging from this research at macro-societal level, determining motivations and true value judgements of prospective care staff during recruitment is fraught with difficulties. These factors are not recognised and addressed by current recruitment practice in the sector (Skills for Care 2014d: 16).

Are Good Care Staff Born, or are They Made?

All three groups of interview respondents also frequently expressed their view that 'good carers were born, not made' and though they did not explicitly talk of care staff having the right 'values' in this context, they did explicitly articulate their belief that the 'born carers' had the 'right attitude' to those in their care. There is perhaps a contradiction in this recurrently expressed conviction that 'good carers are born not made' in that attitudes displayed by care staff are influenced by their value judgements that, in turn, have been formed during childhood and adolescence through socialisation and maturation to adulthood, rather than being present at birth. Massey (1979:71) maintains from his seminal research that young people pass through a 'socialisation period' from the ages of around fourteen to twenty-one, where "...relational interactivity and social values..." are consolidated from earlier 'imprinting' and 'modelling' periods, and remain largely unchanged thereafter, unless

as a consequence of significant personal trauma (Massey 1979; Inglehart 1997). Research by Verplanken and Holland (2002), and Kasser and Kanner (2004), also determined the resilience of consolidated value systems among adults, attributing this to the importance of value formation to the conception of self.

It seems unlikely, then, that people suitable to be good care staff are born with the innate disposition to do so, though the presence of some inborn qualities present at birth cannot be discounted. More probably, they have formed and maintained fundamental value systems during socialisation and maturation that are in harmony with caring for older people, despite the potential attrition from a society that, at least in part, does not value older people living in care homes. It is perhaps this characteristic that is apparent through their caring or non-caring behaviours observed by proprietors, care managers and the care staff that they work with when they first enter the experiential frame of the care home. It is this, perhaps, that leads to the recurring expression from many interview respondents that 'good care staff are born, not made'. However, any reliable assessment of such characteristics, whether innate or learnt, is absent from current recruitment practices in the sector.

Clearly, from the preceding discussion of the values held by care staff, based on the experiences of respondents and on evidence of contemporary abusive practices from anonymous questionnaires, not all of them have formed value judgements that are compatible with providing high quality care to older people who require it. Such negative value judgements and potential prejudicial attitudes are not easily eliminated by simply attempting to impose new value frameworks upon them, though, as Cavendish (2013: 55) optimistically asserts "...training to embed values..."

There are of course other factors that may be operating that affect the conduct of care staff, for example, the capacity to tolerate frustration and to manage anxiety, and the development of fear or dislike for the people they are to care for. Further, the experiments of Milgrom (1974) and Burger (2009) suggest that even those with values compatible with caring for older people may be pressured by their peers or super-ordinates into acting in ways that are incompatible with their established personal value frameworks. The effects of these factors, however, if not the factors themselves, are still likely to be ameliorated if care staff positively value the people in their care from the outset and recognise their unique 'personhood'. But this is not always the case, as frequently asserted by interview respondents (care home owners, managers and care staff).

The proposition that 'good carers are born not made' remains perhaps, unfathomable in that it cannot be demonstrated or otherwise from this research. Yet it is clearly a common perception among respondents in this limited study, and perhaps some means of identifying these potential 'good' care staff, who at least hold value judgements commensurate with the work of caring for older people is required. Such measures might reduce the influx of those into care homes who clearly do not value the people they are charged to look after.

Regarding Older People in the Care Home as 'Other Than People'

The incompatible value frameworks of some care staff were starkly reflected in the assertions of managers and care staff during interviews that, in their experience, some care staff had a tendency to treat the older people in their care as "other than

people”, “less than people”, “not real people” or “not people”. Adjectives used by respondents to describe how care staff viewed older residents from their experiences also included “cargo”, “lumps of meat”, “materials” and “work pieces” with respondents describing how these “not people” were sometimes treated as if they were “all the same”, “mechanistically” as if they were on a “conveyor belt system”, and that the objective of care work for some staff was to yield a “finished product” without consideration of the person’s humanity. A small number [4] of questionnaire responses similarly told of how the abuse they had witnessed had been caused by residents being viewed as “other than people” or “less than human”. Though some interview respondents attributed this phenomenon in part to the limited time in which a defined number of physical care tasks were required to be completed (time limitations was identified as a sub-concept in its own right under ‘No Time for Kindness-No Time for Nonsense’ and is discussed below), others saw its origins in care staff perceiving the older people in their care as a different ‘group’ of ‘not real’ people, set apart from care staff.

Psycho-Social Explanations of ‘Otherness’ and Negative Perceptions of Older People.

Boulding (1956) maintains that the psycho-sociological explanation for viewing, in the case of the research here, older people as ‘other’ than people, is situated in the human construction of ‘mental images’ of old age that generate a subsequent fear of ageing, likely dependency and ultimately death. Boulding and others suggest that this can be a source of psychological conflict within younger people that may be externalised when engaging with older people (Bytheway and Johnson 1990; Butler

1996; Bernard 1998; Harbison 2000). These 'mental images', interpreted at the interface between perception and knowledge, influence the construction of beliefs, and it is through the foundation of these beliefs that value judgements are bestowed upon others. These images, beliefs and subsequent value judgements mediate between the agent and their external environment to influence behaviour (Boulding 1956; Diller 1999; Harbison 2000; Brechin 2000) aligning with the propositions of Fitzsimmons and Barr (1997) cited in the earlier discussion of the value judgement frameworks of care staff. As a consequence, older people may cease to be perceived by staff as human beings, facilitating to a degree negation of their own fear of ageing through a repudiation of their future self (Harbison 2000; Garner and Evans 2002); older people may then come to be viewed as people of a "...distinct and inferior kind..." (Comfort 1977: 35). Boulding (1956) maintains that individuals consequently hold negative images of what they will become, an assertion that might be significant when applied to care staff caring for older people who are often frail, ill and in the last stages of life. This was demonstrated in the assertions of some care staff, for example, one care staff member maintained:

"...if I get to this stage when I don't know whether I am on this earth or Fuller's I would like someone to end it all for me." (CG)

Another stated that

"Well, really I would hate to end up like these people, not knowing who was who or where I was or even what I was doing." (CI)

Care staff behaviour may, therefore, not be a product solely of a particular stimulus in the present time, but, as Stricker (1995) maintains, of the whole image of the world they hold in their minds, and that is beyond their immediate awareness. By this mechanism negative and pervasive stereotypical perceptions may be internalised among groups, and may lead to inequitable and sometimes harsh treatment of older people (Tomita 1990; Levy 2003). That this attitude of mind based on personal unfavourable value judgements may be present among a proportion of those recruited to care is corroborated by the findings of this research. Certainly, some of the behaviours of contemporary care staff, particularly as described by anonymous questionnaire respondents, of which examples were presented earlier in Chapter 5, suggest the presence of forces acting upon some staff consequent to which older people may experience cruel and inhumane treatment meted out to them by those who should be providing their care.

Mackie *et al.* (2000) have demonstrated through experimental research on prejudice that prejudicial feelings among populations toward certain groups are a reliable predictor of subsequent actions. The research of Abrams and Houston (2006: 55), using a nationally representative sample, determined that prejudice against people over the age of seventy years was higher among those under thirty, at 19%, than among other age groups, at 10%. This is again perhaps significant given the 38.4% of care staff in the private sector aged between 18 and 29 years (Skills for Care 2012: 19). Abrams and Houston (2006: 67) also found that 17% of respondents in their research viewed people over 70 as an economic threat, and though sometimes arousing feelings of pity, they also generated contempt and resentment toward this group. These feelings, if present among care staff, may form a basis for the

development of negative evaluations of the older people they care for and militate against them being recognised as unique individuals who retain their personhood that can be reinforced and maintained through opportunities for interaction and creative activity within meaningful relationships with care staff (and others).

Out-group Homogeneity Effects

Further explanation of the underlying reasons for the reported behaviours of care staff toward older people revealed by this research may be found in the seminal research of Tajfel (1982), developed by Ostrom and Sedikides (1992), who established that group membership in populations leads to an accentuation of intergroup differences and of intragroup similarities (Ostrom and Sedikides 1992: 536). There is evidence from the research to suggest that care staff and residents, though in close proximity to each other on a daily basis, were perceived as two distinctly different groups of people by at least some care staff. For example, care managers identified how older people were treated by care staff as a different group of people that were 'all the same' and often treated mechanistically as a result. Care staff spoke of '*exerting control*' over '*them*' and how '*the dementeds*' required most control. Ostrom and Sedikides (1992: 536) determined that the "...asymmetrical accentuation of intergroup differences in favour of the own group...", led in turn to less favourable affective relationships and resource allocation to members of the 'out-group' by members of the 'in-group'. This phenomenon seems to be reflected in some of the care staff behaviours towards residents determined by this research, that demonstrated how older people were often not treated with care or affection and were denied the physical and psychological care that they required.

Additionally, Tajfel (1969 cited in Ostrom and Sedikides 1992: 536), found there to be asymmetrical emphasis of 'in-group' similarities in favour of 'out-group' homogeneity, that is the members of the 'out-group' are perceived by members of the 'in-group' as more similar to one another than members of the 'in-group'. Ostrom and Sedikides consider this perception of 'out-group' homogeneity as stereotyping, in this context placing older people in a defined social group, ignoring individuality and defining fixed expectations of how members of that group will behave. This may lead to possible unfavourable treatment by members of the 'in-group' (Ostrom *et al.* 1993: 21; Ostrom and Sedikides 1992: 536; Park *et al.* 1991: 213), as a result of unfavourable prejudicial attitudes (Abrams and Houston 2006: 57). Though Fiske *et al.* (2002: 878) have critiqued the work of Ostrom and Sedikides, they still found that more positive perceptions of members of 'out-groups', for example, emotional warmth of older people, though present among members of the 'in-group', are subordinated to negative stereotypes, for example, their low competence.

The occurrence of perceptions of 'out-group homogeneity' whereupon care staff view the older people in their care as a separate and undifferentiated group, undeserved of affection and resources, and even "...interchangeable or expendable..." (Linville 1998: 427) was reflected in the experiences of some interview respondents in this research. As described above, respondents had encountered their peers treating residents as what they described as 'work pieces', 'cargo', 'lumps of meat' and 'materials', and being treated, in their perception, as 'mechanistically' in a 'conveyor belt system', and without dignity, confirming that individual older people were not recognised as such. Added to this is an apparent 'dehumanisation' of older residents, illustrated by the experiences of respondents who described residents

being treated as “other than people”, “less than people”, “not real people” or “not people”. One respondent referred to the older people they looked after as the ‘dements’, another as ‘not normal’. A third suggested that when caring for older people care staff should, “*feed them, accommodate them, clothe them, fine, beyond that leave them.*” The presence of these attitudes towards older people in care are strongly supported by the examples of often pre-meditated, reprehensible abusive treatment of older people by care staff recounted by both interview and questionnaire respondents. These experiences are redolent of symbolic interaction theory (McCall and Simmons 1966; Blumer 1969; Denzin 2004) where the older person has become ‘less than a person’, and also suggest a phenomenon akin to that described by Kelman (1973) may be occurring. Kelman (1973: 25) determined that the erosion of moral restraint may be responsible for the ill-treatment of one group of people by another, asserting that this tends to occur following a triad of processes, the first of which he identifies as “Processes of dehumanisation which deprive the victim of identity...”. The clear delineation between the care staff group and those in their care revealed by this research accords with ‘in-group/ out group’ theory that can lead to accentuation of differences between groups, and the homogeneity of the ‘out group’ comprised of those perceived as ‘less than people’, discussed above. The subsequent abusive treatment of members of the ‘out group’ of older people, revealed by questionnaire respondents in particular, resonates with the first of the triad of processes of Kelman’s theory.

Potential Ineffectiveness of Staff Training

Consequently, though care staff training, for example, in the areas of care task performance, maintaining safety and privacy, communication, dementia care, and recognising and responding to mistreatment, is often offered as a solution to abuse, this research suggests that training alone is unlikely to prevent it. This is, in part, because training alone does not address the fundamental value frameworks and consequent propensity of some care staff to view those in their care as belonging to a different group of 'lesser' individuals.

Formal training specifically for care staff has been widely available in the form of National Vocational Qualifications (NVQs) since 1995. High proportions of staff qualified at NVQ levels 2 and 3 in care were evident among anonymous questionnaire respondents, with between 72% and 95% across the five homes holding NVQs at either level 2 or 3. An abundance of specific training designed with the intention of combating abuse was further confirmed as received among anonymous questionnaire respondents who had either witnessed or suspected abuse. Of those respondents, 92% had undergone training on abuse at basic awareness level, and 13.6% at a higher level. However, it is a significant finding from this research that interview respondents repeatedly identified that both training, and the associated organisational artefacts of policies, procedures and formal staff supervision, could have only a limited effect upon the actions of care staff, and that care staff attitudes and their valuing of the people requiring assistance with care were more significant determinants of their behaviours. Interview respondents asserted that care staff would often *not* adhere to training they had received, leading

to abuse of those in their care, an occurrence also expressed by some questionnaire respondents [7]. The specific abusive behaviours of care staff, described by both interview and anonymous questionnaire respondents, were certainly often at odds with the principles of the contemporary training likely received by those who had perpetrated abuse.

A review of the entirety of social care provision in England asserted that any indications of a relationship between the acquisition of qualifications and quality of services were “inconclusive” (Wanless *et al.* 2006: 134). Research on social work practices has also established that organisational intentions expressed through training and policies are not always reflected in practices at micro-level (Healy and Wint 1998; Hughes and Wearing 2007). Similarly, as both Tadd *et al.* 2006 and Furness 2007 found, codes of practice, that, like training, are expected to influence staff conduct frequently have only limited impact on the consequent behaviours of some care staff in both hospitals and care homes. The behaviours observed by these scholars were found to influence the quality of care, though causal factors were not explored, yet the potential ineffectiveness of training aligns with the perceptions expressed by respondents in this research that training was often not put into practice, and, in the experiences of many respondents, abuse was the result.

Consequently, the continuing mantra of ensuring care staff receive training, and the presence of policies and procedures to prevent abuse, have a falsely reassuring sense of legitimacy that tends to deter any questioning of their effectiveness. Though training, policies and procedures may have some effect upon how care staff behave and the prevention of abuse, this research reveals that participants believe that it is

the value judgements of individual care staff that significantly influence their conduct, particularly during the moments of truth when personal care is provided.

7.3.2. Divisions, Alliances and Relationships

This section discusses the divisions that were found to exist between residents and care staff, and the divisions and alliances that may exist within the care staff group. It also considers the complex relationships between care home management and care staff.

The Role of Dementia and Physical Needs

Responses to both the anonymous questionnaire and interviews suggest that there is often little reciprocity or reward subjectively experienced by care staff when interacting with older people who require significant levels assistance, particularly as a result of dementia. Application of social exchange theory (Phillipson and Biggs 1995; McDonald and Collins 2000) to these circumstances, as identified in the literature review, would suggest that some care staff may perceive a lack of reward derived from providing care to people with cognitive illnesses, and that this tends to interfere with the person's ability to reciprocate in what amounts to a 'forced' social situation. Further, the difficulties of providing care to people with dementia sometimes encountered, such as the aggression and resistance described by some respondents, may be perceived by care staff not only as a lack of reward from the interaction, but as a 'punishment' for their efforts. This lack of 'connection' between care staff and residents, the lack of rewarding 'social exchange' and at times

'punishment', seems to facilitate an environment in which abuse may develop, be accepted and perpetuated.

Responses also suggested that task completion and control of residents with dementia were, at times, the main, overriding aim of 'care' provision without regard to kindness or compassion, and any mention of attempting to form positive relationships with the people needing care was notably absent. Some interview respondents explicitly stated that forming such relationships with people who were unable to reciprocate, or who 'were going to die soon', was pointless, a factor that also tends to reduce the likelihood of positive, self-sustaining relationships between care staff and those in their care.

Power Imbalance

Often related to the presence of dementia and physical frailty was an awareness of the imbalance of power between care staff and residents. Responses to both interviews and questionnaires illustrate how *extreme* this imbalance of power between care staff and older residents with significant needs can be in private sector care homes, especially with regard to those who have dementia whose behaviour may need to be controlled. Such a profound imbalance of power appears to create circumstances where care staff are also able to direct the nature of the relationship with those in their care, sometimes leading to subsequent abusive practices. For example, several care staff members explicitly stated that the behaviours of people

with dementia in particular needed to be 'controlled' and that this led at times to, for example, "scolding" of residents (CH, CA) and "treating them like children" (CF).

Providing Care to People who are Strangers

This research has also clearly identified a tension between the physically and emotionally demanding nature of direct care work and the fact that care staff provide care to older residents who were essentially 'strangers' to them within this relationship of significant power imbalance in favour of the staff member. Respondents often pointed out that in such circumstances there is no emotional attachment, and though care staff may be encouraged to provide care as if it were being provided to their mother or father, they were, in reality, not doing so, resulting in a purely matter-of-fact approach. Such pragmatic relationships may also develop between care staff and those they look after because of the likely reduction of subjective stress entailed, perhaps allowing care staff to avoid the realities of physical decline, suffering and death, seen as an inevitable end point among the people they are looking after (Menzies-Lyth 1988: 51).

