

Can You Care For A Profit?

*A Micro-Ethnographic Exploration of the
Lived Realities of Formal Care Workers for
Older People*

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Abstract

As a subject, care for older people is a topical and controversial issue that features regularly on both media and political agendas. This paper is a response to the recent interest into the apparent 'crisis' in care in the United Kingdom, from the perspectives of those currently working within the care industry. This is a topic that needs an urgent and increased level of academic attention, because the average age of society is increasing as life expectancy is rising due to medical and social developments. This paper explores the consequences of the increasing privatization of care work as the state downplays its involvement in health and social care services. It is based on five months of participant and non-participant observations, and developed using the data derived from eighteen in-depth interviews with the staff of three different care homes situated in the East and North East of England.

This paper concludes that unless the tensions discussed within the paper are resolved, the future of care work faces an uncertain future. In today's aging society, urgent scholarly attention should be directed to the notions of gender, trust, emotional labour, body labour and authenticity of the inter-personal relationships within care settings and how they are affected by the increasing privatization of care, in which care is commonly thought of as a business. Furthermore, the perspective of care workers is rarely addressed within academic literature, and in order to ensure a sustained high quality of care, this viewpoint also needs to be considered. I wish to address these issues in this paper.

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Preface

This paper is an original, unpublished, independent piece of work conducted by the author, J. Wolton. The field work reported in chapter three was approved the Sociological Ethics Panel at the University of York and by the managers of the care settings and conducted under the supervision of Professor Sarah Nettleton.

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Authors Declaration

I certify that in submitting this thesis, all the research data is original and conducted by the author. This piece of research was built upon a previous study that was conducted in 2011 by the author. Therefore, some of the interview data was gathered and presented in this previous study and was subsequently utilised for this research project.

Can You Care For a Profit? :

A Micro-Ethnographic Exploration of the Lived Experiences of Formal Care Workers for Older People.

Introduction

In their work Twigg and Atkin (1994) state that '*carers have moved out of the shadows and into the policy arena*' (1). This notion is becoming increasingly apparent within contemporary society where health and social care, particularly for older people is a topical and controversial issue that features regularly on both media and political agendas. However, quite often formal care work is portrayed in a negative manner and from the perspective of service users or regulatory bodies.

Since 2010, I have worked as a care assistant in a residential care home for dementia and older residents. Additionally during the summer of 2009, I also worked as a domestic assistant in a nursing home for older people. In undertaking these job roles on the 'frontline' of care work, I became aware of the tensions that can arise between the nature of care work itself and the on-going process of commodification, as care becomes increasingly located in the private sector. These tensions have been debated in general sociological and academic literature, however, what is seldom explored is the perspective of care workers who have to adapt and carryout labour as this process of commodification occurs. Considering this notion alongside the previous academic literature generates some important empirical questions concerning how paid care work plays out in practice. The overall aim for this thesis will therefore be to conduct a sociological investigation into care work and explore how the increasing privatization of care affects the lived experiences of those who work on the frontline of the care industry.

Outline of Thesis

This thesis is organized so that a reader can gain an in-depth understanding of the lived reality of care workers who are currently working within the contemporary care industry.

The first chapter will briefly discuss the socio-cultural and political changes that have shaped contemporary care work into the form in which it is commonly conceptualised today. This will allow a greater understanding of how care has progressed into its current form and will provide a foundation on which an exploration of the tensions that arise within the current private care culture will be based. Particular focus will be given to the 1980s, which was a time of great social and political change with respect to care. Previously the post-war welfare state had provided health and social care services for individuals; however during the 1980s the state withdrew from its former role and encouraged the growth of the private sector. This action invariably intertwined care work with post-fordist principles. This section will provide the foundation on which the questions in the subsequent sections will be built upon.

The second chapter will review sociological literature that has informed this study. The components of care will be identified and discussed within the context of contemporary privatised care work in which post-fordist principles have been applied. First the definition of what care, care work and care homes are will be analysed. These theories will then be developed using conceptualisations relating to care work. Notably, Arlie Russell Hochschild's notion of emotional labour (1983) and Erving Goffman's dramaturgical metaphor (1959) will be incorporated. This section will consider the emotional side of care work, with particular focus on the authenticity of emotional exchanges within relationships formed in care. The concept of body labour will be introduced and examined in relation to the context of post-Fordism and in relation to notions of industrial and post-industrial clock time and in body labour. The last notion that will be examined is the negative perception of care work within public discourse. Theories deriving from the work of Mary Douglas (1984) and Carol Wolkowitz (2002; 2006) will be utilised to explore the possible origins of the negative perceptions that surround care work. Finally, we will turn to Stuart Hall's (1978) work on the role of the media in influencing public opinions to help appreciate the impact that increased media attention and debate have on the reputation of care work in addition to the possible effects that media attention has on care workers themselves.

Chapter three will then discuss the methodological approaches employed for this study. The potential benefits and impact that research of this calibre can have will be outlined, along with any possible disadvantages of the approaches used. The findings of the research will then be discussed in response to the question raised in the literature review, which will be divided into the subsequent three chapters. Chapter four will examine the tensions that can arise within care work as the process of privatisation increases and the labour demanded from the workers becomes intensified. Issues pertaining to time and the organisation of care work will be examined in the context of industry intensification and speed up. These issues will be considered alongside the potential consequences that can arise throughout the on-going processes of industrial speed up. This includes the possible routinization of caring labour and the prioritization of particular tasks or aspects of caring labour at the expense of another. Chapter five will follow on from the discussion in chapter four to examine notions of authenticity and dramaturgy within the context of the emotional labour of care work. Opinions and experiences that comment on the authenticity of relationships located within care settings will be discussed, with a view to observe if the relationships formed within care could be considered to be inauthentic. This notion is significant, especially when it is understood that to some degree, formal care workers are paid to form these affective relationships. The last thematic chapter will focus on perceptions of care within the public consciousness and the possible influence that media sources have in shaping these opinions of care work. The possible stigma that surrounds and influences care work and its workers will be discussed using the accounts and experiences of those currently working in this highly political and controversial industry. Chapter seven will then consider and discuss all three themes collectively and summarise the pressures, tensions and issues that have arisen within the contemporary and privatised care industry. This discussion chapter will be organised in a manner to answer three questions. These include what has happened to care? What is the future for care? And finally the overarching question that underpins the entire research project will be addressed; namely can you care for a profit?

Finally there will be a critical outlook for research chapter. This final chapter will also comment on the impact that research of this calibre can have both within and outside academic circles. The need for further research around this highly topical issue will also be

stated. However, before discussing the conceptual issues that surround and influence contemporary care work, this thesis will first briefly analyse the social and political history around health and social care. This will allow a greater understanding of the social, political and cultural changes that have allowed contemporary care work to evolve into its current form. These factors will now be examined.

Chapter One: Socio-Cultural and Political Changes

Historical Changes

Although health and social care for older people has had a complex and extensive history within the United Kingdom, this chapter will focus primarily on the changes that occurred from the 1970's onwards. This is because in terms of health and social care, this period of history was possibly the time of greatest social change in post-war Britain. At this time care began to leave the arms of the kinship networks and the state. As the role of kinship networks and the state in providing care diminished, care work began to become established as an industry in its own right. This was in part fuelled by political and social changes which created a social environment that allowed a profitable market around care to be established.

This emerging market based around care work, not only encouraged the growth of the independent sector but it also served to fundamentally alter care services. This is because instead of adhering to achieving equity, the private care industry began to be led by market forces (Hayes and Prior: 2003: 27-28). This continues to the present day and care work is becoming increasingly intertwined with capitalism and underpinned by post-fordist ideology. Not only has this changed the nature of care itself, but it also altered how care was conceptualised and approached. Individuals are now increasingly approaching care as service users rather than citizens (Land and Lewis: 1998: 51-80). The changes that prompted this transition of care will now be explored.

Before the 1970s, older individuals who required care would generally rely on kinship networks for support (Brody: 1985: 19-21). However the formation of the National Health Service (NHS) in 1948 resulted in the state taking a greater role in the provision of health and social care of older people. This was undertaken through the provision of funding for care relief or in some instances providing care through care homes and day hospitals. But, from the mid 1960's a distinguishable veer towards the privatized care sector can be observed (Little: 1983: 125). This was due to a number of socio-cultural and socio-political changes which will now be examined.

The first and possibly the most significant socio-cultural change was the transformation of the family structure. This has meant that kinship networks can no longer be relied upon to always provide informal care for elderly relatives. The structural alteration of the family can be attributed to a number of changes. These include the fragmentation of the family through greater geographic mobility. Innovations in industry and technology resulted in the decline of a cottage based industry to factory based industry (Winstanley: 2011). Consequently this has meant that individuals are more likely to relocate from their place of birth for work and other pursuits. This has meant that families can now be very geographically dispersed compared to past generations. This has in turn meant that it is currently more problematic and difficult for families to be informal care givers to their elderly kin (Heida: 2012:1).

This changing family structure was also partly influenced by another cultural change that began to emerge in the 1970s, namely; the increasing participation of women in the labour market. Not only did this action have an impact on family structure by changing the traditional nuclear form presided by a male breadwinner, into a plethora of contemporary forms; but this occurrence also effected how care was provided. As women became increasingly involved in the labour market, their prior role as primary care givers (Stone et al.: 1987: 620) became more complex. Through women becoming more involved in the labour force, the number of working age women who would be able and willing to provide informal care and domestic labour for their elderly relatives was reduced substantially (Timonen and Doyle: 2008:76). On the other hand, the inclusion of women into the work force has transferred their perceived natural affinity affective labour such as care and

domestic skills into the realm of paid employment (Brody: 1981: 471). Thus this process almost created a foundation of resources on which a formal care industry could draw upon.

Additionally, major innovations and improvements within the realms of health care, medicine and housing resulted in a vastly improved standard of living. Consequently these developments have enabled life expectancy to increase and have allowed an aging population to emerge (Vincent: 2006: 204). Therefore, it is evident that the population of very aged people in need of care was increasing. Furthermore since the 1970s, there has been an observable decline the number of children per family (ONS: 2013: 5). These population trends continue to the present day and contemporary society is confronted with a relatively smaller population of younger people with the ability to provide the required level of care (Gerstal: 2000: 480; Timonen and McMenemy: 2002: 21; Ungerson and Yeandle: 2007: 4). Therefore, it can be asserted that this change in family structure and the continually increasing societal age has meant that depending on informal kinship networks to provide care can no longer be seen to be a viable default option, and this has consequently created a demand and a need for care that must be fulfilled by organizations outside of the family. This occurrence put great strains on the NHS and Local Authorities to replace the role that informal kinship networks occupied in providing care for older people.

This structural reordering of the family was occurring in a cultural context which was also experiencing socio-political changes, which became solidified in the 1980s. Possibly one of the greatest changes that affected care was the establishment of capitalism within society. The earliest introduction of capitalism could be dated back to the industrial revolution which witnessed the decline of cottage based industries. This was to have a profound effect on the world of work because within capitalist societies, the resources that produce the most wealth are often privately owned. The majority of individuals are no longer wholly self-sufficient and quite often are dependent on paid employment to be able to meet their everyday needs. Mostly, individuals are involved in the production of goods that are sold as commodities in local and global markets. Modes of production and industries are based around the primary goal of profit (Cohen and Kennedy: 2007: 70). This continues to the present day but, with the introduction of post-Fordist principles in the early 1970s, it could

be asserted that many industries were and continued to be guided by the post-Fordist market principles of; efficiency, calculability, predictability and control. These principles apply to not only work processes and the associated outputs but to the workers themselves (Kennedy and Cohen: 2007: 104).