A frequently assumed model in the context of care provision, predominantly to older people, is the "kinship model" (Willcocks *et al.* 1987: 54), where care is constructed as that provided within traditional "...kinship boundaries..." particularly that given by parents to their children. The kinship model has again recently been offered as a principle to which care staff should adhere in order to prevent abuse in hospitals, once more couched in terms of the 'values' that care staff should unquestioningly

adopt (Tadd *et al.* 2011a: 27). Notwithstanding contemporary knowledge of the significant extent of abuse of older people by their spouses or children or both in domestic circumstances (O’Keeffe *et al.* 2007; Health and Social Care Information Centre 2014) identified in the literature review²³, the kinship model proffers an amicable combination of the performance of physical care tasks *and* activities that ensure psychological and emotional care. As this research has revealed, however, it seems that, faced with the significant volume of care required, limited time, and the emotional demands of care work in care homes, the kinship model is often untenable, leading at best to emotionless, task based care, and at its worst, incidents of serious, calculated abuse.

Stevenson (2008: 26) usefully raises the notion of “filial piety” as a sociological concept allied to the kinship model, wherein the older generation within a society is honoured, and an obligation is inculcated in all citizens to care for them, based upon affection and duty, rather than love and reciprocity. Stevenson found this model, which she asserts has a tendency to prevent negative perceptions and poor treatment of older people, to be prevalent in middle and far-eastern cultures, but distinctly lacking in the United Kingdom. Its absence is perhaps supported by the presence of value systems among care staff revealed by this research that are sometimes incompatible with the provision of care to older people, and is perhaps further reflected in the identified influencing concept of “Societal Value Judgements” conferred upon care staff and the older people they look after, discussed later in this work.

²³ Acknowledging that a myriad of other factors may also come into play with regard to domestic abuse causation.

Barriers to Positive Relationships

Respondents in this research have confirmed that they or their peers had either formed the viewpoint through personal experience, or had been advised by other staff, that it was unwise to form emotional attachments to older residents because their death was inevitable in the shorter term. This may be significant given that Lee-Treweek (1996: 122) found in her research that the behaviours of staff in could at least “mimic kinship” relationships, with the formation of limited, and sometimes selective, but beneficial emotional ties between care staff and residents. However, if care staff are advised, or decide by virtue of their own experiences, not to form emotional bonds with those they look after, it is less likely that such kinship-like relationships will develop. Further, responses to the anonymous questionnaire in particular indicate that in some cases the characteristics of relationships between care staff and older people receiving care are such that abusive behaviours are perpetrated. The acts of abuse described by respondents, sometimes pre-meditated and cruel, suggest an absence of positive dimensions of any kind to these relationships.

It is also possible that the profound physical and cognitive illnesses of a significant proportion of those older people residing in care homes identified in the review of the literature (Bowman *et al.* 2004; Office of Fair Trading 2005; Darton *et al.* 2006; Alzheimer’s Society 2007), will erode the likelihood of a caring residential community forming. Instead, the needs of the organisation and its staff, and subsequent control of residents, become salient at the expense of respect, compassion and nurturance of those in need of care by those who are able to provide it. Given the examples of

abuse described or referred to by participants in this research that sometimes arise to meet the needs of care staff rather than those of residents, it seems perceived individual and institutional imperatives often take precedence over the needs of older residents.

From his research into the technical and non-technical care provided in hospitals, Fox (1995) asserts that the nature of non-technical care, as predominates in care homes, should be about love, generosity and the celebration of otherness, but as O’Keefe (2007:81) found, neglect is the predominant form of abuse in domestic settings, perpetrated primarily by partners, followed closely by other family members. Given this frequent abuse within marital, sibling and filial relationships, perhaps too much is expected of care staff paid to care in a privatised market, and who have no familial or emotional bond with those demanding of their care.

Confounding the likelihood of ‘kinship-like’ or caring relationships are facets of the personal characteristics of the people who are in need of care revealed by this research that might tend to actively precipitate negative, abusive reactions²⁴ from staff within what is essentially a forced social relationship. Respondents told of how they encountered older people in their care, who were “not nice” or “nasty”, and recounted how they had experienced verbal abuse, lies, and strategies from residents they looked after that they believed were designed to “push their buttons” (deliberately intended to provoke a reaction in the negative sense), and of how this behaviour could lead to care staff “retaliating”. Again, the absence of positive evaluations and respect for older people, and of any ‘kinship’ associations, will have

²⁴ For a seminal discussion of how staff acknowledge and respond to negative feelings about those in their care see Winnicott (1949).

bearing on the nature of the subsequent dyadic relationship between care staff member and the person requiring care. The absence of positive evaluations and any semblance of kinship and reciprocity seems to be reflected in responses from both interview and anonymous questionnaire respondents that are indicative of enduring and sometimes extreme abuse.

Social exchange theory of abuse causation may again be applied to these circumstances where the care staff member, in a position of superior power, perceives no reward, or indeed 'punishments', from investing in relationships with the residents who are labelled as 'not nice' or 'nasty', or perhaps the 'dements' as pejoratively described by one respondent. Given the often difficult nature of the caring task, the staff member may resent the amount of effort they must expend for either little or no perceived interpersonal reward, or perhaps even subsequent 'punishment' in terms of unpleasant interactions with residents or aggression and violence, and consequently engage in retaliatory abusive behaviour. Similarly, it is conceivable that the potential withdrawal of emotional engagement with residents who are perceived to be 'not nice' or 'nasty' by care staff may contribute further to their ultimate 'dehumanisation', and consignment to a distinctly separate group of 'others', set apart from the staff employed to care for them, as discussed previously.

Though social exchange and symbolic interaction theories of abuse causation resonate with some of the discussion above, situational theory may also be applied to the findings of this research to explicate potential factors that contribute to the occurrence of abuse (McDonald *et al.* 1991; Penhale and Parker 2008). For example, high levels of need, demanding behaviours and personalities among

residents in the care home *situation* increases the propensity of staff to abuse, possibly fuelled by subjective stress experienced by some carers that is an almost inevitable circumstance of working in contemporary care homes for older people.

Divisions and Alliances among the Staff Group

Notwithstanding these dimensions of care staff/resident relationships that seem to reinforce 'difference' between the two groups, interview respondents also spoke frequently of relational divisions between care staff in terms of the formation of sub-groups or factions, often being referred to as 'cliques', within the care staff group. They also told of how established staff within the care home sometimes attempted to influence newly recruited staff, and of the apparent separation between the staff working days and those working nights, as contributory factors to the occurrence of abuse. Again the in-group/out-group theory of Ostrom and Sedikides (1992: 536) may be applied to such groupings based on, for example, length of employment and working patterns.

Care managers had frequently encountered neglect of residents because of the formation of sub-groups among staff, for example "mates working with mates" (MD), as a result of staff behaving in a manner that made their work life more bearable. They saw this as contributing to the occurrence of psychological abuse in particular, such as taunting by groups of staff, for "...a bit of entertainment..." (MD), by these staff cliques. The treatment of older people in this manner demonstrates that active abuse may occur as a consequence of group formation, perhaps as a result of

accentuation of the 'otherness' of the people requiring care espoused by Ostrom and Sedikides (1992). In the experiences of respondents sub-group formation also led to group members blaming members of other sub-groups for care tasks that had not been completed, creating further intergroup tensions. Respondents also identified the existence of a 'code of loyalties' between sub-group members that led staff to close ranks to defend a member under scrutiny for abuse. This same code of loyalties among them at times led to a 'blind-eye' being turned to abuse by other group members, an occurrence likely to suppress reports of abuse. Care managers similarly identified a fear of retaliation from other group members that sustained such behaviour, citing fear of ostracism by those they must continue to work with as a means of retribution, a factor that may lead to abusive acts remaining unchallenged and unreported.

Possible Reasons for Sub-Group Formation

It is unclear from this research why such sub-groups should be present among care staff, though it is possible that such cohesion occurs as a result of the difficult and stressful tasks faced by care staff every day, the effects of which are eased by the formation of supportive bonds that demand loyalty for them to be sustained. Though Gattuso and Bevan (2000) similarly identified strong collegial support among nurses caring for older people in hospitals, this support extended among nurses *in general* without any reports of sub-group formation, and was not determined as a cause of poor care or abuse.

As will be discussed further in Chapter 8, the research has also determined that all groups of respondents perceived care staff and the work they undertake as devalued role within society, giving rise to consequent low self-esteem, with care managers and care staff in particular expressing this to be unfair, given the important social role they undertook. Care staff also expressed an awareness of their position at the bottom of the hierarchy within the care home, a factor that may encourage group formation as a means of coping with this perception, conveying power, or the illusion of power, upon them. Schneider *et al.* (2010: 55, 73) found that because of society's negative evaluation of them, strong group boundaries also tended to form among care staff working in NHS hospitals, in response to what they perceived as an external threat, and that a sense of injustice is liable to reinforce this group identity. Power (2004:181) similarly maintains that self-protection amongst staff groups in hospitals is a natural tendency, but may include the development of an attitude identifying patients as an enemy to be defended against, resulting in a lack of engagement with them, echoing again the formation of factions and cliques found to be present in care homes and discussed above.

The sub-group formation among care staff determined in this research can clearly become a malevolent force within the care home, as, for example, expressed by an experienced proprietor 'PF' who described an identifiable group of care staff in a home he had purchased as a "wolf pack" preying upon both residents and other staff alike, bullying and intimidating staff and perpetrating acts of abuse toward residents. Again, it may be that though group formation among staff may be viewed as a natural occurrence, if these groups are formed among staff who do not fundamentally value the people they should be caring for, the potential exists for

abusive practices to develop. Such practices may include collective, pre-meditated acts, such as taunting residents, and activities such as the 'wheelchair racing' described by one respondent that involved three staff perpetrators, or acts of individuals in which other sub-group members are vicariously complicit, in order to service group dynamics. Taylor and Dodd (2003: 29) determined the possibility of collusion among care staff in hospitals, with 10% of care staff in their sample asserting they would be reluctant to report a colleague who they knew had abused, echoing the 'code of loyalties' among care staff described by some care staff and managers in this research. Tadd *et al.* (2011b: 179) similarly found evidence of a "culture of fear" in NHS trusts, wherein staff would immediately defend themselves and each other against allegations of abuse and unsatisfactory practice that they perceived as an 'external' threat. Group norms like these have been found to be a powerful force, often beyond conscious appreciation, that may lead to the acceptance of abusive behaviours in psychiatric hospitals (Garner 2002: 163), and, as Zimbardo (2007: 259) determined by experiment, collective actions in institutional settings are another expedient for weakening moral restraint, often a precursor to abusive behaviours.

'Old' Staff/ 'New' Staff Tensions

Respondents in this research recounted experiences of how some of the established staff in their care homes attempted to influence and inculcate newly appointed staff in manners of working that were abusive, including 'short-cuts' to complete tasks more quickly that led to 'bad habits'. Any resistance to adoption of these task oriented behaviours resulted in negative reactions from the established staff group.

This phenomenon was perhaps demonstrated by the frequency and nature of examples of abusive behaviours related by anonymous questionnaire respondents that revealed that abuse continues to occur in care homes, despite a predictable influx of new staff due to staff 'turnover'. The specific examples of threats and intimidation towards care staff to conform to established abusive regimes and not report abuse carried out by care home owners, care managers and existing care staff may have also been another manifestation of this behaviour.

A Night Staff/Day Staff Divide

In this same vein, care managers and care staff also spoke frequently during interviews of a divide between day staff and night staff that resulted in members of each group blaming the other for care tasks not completed and that sometimes amounted to abuse. This described behaviour was at odds with the co-operation between day and night workers identified previously within the sub-concept 'No time for Kindness-No Time for any Nonsense', where day staff would put a quota of residents to bed in exchange for night staff getting a similar number of residents up, irrespective of residents' wishes. However, it appeared to be further evidence of a propensity among care staff to form factions and cliques, in this case based upon patterns of working, to the detriment of the people in their care. Instead the behaviour appeared to be for the benefit of sub-group members and to implicit organisational needs, such as task completion and concealment of abusive practices.

The Importance of Effective Management

Effective management oversight may be able to prevent these errant behaviours born of relationships between care staff and residents, and among cliques of care staff, that tend to lead to abusive practices. But, as has been identified within the concept of 'The Right Manager', the operational management of care homes was not always as may be expected by normative standards. This research has revealed that the management of each care home is crucial to mitigating the effects upon staff of the demands of the work of providing care to older people, and ensuring individual residents' needs take precedence over individual staff and micro-level organisational needs. This includes both the characteristics of undertaking the tasks of care provision that impact upon care staff, the relationships between care staff and residents, *and* the relationships and interactions among care staff.

Management Vigilance and Diligence

There was evident recognition among respondents of the importance of effective relationships between managers and care staff. Identification of a need for effective management and leadership that was vigilant against the vagaries of care staff, including a tendency for them to 'slip back' into abusive behaviours despite training and repeated admonitions from managers, was common. Care staff themselves also raised the importance of management vigilance and a positive response to abuse. Further, a need for an awareness of and ability to mitigate the everyday stresses faced by care staff was identified. However, respondents cautioned against a propensity for care staff to 'run' the care home to meet their own ends, and to even

'manage the manager' if allowed to do so, an example of how a care home culture of a particular type might emerge. Again, repeated assertions that care staff would engage in abusive behaviours, often to satisfy their own needs rather than those of residents, suggests that they conduct themselves with reference to a value judgement framework that is awry with the work of caring for older people and contrary to the principles of the training they receive.

Care staff, however, related experiences in both interviews and questionnaire responses where abuse had been ignored by managers and no action taken. They suggested this lack of response was to avoid attracting negative attention from the authorities, and that their reports, as care staff at the bottom of the hierarchy, were sometimes ignored. Similarly, though 73% of care staff completing the anonymous questionnaire in this research stated that action had subsequently been taken following their reports of abuse, 22.3% maintained that no action had been taken, and 16% that action was not always taken by their managers, strongly suggesting that managers are themselves motivated by factors other than ensuring abuse is reported and confronted.

Specific aspects of management as contributory factors in the occurrence of abuse were identified by questionnaire respondents, including "weak" management [4], managers that did not care [2] and managers that did not spend much time "on the floor" [7]. These responses echoed the perceptions of interview respondents that management effectiveness is also likely to effect the overall culture of the care home, by, for example, allowing the formation of cliques among staff that have abusive consequences. Care staff also suggested during interviews that some

managers did not challenge the issues of care staff not caring, and that staff behaviours endured and deteriorated into abusive practice as a consequence. Some care staff told of their experiences of this happening, suggesting that as long as the care managers continued to get paid, they were not concerned about what care staff did to 'get the job done', congruent with Kelman's (1973: 39) identification of "...tacit approval, or at least permission from legitimate authority..." as a cause of abusive behaviours from one group of people toward another.

Care Home 'Cultures'

Poor management and/or leadership have been found to be key determinants in the occurrence of abuse in hospitals (Commission for Health improvement 2002a; Commission for Health Improvement 2002b; Commission for Health Improvement Investigations 2003) where much of the focus of enquiry into the organisational cultural aspects that may engender poor care has remained. However, the Commission for Social Care Inspection (2006a: 26), Care Quality Commission (2014a: 7), and the Royal College of Nursing (2011: 17) have found that a lack of clinical oversight and leadership by operational managers in care homes also puts residents at risk of abuse.

No authoritative studies have been identified that explore the correlation between occurrences of abuse and management calibre in private sector care homes in the UK, though there is recent evident interest in how care home 'cultures' influence quality of care (Meyer and Owen 2008; Killeth *et al.* 2011), and further examination of care home cultures may be informative in identifying causes of abuse. Though

several proprietors, care managers and one care staff member among interview respondents in this research *explicitly* referred to the culture of their care homes, many responses from interview participants and the anonymous questionnaires were replete with implicit references to the culture of the care home organisation and how it may contribute to abuse. Schein (2004: 17) defines the nature of organisational culture as:

“...a pattern of shared basic assumptions that was learned by a group as it solved its problems of external adaption and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as a correct way to perceive, think and feel in relation to those problems.”

Applying Schein’s depiction to characteristics of private sector care homes revealed by this research, the oft-mentioned dominance of task orientation and clear propensities of care staff to ignore the principles of received training are likely representations of “...shared basic assumptions...” embedded within their cultures, and are organisational facets that should be mediated by management, particularly if found to have a detrimental effect upon care provision.

Kirkley *et al.* (2011) and Tadd *et al.* (2011b) both found that management that fostered a culture wherein care staff were valued and supported led to improved person-centred care. Though these two studies examined the effects of culture on person-centred care and promoting excellence, not avoidance of abuse, it seems likely that the presence of such care, and of aspirations to excellence, would deter

the occurrence of abusive practices. The Commission for Social Care Inspection (2005) similarly recognised from analysis of inspection findings that the quality of management is fundamental to running a 'good' home, a view supported by the Social Care Institute for Excellence (2012). Cole *et al.* (2000) report that the psychological wellbeing of staff in nursing homes is related to the degree of supportive management relationships they experience, and both Goodrich (2011) and the Hospice Foundation (2013) have determined that, if care staff feel supported in their work, they are more likely to provide compassionate care in hospitals and hospices respectively. Killett *et al.* (2013: 23) also maintains that care home organisational cultures are highly dependent on how managers relate to their subordinates and their leadership, and those that encourage both autonomy *and* responsibility among care staff result in improved quality of care.

It appears, then, that a care home 'culture' has an influence on the *quality* of care and therefore possibly on the occurrence or absence of abuse. Care home cultures are no doubt influenced by many factors, but these influences clearly include the effects of management, particularly upon the well-being of care staff, the principle arbiters of the nature of care. Care staff may respond favourably if they feel valued, and where efforts are made by managers to reduce the levels of stress they experience. Yet, in the responses of both interview and questionnaire respondents, there was also recognition of the role of management in diligently addressing the inveterate vagaries of care staff behaviour that, it seems, sometimes fostered an environment in which abuse is more likely to occur. Certainly, many of the abusive practices described by questionnaire respondents in particular could be eliminated by effective management oversight and consequent remedial measures.

7.3.3. Behaviours and Trust

The preceding discussion has highlighted both explicit and implicit indications cited by respondents of how care home staff may behave in a way that confirms they are not always deserving of the trust placed in them to care for older people. All three groups of respondents described specific care staff behaviours that they had encountered to support their perceptions, and a consequent need for continuous scrutiny from their super-ordinates. These facets of care staff conduct have been isolated here because of the unique insights they give into the semi-public world of the care home.

Proprietors and care managers described a range of care staff behaviours during the interviews that they cited as indicative of sometimes misplaced trust²⁵. These behaviours ranged from staff taking cigarette breaks together so that residents were left unsupervised, to circumstances where care staff would be effectively “running the home”, irrespective of the proprietor’s or care manager’s wishes, but in a manner that met their own needs, rather than the needs of the residents, and that was abusive in nature or consequence. Significantly, care managers expressed their exasperation at their belief that, though care staff knew what they should be doing and how they should be conducting themselves, without constant monitoring and correction, they had a propensity to revert to performing their work in an

²⁵ Though the meaning of ‘trust’ when voiced by respondents was not explicitly explored during interviews, it is conceived here to be underpinned by the concept of ‘duty of care’ as discussed in the preceding literature review, wherein paid care staff have a duty of care as a result of both legal and physical proximity to those in their care, and should be trusted to fulfil that duty because that is what they are employed to do.

unsatisfactory manner that could include abusive practices, or not to perform it at all. Interview respondents described how abuse, predominantly neglect but also psychological and physical abuse, could occur by these means. Saving time by taking 'shortcuts' and by avoiding unpleasant aspects of physical care were again provided as examples of the inability to trust care staff. Both proprietors and care managers asserted that weekends were a particularly vulnerable time for such behaviours to occur because of a lack of management scrutiny.

That some care staff could not be trusted and required diligent management oversight was also confirmed by care staff during the interviews. Care staff told of how their peers would behave in an apparently caring manner when visitors were present, for example giving residents drinks, but that this demonstration of caring would not occur if visitors were not present²⁶; of how turn charts and fluid intake charts would be completed dishonestly, including ensuring that it would appear that a resident had been turned throughout a shift when in fact they had not; of how residents would be blamed for their own injuries when those injuries (the respondent claimed) had been caused by staff; and of the previously described behaviour of day staff putting a quota of residents to bed irrespective of residents' wishes, so that night staff would reciprocate by getting an equivalent number up in the morning.

²⁶ Similar to the "institutional display" by staff for the benefit of visitors in psychiatric hospitals described by Goffman (1961: 96).

Revealing Specific Abusive Behaviour

The need for unrelenting scrutiny of care staff was further reinforced by anonymous questionnaire respondents who described a number of disturbing abusive occurrences, including the techniques of 'hooking' or 'snagging', the use of the 'cocoon' during the night, and of 'speed feeding' (page 146 herein), the first two of these activities almost certainly occurring beyond the routine gaze of management. Many additional examples of abusive practices, either witnessed or suspected, were also recounted by anonymous questionnaire respondents, as listed in Tables 5.6 and 5.8 of Chapter 5 respectively, further suggestive of the need for care staff to be diligently supervised. These experiences and observations among respondents are again perhaps indicative of value judgements among care staff that are incompatible with the work of care, and of a propensity not to regard those requiring care as fully human, conveniently ignoring the tenets of received training to complete the tasks required of them.

Though many care staff can be trusted in the conduct of their work, the concept of an inability to trust *some* care staff in the absence of direct scrutiny is gathering momentum in the current health and social care regulatory arena. This is reflected in the most recent and largely unprecedented debate about the use of closed circuit television (usually overt), and concealed (covert) cameras in care homes, sparked by the footage from clandestine filming of abuse at Oban House in Croydon, televised in 2014. The national care home operator HC-One that owns Oban House subsequently suggested that CCTV cameras should perhaps be installed in care homes as a matter of course to protect people against abuse. The Care Quality

Commission, the sector regulator, has strongly supported progressing discussion of how this could be implemented (2014b). That this debate is happening at all perhaps confirms an implicit view that at least in some care homes, some care staff do require significant levels of observation at work, and that the deterrence of abuse might be effectively strengthened by these means.

Yet the more fundamental conundrum of *why* care staff abuse those in their care is not similarly being raised and subjected to scrutiny. Unfortunately, the debate about recording images of the activities and behaviour of care staff again directs attention toward reactive secondary and tertiary interventions of response and remedy to individual cases after abuse has occurred (Kalaga and Kingston 2007: 7), rather than primary interventions that might determine and tackle the fundamental underlying causes of abuse. Notwithstanding the myriad ethical issues of deploying image recording devices in care homes, no consideration has yet been given to the effects that the presence of overt, or possibly covert cameras in the care home workplace might have on the recruitment of new care staff both now and in the future in a labour market that already struggles to recruit sufficient suitable staff. Similarly, little consideration has yet been given to the effects on existing care staff, many of whom most likely *can* be trusted to undertake the tasks they are paid to do with care and compassion, but who may be lost from the sector as a result.

The Care Home as Workplace or Social Gathering?

Observations from all three groups of interview respondents also confirmed that some care staff viewed the care home primarily as their place of work, and/or some

form of social gathering with their peers, rather than as the home of the older residents whom they were employed to look after. Proprietors and care managers in particular spoke of how some care staff often disregarded residents' needs, perceiving them as a secondary consideration, or even a nuisance, suggesting that the desire to socialise with peers was another driver for the rushed completion of physical tasks and the reason why some forms of neglect occurred, such as omitting to give some residents drinks, food or proper assistance with hygiene needs. A number of questionnaire respondents [6] similarly cited care staff talking to each other rather than working as a reason for the occurrence of the neglect and abuse they had witnessed.

During interviews some care staff confirmed the observations of proprietors and care managers, telling of how some of their peers were more concerned with meeting their own needs, socialising with those they worked with, taking cigarette breaks, tea breaks and eating together, so that residents were left unattended or unobserved, resulting sometimes in preventable accidents and injuries. Care staff also referred to hurried and inadequate care being given beyond the scrutiny of others in order that care staff needs could be met.

Interview participants described how weekends were particularly significant as times when staff needs for socialisation with each other tended to take precedence, simply because of the paucity of management oversight, again emphasising the need for management vigilance over care staff. One care manager (MI) interviewed during this research suggested that an emphasis on the social needs of care staff might be a significant reason for the formation of factions and cliques within the care staff

workforce. These behaviours of care staff also suggest that not all management systems of oversight are effective all of the time and confirm that some care staff require constant and diligent scrutiny.

Tactical Manoeuvres?

The need for diligent management was further confirmed by the occurrence of tensions and divisions among staff within the social milieu of the care home. This was further reinforced by some proprietors and care managers who described how they believed that care staff had made fallacious accusations of the perpetration of abuse to the relevant authorities. This they had done in order to “hit back” at the care manager where they thought this was justified, for example, following disciplinary action against them; this was another manifestation of divisions and alliances that may exist within the staff group. These respondents also spoke of how care staff would use the threat of a person’s name being placed on the Protection of Vulnerable Adults (POVA) list as a means of reprisal towards their care staff colleagues with whom they did not ‘get on’, or who they perceived to have wronged them in some way. These behaviours were also corroborated by care staff respondents, and might also be relevant to the concept of ‘Factions and Cliques’ discussed previously, because of their role in reinforcing divisions and alliances between staff.

Schneider *et al.* (2010: 48) describe what they term “tactical manoeuvres” employed by care staff on hospital wards for older people to control ward atmospheres. Though described predominantly as means of producing positive benefit for patients, these

tactical manoeuvres were also noted on occasion to be to be of benefit to the staff group. It seems from this research that various tactical manoeuvres may be deployed by care staff in private sector care homes in a more sinister manner to meet their own needs, possibly perpetuating abuse through exerting influence on other care staff to engage in abusive practices, and, by making spurious claims of abuse, diverting resources from tackling actual occurrences of abuse.

7.4. Conclusions

This chapter has discussed the findings in relation to the first two of the research questions, and has drawn on theories from other disciplines to begin to generate substantive theory explaining why abuse of older people living in care homes occurs. The research has revealed that the personal value bases of staff and how they view those in their care, coupled with the nature of the relationships between staff and residents, and within the staff group, can create the conditions for abuse to occur. Additionally, ineffective management oversight, confounded in part because care is often provided beyond scrutiny, may further contribute to the incidence of abuse.

The following chapter continues the discussion of findings in relation to the last of the research questions:

‘What other aspects of the care provision process and the care home context contribute to or prevent the occurrence of abuse?’

8. Explaining Abuse: Care Provision Processes and the Care Home Context

8.1. Introduction

The following discussion focuses particularly on two broad aspects of the environment of care, the internal micro-environment of the care home, and the external influences upon it from the macro-societal environment in which care homes are embedded. The discussion contributes further to building the theoretical explanation of the factors that contribute to the abuse of older people in care homes.

8.2. The Nature of Care and the Internal Environment of the Care Home

The necessary presence of positive personal evaluations of the value and worth of older people discussed previously was reflected in the depictions of all three groups of interview participants. Respondents described the often extremely difficult, tiring and unpleasant nature of the physical task of caring for older people with high support needs, who at times could also be resistive and violent in response to carers' efforts. Questionnaire respondents confirmed the difficult and demanding nature of care work as a progenitor of abuse [6], with some citing residents' aggression and significant needs for care as specific contributory factors [8]. Proprietors and care managers who were interviewed suggested care staff could become hardened emotionally to those in their care because of undertaking hard, physically unpleasant tasks, often dealing with excrement, urine and blood, as a result creating a fertile ground for abuse to occur. As previously identified, some respondents suggested

that the impending and inevitable death of those to which care was provided could reinforce this emotional hardening as a mechanism to avoid the consequent pain and grief that might otherwise be experienced. Others talked of how care staff were essentially 'caring for strangers', in the sense that they were not related. This research in private sector care homes strongly suggests the often unpleasant nature of the caring task is significant in the relationship between care staff and recipients of care, leading to care staff becoming "disconnected" and "hardened" to residents, and might contribute to care staff perceiving residents as belonging to a separate group of those who are 'other than people' in some instances, as previously discussed. These perceptions might then legitimise uncaring and abusive treatment evident within data from this research.

Time, Task, Stress and Routine

Interwoven with reports of the hard work of care was an ever present tension between the time available to undertake the volume of physical care tasks to be completed when caring for older people with high levels of need. This pressure was frequently described during interviews by care managers and care staff in particular, and also cited by a significant number of questionnaire respondents [14]. Respondents to both interviews and questionnaires asserted that the volume of work required of them in insufficient time was a contributory factor to the abuse they had witnessed, with some confirming that care became routinised as an expedient to 'get the job done'. The volume of care tasks required to be completed in a given time was also identified specifically as a significant source of stress in the daily working experience of care staff. Similarly, care staff also isolated the considerable

psychological and physical demands of their work as generating stress, often as a result of caring for people with dementia who exhibited testing behavioural repertoires.

The research therefore confirms a continued presence of an imbalance between time and task that, though recognised in pre-existing literature, has not been addressed by contemporary policy, practice or regulation. The significant stress and tiredness experienced by care home staff that continues as a result of this imbalance, and the challenging personal and pathological characteristics of those they look after, has also been identified by this research as contributing to abuse occurring. More importantly, however, it exposes for the first time some particular time saving behaviours that are abusive arising as a result, and the likely extent to which such abuses persist within contemporary private sector care homes for older people. These behaviours reported by interview respondents included denying residents' choice, withholding communication, and rough handling, all in the interests of task completion in a limited time. Respondents also hinted at perhaps more sinister occurrences, referring to fluids not being given to residents, residents 'getting in the way', and there being 'no time for any nonsense' from residents because tasks needed to be undertaken within a finite period of time. Questionnaire respondents confirmed a range of disturbing practices reflective of insufficient time to provide care properly, as depicted in table 5.6 on page 145, including, for example, not washing residents, not attending to oral hygiene and not giving residents food or drinks. Some respondents also described the disturbing abusive practices of 'hooking' or 'snagging', and the use of the 'cocoon', both designed to reduce the time and effort expended by staff on care tasks.

The research has also evidenced other specific, routinised abusive practices adopted by care staff to complete necessary tasks within the limited time available. Though Killeth *et al.* (2011: 56) assert that routines are necessary and "...vital to the organised ordering of activities and expectations for residents and staff..." this research suggests that practices that have become routine might also be abusive when serving to meet implicit organisational needs rather than the needs of residents. Interview respondents described how care staff might spray residents with deodorant, or use talcum powder to create the impression that they had been washed, and how mouthwash was sometimes used rather than brushing residents' teeth, techniques described as time saving devices, but that are all essentially unkind. Similarly, the task orientated, established phenomenon of night staff getting up a quota of residents in the morning in order to ensure that day staff reciprocated by 'putting' to bed an equivalent number, thereby making the working lives of respective care staff on each shift easier and less time consuming, irrespective of the wishes of residents, was evident as a widespread, routine practice. One care staff member perhaps summed up the identified behaviours of care staff in stating "*...there is no time for kindness...*" (CK), possibly also explaining to a degree the occurrence of emotional 'hardening' among staff.

Responses clearly indicated that the limited time available to care staff to complete necessary tasks was viewed as a contributory factor to the occurrence of abuse. Responses suggested that routinised and abusive practices might be adopted surreptitiously among care staff to reduce their subjective stress and fatigue, and achieve task completion that in itself may become the measure of care provided 'successfully'. It might be that the stress and tiredness described by respondents in

this research further contributes to the 'dehumanisation' of older people in care homes because care staff do not have the mental or physical resources to engage with them as a result. Similarly, the in group/out group dynamic asserted by Ostrom and Sedikides (1992: 536) may be fuelled by this characteristic of care staff perceiving themselves as a group facing common hardships, in turn setting them apart from the group of older people they should be caring for, and thereby impeding a relationship within which the care staff member actually *wants* to care.

Normative, Existential and Phenomenal Primary Tasks

Further, it appears that there are implicit incongruities between what older people in care homes should be experiencing and what some of them actually do experience in reality because of the demands of care work and time limitations. Lawrence and Robinson (1975) and Miller (1995) contribute to understanding how such circumstances arise from their description of the 'normative', 'phenomenal' and 'existential' primary tasks of organisations and organisational members. Applying these principles to care homes, the 'normative' task of care home staff, what they *should* be doing, is caring for older people; the 'phenomenal' task, what some of them *appear* to be doing, as revealed in some care homes by this research, and by televised covertly obtained footage in recent years, is abusing older people in a multitude of ways; and the 'existential' task, what some care staff believe they are doing as revealed in part by this research, appears to be grounded more in exigency, 'to get the job done' because of personal and organisational constraints, without an understanding of the primacy of the needs of the older people receiving care.

Why are Abusive Behaviours Tolerated?

These findings of persistent, routinised and abusive behaviours raise the issue of why some care staff tolerate and engage in such practices rather than having the moral agency to challenge their occurrence. The origins of such practices that have been evidenced by this research that appear to be normalised might be nested within the sub-concepts of 'The Right Values', 'Good Care Staff are Born Not Made', 'Treating Older People as Other Than People', and 'Training Not Always Put Into Practice'. The research suggests that because some care staff do not hold positive value judgements towards the older people they are charged to look after, whether inborn or developed, a tendency to treat them as 'other than people' can sometimes arise. This is counter to the training they have received, leading to the prioritisation of tasks to be completed within short timescales, rather than the provision of good care. These demands, however, may also become more salient to care staff who *do* hold positive evaluations of older people, but who are subject to powerful pressures from care home owners and managers driven by income maximisation, whilst also trying to satisfy regulators, families and residents. Though these care staff generally strive to meet the needs of those in their care, they may be overwhelmed by these pressures and find that abusive practices, either intermittently or regularly, are the only means by which they can complete the tasks expected of them. Similarly, ignoring the abusive practices of their colleagues might be a way of avoiding additional, unwanted pressure and conflict.

There may be parallels between these phenomena emerging from this research and the 'routinisation' described by Kelman (1973). Kelman (1973: 38, 46) asserts that

the behaviour of perpetrators occurs and is organised so that there is little opportunity or desire in the face of peer pressure (as identified within the concept 'Factions and Cliques' and 'Care Staff Revenge'), or need, in the absence of strong and diligent management oversight (as identified within the concept 'The Right Manager'), for questioning the morality of what is being done. According to Kelman (1973: 25) the process of "routinisation" is a process that is inextricably linked to the process of "dehumanisation" identified in the preceding discussion (page 247), and is the second of Kelman's triad of conditions found to be associated with the inhumane treatment of one human being by another.

Though no panacea for preventing abuse, it is likely that increasing the numbers of staff might alleviate some of this evident tension between time and task within the care home, perhaps allowing kindness and compassion to manifest. There is evidence to suggest that increasing the staff to resident ratio improves the *quality* of care in nursing homes (Schnelle *et al.* 2004), and it is perhaps significant then that only one care home proprietor confirmed the issue of the imbalance between time and task that was clearly and abundantly identified by care managers and care staff from both interviews and anonymous questionnaires. Given that this research is concerned exclusively with care homes that must make financial profit to endure in an ineffectively regulated²⁷ but competitive market, it is perhaps unsurprising that proprietors refrained from drawing attention to minimum staffing levels endemic among private sector care homes, considering that the potential remedial strategy of

²⁷ There is no prescription for a defined number of care staff required to be on duty at any particular time in care homes within any current legislation.

employing more care staff could have the consequence of reducing profit and possibly continued viability.