These developments almost formed the foundation on which a formal privatized care industry was established. However, it was not until the 1980s where a formal privatized care became established and was encouraged to grow under the conservative government led by the late Margaret Thatcher. During this administration, it was made explicit that one of the main priorities of this government would be to contain social expenditure by simultaneously increasing the provision of care services from the independent sector. Consequently this action meant that the private sector became the alternative care provider and the role of the state in providing care services diminished (Land and Lewis: 1998: 51). This was encouraged and made possible through a few policy changes such as the introduction of the National Health Service and Community Care Act 1990 and through the implementation of proposals made in the 1989 White Paper entitled *Caring for People*. These policies and the effects they had on the provision of health and social care will now be examined.

Among the policy changes that the Conservative government implemented into health and social care was the introduction of market principles into the public sector. These principles were underpinned by a capitalist ideology, and the primary aim of this policy change was to increase the efficiency and the quality of public services. However, one of the actual outcomes that this action achieved was the altering the role of the state in delivering health and social care. By introducing market principles into health and social care services, rather than being focused on the actual delivery of care services, the state became increasingly preoccupied with the control of finances. This action almost began the process of dissolving the state's responsibility for care, and opened health and social care services to wider market principles.

Moreover, in addition to changing the role of the state, these public sector services also experienced a move to formal contracts. The rationality behind this action was to enable

individuals to understand the sort of services that they should expect and be entitled to (Vabø: 2006:403-404). However this action also transformed the relationship between individuals and health and social care services, because individuals would approach these services as service users rather than citizens. Therefore not only did this change the fundamental nature of care by beginning to expose care to market forces, but an individual's relationship with care was also transformed. This notion is further reinforced when considering the introduction of contracts into health and social care alongside the transition of society into what is often referred to as a '*consumer society*' (Baudrillard: 1998:37). By utilising these concepts, scholars such as Henderson and Peterson (2002) identify a process of commodification of care services, where individuals will behave in a manner associated with consumers paying for care services rather than citizens freely giving and receiving care support (1-3).

Additionally, along with the introduction of market principles into the public sector, other socio-cultural and political changes occurred that served to change the role of the state in implementing health and social care and created a marketable space for a care industry to be established. For instance, in an effort to contain the cost of health and social care, the government changed the role and the nature of state involvement in the provision of care. This was undertaken through introduction of the National Health Service and Community Care Act 1990, which resulted in managerial changes within local authorities. As a consequence of this legislation local authorities were given a larger responsibility and control over a '*single unified budget*' (Langan: 1990: 58-59) with the stipulation that their bureaucracies would not increase.

Hence an internal market was introduced into the supply of health and social care. This meant that local authorities would not be direct providers of care; instead they would assess the needs patients and purchase the required care services from hospitals, other local authorities or private companies. The state promoted the importance of this action in the 1989 White Paper which stated that '*...whenever possible of services from voluntary or "not for profit" and private providers insofar as this represents a cost effective care choice*' (Department of Health: 1989: 22). Through adopting this ethos towards health and social care the role of the

state in providing health and social care services diminished. Instead local authorities became '*enablers*' of care (Land and Lewis: 1998: 53), where their main role was to direct individuals to the appropriate services.

Furthermore as alluded to previously, another action that the Conservative government was committed to fulfil, was the reduction of public expenditure (Thane: 2009: 11). After being elected in 1979, the Conservative government were faced with budget deficits and high unemployment levels. Additionally the Iranian revolution in 1980 resulted in an oil price crisis which caused the U.K economy to enter into a recession. As a response to these societal issues, the state raised interest rates and heavily restricted public spending in an effort to reduce inflation (Cowper: 2008). As a consequence, the budgets given to the NHS and local authorities were reduced. However, the governmental grants and funding allocated to the private sector increased (Gosling: 2013).

Additionally with the implementation of the NHS and Community Care Act of 1990, the responsibility of long term care was devolved to local authorities. This act continued to diminish the role of the NHS (Harrington and Pollock: 2006:1806), and as a consequence meant that the primary role of the NHS was restricted to providing acute care services for older patients. Typically this population of patients tended to be chronically ill and required longer periods of time in hospitals and therefore older patients were deemed to be 'bed blockers'. As a consequence, in the 1980s the NHS reduced its nursing home care and increased its day surgery services. By undertaking these actions, the role of the NHS was restricted to primarily dealing with acute care services, which resulted in the more chronically ill and older patients relying on local authority care services or their families for care. However as noted previously, as women were increasingly entering the labour force, and geographic mobility increased, the number of families that would be able to provide care for elderly relatives were diminishing. This has created a great demand for care (Land and Lewis: 1998: 54), and has led to the current care climate which will now be briefly examined.

Contemporary Context

The aforementioned actions and processes have laid the foundations on which the contemporary care context that we are more familiar with today has been built upon. As society has progressed into the contemporary context, individuals continue to have a greater life span. For instance data from the most recent census survey indicates that,

"The population of the UK aged 65 and over was 10.4 million (16 per cent of the UK population) in 2011, 9.4 million in 2001 (16 per cent) and 2.2 million in 1911 (5 per cent)"
(Census: Population estimates for the United Kingdom, 2011:1).

While most of the population of older individuals are in relatively fair health, as a whole population they still require the greatest use of health services (Walker and Maltby: 1997: 91), as their bodies age and begin to decline. Therefore in some instances, independent living has become a less viable option for a proportion of the population of very aged individuals. This occurrence in conjunction with other socio-political and cultural changes has allowed a profitable market around health and social care to be established that has a monetary value of approximately £13 billion (Bäumker and Netton: 2011: 89).