Stress and 'Burnout'

When exploring the issues of time to task imbalance and the incidence of significant stress among care staff during interviews, the occurrence of 'burnout' among care staff was identified by only one respondent (PH). This may have been a vernacular expression, but the recognised phenomenon of 'burn out', a constellation of symptoms related to prolonged stress, including emotional dullness, disengagement from others, detachment and extreme tiredness (Maslach and Leiter 2008), has some parallels with the findings of this research. Interview respondents frequently cited stress and tiredness as an integral, inevitable consequence to the nature of care provision to older people with multiple, complex needs, and it is conceivable that some staff are therefore experiencing this 'burn out' syndrome. The role of fatigue among the causes of abuse was certainly confirmed by examination of the first one hundred referrals to the Protection of Vulnerable Adults (POVA) list (Stevens and Manthorpe 2005), 67% of which emanated from private for-profit care homes (all client age groups), involving predominantly neglect, physical or psychological abuse, and where *all* of those listed cited tiredness due to long periods of work as contributing to their abusive actions²⁸.

²⁸ This assertion assumes that the individuals concerned were truthful when explaining the reasons why they abused.

The physical and emotional demands of completing myriad unpleasant and sometimes dangerous tasks in a limited time as recounted by respondents are inextricably linked to, and may be a progenitor of, the stress and tiredness experienced by care staff. In turn, these characteristics may reinforce the divide between care staff and older residents, further contributing to dehumanisation and objectification of residents, creating circumstances under which abuse is more likely to occur.

Further, the adoption of routinised abusive practices that may ameliorate the effects of tiredness and stress becomes particularly significant when considering the frequency with which respondents cited that the majority of personal care is undertaken 'behind closed doors', beyond the scrutiny of management, peers and visitors. Both interview respondents and those completing the anonymous questionnaire [7] pointed out that care, and usually intimate care, was almost exclusively delivered in these circumstances in the 'private' spaces of bedrooms, bathrooms and toilets, and that this was a contributory factor to the occurrence of abuse. As one care manager commented during interview, *"In care homes you can only see a piece of care home life and lots goes on behind closed doors..."* (MH).

The 'Deterrence Environment'

Harris and Benson (2006: 35) refer to the "deterrence environment" of organisations, describing this as the perceived certainty of detection combined with the perceived severity of punishment among those who may commit transgressions, a concept that has utility in consideration of the findings of this research. Respondents in this study

almost exclusively cited the abuse they had encountered as occurring in private spaces beyond management scrutiny, and this was also true of both interview and anonymous questionnaire respondents who *suspected*, (though had not witnessed) abuse. These experiences and observations suggest that the “deterrence environment” of private sector care homes as described by Harris and Benson is weak and ineffective, in part, because of this characteristic barrier to scrutiny. This proposition was also supported by some questionnaire respondents [8] who specifically stated that abuse had sometimes occurred in the care homes in which they had worked because ‘the chances of getting caught are small’.

It is behind the closed door that the care staff member, frequently working alone, decides how care will or will not be provided, and is therefore able to exert significant power over the resident, especially when the person receiving care has cognitive limitations to the extent that they are unable to recognise or report that they are experiencing abuse. It is also behind the closed door that staff will choose whether or not to adhere to the tenets of the training they have received, or to organisational policies and procedures that should guide their actions, as has previously been discussed.

Care Staff as Principal Arbiters of Care Behind Closed Doors

Care staff participating in this research spoke of exerting ‘control’ over residents who had dementia, though they did not elaborate on the nature of this control apart from suggesting that sometimes residents were treated like children might be treated. However, the specific ‘shortcuts’ identified by interview respondents, the use of

deodorant, talcum powder and mouthwash to simulate completion of aspects of personal care that had not, in fact, been undertaken, and the techniques of 'hooking' and 'snagging', and the 'cocoon', for example, reported through questionnaires, are activities associated with providing personal 'care' that allow care staff to exert such 'control'. These abusive activities would, almost certainly, be carried out in the privacy of the bedroom, the bathroom, or toilet, behind the physical barrier to scrutiny that is the closed door.

Consequently, in care homes it is the care staff who have the most significant influence upon organising care at the immediate interface between the care staff member and the resident. In the face of limited time available to complete sometimes unpleasant care tasks for people who are not valued and perhaps not liked, coupled with the stress and fatigue arising from both within and without the workplace, it appears care staff may adopt strategies to minimise the effects of both. As a result, they may engage at times in practices to reduce physical and emotional effort, facilitated by the closed door behind which much of their work is performed.

The 'closed door' therefore contributes to the creation of the weak 'deterrence environment' described above in which abuse may be perpetrated with little chance of detection. As one care staff member opined:

"I have worked in homes where I have just been left to get on with it so if my intention is to abuse I can. Nine times out of ten there is nobody with me to see...it's a hard job, dirty sometimes and you have to trust what people are doing especially as a lot of care is given in bedrooms..." (CD)

another stating:

...who is going to know? Much of the abuse here happens behind closed doors..." (CB).

These assertions suggest that abuse in care homes is likely to remain frequently undetected, given the prevailing conditions under which much of the required personal care is provided. Further, the second component of the deterrence environment, the 'perceived severity of punishment', (Harris and Benson 2006: 35) may also be considered weak within the care sector given, for example, that in the six-month period June to November 2005, of 639 safeguarding referrals (all environments) only 5 (0.78%) resulted in a decision to proceed to criminal prosecution (Action on Elder Abuse 2006: 16).

Consequently, it seems likely that the provision of care behind the physical barrier of the closed door might be a significant factor in the occurrence and perpetuation of abuse because the components of the 'deterrence environment' of the care home are ineffectual, partly by virtue of the nature of one of the fundamental functions it performs, the provision of intimate personal care in private spaces.

The ever increasing need for assistance with care needs experienced by older people entering for-profit care homes that dominate the sector (Bowman *et al.* 2004), and no foreseeable prescription from government of required ratios of staff to residents (as far as this might impact upon the current incidence of abuse), suggests that the task confronting care staff will become even more demanding over time. As

a result, there will be likely concomitant increases in stress and fatigue as staff attempt to undertake all of the tasks they must complete to provide care in limited time. Consequently, the job of providing care may be beyond the personal resources of many staff without recourse to abusive practices, practices that remain undetected because care is often provided in private spaces, factors again redolent of the situational theory of abuse (McDonald *et al* .1991; Penhale and Parker 2008).

8.3. The Nature of the External Environment of the Care Home.

This research has revealed that there are socio-cultural influences²⁹ embedded within wider society that impact upon the micro-organisational dynamics of care homes in terms of their effects upon staff perceptions of their own societal positioning, and that of the older people they are employed to look after. This research has also determined societal factors that influence why and how care staff enter the labour force of care homes, including the flawed mechanism of their recruitment, that may contribute to conditions under which abuse is more likely to occur. There is also confirmation that current English safeguarding responses from the responsible authorities may actually deter the likelihood of abuse being reported to them from within care homes.

Though a clear perception amongst all groups of respondents that societal values contributed to circumstances that could lead to abuse was apparent, the specifics of

²⁹ In accord with the ecological model identified in the review of the literature as an explanatory framework when considering the causes of abuse (Schroder-Butterfill and Marianti 2006; Schiamberg *et al* 2011).

these varied. Proprietors and care managers identified the generally low value attributed by society to care staff *and* older people, whilst care staff spoke only of the low value attributed to *them* as workers in the care industry, not only by society, but also by the proprietors and care managers set above them in the hierarchical structure of the care home.

Proprietors and care managers explicitly stated their conviction that the care staff they employed were regarded as having low value within society, citing the predominant evidence for this to be the low pay they received for their labours, usually the national minimum wage³⁰. The prevalence of the minimum wage paid to basic grade care staff is confirmed by research of the Alzheimer's Society (2007: 39), The Royal College of Nursing (2011: 17) and the Joseph Rowntree Foundation (2015: 9). Proprietors and care managers also believed that society placed low value on older people, and that this was inextricably linked to societal evaluation of the staff that were employed to look after them. These attitudes were identified as sanctioning the poor treatment of older people consigned to care homes, and there was clear recognition among proprietors and care managers that increasing care staff pay would at least be an acknowledgment of the positive value of the difficult work they undertake, perhaps deterring abusive behaviour. This might be particularly pertinent given Skills for Care (2012: 37) have provided evidence that the wages of care staff have actually decreased in real terms by 1.7% since 2010, though Carr (2014: 10) and Owen *et al.* (2014: 48) caution that there is no conclusive evidence of a direct causal relationship between pay and the *quality* of care.

³⁰ A facet of current prevailing care home market conditions in England that accord with a political economy model view as a complementary explanatory model of abuse causation (Biggs 1996b; Wolf 2000; Ramsey-Klawnsnik 2000) identified in the literature review.

Though proprietors supported the notion that care staff should be paid more, they simultaneously asserted that to allow this the fees paid by the state to support older people in care would have to increase considerably. This they believed to be unlikely because of its predicted unpopularity with the electorate, should any increased revenue required be raised through general taxation.

Social Perceptions of Older People and of the Work of Care

Phillipson and Walker (1986: 281) observed "...a tendency to 'ghettoise' work with the old [sic], often placing it in the hands of the lowest paid and least trained", and both Wild *et al.* (2010b: 16) and Tadd *et al.* (2011b: 130) have more recently determined from their research that it is enduring ageism, by association, that continues to lead contemporary society to also place low value on those employed to care for old people. Stevenson's (2008: 26) notion of "filial piety, wherein the older generation within a society is honoured, and an obligation to care for them is inculcated in all citizens based upon affection and duty, rather than love and reciprocity, that is largely absent from western societies, seems relevant to perhaps perpetuating these perceptions. As Bytheway (2001: 60) has asserted, the very language of policy often continues to identify older people as a group who have conspired to place this burden upon 'us', rather than a group that should be revered, and Abrams and Houston (2006: 82) maintain that such institutionalised assumptions about older people may then be generalised and attributed to individuals.

Killett *et al.* (2013: 42) assert from their research that the popular view of care homes has *deteriorated* in recent years, so they are seen as a last resort, or as a failure of a society unable to care for older people in the manner they would choose, rather than as a positive choice. Killett *et al.* (2013) maintain that as a result care work continues to be viewed as low value, a phenomenon they also ascribe to inveterate societal ageism, a societal prejudice confirmed as enduring in the perceptions of respondents in this research. However, some care staff respondents recognised that despite their low status in society reflected by their pay, their role was socially important, a view also encountered by Schneider *et al.* (2012: 44) among care staff employed in hospitals. Care staff interview respondents in this research also reported that their friends and family sometimes devalued the work that they undertook, with other interview respondents citing reinforcement of such perceptions by their depiction in the media, a view supported by Abrams and Houston (2006), Wanless *et al.* (2006) and Stevenson (2008) cited in the literature review of this thesis. Though making for popular viewing, pejorative depictions of care staff and care homes are likely to be reinforced and perpetuated by recent, successive television broadcasting of images of abuse from within care homes that may serve to further diminish, rather than enhance, societal evaluations of staff working in the sector. It is perhaps easier to blame care staff for these occurrences than to acknowledge underlying contributory factors embedded within wider society, but the overall effect of doing so will likely be to suppress progress in the fight to prevent abuse in care homes.

Growth of the Private Care Home Market and its Effect on Staff Pay

Because of the continued growth of a competitive market providing care since 1979, the care home sector has come to be dominated by for-profit providers. These providers are dependent on generating profit of sufficient magnitude to yield an acceptable return on investment, in both financial and personal effort terms, to prevent proprietors investing their money and time elsewhere. The sector consequently depends on a workforce that is low-paid, arguably because income, predominantly from local authority budget holders, is below a level required for homes to be economically viable unless staff are poorly paid. This is a particularly salient characteristic of the care home industry where the wages paid to staff who provide care can consume in the region of 70% of pre-tax income (Laing and Buisson 2013). Continuing rapid diminution of public sector provision over the last decade has also served to perpetuate poor pay and minimal conditions of service that tend to exist in the for-profit sector because of the removal of state funded competition as potential employers. This change in the supply-market structure of care homes has therefore likely served to reinforce the perceived low value attributed by society to care work, and perhaps the older people who need help with care.

There is, however, some recent tentative recognition that persistent suboptimal quality of care and poor care practices, including those that are abusive, within both hospitals and care homes, some of which have which have been extensively depicted in the media, might be as a result, in part, of low rates of pay (Cavendish 2013). This recognition has been accompanied by a growing realisation that current systems of regulation alone appear to be ineffectual in preventing abuse.

Consequently, the *Kingsmill Review* (Kingsmill 2014:10), that also tangentially suggests the low societal value attributed to care staff is reflected in their pay, has identified that the minimum wage paid to the majority of basic grade care staff is inadequate, and should be increased to the 'living wage', that is currently set at £1.34 per hour more during 2013/14, for a worker over 21 outside London.

However, there is a corollary risk that increasing the pay rates of care staff further compounds the problem. It is possible that doing so may attract more people to the sector who do not value those they are paid to care for, but, tempted by higher pay, become even more determined and sophisticated in the deceptions they might employ to gain entry to the care staff labour force. This potential unintended consequence of increasing pay might be rendered more likely given recruitment processes are weak as identified by respondents in this research and discussed in the following pages. The possibility of this happening is perhaps compounded by a predicted significant increase in the need for care staff as the population ages.

The Positioning of Care Staff in Society and Potential Consequences

Though making no references to the value judgements made by 'society' about the older people receiving care, care staff also voiced their clear belief that they as care workers were not valued by society, and asserted, as did proprietors and care managers, that this was unambiguously reflected in the low pay they received. Some care staff maintained they performed an important job in which they could take pride, however, they also believed they were looked down upon, not only by society at

large, but also be the proprietors and care managers within the hierarchy of their care homes. Though mostly implicit, some recognition was evident among care staff that irrespective of their perceived lowly position within the care home organisation, they still had more power than the older residents charged to their care.

As previously stated, Schneider *et al.* (2010: 55, 73) assert that because of their devalued role within society and consequent low self-esteem, strong group identities tend to form among care staff in hospitals, and that a sense of injustice, as also perceived by some care staff in this research in terms of their perceptions of hard, poorly paid work, is liable to reinforce such group identity. Fein and Spencer (1997: 40) argue that individuals and groups in society that have low self-esteem are more likely to express prejudice toward non-group members. It is possible that these phenomena are in part responsible for older residents being viewed by some care staff, using the terminology of Ostrom and Sedikides (1992), as an 'out-group', divorced from the in-group of care staff, and more extremely as 'non-people' or 'other than people,' as determined by this research. The presence of such attitudes also aligns with the processes of "dehumanisation" identified by Kelman (1973: 25). Certainly, as Nolan *et al.* (2001; 2002) established, where staff feel valued through resources, training and recognition (through pay for example), they were better able to value and support those in their care. This characteristic of the care home organisation is also apparent in the research of Killett *et al.* (2011, 2013), Tadd *et al.* (2011b), and Cavendish (2013) into the *quality* of care provision. Yet, as Massey (1975), Verplanken and Holland (2002), and Kasser and Kanner (2004) determined, (discussed on page 241), these potential factors are unlikely to change negative

evaluations already present among staff, though they may serve to preserve the value frameworks of those who do hold positive evaluations of the people they care for.

However, as stated in the literature review, both Owen *et al.* (2014: 48) and Carr (2014: 10) found that there was no conclusive evidence of a causal relationship between increased pay and staff performance, and quality of care, suggesting other means of conveying a sense that care staff are valued must also be sought. It is likely that valuing staff can be expressed in part by rates of pay, but pay is only one facet of the relationship between the care staff member, the organisation, residents, and wider society. Care home organisations therefore need to explore and understand the personal value judgements, motivations and expectations of care staff, particularly prior to recruitment.

Unchallenged Ageist Presumptions

It is conceivable that the ageist prejudices and the consequent low value attributed to older people expressed by some staff, when remaining unchallenged by managers as care home organisational leaders, and by influential elements of wider society, might equate to an implicit 'giving of permission' to perpetrate abuse. Though this may not be operating at a conscious level, it is likely to be a powerful force upon those who already hold negative value judgements of the older people in their care. As this research has found, older people are sometimes viewed as less than fully human and therefore only worthy of care that is routinised and provided in a manner designed to accommodate staffs' personal needs and organisational

imperatives, rather than individual resident needs. Latimer *et al.* (2011: 13) assert that society in the United Kingdom unfortunately still continues to view care of the elderly as “denigrated and denigrating”, and Carruthers and Ormonroyd (2009:42) have suggested that leaders of health and social care who remain ‘silent’, leaving ageist presumptions unchallenged, are ‘giving permission’ for these ageist views to persist and to become normalised. Kelman’s (1973:39) final element of the triad of characteristics that allows human beings to engage in the abuse of their fellows is “authorisation”, the ‘giving of permission’, a progenitor of prejudice also identified by Abrams and Houston (2006: 45). As Kelman determined, the process of ‘authorisation’ co- exists with the processes of “dehumanisation” and “routinisation” as have also been identified in this research to create the conditions under which abuse may occur.

The Need for a Job of any Kind

Perhaps perpetuating circumstances that lead to an unfavourable social positioning of care work is the characteristic identified by interview respondents that the need for a job of *any* kind was instrumental in bringing many unsuitable people into care homes, and that many of these people did not positively value or care about older people, but just needed income. Respondents asserted their belief that as a consequence, these staff were more likely to engage in abusive behaviours.

Those interviewed who had responsibility for recruiting care staff told of the increasing number of unsolicited telephone calls and enquiries they received from people seeking care work, attributing this to prevailing high levels of unemployment.

Many of these calls were from people judged unlikely to be suitable to provide care, often because they had little conception of the nature and demands of the work they would be undertaking. Respondents asserted that care work was also a last resort for many, often because that was all they were likely capable of securing as a result of a lack of formal qualifications or work experience. These factors were viewed by respondents as unlikely to be the optimum motivation for entering the occupation. Some care staff were similarly explicit in relating that they, or their peers, just needed a job and any job that allowed them to pay their bills would do. Out of the twelve care staff interviewed in this research, none had intended to pursue a career in care, but had drifted into it because they needed to work. Though a small number of care staff asserted they had not regretted doing so, the majority remained ambivalent, expressing that care work was "...just a job...".

There is little research on the motivations of people who enter care work, and it is perhaps often assumed that those that do are driven by a desire to care and will value those whose needs they must endeavour to meet. However, this research strongly challenges that view, given responses during interviews and to the anonymous questionnaire that described a wide spectrum of abusive behaviours.

Notably, Willcocks *et al.* (1987: 67) found in interviews with local authority care staff that though altruistic explanations were often given by them for entering care work with older people, over half of respondents also recounted that it was a job of "convenience and accessibility". These findings suggest at best a confusion of motivations among her respondents, rather than a singular desire to care for older people. Peace *et al.* (1997: 38) similarly determined that people often began

working in care homes in the absence of any alternatives. Undoubtedly, these are not the best motivations for people to enter care work that is physically and emotionally demanding, sometimes dangerous, and where care staff have considerable degrees of practical autonomy and power over the often physically frail and cognitively limited older people they are employed to care for. Further, these activities of care take place within an organisational deterrence environment (Harris and Benson 2006: 35) identified from this research as weak. It is perhaps significant that in terms of how society currently views care staff within the societal hierarchy, confirmed by rates of pay, little has changed in terms of motivations to enter care work during the past two to three decades since the findings of Peace *et al.* (1997) and Willcocks *et al.* (1987).

Weak Staff Recruitment Methods

Compounding the likely effects of the need for *any* job, and the low pay associated with care work, is an interview process as the key means of selecting suitable care staff that all groups of respondents confirmed to be of limited efficacy. Those engaged in care staff recruitment confirmed that they could not, as a rule, determine the true motivations, value frameworks and attitudes of prospective employees. These respondents related their experiences of prospective care staff giving the 'right' responses at interview, but that when they were employed their behaviour did not correspond with what they had expressed during the selection process. They also related how newly recruited care staff would perform adequately during probationary periods, but that their behaviour would then deteriorate to include sometimes abusive actions once that period had expired, suggesting deliberate

strategies adopted to gain entry to the sector. Care staff reinforced these perceptions of their employers, confirming that the interview process was easily manipulated, for example that by “...*speaking the best garbage...*” (CD) a prospective care staff member could easily “...*get a job, and once you’re in, you’re in...*” (CK). A number of anonymous questionnaire respondents [4] supported this notion of weak interview processes by suggesting that care homes would “take on anybody” to ensure they had sufficient numbers of staff, irrespective of their propensity to provide good care.

Respondents from all groups interviewed also asserted that POVA list and CRB checks were of restricted worth as they identified only those who had been *caught* abusing, and that references, in their experience, were similarly unreliable testimonies to the character and capabilities of care staff. Proprietors and care staff asserted their belief that ‘good’ references were sometime provided by erstwhile employers in order to ease the departure of unwanted employees, and that these might be the care staff more likely to abuse.

There is inchoate interest within the care home sector in more sophisticated methods for selecting potential employees for caring roles, based upon diluted forms of psychometrics applied to recruitment processes. Psychometric testing applied to staff recruitment is concerned with the objective measurement of knowledge, abilities, attitudes and personality traits (Kaplan and Saccuzzo 2010), and therefore has potential in selecting care workers more suited, in terms of personal value frameworks, and able to cope with the demands of the work involved. However, this interest has been prompted not by concerns about enduring abuse, but by more pecuniary considerations arising from perceptions in the care home sector of high

turnover rates leading to constant vacancies among staff complements, and the additional costs associated with repeatedly recruiting and training new staff. High levels of turnover in the care sector are confirmed by national figures collected by Skills for Care (2012: 28) for adult residential care that reveal a care staff turnover rate of 20%. However, the same dataset reveals a vacancy rate of just 2.5%, suggesting, in a time of high unemployment, that there is significant internal movement within the sector as care staff move from one home to another.

Nevertheless, psychometrics has the potential for securing care staff who hold appropriate value judgements and attitudes towards the older people they will be caring for. Harris and Benson (2006: 31) assert that those who hurt or take advantage of others have low self-control, are impulsive, self-centred, short-sighted people who are both easily provoked and willing to take risks. Psychometric testing during recruitment could screen out many potential employees with these and other incongruous characteristics, at least to some degree, and would be a significant advance on current, generally superficial recruitment processes. In a similar vein, observers of recruitment practices in the United States have found employers of care staff to be augmenting traditional recruitment advertising with planned targeting of local churches and religious groups, following recognition of a strong correlation between religious belief and compassion (Eastwood 2014).

Evidence of Underreporting of Abuse

However, recruitment processes that are more effective are yet to be adopted within the care home sector in England and abuse seems likely to continue, in part

because of this. Of added concern in terms of the perpetuation of abuse is the finding of this research that though a majority of 91.4% of respondents to the anonymous questionnaire stated that the incidents of abuse they had witnessed had been reported to their managers, 8.5% stated that they had not, and a significant 29.8% indicated that not *all* incidents had been reported. These findings support the assertions of Wolf 2000:7; Bonnie and Wallace 2003:9; Goergen 2001: 19 and Cooper *et al.* 2008: 1), cited in the literature review, who also found that not all occurrences of abuse were reported within the care homes they studied.

Further, though 64.9% of respondents asserted that abuse was subsequently reported to external agencies, 25.5% stated that external agencies had not been involved in investigating allegations, and 29.8% that external agencies were not always involved. Respondents also gave examples of deliberate strategies that had sometimes been employed to suppress reports of abuse, including threats to terminate the employment of those who might otherwise report abuse, as depicted in table 5.5 on page 144, aligning with the findings of Goergen (2001) cited earlier.

This research has therefore confirmed suggestions that the limited estimates of prevalence and incidence of abuse in care homes described in the literature review are likely to be under estimations of its true extent in whole populations of older people. It has also revealed a significant, contributory fear of reporting abuse expressed by respondents as extant at two levels:

- The first level is at the interface between care staff and their managers/ proprietors, with care staff fearing loss of employment as a result, confirmed

by examples of threats of this occurring by anonymous questionnaire respondents [9].

- The second level, as intimated by all groups of interview respondents, is at the interface between the care home and the authorities. The reason for this was given by respondents as the nature of the subsequent safeguarding response, described as “negative”, “intimidating” and “an awful experience” that generated feelings of “fear” and “terror” among those required to attend safeguarding meetings. Respondents confirmed how this response tended to presume guilt, in that allegations of abuse were assumed to be true before they were actually proven. Proprietors and care managers told of their belief that these negative aspects of the response were driving abuse further underground, with some revealing they had colleagues who had ignored the occurrence of abuse to avoid the inevitable negative consequences.

Among respondents to the anonymous questionnaire a significant 47.4% also stated that the abuse they had witnessed had *deliberately* been concealed within their care homes, and outlined how they believed this had been achieved (see table 5.5 page on page 144), including in *addition* to staff being told to keep quiet about occurrences, the manipulation of records, and lies told to relatives. These behaviours perhaps corroborate the perceived fear of the consequences of current reporting processes, though there may be other, as yet unknown, contributory factors.

Intimidating Responses to Reports of Abuse from the 'Authorities'

Respondents to this research clearly perceived the prevailing practice environment in which they are required to report abuse to be antagonistic and intimidating, a view supported by my personal experiences of the operational safeguarding response towards care homes. Proprietors and care managers expressed that they were desirous of an approach from the authorities that instead displayed a common purpose and effective collaboration between agencies, rather than the current attribution of blame and punitive reactions they described.

Simic *et al.* (2012: 27) similarly determined through action research that safeguarding responses are indeed sometimes “inquisitorial and quasi-judicial” with respect to independent sector providers (all service types). However, there is nothing awry with a quasi-judicial approach, provided the principles of natural justice are followed and providers and their staff are presumed innocent until guilt is proven on the balance of probabilities. Proprietors’ and care managers’ perceptions that this is not the case is possibly another reflection of negative societal evaluations of care homes, and of the character of staff responsible for providing care, among some of those involved in the safeguarding response. This view is perhaps confirmed by the ruling of the Care Standards Tribunal (2007) finding against the Secretary of State and in favour of the petitioning care organisation that:

“...the adult protection strategy meetings lacked focus on the reasons for concern or any structured assessment of the risk allegedly posed by the applicant...Decisions were made on the basis of ‘feelings’ and ‘felt fear’ ...not linked to any formal process of structured risk assessment...”

As a consequence, a process that should encourage reporting of abuse has become something to fear, at least among some personnel in the care home sector. All twelve of the care managers interviewed during this research unanimously raised the nature of the safeguarding response drawn from personal experience as a deterrent to open and honest disclosures of abuse. Though this perceived characteristic is not likely to cause abuse, it may well contribute to its concealment and perpetuation, *“...driving it further underground...”* (PF), and may reflect the assertions of Collins (2010: 5), cited in Chapter 3, that what are perceived as ‘smaller’ concerns by staff are those that sometimes remain unreported.

The safeguarding response from authorities therefore needs to manage the tension between fault finding and apportioning blame, and determine a way forward that facilitates the effective scrutiny of abuse allegations whilst encouraging openness among providers. Clearly there is desire in the care home sector revealed by this research to avoid blame and stigmatisation, to work with the authorities collaboratively to achieve remedy, and to learn from errors and occurrences of abuse. Doing so may reduce the likelihood that abuse, when it does occur, is ignored or concealed.

8.4. Conclusions

This chapter has continued the discussion of my findings from Chapter 7, again integrating them with theory from other disciplines, to augment the construction of substantive theoretical explanations of why abuse of older people in care homes occurs and persists. The research has revealed additional features attributable to the task of providing care to older people, and to characteristics embedded in wider society that further contribute to circumstances under which abuse may arise.

The following chapter draws conclusions from my research and proposes substantive theory to explain reasons for the abuse of older people in care homes.

9. Conclusions: The Persistence and Curtailment of Abuse in Care Homes

9.1. Introduction

This chapter draws conclusions from the research. It brings together the findings from the analysis of experiences and perceptions of care staff who responded to the anonymous questionnaire with those that emerged from the grounded theory analysis of interviews with proprietors, managers and care staff. In so doing, the chapter begins by theorising from the findings to provide a clearer explanation as to why the abuse of older people occurs in private sector care homes. It then proceeds to discuss the policy and practice implications of such grounded theorising, and to consider the remedial actions that might be most appropriate by way of response.

The research has deconstructed normative notions of the provision of care to older people at a micro-level in private sector care homes, and has revealed aspects of the prevailing dynamics of care in these environments from the perspectives of the people who own, manage and work in such homes. It has confirmed both subtle but pervasive everyday abuses, and revealed examples of more sinister and severe forms of abuse that are still perpetrated by some staff in contemporary care homes.

This, and other published research studies, also suggest that there are additional, higher level dynamics embedded in societal structural frameworks, some of which reflect continuing ageist perceptions and attitudes, that underlie the perpetuation of attitudes of indifference and disdain towards older people and those who care for

them, and perhaps gives tacit societal acquiescence to the continuance of such abusive behaviours in care homes.

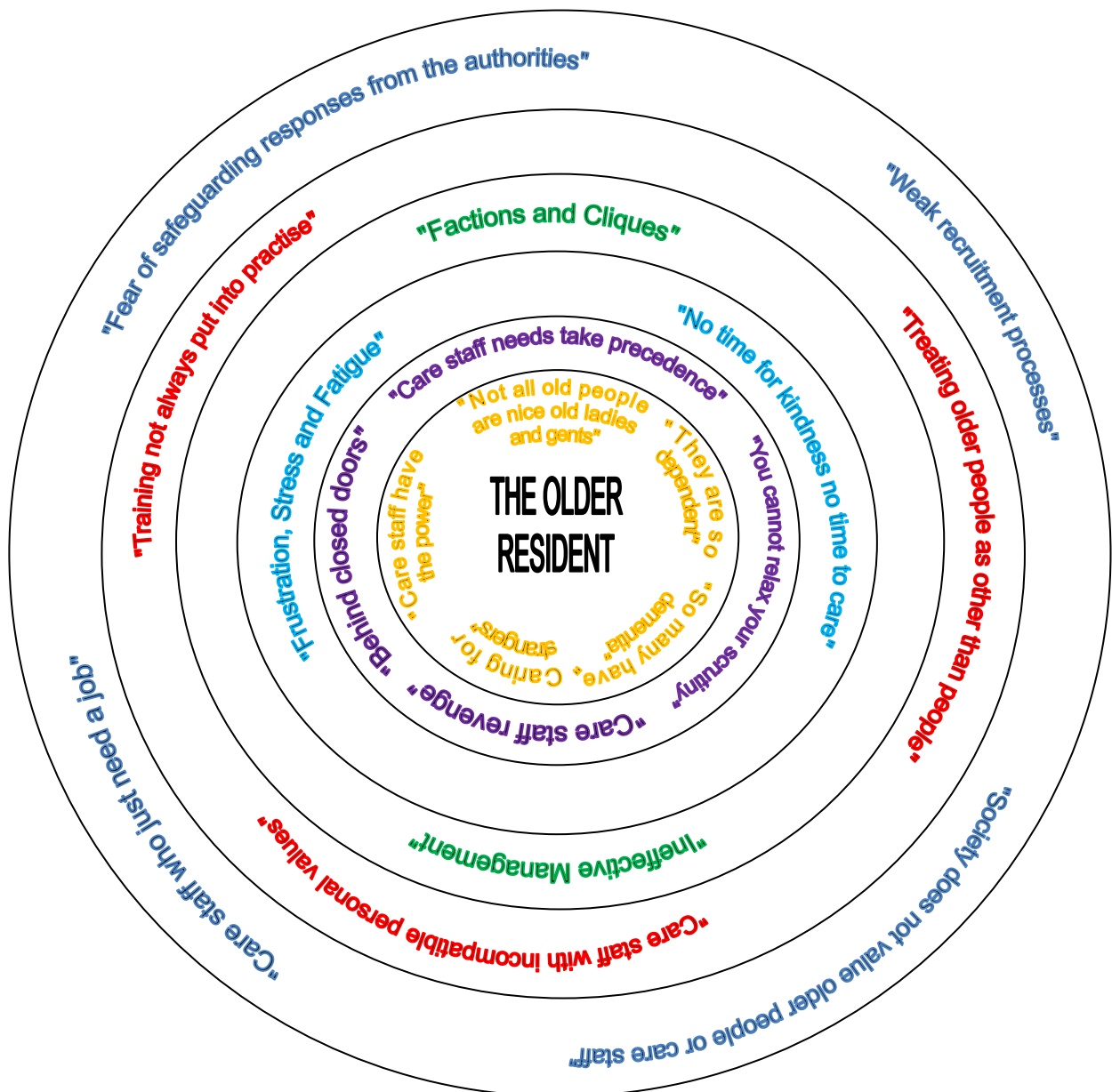
Figure 9.1 (page 307) below depicts in graphical terms the findings of the empirical research for the thesis. It highlights the layers of influences upon the occurrence of abuse in care homes as identified in the research. The outer concentric ring encompasses those influences within contemporary society upon care homes, with successive concentric rings including, in turn, the value systems, personal characteristics and behaviours of staff, the nature of relationships and trust between care staff, and between care staff and their managers, the challenging nature of the work they undertake, and the varying quality of the all-important care staff-resident relationship. Inevitably, such a diagrammatic representation oversimplifies the complex dynamics within care homes and how they act upon staff working in them. However, for the purposes of providing clarity on the most important dynamics in the private sector care home context, it does demonstrate, albeit in simple terms, how co-existing phenomena can combine to create conditions that render abuse more likely to occur. The following conclusions are drawn from the research.

9.2. Interaction Between Value Judgements and the Work of Care

There is strong evidence from the research that negative personal evaluations of the worth of older people, and unfavourable perceptions and attitudes towards them, compound problematical features of the care home organisational context to engender a culture and environment in which abuse is most likely to be perpetrated. Examples of this are the decisions of some care staff not to adhere to the training

they have received when faced with the difficult tasks of caring for older people who they do not value positively, and a tendency of some staff to prioritise their own aspirations for socialisation and comfort above the needs of residents.

Figure 9.1: Macro and Micro-Level Forces That Contribute to Abuse within Care Homes.