In the current social context, it can be observed that independent private companies undertake most of the care provision for older people. As mentioned previously since the 1980s the number of state run care homes has decreased (Harrington and Pollock: 1998: 1086). This is demonstrated in a study conducted by Lievesley et al. (2011) whose results indicate that in 1980, 63% of residential care home places were provided by local authorities, whereas the private sector provided just 17%. By 2002 this situation had reversed and this trend continues to the present day (3-4). This development has led to the contemporary care context which, as a society we are more familiar with to arise. At the time that this research was conducted there were an estimated 11,501 residential care and nursing homes for older people in the United Kingdom. Within this total, 9,320 of these care homes are classed as

private homes (www.carehome.co.uk: 2013), which equates to about 81% of residential care and nursing homes in the United Kingdom being classed as private institutions.

Additionally, if these figures are considered within the current national economic climate where austerity measures are common, the number of state run care homes is set to fall further (Hope: 2009). This indicates that this paradigm shift is only set to continue, thereby further promoting the longevity of private health and social care. This may in part be due to changes in legislation, however what cannot be ignored as a major contributory factor to the decline of state funded care is the most recent global economic recession. There are many contributory factors that resulted in this most recent recession; however the effects have spread across the globe. These effects include the Euro-zone crisis, where many European states are confronted with governmental debt and a lack of economic growth. Additionally on a more micro scale, individuals will often face high levels of household debt and high levels of unemployment (Economist: 2013).

Therefore, in an effort to contain and reduce the national debt of the United Kingdom, the coalition government imposed public spending cuts in a variety of sectors. This has meant that the budget that local authorities receive has been severely reduced. As a consequence local authorities have had to freeze or reduce the amount the amount of funding that they contribute towards caring costs in state run care homes (Laurence: 2011). This action has ultimately resulted in a number of care homes that are funded and run by the state being forced to close and send their service users to alternative care settings.

However, as society has undergone a movement to private social care, the nature of care work itself must be questioned. As alluded to previously, the transition from a producer to a consumer society has altered the manner in which individuals interact with organisations and services, and like many other forms of industry; care work has also become intertwined and driven by market forces. Hence, like many other facets of society, it can be asserted that private care homes must at some level have a profit motive incorporated into them.

Therefore, the possible consequences that a profit motive can have for care work, its workers

and services users must be explored. The aim of this research is to investigate the views and lived experiences of paid employees currently working within the private care sector and how the requirement to generate profit impacts the everyday working lives of residential care staff. Notions concerning the spatial-temporal ordering of care homes will be considered with reference to the struggle of attempting to meet with post-fordist expectations and policies. Additionally, motivations, authenticity, gender and trust within care work will also be explored. But first it may be pertinent to state what a care home is and theoretically define what care as a concept entails, before examining the substantive topics that are present within contemporary care.

Chapter Two: Conceptualising the Notion of Care, the Labour of Care Work, and Care Workers

Who Are Care Workers?

Before commencing with an examination into what care is and how it is shaped by different cultural and social contexts, the term care worker should first be defined. The term formal care worker has been used on numerous occasions throughout this project. It is therefore necessary to conceptualize who formal care workers are. A good starting point is to comprehend formal care work as caring labour that

'is provided by paid staff, such nurses and care workers, working in either care settings such as hospitals or care homes, or in people's own homes' (Alzheimer's Society: 2013).

In terms of this study, emphasis will be given to paid care assistants, who are responsible for aiding service users with activities of daily living. The above quotation illustrates that care assistants can operate in a number of settings within the community or within care institutions such as hospitals and care homes. These can be funded by the state grants or by

independent companies. However, for the purpose of this study, there will be a specific focus on paid care workers who are employed by independent care companies to provide care services within private care institutions or care homes.

Universally, there are two main types of contract within care work; namely permanent and flexible. Those on a permanent contract have a fixed set of hours and can work up to about 36 full time hours or 28 to 30 part time hours per week. However, those working on a flexible contract have no fixed hours and are often required to work the shifts of permanent workers who are unable to attend work because of annual leave or through illness. In my own experience of working in care, I was employed on a flexible contract by my employer. This is because at the time this research was conducted I was full time university student and would only work a maximum of three months at a time, during the university holidays. My employer utilised my position to allow the permanent staff, many of whom had families and young children, to be able to book annual leave during school holidays without leaving the rest of their care team understaffed. Now that the term care worker has been explored, this chapter will now seek to explain define the concept of care and clarify what is meant by the term care home.

What is Care and What is a Care Home?

Along with the definition of a care worker, the concept of what constitutes caring and care work remains as equally as ambiguous. This is because the term '*care home*' encompasses a broad variety of services and is often used without a strict definition. Yet, for the purpose of this study, care homes for older people will be classified as institutions that '*house older individuals with various diagnoses and functional limitations*' (Mortenson et al.: 2012: 315) and provide them with long-term care for their on-going health and social care needs (DoH: 2003; Froggart et al: 2009: 10).

Furthermore like the term care home, the definition of what care is as a concept has remained just as ambiguous.

'Care has until recently been an equally unrefined notion. It has been used

to denote the provision of assistance to those in need, either in the recovery of their health (social, physical or mental) or in helping them to complete tasks which they can no longer undertake independently and can cover a multitude of actions'

(Department of Health and Security: 1983: 94)

This is perhaps a good starting point to summarise the action of care, however what it fails to capture the complexity and potential emotions that it entails. According to academics like Bubeck, '*care is a deeply human practice*' (1995: 160) and to care for others involves '*feelings of affection and responsibility combined with actions that provide responsively for an individual's personal needs or well-being, in a face-to-face relationship*' (Cancian and Oliker: 2000: 2). This can potentially occur in many facets of everyday life, and prime examples that can be associated with this definition of care include, parents or schools with children. One of the primary responsibilities of both schools and parents is to ensure the physical, mental and emotional safety and well-being of children. This is particularly evident when considering private boarding schools who act '*in loco parentis*' or place of the parent. In general, most individuals will tend to care for those closest to them in some capacity; however this project is examining the concept of care that takes place in institutional setting for older individuals.