Though this research demonstrates the complexity of interacting elements that may contribute to the occurrence and endurance of abuse, the deployment in care homes of staff whose personal value frameworks are incompatible with caring for older people is identified as a fundamental factor in the perpetration of abuse. Conversely, if older people are valued positively by staff, then the effects of some of the other circumstantial and contextual problems, notably the predominance of task orientation over compassionate care, factions among staff that lead to abusive behaviours, and the tendency of some staff to prioritise themselves and their interests over those of the residents for whom they are responsible, would be far less evident. Though this research has not sought to measure the proportion of staff entering care work with incompatible values, or to determine how the nature of care work might erode their sense of compassion and respect for older people over time, it has identified that, at best, the priority for some care staff is task completion. As a consequence, the environment is one where predominantly people 'have things done to them' to meet only basic physical needs, rather than one where relationships are formed and fostered, or where care is provided in a manner that reflects positive values about older people, and particularly those least able to show appreciation. But often it is worse, with the research highlighting how carers' individual ambitions and the convenience of care home organisations sometimes takes precedence, meaning that care becomes overly-routinised, and residents 'dehumanised' and 'objectified'. This in turn creates fertile ground for abuse, especially if the circumstances are aggravated by some of the behaviours and personal characteristics of residents that mean they are perceived more as problems to be dealt with, rather than as people who need assistance with care needs.

Further, the often extensive training programmes provided in contemporary care homes have clearly failed to eradicate the abusive behaviours of some care staff. This failure is compounded by instances where the practices of staff remain unchallenged by peers or managers, in part because of the formation of factions among staff or ineffective management, but more significantly because care staff are often working alone behind closed doors, unobserved, and in settings where perpetrators of abuse are only rarely identified and reported. Additionally, criminal convictions for those found to have committed acts of abuse are rare, and any consequent sanctions generally less than severe. Moreover, evidence gathered through the anonymous questionnaire also revealed that the abuse perpetrated could at times be extremely cruel.

Though there are contributory factors arising from characteristics of both the care staff group, the older people in their care and the relationships between them, it is also clear from this research that staff behaviours cannot always be abstracted from the influences of the institution whilst undertaking the difficult task of care provision, and doing so within the context of a society that places low value upon older people and upon those that care for them. Consequently, the nature of value judgements reflects the link between how society views older people in care homes and of how individual staff members perceive those in their care. Understanding both the micro- and macro-contexts of care, placing emphasis upon both the behaviours of individuals influenced by the care home organisation *and* the society in which it is embedded, is therefore particularly important if sustainable changes are to be achieved to practices supposedly designed to prevent the perpetration of abuse.

9.3. Hidden Cultures and Hidden Behaviours

There is much interest in how the cultures of care homes can influence primarily the quality of care, and as a secondary consequence, behaviours that are considered abusive (Care Quality Commission 2013: 5). As a result, increasing emphasis is now placed upon the benefits of open cultures and good leadership (Social Care Institute for Excellence 2011: 22) that, amongst other things, encourage people to speak out about abuse. However, there is still an enduring and misleading perception that cultures of care homes are apparent to the observer by means of what can simply be seen, felt and heard, as is asserted by Powers (2003) and Tuckett (2007), for example. Though positive cultures may well be those that maintain a visible ethos of care centred on the individual resident (Manley *et al.* 2004), this research confirms deeply hidden, effectively invisible, cultures, or perhaps sub-cultures, within some care homes that are neither observable nor detectable by what may be readily seen, touched or heard. This was starkly illustrated in the richness of information yielded through the anonymous questionnaire, devised specifically for newly recruited care staff in newly opened care homes who, in describing their previous care home experiences, had nothing to lose as a consequence of their honesty

Just as Schein describes the superficial *artefacts* of an organisation's culture that are readily observable, he also identifies the deepest organisational level of "tacit assumptions" (Schein 2004: 344). These tacit assumptions generate behaviours that remain unseen, lurking within the relationships and interactions of organisational members. From this research it is concluded that within care homes there may exist a causal web of such tacit assumptions, and the consequent behaviours generated

can be both abusive and self-perpetuating if unchallenged. These are the 'everyday', unspoken and sometimes hidden rules and mores of the organisation expressed in comments such as "...*the unwritten rule in this game is that you don't grass on the people you work with.*" (CJ)

The behaviours described by both interview participants and questionnaire respondents highlight the apparent paradox that is the *care home* in which incongruous acts of cruelty are perpetrated against older people by some of the staff who should be caring for them. Some explanation for this incongruity between rhetoric and reality may be found within the apparent task confusion among care staff described by Lawrence and Robinson (1975) and Miller (1995) in the preceding discussion. That is, there appears to be a dominance of the 'phenomenal' and 'existential' primary tasks amongst some staff who consequently provide care in a manner that allows them to meet their own and their organisation's needs, at the expense of the 'normative', primary tasks of providing care of a high standard. Of particular significance was the finding of recurring instances of psychological abuse and neglect of older people that prevailed in the care homes reported on by the anonymous questionnaire respondents. Moreover, many such psychological abuses and instances of neglect that were related by respondents would have left no physical evidence of their occurrence, and would have most likely remained undetected as a consequence; they were revealed only because those care staff completing the questionnaire had no fears of repercussions as a result of their honesty. The apparent frequency with which these abuses were observed, yet not reported to the appropriate authorities, and/or did not result in corrective action being taken, also suggests that the reality of practice within some care homes is

incompatible with the normative primary task of providing care that is the foundation of their existence.

9.4. Care Home Cultures

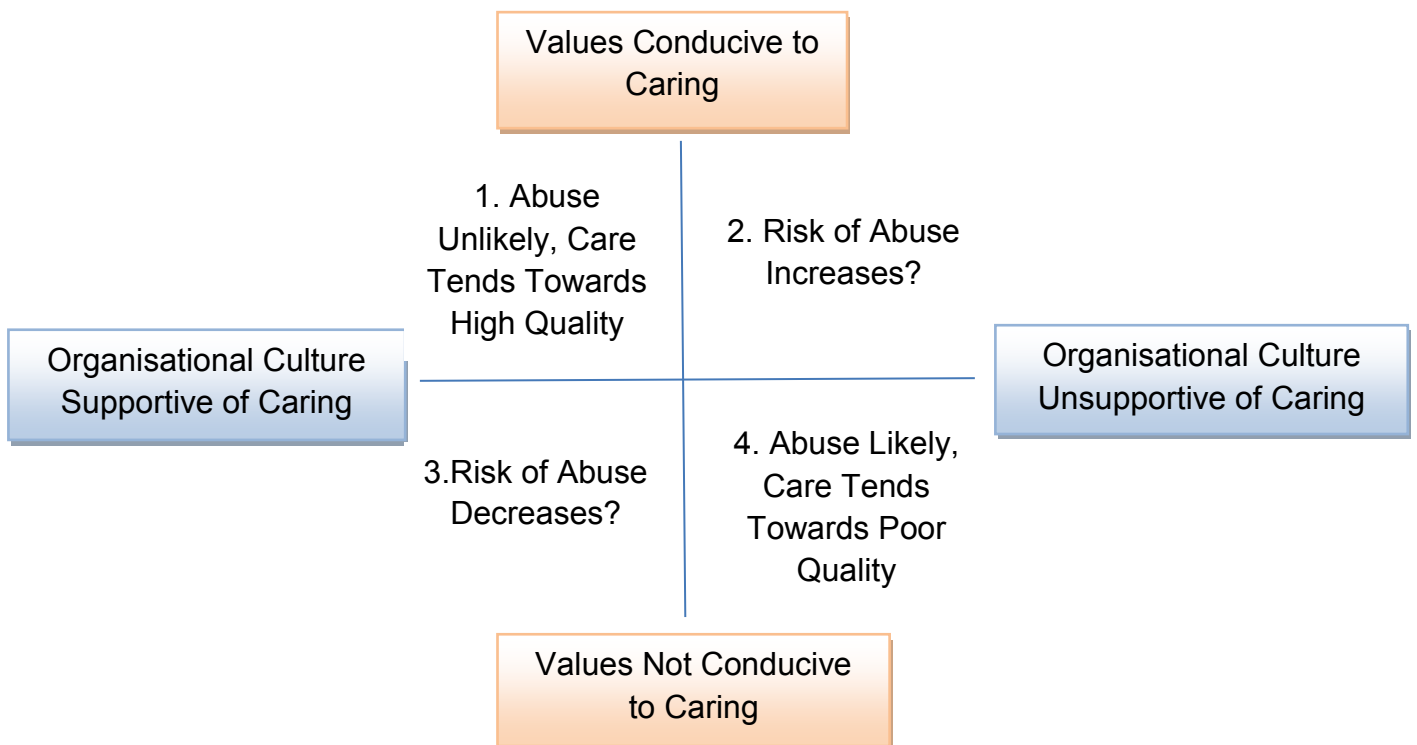
This research reveals that neither the situational circumstances, for example, the physically hard work of care, nor iniquitous individual staff alone provide a wholly adequate explanation for the continuing abuse of older people in care homes. The occurrence of abuse, it seems, requires individual, institutional, and social conditions conducive to its genesis. This research suggests that in the particular context of the private sector care home traditional restricted conceptualisations of perpetrator, victim and type of abuse have limited utility in finding preventative solutions. Within the care home there is a complex interplay of micro-level individual, sub-group and organisational factors, and macro-level social attributes, that are the progenitors of abuse. Not least of these is the tension between the care home's societal function as both a home for older people and a workplace for care staff who have personal and collective needs. It seems likely that to prevent abuse a central organisational culture is required that, by means of strong and purposeful management, maintains a shared focus on the organisation's primary task to provide care and simultaneously attends to the needs of its staff who provide this care. Nonetheless, though a central organisational culture is a valuable characteristic in terms of preventing abuse, the staff that are the foundations of that culture must first be selected by assessment of their personal values that must be congruent with caring for older people under often difficult circumstances. To do so will require a more sophisticated approach than one

based essentially on superficial interviews, reference provision, and mandatory vetting procedures.

The research here has confirmed that the task of those providing direct care is often difficult and demanding of both physical and psychological personal resources, generating notable levels of stress among those who must deliver a range of caring activities within limited time. The work is often distasteful and undertaken with people whose relatively short term destiny is death, often preceded by degrees of progressive cognitive and physical decline that are the consequence of dementia. Despite the capacities of people with dementia to experience interaction and creative activity when such opportunities are facilitated by others through relationships that recognise their 'personhood', the use of familiar and comforting routines, and the provision of care that is personalised to individual needs (Kitwood 1997; Killick 2012; Downs 2013), they will probably, for a period, be extremely reliant on care staff for their physical, psychological and, ultimately, terminal care. Arguably, to provide such care requires both a resilient, caring, beneficent disposition coupled with degrees of practical and technical knowledge, and sufficient time to apply these assets effectively. Sufficient time is a necessary prerequisite for prioritisation of psychological care within developed and sustained relationships that appears largely absent in care homes presently. However, central to enabling sufficient time is a requirement for higher numbers of care staff to meet residents' ever increasing needs. Achieving this would require a revision of the funds available from central government to local authorities, generally regarded as currently inadequate. Nonetheless, many of the prevailing conditions in private sector homes, for example, insufficient time to provide good care to people who are often very reliant on staff to

meet their physical and emotional needs, suggest that care staff are placed in situations where high quality care is often impossible. Consequently, even those staff who *do* value the older people they look after may find they are unable to act in ways that accord with their value systems because of pressures from care managers and proprietors. Figure 9.2 below depicts the interaction between the value frameworks of staff and the organisational culture of the care home that may give rise to, or tend to prevent, the occurrence of abuse.

Figure 9.2: Relationships Between Value Frameworks of Staff and Organisational Culture That May Lead to or Prevent Abuse.



The findings of this research have determined that an absence of values among staff that are compatible with care, and an organisational culture that does not moderate the difficulties that may be associated with providing care tends to lead to abuse (quadrant 4 of figure 9.2 above). Conversely, this research suggests that when value bases of staff are commensurate with the care of older people, and organisational cultures mitigate some of the demands of caring, then care tends to be non-abusive (quadrant 1 of figure 9.2 above). However, though identified as a possibility, this research has not confirmed that an organisational culture that is unsupportive of caring can cause the positive value bases of staff to be suspended, or worse, abandoned entirely when the demands of the work are excessive (quadrant 2 of figure 9.2). Similarly, this research has not identified whether an organisational culture that *is* supportive of caring can modify positively the value bases of staff who may otherwise hold negative evaluations of the people to whom they are expected to provide care (quadrant 3 of figure 9.2).

9.5. Constructing Substantive Theory

The findings of this research allows the development of substantive theory, that is theory applicable to a *specific delimited* area (Becker and Bryman 2004; Corbin and Strauss 2008; O'Reilly 2009; de Vaus 2010), of the factors that contribute to the occurrence of abuse of older people in private care homes, and which might subsequently be subjected to further empirical enquiry, as follows:

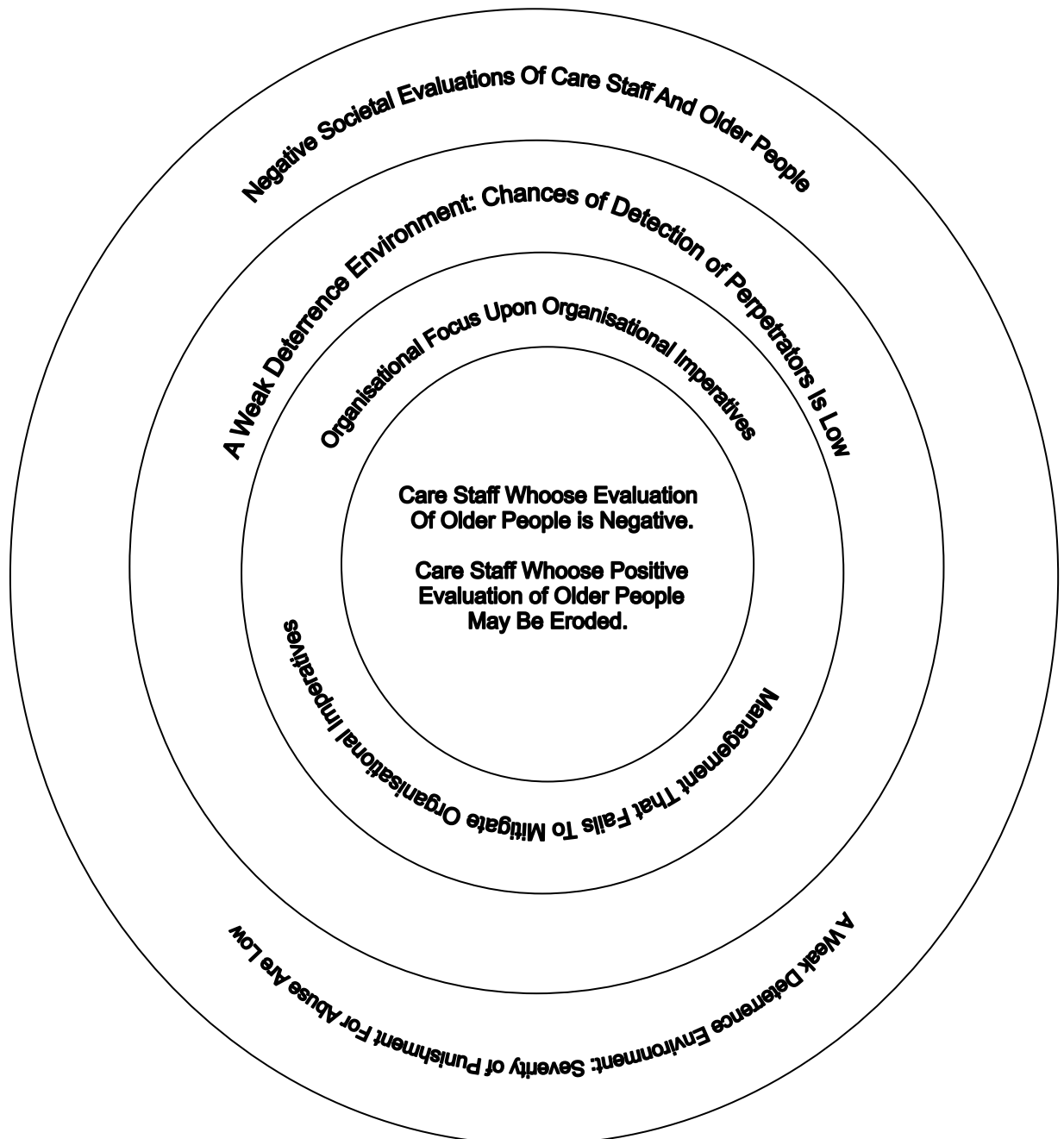
- Not all care staff hold the personal value judgements that are compatible with the often demanding work of caring for older people. Moreover, processes for recruitment of care staff to the sector are currently weak in terms of ensuring new entrants to the care staff labour force hold, or are capable of sustaining, appropriate values to mediate their interactions with those to whom they should provide care, reducing the likelihood of abuse.
- Care home organisational cultures do not always support caring that focuses upon meeting the totality of individual resident's needs, and can encourage a tendency to concentrate on organisational imperatives such as task completion, idiosyncratic routine, and emphasising the difference or 'otherness' of the people requiring care, increasing the likelihood of abuse.
- Capable and diligent managers are required to shape and maintain organisational cultures that concentrate on meeting the needs of residents, and mitigate any detrimental effects upon staff arising from organisational priorities, for example stress that may arise as a result of the physically and emotionally demanding nature of care work.
- The deterrence environment within care homes is weak in terms of the probability of those that perpetrate abuse being detected, and the severity of consequences for those that are.
- The positioning of older people and the staff employed to look after them in care homes are significantly influenced by current societal imperatives. The

widespread attention devoted by various media to, for example, the lives of 'celebrities' and to their ostentatious displays of wealth and success, contrasts starkly with that focussing on the worth of caring for other people who are in need, and such subordination of the status of both older people and care staff, serves to lessen the sense of respect for older people that in turn makes the perpetration of abuse more permissible.

Figure 9.3 (page 318) below positions the care staff member and their personal value frameworks at the centre of a series of concentric rings that represent the potential factors identified from the research as impacting upon them and potentially contributing to the occurrence of abuse.

The outer concentric ring includes the macro-social level evaluations of the care staff that provide care to older people and the older people themselves, and the component of the deterrence environment *in which the care home operates* that does not punish sufficiently those people who perpetrate abuse. The second ring incorporates the second element of the deterrence environment, operating *within* the care home, in that a preponderance of personal care where the opportunity to abuse might arise is conducted behind a closed door. The third ring includes the organisations focus upon organisational needs, and management that does not effectively manage the balance between organisational and individual resident imperatives. At the core of these influences are the staff who do not value older people as individuals worthy of their care, and those care staff who find they must at times abandon their positive evaluations of older people to meet pressing organisational needs rather than the needs of residents.

Figure 9.3: Intrapersonal Value Frameworks of Staff and Interaction with External Factors That May Give Rise to Abuse.



9.6. Policy Implications

9.6.1. Altering Individual and Societal Value Judgements and Perceptions

Awareness and training can no doubt go some way to reducing abuse by, for example, overcoming the task orientations of care homes, to promote an organisational culture that ensures a focus upon meeting individual resident needs whilst recognising the ‘personhood of individuals. However, any strategy to prevent abuse needs to include far greater emphasis upon inculcating the perception that older people are valuable members of society who deserve good care, irrespective of the characteristics and behaviours they may present. It seems likely, according to Massey’s (1979: 71) theory of “imprinting” and “modelling” periods among younger people discussed previously in Chapter 7, that such a strategy will be more effective if undertaken at an early age, before younger adults entering care work have developed largely fixed value systems that will shape their attitudes and behaviour and make change in this respect difficult. There has been some recent recognition of the potential value of such a strategy in terms of encouraging intergenerational solidarity to achieve both economic and social cohesion, given that older people make up an ever increasing proportion of the population (Zaidi *et al.* 2015).

Interventions to engender positive relationships between generations and establish revised moral imperatives that erode the social origins of abuse are required to modify the perceptions of the worth of older people, particularly those who require care in care homes. These could include introducing young people to the origins and consequences of ageism during their educations, volunteer programmes that

introduce younger people to interacting with older people in a variety of environments, including care homes, and mentorship arrangements that enable the skills and knowledge of older people to be passed on to younger generations. Localised examples exist in the UK, for example Manchester's intergenerational practice toolkit "Creating Connections, Breaking Down Barriers" (Manchester City Council 2012), and, in the USA, the "America's Best Intergenerational Communities" programme (MetLife Foundation 2012) is attempting to achieve national coverage of intergenerational cohesion projects. In time, such activities on a national scale in the UK may help to alter negative evaluations of older people in care homes, those who care for them, and notions of 'us' and 'them' that currently seem so often to prevail. Thereby, the value base of individuals and society that tend to brand older people in care as undeserving of respect, compassion and care may also be changed, rescinding the tacit permissions to treat them poorly. Such strategies may not only encourage the development of 'filial piety' described by Stevenson (2008: 26) within English society, but may also foster resilience to the ongoing attrition by a media that continues to reinforce the disparagement of older people, and sometimes presents negative images of their care and those who are employed to provide care. Perhaps preparing young people to view entering the care industry as a positive, premeditated and worthwhile choice, rather than simply as a job option to fulfil economic needs, can be instrumental in developing intergenerational solidarity and demonstrating how we are all the richer when older people are valued and respected. Similarly, re-positioning older people and those who care for them in society's hierarchy, and resourcing their care adequately, will reduce the likelihood that staff who enter care work with value frameworks that *are* compatible with their work come to act in ways that are contrary to their values by engaging in abusive

practices. This challenge will become ever more significant given the predicted increase in the number of older people in the United Kingdom, consequent increases in the numbers of those with dementia and multiple age related pathologies (Her Majesty's Government 2005), and the consequent future requirement for many thousands of additional care workers to meet their needs (Franklin 2014).

9.6.2. Acknowledging the Role of Funding

It is clear from this research that organisational needs sometimes continue to take precedence over compassionate care as a component of a wider social system in which the care of older people must remain affordable. For example, were care staff to resident ratios to be prescribed by regulation, the pressures of task completion in limited time might be alleviated and one stressor upon staff therefore reduced. However, though the primary task definition has already been referred to above, there is, in addition, the primary requirement (or task) for private sector care homes for older people to make a profit to survive and prosper. Historically and currently, uneconomical fees paid by local authorities and limited access to residents as customers who can pay their fees from their own resources, tends to result in staffing levels on shift at any one time being at the lowest level required to comply with regulations. Though the pursuit of profit by care home proprietors was, counter intuitively, barely mentioned by any respondents in this research as a cause of abuse, doubts about the compatibility of generating profit from providing care to older people have persisted since the advent of Community Care in 1993 that catalysed the major expansion in for-profit care homes at that time (Wistow *et al.* 1996), leading to their current significant domination of the sector.

Ultimately perhaps, the prevention of the abuse of older people in private sector care homes (now dominating over 90% of the market of care for older people) is a political issue. This is because the fees paid to care homes by local authorities, which in turn are heavily dependent upon central government fiscal allocations, have been demonstrably inadequate to ensure sufficient staff of compatible character and expertise, and have perhaps allowed what should be the primary task of the care home to be undervalued. Effectively, older people are being warehoused *en masse* in private sector care homes whilst they await death, as an economic alternative to their proper care in their own homes that research has consistently shown to be what most of them, and their families, would choose, (Tinker *et al.* 2000; Commission for Social Care Inspection 2004; Audit Commission 2004a; 2004b; Poole 2006; Yeandle 2009). These circumstances prevail because sufficient funds to care for older people in their own homes, particularly as their needs increase, are not made available. As one consequence of insufficient central government funding the pay of care staff is so low that, under current social conditions, it attracts some, perhaps many, who are inept and sometimes brutal, not unlike the characteristics of the cruel workhouse masters of the nineteenth century described by Anstruther (1973). However, increasing the rates of pay alone is unlikely to eradicate abuse; indeed, it may have the opposite effect in that those in need of *any* form of paid employment may become more sophisticated in entering the care workforce by circumventing current, weak recruitment processes. Instead, rates of pay need to be increased alongside revised recruitment methods to ensure that all staff hold compatible values, and strategies to support the maintenance of such values whilst undertaking a very demanding job.

9.6.3. Examining the Limited Effectiveness of Regulation, Contract Monitoring and Safeguarding Responses

After more than twenty years of formalised safeguarding policy it now seems unlikely that safeguarding interventions, regulation, and prescription from purchasers of care will, on their own, put an end to the abuse evident within care homes. This is arguably particularly true in a for-profit dominated sector characterised by cost containment and faced with ever growing numbers of older people in need of care. As the statutory regulator has unfortunately declared, “...abuse and neglect are the result of human interactions in care homes and cannot be completely eliminated” (Commission for Social Care Inspection 2006a: 8). Besides tending to endorse this viewpoint, it is also clear from this research that other factors contribute to the perpetration and resilience of abuse in care homes. Moreover, it certainly seems impossible to introduce sustainable, non-abusive conduct *into* care homes by means of external inspection processes. Such inspection processes would be unlikely to prevent established abusive regimes and cultures if the raw materials are not present to allow this, that is, staff who positively value the older people in their care. The foundations of care homes that minimise the likelihood of abuse are, kind, compassionate and trustworthy staff who positively value those they look after, capable managers, and open and receptive cultures that are amenable to change for the benefit of residents. These foundations must be built upon by more concerted government policy and legislation that strengthens the deterrence environment in care homes, and that ends current authoritarian and judgemental approaches to scrutinising allegations of abuse identified by respondents to this research, that may actually be counterproductive by discouraging openness about the occurrence of abuse.

With a view to strengthening the deterrence environment, the use of closed circuit television (CCTV) and covert surveillance in care homes is currently being explored by the care home sector and the regulator, and guidelines for providers have recently been produced by the Care Quality Commission (Care Quality Commission 2014b). The idea of such surveillance is understandably contentious and, at the time of writing, the debate remains unresolved. However, there are other, potentially less intrusive, systems for monitoring the activities of staff who provide care that are not yet in widespread use, for example the “Mobile Care Monitoring” system available at cost from Person Centred Software (www.personcentredsoftware.com), that allows the presence of care staff in certain locations to be determined without images being recorded. Such systems could be more widely promoted by local authorities and care home associations, for example, and would improve the deterrence environment of care homes.

9.7. Policy Responses

Continuing to pour resources into the current ineffective safeguarding response that fails to take account of the deeper organisational and personal dynamics operating beneath the facade of some care homes in the vague hope that people will be protected is not the way forward. Instead the fundamental mechanisms of the care home, its tacit cultural norms and its place in society, must be examined, and regimes reconstructed to enable effective safeguarding policy to be put into practice.

Comprehensive responses to abuse that transcend linear, formulaic procedures and penetrate and scrutinise the cultural norms and embedded behaviours within care

home organisations are therefore required. Such responses can then lead the necessary processes of change to reduce the prevalence of abuse. Such change will only be fully effective if it is coupled with high level policy discourses that challenge prevailing intergenerational inequity that sustains the unfavourable positioning of those who require care and those who provide it in the societal hierarchy. This may need to include new sentencing guidelines for magistrates and judges to permit the handing down of more severe punishments for staff who are found guilty of abuse, thereby strengthening the deterrence environment within care homes.

Value bases that support non-abusive practice must be inculcated among the population that includes potential future staff, as well as those already working in the sector, insofar as this is possible. Doing so will support the foundation of care home organisational cultures and that of the wider society from which care staff may be drawn, who deplore abuse, *want* to care, are *equipped* to care, and who are more appropriately *rewarded* for doing so.

Table 9.1 below (page 326) documents a set of specific actions that, from the findings of this research, are considered to be required of central government by means of both policy and primary and secondary legislation

Table 9.1: Actions to Achieve Specific Recommendations from this Research

Recommendation.	Action through policy, research and/or law.
<p>Declaration by Government of acknowledgement that abuse of older people in care homes continues despite current policy, and is a priority for action at central and local government levels.</p>	<p>In support of this declaration, Government should commission and fund further dedicated research to establish the extent and prevalence of abuse of older people in care homes in England and keep this under review.³¹</p>
<p>The introduction of programmes within primary, secondary and further education that raise the awareness among young people of the processes of ageing and the concepts of 'personhood', the contribution older people have made, and can continue to make, to many aspects of society, reinforcing intergenerational solidarity.</p>	<p>Government should mandate education at all three levels on ageing, potential causes of stigmatisation, prejudice and forms of discrimination.</p> <p>Local authorities should arrange knowledge and experience exchange activities between younger people in education and older people.</p>

³¹ Data currently exists within all local authorities in England to facilitate this work, though there are issues of nomenclature and resourcing of data recording that need to be addressed to generate reliable figures of prevalence and incidence

<p>Assist care providers to recruit managers and care staff who hold personal values compatible with the demanding work of caring for older people.</p>	<p>In partnership with the care home sector and academic researchers Government should evaluate emerging psychometric recruitment applications for their effectiveness, and explore the potential of any other mechanisms to assess personal values at the recruitment stage³².</p>
<p>Care providers should protect staff from factors that may lead them to provide care that is in conflict with their otherwise positive evaluations of the older people they care for, for example, dominance of routinised task completion, workplace fatigue and stress.</p>	<p>The statutory regulator should ensure that care managers have appropriate management skills by making accredited care management programmes mandatory for registration as a care manager by amendment to current regulations</p> <p>Regulators should ensure that managers and proprietors create supportive workplace cultures that support intergenerational understanding and where managers support and lead care staff by recognising factors that may result in task domination and unhealthy levels of stress, for example, ensuring sufficient staff to meet the needs of residents, through additions to existing areas of regulatory scrutiny.</p> <p>Regulators should ensure care managers and proprietors offer constructive supervision that is supportive and recognises symptoms of fatigue and stress among staff.</p> <p>Care homes should introduce means of demonstrating to their staff that they are valued and respected, for example, training opportunities that enhance career prospects, particularly those that lead to formal certification.</p>

³² For example potential applications of formal axiological psychology (as distinct from classical axiology), that employs mathematics to rank human values. (Pomeroy 2009).

<p>Ensure care providers have adequate numbers of staff on duty at any one time to meet the physical, psychological and social needs of residents, thereby reducing the conditions under which staff stress and routinisation of care may occur.</p>	<p>Regulators should prescribe ratios of care staff to residents taking account of residents' needs and the environment in which they live by means of regulations, and facilitate this by means of a parallel increase in funding available to purchase care home provision.</p>
<p>Evaluate the effectiveness of the measures detailed above before considering mandating the widespread use of CCTV in communal care home areas, and of recorded entry and exit systems to private areas where intimate care is given, thereby significantly strengthening the deterrence environment of care homes.</p>	<p>Government should commission a programme of research into the effectiveness of a variety of potential surveillance systems and associated ethical dilemmas.</p> <p>Any programme of research must include evaluation of the perspectives of residents and their relatives on the implications of surveillance systems.</p>
<p>Revise current law so that <i>all</i> abuse is classified as a crime, further strengthening the deterrence environment.</p>	<p>Government should request that the Law Commission revisits current legislation as part of its law reform programme with a view to making recommendations to incorporate certain acts of abuse into criminal law.</p>

<p>Evaluate the current effectiveness of regulation and controls exercised by the Care Quality Commission, local authority commissioners and NHS Clinical Commissioning Groups, and consider mandating additional compulsory measures of scrutiny.</p>	<p>The current regulatory regime should be revised, including ways to increase the frequency of on-site care home inspections, increase the number of unannounced inspections, particularly those conducted outside 'office hours', including during the night.</p> <p>Augment the current regulatory process with resident and relative ratings of services, independent visitors and widespread use of advocates to address current power imbalances between residents and care providers.</p>
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9.8. Contribution to Knowledge and Understanding

By means of the anonymous questionnaire to care staff in newly opened care homes this research has confirmed that different forms of abuse of older people in these facilities continue to occur. It has also provided some limited assessment of the extent of the prevalence of abuse in care homes. Further, the research has increased understanding of the nature of the abuses to which some older people are subjected, and highlighted a number of apparently normalised abusive behaviours of staff within extant care home cultures. Of further concern are the various previously unarticulated abusive practices that have been revealed by staff who worked in different care homes prior to completing the questionnaire and that may well, therefore, extend more widely in the sector.

Additionally, the anonymous questionnaire method identified that not all occurrences of abuse are reported to the authorities, contrary to current policy requirements, and that deliberate strategies are sometimes actively deployed by proprietors, managers, and care staff to prevent disclosures of abuse, further limiting the effectiveness of contemporary national safeguarding policy. This finding suggests that the current limited numerical records of referrals of abuse in care homes, such as those of the NHS Information Centre (2012; 2013; 2014a) are likely to be under-representative of the extent of actual occurrences of abuse.

Importantly, this research, particularly through the qualitative interviews, demonstrates the need for people who enter care work with older people to hold personal values that are commensurate with the demanding role that they will be

undertaking. Similarly, those staff who enter care work with appropriate value frameworks must be protected from their possible erosion as a result of, for example, the difficult and often stressful work they undertake, peer pressures from factions among the staff, or the challenges presented by those whom they care for. Additionally, this research has shown that current methods of recruiting care staff are relatively undemanding and unlikely to uncover the value frameworks of potential employees. Present methods are therefore unable to establish the true motivations of staff entering care work, and allow some to enter the sector who simply need to secure employment and have only superficial interest in the notion of care.

Further, the continued occurrence of abuse of older people in care homes calls into question the efficacy of current methods of regulation by the statutory regulator for care homes, and of the work of local authorities' and clinical commissioning groups in seeking to ensure good quality care by means of safeguarding responses after the occurrence of abuse, and through contract design and management within the competitive care home market. This research suggests that the current methods of safeguarding, regulating and contract monitoring focus largely on the superficial artefacts of care home organisations, and do not reliably address potentially abusive characteristics that may reside beneath the overt, and more easily observable institutional displays of the care home regime. Consequently, continuing to respond to allegations of abuse and to regulate in the same way is unlikely to prevent future abuse, because fundamental causal factors are likely to remain unnoticed, unchallenged, or unaddressed. Until these approaches are more fundamentally revised to 'dig deeply', as several interview respondents put it, into the tacit behaviours, norms and customs of the care home organisation, the instances of

abuse that have regularly come to light over the past three decades will continue to occur.

This research has also highlighted how care staff, who provide the vast majority of personal and intimate care, do so under extremely difficult circumstances, partly as a result of the challenging nature of the work itself, and partly because of the generally pejorative view of the care sector within a society that undervalues both the importance of the work being performed and the older people living in care homes. Against such a background it should perhaps be no surprise that the perpetration of abuse takes place, and that it often remains unreported or unchallenged. Indeed, such a background may also lead to some of those who *do* value the older people in their care to suspend or abandon their value systems simply to 'get the job done' and survive the demanding environment and pressures they experience from one working day to the next.

9.9. Priorities for Further Research

This research has provided perturbing insights into the extent and nature of abusive practices as witnessed by ninety-four care staff in homes in which they have worked, along with the disquieting perceptions of thirty-six interview participants drawn from a sample of care home proprietors, managers and care staff. Use of the anonymous questionnaire in revealing hitherto unreported behaviour among care home staff, and the application of principles of grounded theory analysis to the transcripts of the interviews, has enabled and informed theorisation to help understand and explain the occurrence of abuse in care homes.