Therefore to summarise, the notion of care is evident in numerous institutions and social relationships in various capacities. However in acknowledging this notion, the following question must be considered; what differentiates caring found in situations of everyday social life, from that conducted within the professional care industry? It can be asserted that care in these situations is almost a form of forced behaviour. As such it could potentially lose its naturalness and at times could be considered to be inauthentic. This is because although care is given, an individual who works within the care profession might not be as emotionally invested with service users, as they would otherwise be with their other interpersonal relationships.

Additionally, care within social relationships almost infers a sense of reciprocity, that is care is not '*unidirectional*' (Victor: 2005: 272) but is given and received in various measures.

Alternatively, care work can be viewed as one-sided, because the care worker is principally

employed to provide a service. Therefore, caring for others within the context of capitalism has arguably become commodified and risks marginalising the emotional dimensions of care work. In considering these notions, it is evident that the placement of this affectively motivated act which is traditionally associated with close interpersonal relationships, into an institutional setting, has allowed a number of issues to arise. However before discussing these issues in any depth, it would be best to sociologically examine the components of formal caring labour within institutional settings and consider how caring labour is impacted under conditions of industrial speed up. First the notion of emotional labour will be analysed.

Emotional Labour

In its' current form, care giving is commonly conceptualised as *"an activity encompassing both instrumental tasks and affective relations. Despite the classic Parsonian distinction between these two modes of behaviour, care givers are expected to provide love as well as labour"* (Abel and Nelson: 1990: 4). In considering this statement, it can be asserted that the actual labour conducted by care workers can be dichotomised into physical labour and emotional work. Using this notion as a starting point, the affective aspect to care giving will now be explored using notions that have been established in previous theoretical and qualitative work

Care work is considered to fall under the umbrella of intimate labour, and one of the central components that constitute care work is *'emotional labour'*. This concept was first established and explored by Hochschild who devised the term emotional labour,

'to mean the management of feeling to create a publicly observable facial and bodily display; emotional labour is sold for a wage and therefore has an exchange value' (1983: 7).

Previously emotions were something to be managed in the private sphere but are now considered to be resources that can be bought and sold for use by corporations (Ibid: 45, 90,

118). This is not just limited to care work and can be found in a multitude of other professions (Wharton: 2009: 61).

Although this theory was originally derived from an ethnographic study of those working in Delta Airlines as the hostesses; since its inception it has been applied to many other service professions and likewise can be applied to care work. In such instances, these professions require employees to present themselves in an idealised image that a company wishes to promote. In the instance of Delta Airlines, Hochschild (1983) asserted that this company chose to adopt the image of air hostesses who were *'beautiful and smartly dressed Southern white women, the supposed epitome of gracious manners and warm personal service'* (93). As a consequence staff were selected and trained to conform to this idealized image (Fulcher and Scott: 2011: 142). This notion can be equally applied to other service sector work including care work. Care workers need to appear to be genuinely caring, energetic, polite and nurturing individuals.

The process illustrates that even the most seemingly banal aspects of human behaviour and nature are not immune from the effects of contemporary capitalism and have been commodified. Even emotions which can be viewed as seemingly trivial entities have been turned into a form of currency with an exchange value that is exploited by contemporary society. *'The one area of her occupational life in which she might be "free to act" the area of her own personality, must now also be managed [and] must become the alert yet obsequious instrument by which goods are distributed'* (Mills: 1951: 184). Emotions are no longer considered to be entities that are managed outside of the world of work, rather they are now a resource that needs to be harnessed as a means to an end for an organisation (Bolton: 2005: 47).

During this process of commodification, organisations began to establish a specific set of rules that determine not only what is the appropriate type and amount of feeling that should be displayed and experienced. This requires feeling management, which is a process that occurs as workers attempt to accommodate these rules (Hochschild: 1983: 89-90). In order for individuals to manage their emotions in this manner, emotional labour encapsulates two slightly different processes. The first is *'surface acting'*. This entails the presentation of

affective displays to an observer that conforms to a desired or expected emotional display. This can either be an extension or conversely, a masking of an individual's actual emotions and in the instance of the latter can be considered to be a facade, for instance a '*friendly smile*' put on to conform to a company's image and expectations (Pisanello et al: 2012: 580). The other part of emotional labour entails '*deep acting*'. This is a process in which immediately before an emotional display, an individual will attempt to align their own feelings with those that are demanded of them by their employer through the use of emotion memory and association (Hülseger and Schewe: 2011: 362).

This theory infers that although an individual remains the locus of acting, organizations are now imposing a greater level of control over emotion management. Workers are no longer simply required to merely surface act and put on a smile. Instead it seems that institutions are placing parameters around a worker's emotion memories, in order to be able to foster desired feelings within their workers. Essentially this means that workers will be deep acting a series of emotions (Hochschild: 1983: 49). This notion raises an interesting conceptual issue. As noted previously, the motives underpinning care work have been exposed to the demands of market forces. Within the private sphere, the basic purpose of emotional exchange is for the individuals involved is gratification, well-being and reciprocity. However, when this system of emotional exchange is placed within a commercial work setting, the meaning behind it becomes transformed and it can be argued there is a profit motive underlying emotion management and exchange (Hochschild: 1983: 119).

Furthermore, if the process of commodification of emotions is revisited, the motives underpinning care work can be questioned further. By transforming emotions into commodities, it can be asserted that institutional profit motives can seep into individual reasons for becoming a care worker. By almost transforming emotional labour into a fetishized entity, it can be argued that the social relationships that are formed within care have altered. This is because within a capitalist society, individuals become increasingly linked with each other through the buying and selling of commodities (Cutler et al: 1977: 75). If this theory is applied to the relationships found within care work, it can be questioned

if the nature of care work itself has actually been altered. It could be argued that relationships within care are created out of a '*sense of obligation on the part of the carer [which] is socially rather than affectively constructed, through the payment of services rendered or the exigencies of a social norm*' (Ungerson: 1983: 32). Therefore, it can be questioned whether a love and money dichotomy exists, or a does this reductionist approach fail to capture the complexity of caring labour? Has care work been hollowed out and approached more as a job? Or does it still retain the primary essence of care?

Additionally, if there is indeed a profit motive and care work is approached solely as a job then could the relationships formed between the workers and service users be considered to be inauthentic? This is perhaps due in part to an underlying profit motive and the very nature of emotional labour. Emotions are subject to strict control and management and therefore associated relationships could be considered to be inauthentic (de Raeve: 2002: 466), within an institutional care setting. This notion of authenticity within the performance of care work can be examined using the dramaturgical metaphor which will now be briefly explored.

In essence the '*the dramaturgical approach is a metaphorical technique that is used to explain how an individual presents an "idealized" rather than authentic version of herself*' (Hogan: 2010: 378). Within this approach three components of performative behaviour can be identified; the front, the audience and back regions. The front is where an individual performs and adheres to the conventions that carry particular meanings for their audience. This can include a physical setting, which in this study includes institutional care and nursing homes. However this can also mean the workers themselves, because it is through their actions and expressions that emotional labour is performed in an expected manner (Smith: 2006: 42-3). The expectation that almost directs this performance stems from the second component of dramaturgy; the audience (Goffman: 1959: 19-25). In the instance of care workers, the audience can include the institution, service users as well as the general public. Each has a particular set of expectations that a care worker has to meet or fulfil. Finally, the last part of dramaturgy is the back regions. These are spaces where the audience is absent, and allows individuals to step out of their constructed character (Ibid: 1959: 97). In the instance of care

workers this can include staff rooms and other domestic spaces out of the view of the audience such as kitchens and laundry rooms.

Utilising this approach, emotional labour could be considered as part of an adopted front that care workers employ as part of their professional identity, and it is only in the back regions where the pressure of performing is alleviated. In this space, unbounded from the gaze of the audience, care workers can freely express what they actually feel and discuss their lives out of the work domain without the risk of acting in an unprofessional manner. This notion consequently infers that care workers could potentially engage in inauthentic relationships with their service users (Lopez: 2006b: 141). However it should also be questioned whether what is presented on the front and what occurs in the back regions are distinctly different from each other. Are workers fully emotionally detached from their roles and essentially view their capacity to emotionally act as a job requirement (William: 2008: 358)? Using this notion care workers could essentially be considered as emotional actors presenting insincere emotional displays and engaging inauthentic relationships with service users. On the other hand what is presented on the front and what is displayed in the back regions may not be too dissimilar. In this instance, the essence of care remains and the relationships formed in care settings can be thought to be authentic because the emotional labour conducted goes beyond surface or deep acting.

Therefore a question that should be addressed is what is actually occurring in contemporary care work? Does the fact that care workers are paid to perform emotional labour and work detract from the authenticity of the relationships that emerge in these care settings? Or is emotional labour within care work more complex and authentic than the notion first described by Hochschild? Does a profit motive affect the authenticity of emotional labour and the relationships formed in these settings? Moreover are care workers simply surface acting or are they deep acting and empathising with the service users? These questions will be kept in mind and once the research has been conducted will be addressed in later chapters. Now that the affective component of caring labour has been discussed, this chapter will now examine the instrumental aspect that care workers are expected to undertake.

Body Labour

As stated previously, the other more physical component of care work is body work, and can encompass a wide range of activities that can occur both in the domestic and occupational spheres. Therefore, due to the existence of body work in this manner, a distinction must be made between the notions of body work and body labour.

Body work refers to all work that is conducted on the body of an individual and this can occur both in the domestic and occupational sphere. Conversely, body labour refers to forms of body work which have been commodified and like aspects of emotional labour have almost become a form of exchange within care work (Kang: 2010: 20-1). This signifies a shift in the focus of economic activity and a growing sector of employment that entails specific and personal relationships with the bodies of service users (Wolkowitz: 2006: 18-19). Shilling (2011) estimates that between 10 to 30 per-cent of all jobs in Britain involves body work in some capacity depending on the conceptualisation used (336).

Additionally due to the inherent nature of body work and labour, the body of the service users have been transformed into the object of labour (Twigg, et al: 2011: 173). Within care, body labour can incorporate many activities ranging from manicures to intimate personal and perineal care which can involve aiding clients to use the toilet, bathing and washing their bodies. The latter examples infer that body labour can be considered to be both sociologically and literally dirty work because in some instances, this form of labour can violate norms of body management. In such instances, workers are required to engage in intimate and messy contact with the body and its' by-products (Wolkowitz: 2002: 497; 2006: 147).

Perceptions of Care Work

This aspect of care work undoubtedly impacts the perceptions around care work. Quite often this part of care work requires care workers to handle '*matter out of place*' (Douglas: 1984: 36). This potentially fosters connotations of care work being a 'dirty' occupation, which entails tasks that are considered to be disgusting, demeaning and tainted in some physical,

social or moral manner (Hughes: 1958: 122). Consequently this could promote the opinion that the jobs and workers associated with the care industry are widely thought entail low prestige and status (Ashforth and Kreiner: 1999:425).