However, it is important to acknowledge the limitations of the research given that the number of respondents was relatively small in relation to the population of care homes and care staff in the country as a whole, (there being some 14,500 care homes for older people, employing an estimated 320,000 care staff). So although the research design, data-collection and subsequent analysis have been conducted with due rigour, further investigation in other care homes, in other regions of the country and perhaps also in the not-for-profit sector, as well as follow-up empirical testing of the theoretical framework offered here, would be particularly valuable in further validating the findings and offering additional comparative insights.

As was explained in Chapter 4, older residents residing in care homes were not themselves included as interviewees or participants in this research because of the significant practical and ethical difficulties likely to be raised, especially in relation to those suffering from dementia. That said, as Reed et al. (2004) maintain, such residents have quite as much as anyone to contribute to our knowledge and understanding of the care they receive, and particularly perhaps in relation to abuse. Consequently, further research that is focussed on the experiences and perceptions of older people receiving care, and probably also their relatives, would be greatly helpful in corroborating the findings here and in contributing to the formulation of future policy to prevent abuse.

Further, while as depicted in Figure 9.2 (page 314), this research has identified the significance of value judgements of staff about older people, of how these may influence the incidence of abuse, and of their relationship with other factors and characteristics within the care home organisation, there remain some unanswered

questions about whether or not care staff who do hold positive evaluations of older people are themselves drawn into abusive practices, by the pressures of the job and those priorities and aspects of the organisation that militate against good care. Also important is the question of whether, and to what extent, those who enter care with value judgements that are *not* commensurate with providing good care can still be positively influenced by features of the organisational culture so that they do not engage in abusive practices. Further research into these possibilities to better understand relationships and causality between personal value frameworks of staff and features of the care home environment would similarly be invaluable to future policy development in this field.

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Appendix 1

Proprietors' Questions for Qualitative, Semi-structured Interview

1. Tell me what brought you into operating a care home/care homes?
2. Why care home operations rather than any other?
3. Why do you look after older people rather than other groups of people, for example younger people with mental illness?
4. Tell me about the most significant challenges facing you currently as a care home operator.
5. Why do you think older people living in care homes are sometimes abused?
6. What do you think of the response from local authorities to allegations of abuse in care homes?
 - (i) From own experience or non-experiential?
7. What do you think of the response from the Care Quality Commission, police, Primary Care Trust or any other involved agency to allegations of abuse?
 - (i) From own experience or non-experiential?
8. What do you think the authorities or care providers could do to prevent or reduce the abuse of older people in care homes?
9. Faced with increasing costs (utilities, food, insurances etc) and limited or no increases in local authority fees, what can you do as a care home provider to maintain or improve your level of care and service to those you look after?
10. What do you think about the requirement of national safeguarding policy to report all known or suspected instances of abuse to external authorities?
11. Do you think there are any differing factors that contribute to abuse in care homes compared to abuse occurring in, for example, hospitals and peoples own homes?
12. Have you ever encountered abuse of an older person in your own experience? (If no go to question13)
 - (If yes)
 - 12.1 Tell me what happened?
 - 12.2 How did this make you feel?

13. What training have you had on abuse?

(i) Does this include how to recognise abuse and/or

(ii) How to respond to abuse?

14. What do you think about the way that people who are proven to have abused older people are dealt with?

(i) What changes do you suggest?

15. Do you find running a care home causes you levels of stress that affect your wellbeing?

16. What are the factors that make you feel stressed?

Question 17 only for homes where there has been reported, confirmed abuse:

(Only if the owner was the owner when the abuse occurred)

17. What factors do you think contributed to the abuse that occurred in your care home?

18. Is there anything else you feel to be important that you would like to tell me?

Appendix 2

Care Managers' Questions for Qualitative, Semi-structured Interview

1. Tell me what brought you into care home management?
2. Why do you look after older people rather than other groups of people, for example younger people with mental illness?
3. Why do you think older people living in care homes are sometimes abused?
4. What do you think of the response from local authorities to allegations of abuse in care homes?
 - (i) From own experience or non-experiential?
5. What do you think of the response from the Care Quality Commission, police, Primary Care Trust or any other involved agency to allegations of abuse?
 - (i) From own experience or non-experiential?
6. What do you think the authorities or care providers could do to prevent or reduce the abuse of older people in care homes?
7. If the owner of your care home asked you to reduce costs incurred by the home, what would you do?
8. What do you think about the requirement of national safeguarding policy to report all known or suspected instances of abuse to external authorities?
9. Do you think there are differing factors that contribute to abuse in care homes compared to abuse occurring in, for example, hospitals and peoples own homes?
10. Have you ever encountered abuse of an older person in your own experience? (If no go to question 11)
 - (If yes)
 - 10.1 Tell me what happened
 - 10.2 How did this make you feel?
11. What training have you had on abuse?
 - (i) Does this include how to recognise abuse and/or
 - (ii) How to respond to abuse?

12. What do you think about the way that people who are proven to have abused older people are dealt with?

(i) What changes do you suggest?

13. Do you find managing a care home causes you levels of stress that affect your wellbeing?

14. What are the factors that make you feel stressed?

Question 15 only for homes where there has been reported abuse:

(Only if the care manager was the manager or a staff member when the abuse occurred)

15. What do you think caused the abuse that occurred in your care home?

16. Is there anything else you feel to be important that you would like to tell me?

Appendix 3

Care Staff Questions for Qualitative, Semi-structured Interview

1. Tell me what brought you into looking after older people in a care home?
2. Why do you look after older people rather than other groups of people, for example younger people with mental illness?
3. Why do you think older people living in care homes are sometimes abused?
4. What do you think of the response from local authorities to allegations of abuse in care homes?
 - (i) From own experience or non-experiential?
5. What do you think of the response from the Care Quality Commission, police, Primary Care Trust or any other involved agency to allegations of abuse?
 - (i) From own experience or non-experiential?
6. What do you think the authorities or care providers could do to prevent or reduce the abuse of older people in care homes?
7. What do you think about the requirement of national safeguarding policy to report all known or suspected instances of abuse to external authorities?
8. Do you think there are differing factors that contribute to abuse in care homes compared to abuse occurring in, for example, hospitals and peoples own homes?
9. Have you ever encountered abuse of an older person in your own experience? (If no go to question 10)
 - (If yes)
 - 9.1 Tell me what happened
 - 9.2 How did this make you feel?
10. What training have you had on abuse?
 - (i) Does this include how to recognise abuse and/or
 - (ii) How to respond to abuse?
11. What do you think about the way that people who are proven to have abused older people are dealt with?
 - (i) What changes would you suggest?

12. Do you find working in a care home for older people causes you levels of stress that affect your wellbeing?

13. What are the factors that make you feel stressed?

Question 14 only for homes where there has been reported abuse:

(Only if the care staff member worked at the home at the time of the abuse)

14. What do you think caused the abuse that occurred in this care home?

15. Is there anything else you feel to be important that you would like to tell me?

Appendix 4

PARTICIPANT INFORMATION SHEET

A research project exploring the organisational characteristics of care and nursing homes related to the abuse of older adults.

Introduction

My name is Steve Moore and I am conducting independent research as a student to fulfil the requirements for the award of a PhD from the University of Birmingham under the supervision of Professor John Raine () and Doctor Denise Tanner . I am employed by Dudley Council as a commissioning officer.

This research project is attempting to identify organisational characteristics that contribute to the prevention or occurrence of the abuse of older people within care homes. This research is important as it may contribute to improvement of the wellbeing and quality of experience of older people living in these homes. Research findings will therefore also be of practical benefit to care home owners, managers and staff.

Upon completion of the research you will be sent a summary of the findings if you elect to provide an address to which these may be sent. To do so is optional and provision for this is made on the notice of consent form you have been given with this information sheet.

Participating in the Research

The research will involve care home owners, managers, and care staff within older peoples care and nursing homes in the private sector. If you agree to take part I would ask you a series of questions in person in a private setting that may be either at your care home or elsewhere if you prefer. That process will take around one hour and would be at a time mutually agreed by us.

My questions and your answers will be audio-recorded provided you agree. Otherwise I will write down your answers.

Your answers will not be identifiable to you and will be anonymised in reporting the study. Data collected will be handled in complete confidence in accordance with Birmingham University standards of data storage and recording. No data will be shared with a third party.

Confidentiality

The subject of abuse can be distressing. Though I will be asking about organisational characteristics relating to abuse, you may have experienced something that upset you. If this is the case I will assist you to access professional counselling should you wish to.

If through talking to me you should disclose information relating to abuse you have not previously shared I will provide you with the contact details of the appropriate agency and I am required to ensure that a referral of the occurrence of abuse is made to the appropriate public agency. In the first instance, this will be the local authority.

Benefits of taking part

Though you will not benefit personally from the research you will be contributing to new knowledge of an important subject that will be of benefit to society.

Taking part is voluntary. If you do not want to take part you do not have to give a reason.

You may also withdraw your consent to participate at any time without giving a reason and there will be no consequences to you doing so.

Defining Abuse

Some older people are vulnerable to abuse. That abuse may take one of the following recognised forms:

- Physical abuse- including hitting,slapping,pushing,misuse of medication and restraint.
- Psychological abuse – including emotional abuse, threats of harm, deprivation of contact with other people, humiliation, intimidation, coercion, harassment, name-calling and isolation.
- Financial or material abuse – including theft, fraud, exploitation pressure in connection with wills, property, inheritance or financial transactions or the misuse or misappropriation of property, possessions or benefits.
- Sexual abuse – including sexual assault or rape or any sexual acts to which the adult has not consented, could not consent or was pressured into consenting.
- Neglect or acts of omission – including ignoring physical or medical care needs, failure to provide access to appropriate health or social care services, or withholding the necessities of life, such as medication, food and warmth.
- Discriminatory abuse – including racist, sexist, that based on a persons age or disability and other forms of harassment, slurs or similar treatment.

This research will explore organisational characteristics that have a propensity to prevent or contribute to abuse occurring.

Next Steps

I will contact you in the near future. I will answer any questions you may have and you can tell me if you are willing to take part.

I thank you for considering participating in this research.

My contact details for further questions or discussion are:

Postal Address: Steve Moore, [REDACTED]
[REDACTED]

Telephone: [REDACTED] or mobile [REDACTED].

E mail: [REDACTED]

Appendix 5

Notice of Consent

Name of participant _____.

Name of Research Study: **An Exploration of Organisational and Agentic Characteristics related to prevention or occurrence of abuse in care homes.**

Principal Researcher: Steve Moore.

Postal Address: Steve Moore, _____

Telephone: _____ or mobile _____.

E mail: _____

Dudley Metropolitan Borough Council – Adult Services Research Governance and the University of Birmingham Ethics Committee have approved this research study.

I have read the participant information sheet on the research study named above and have had the opportunity to ask questions and discuss further details with the principal researcher.

I understand that my responses will remain confidential to the researcher and my identity will remain anonymous.

I have voluntarily agreed to take part in the study but I understand that I am free to withdraw from the study at any time and in doing so there will have no consequences to me.

I hereby freely consent to participate in the research study.

Signature of Participant _____.

Date _____.

Signature of Principal Researcher _____.

Date _____.

I would like to receive by post or e-mail a summary copy of research findings once the research is completed:

Yes No

(Please circle your choice)

The address to which I would like these to be sent is:

Appendix 6

Questionnaire for New Caring Staff

1. Are you Female Male

2. How old are you years

3. How many years' experience in a paid, caring role do you have years

4. Please state your ethnicity:

White: British Irish Any other white background

Mixed: White and Black Caribbean White and Black African

White and Asian Any other mixed background

Asian or Asian British: Indian Pakistani Bangladeshi

Any other Asian background

Black or Black British: Caribbean African

Chinese or other ethnic group: Chinese Any other ethnic group

5. Have you come to work at this new home from:

Another Care Home in xxxx

From a care home outside the xxxx Borough

6. At your previous home were you:

Senior Care Staff

Care Staff

Registered Nurse

Care Manager

Other

If other, please state your role _____

7. Was your previous home a:

Nursing Home

Residential Home

Both Nursing and Residential

8. Did your previous home care for?

Tick all that apply

Older People

Older People with dementia

Younger People with mental illness

Younger People with learning disability

Other

9. How long did you work at your previous home: _____

10. Have you had training on the abuse of vulnerable adults, sometimes called safeguarding or adult protection training:

YES

NO

Don't Know

Was this basic awareness training

or

Higher level of training:

Please specify if a higher level: _____

Don't Know

11. Do you have any of the following qualifications: (tick all that apply)

NVQ Level 2

NVQ Level 3

NVQ Level 4

Registered Managers award

Registered Nursing Qualification

No Qualification currently

Other

If other, please state qualification _____

For the following questions, to understand what is meant by abuse, please refer to the 'information sheet' provided with this questionnaire

12. Did you ever witness abuse of residents at your previous home:

Yes Not Sure No Not sure or No, go to Q 21.

If yes was this abuse:

(tick all that apply)

- Physical
- Psychological
- Financial
- Neglect
- Sexual
- Other

If other, state what you witnessed:

13. Please describe what you witnessed:

14. How often did the abuse you witnessed occur:

15. Was the abuse you witnessed carried out on:

Day Shift Night Shift Both Day and Night Shift

16. Was the abuse you witnessed carried out during:

(tick all that apply)

The past 12 months

Over 12 months but less than 3 years ago

More than 3 years ago

17. Was the abuse you witnessed, reported to the manager and/or the owner of the care home:

YES NO

Not Always Don't Know

18. Was action taken:

YES NO

Not Always Don't Know

19. Were people external to the care home involved in looking into the abuse, such as Social Services, the Police, or the Care Quality Commission:

YES NO

Not Always Don't Know

20. Why do you think the abuse that you witnessed took place in your previous care home:

21. Do you know of any instances when abuse happened in your care home and was deliberately not reported to anyone external to the care home:

YES NO

Not Always Don't Know

22. How was this done:

23. Have you ever been aware or suspected any of the types of abuse listed previously were being carried out by other members of staff though you did not witness it:

(tick all that apply)

- | | |
|---------------|--------------------------|
| Physical | <input type="checkbox"/> |
| Psychological | <input type="checkbox"/> |
| Financial | <input type="checkbox"/> |
| Neglect | <input type="checkbox"/> |
| Sexual | <input type="checkbox"/> |

24. Please describe what you suspected may have occurred:

25. Any other comments or information you would like to provide, for example common practices you have observed that may be abusive:

Thank you for your assistance.

Note: Though this questionnaire is designed to be completed anonymously, if you would like to receive a summary of the findings of the research, please provide an address to which they may be sent.

Appendix 7

PARTICIPANT INFORMATION SHEET

(For Anonymous Questionnaire)

A research project exploring the organisational characteristics of care and nursing homes related to the abuse of older adults.

Introduction

My name is Steve Moore and I am conducting independent research as a student to fulfil the requirements for the award of a PhD from the University of Birmingham under the supervision of Professor John Raine [REDACTED] and Doctor Denise Tanner [REDACTED]. I am employed by Dudley Council as a commissioning officer.

This research project is attempting to identify organisational characteristics that contribute to the prevention or occurrence of the abuse of older people within care homes. This research is important as it may contribute to improvement of the wellbeing and quality of experience of older people living in these homes. Research findings will therefore also be of practical benefit to care home owners, managers and staff.

The questionnaire attached is being given to newly employed care staff in newly opened care homes to be completed during, or shortly after, their induction period.

The questionnaire is designed to be **completed anonymously** by care staff and seeks to find out about their experiences of abuse, if any, in the care home or homes in which they have previously worked. **You are not required to provide any personal information or contact details on the questionnaire or identify at which care home you may previously have worked.**

Upon completion of the research you will be sent a summary of the findings if you elect to provide an address to which these may be sent. **To do so is optional** and provision for this is made at the end of the questionnaire.

Benefits of taking part

Though you will not benefit personally from the research you will be contributing to new knowledge of an important subject that will be of benefit to society.

Taking part is voluntary. If you do not want to take part you do not have to give a reason and you are not obliged to complete the questionnaire if you do not want to.

Please turn to next page.

Defining Abuse

The following definitions of recognised forms of abuse are provided to inform your responses:

- Physical abuse– including hitting, slapping, pushing, misuse of medication or of restraint.
- Psychological abuse – including emotional abuse, threats of harm, deprivation of contact with other people, humiliation, intimidation, coercion, harassment, name-calling and isolation.
- Financial or material abuse – including theft, fraud, exploitation pressure in connection with wills, property, inheritance or financial transactions or the misuse or misappropriation of property, possessions or benefits.
- Sexual abuse – including sexual assault or rape or any sexual acts to which the adult has not consented, could not consent or was pressured into consenting.
- Neglect or acts of omission – including ignoring physical or medical care needs, failure to provide access to appropriate health or social care services, or withholding the necessities of life, such as medication, food and warmth.
- Discriminatory abuse – including racist, sexist, that based on a persons age or disability and other forms of harassment, slurs or similar treatment.

Next Steps

Please use the postage paid, pre-addressed envelope provided to return your completed questionnaire to me.

I thank you for considering participating in this research.

My contact details for further questions or discussion are:

Postal Address: Steve Moore, [REDACTED]
[REDACTED]

Telephone: [REDACTED] or mobile [REDACTED] (Call between 08.00 and 18.00hrs or please leave a message at any time).

E mail: [REDACTED]

Appendix 8

Ethical Approval: University of Birmingham