Furthermore, after exploring the nature of care work, it can be ascertained that this labour is very intimate. Quite often service users will have to expose parts of their bodies or themselves that are normally hidden from others. Additionally, service users have to allow care workers to help them in what could potentially be vulnerable or embarrassing situations. The ability to this periodically within a care setting, illustrates that a great amount of trust is needed between care workers and service users, demonstrating that these relationships have a unique quality about them (Lupton: 1996: 165).

The care industry needs current service users and potential clients to have trust in them. In basic terms trust can be defined as *'the expectation that individuals and institutions will meet their responsibilities to us [as service users]'* (Mechanic: 1998: 662). In other words individuals must have

'confidence in the reliability of a person or system, regarding a given set of outcomes or events where that confidence expresses a faith in the probity of love of another, or in the correctness of abstract principles' (Giddens: 1990: 34).

In considering these definitions, it would seem that for trust to be present in any relationship, the trustee has a set of expectations or responsibilities that must be consistently met or maintained. Therefore, trust is a vital component for stable, cooperative relationships to be established, and it is essential for even the most mundane interactions and fundamental for any form of exchange (Misztal: 1996: 12). As a consequence, the place of trust within caring relationships should not be understated.

'Patients trust staff not to hurt them unduly, to treat them with compassion and as fellow humans, not to exploit them for sexual fantasy or actually use, not to breach confidentiality. Staff trust patients to cooperate and submit to the technologies and

competences claimed by the discipline. Both parties invest the other with a degree of responsibility. Patients we might expect, would invest staff with caring and curing capabilities, or with more general human attributes as comforters or advisers' (Fox: 1993: 42).

But it would seem that media seems to demonise care workers and seems to constantly undermine these trusting relationships by showing instances where there are inconsistencies within the deliverance of care. Erikson stated that *'a considerable portion of what we call "news" is devoted to reports about deviant behaviour and its consequences'* (1966:12). This is illustrated by the following excerpts from media reports. For instance, *'the health and care system in England is "struggling" to look after people with dementia, according to the regulator'* (Triggle: 2013). Other reports claim that *'elderly care home residents in Britain are being denied "basic justice" as austerity cuts leave the system in "crisis"'* (Ross: 2011). Furthermore, there are also damning reports deriving from spot inspections of care homes and hospitals that found that *'more than a third are still failing to respect elderly people's basic dignity, despite a series of scandals'* (Bingham: 2013). This is just a few of the many media reports about health and social care currently in circulation, and arguably such a vast sum of negative coverage about care must to some extent influence the perception and reaction to the care industry and its workers. This is because the media are *'among the most powerful forces in the shaping of public consciousness about topical and controversial issues'* (Hall et al: [1978] 2006: 41). The power of the media could derive from the ubiquity of communication technology available today, which can enable the media to present and communicate stories about care to vast audiences. However, the emphasis that the news media gives to particular, quite often negative stories can possibly influence how specific organisations and its workers are perceived, which can damage relationships not just within the sphere of care but to other related organisations.

Additionally, it could be asserted that another notion that is commonly associated with care work is that it is gendered work. In other words care work is widely considered to be women's work. Definitions of work being either masculine or feminine are not fixed. However with two thirds of the overall employment of this sector being occupied by women (Mclean: 2003: 46), there is a female dominance within care. Furthermore there is also a widely held notion that women have a perceived 'natural' affinity for nurturing and caring

labour (Gerstal: 2000: 468). These occurrences perhaps contribute to the notion that care work is women's work. While classifying care work in this manner is a natural human tendency (Bowker and Star: 2000: 1), why this distinction has been made should be examined. It can be asserted that care work is considered to be women's work because it requires characteristics that are thought to be more typical of women such as nurturance and caretaking ability (Wharton 2012: 203-204). Therefore it is not unusual that caring occupations are female dominated because by engendering female qualities it seems almost natural for women to occupy these job roles.

Debatably, this cultural norm and expectation has arisen from the experiences of the middle class in post-industrial societies. It has been argued that these cultural norms were derived from the emergence of what has been deemed '*the doctrine of separate spheres*' (Cancian: 1987). This is where a link was made between what was thought to be desirable qualities of men and women and the division of the home and work spheres. The sphere of paid employment came to be viewed as a space of '*competition, rationality and achievement*' (Wharton: 2012: 103). These characteristics came to be commonly associated with masculinity because traditionally, men were primarily the breadwinners and were the most immersed in economic work. Likewise, as the primary inhabitants of the home, women came to be closely associated with attributes such as '*domesticity, purity and submissiveness*' (Ibid: 103-104). This meant that the traditional role for a woman was to be the nurturer, the mother and the carer. These roles not only appealed to their affective strengths but to the natural maternal instincts as well. Additionally because women were not previously as immersed in the work force to the same extent as their partners, they were almost expected to carry out these roles.

However, it can be observed that between 1960 and 2006 women's participation in the labour force has increased worldwide, albeit by varying degrees (Heymann and Earle: 2010: 125). Indeed women's increased participation in the workforce has been deemed '*the single most influential change in labour markets of industrialized countries in the post-war period*' (Gornick et al.: 1998: 35). Women's increasing participation in the labour force can be attributed to many interconnected factors including rising levels of education. This greater level of education has thrust women into the workforce by allowing them to compete for a

greater number of jobs. Furthermore, as education levels increase and women participate in the workforce to a greater extent, more egalitarian gender beliefs have developed (Wharton: 2012: 108-109). This occurrence has consequently enabled family structures to change. In contemporary society, because women participate in the work force to a greater extent, men's financial responsibility as the sole breadwinners has been eased. This has allowed more diverse family structures to develop. Finally another factor that has allowed women to participate in the labour force to a greater extent is the expansion of the service sector and the decline of manufacturing industries. This occurrence has created new job opportunities for women (Ibid: 107-108). These factors have enabled social change to occur and have altered gender expectations.

However, due to the nature of the labour of care work, it can be viewed as an extension of women's traditional roles within families and domestic settings as mothers and primary care givers (Evans: 2004: 323). This sort of occupation can be perceived to fit into and be a part of women's natural attributes and qualities (Evans: 2002: 441; Evans: 2004: 324). Furthermore, in conjunction with the traditional view that the role of men was to be the main breadwinner for their family or household almost portrays men to be rational and logical and perhaps less emotional than their female counterparts. So, considering men in such roles would almost defy traditional and accepted norms of expected behaviour, and men who occupy job roles traditionally associated with femininity carried connotations of homosexuality (Harding: 2008: 641). Moreover, these traditional assumptions can be questioned further when considering the aforementioned structural changes that have shaped the contemporary social context. For instance, women are now greater participants in the workforce. Indeed women are commonly involved in both paid employment, family life and other pursuits. Additionally, society has also experienced the decrease of traditional masculine manual labour sector which has almost been replaced with the rise of service work (Wharton: 2012: 107). As discussed previously, service work labour requires a greater use of emotions. This structural reorganisation of the world of work has partly contributed to a loss of traditional masculinity (Mcdowell: 2000: 204-207). Consequently, it can be asserted that this process of blurring gender and work boundaries and rise of the new age, metro-sexual modern man (Jack: 2011). Therefore these asserted that these changes to

gender expectations have arguably enabled a greater level of social acceptance for men to occupy job roles that have been traditionally associated with women and femininity.

Conversely despite these considerations it would appear that more and more men are entering into the care profession, and in doing so challenge the notion that men are inappropriate caregivers. However in entering this female dominated profession, prospective male care workers are confronted with negative gender stereotypes of either being sexual aggressors or homosexual. This underlying stigma can make the process of establishing comfortable and trusting relationships between workers and service users more problematic. This may be because in some instances, the use of touch in the form of body work can become sexualised (Evans: 2002: 441-442). This underlying stigma almost infers that service users may be more receptive and trusting towards female care workers delivering care services because of the traditional affective role that they have occupied in the past. Or perhaps individuals would be less responsive to men because of the perceived inability of heterosexual men to care and empathise with other individuals (Calasanti and King: 2007: 517). This thought becomes more prominent especially after acknowledging that women are more likely to be the recipients of care (McLean: 2003: 50), and may be more comfortable with other women because of a fear of being objectified or sexualised, or because of feelings of embarrassment and vulnerability in the presence of the opposite gender.

Yet, in considering gender, gives rise to the following questions. Although this blurring of gender and occupational boundaries may be more accepted, does this challenge invoke negative stereotypes? Is care work still thought of as women's work? Does this impact the nature of relationships between service users and clients? Additionally, how do individuals react to male care assistants? These issues highlight a number of issues and this research will attempt to ascertain whether this is actually the case. However, before discussing these themes using the research data, a final theme that has become highlighted at the end of this section, namely trust, will now be examined.

Time and Routinization

The commodification of emotional labour and body work has meant that care work in the contemporary context is now subjected to the same economic and political pressures as other forms of labour. The principles of capitalism and post-Fordism promote greater efficiency and productivity, while maintaining low expenditure levels, and care work has not been immune from this process.

Like other industries, care work is not immune from capitalism's desire and need for increased efficiency. This notion was explored in the context of community care by Aronson and Neysmith (1996). However the themes that they identified concerning time management and organisation of care work can translate to institutional care. In their work Aronson and Neysmith commented on the differences in understanding of the definition of care work. This often produces to managerial policies and practices that narrow the definition of care. This in turn causes the labour of care to be intensified; work is sped up and costs are reduced in an effort to comply with an industrial image and capitalist ethos (1996: 60-62). Increasing efficiency through industrial 'speed up' means that the time available for interaction with each service user decreases, making it increasingly impossible to perform emotional labour. This has allowed a contradictory policy to arise that seeks to meet the demands for emotional labour alongside promoting conditions which makes this increasingly less feasible to achieve (Hochschild: 1983: 121-125).

Additionally a similar argument could be made with respect to body work. Individuals and their bodies are inherently complex and attempting to schedule care work is a difficult task. This is because unlike other conventional labour tasks, duties cannot simply accumulate and be completed in one attempt. In the same manner that bodily processes such as urination and bowel movements cannot be saved up for a week to go just once. The body is not a passive article; it is reactionary. Bodies have their own processes that transpire in their own time and quite often this can become more unpredictable as the body ages (Twigg: 2006:128). Consequently in a social context where industry is dependent upon clock time (Adam: 1993: 164), a mismatch exists between the care industry and the market driven capitalist

rationality. This is because individuals and their bodies have their own requirements and rhythms that do not always necessarily adhere to clock time.

However, despite individuals' inherent complexity, care institutions still seek to establish routines that dictate allotted times in which care work must be performed. But conducting care in this manner poses the risk of diminishing the quality of care. Writers such as Diamond (1992) also asserted that privatising care work in this manner carries the risk of not only turning care into a commodity but this process can also dehumanize residents into manageable units (204). Furthermore, in considering the imposed routines of care homes, it can be asserted that at least on a managerial level, this risk of dehumanisation is a reality. Particularly within body labour, the body of the individual becomes the object of labour and so this carries the risk of the person within the body almost disappearing. It seems that care work has in some capacity become routinized. A production line ethos, similar to that which is found within manufacturing industries has been applied to care work, and as a result service users have been transformed into units of time or jobs that have to be completed.

Not only does this dehumanise the clients by reducing them to jobs that have to be completed, but this can potentially compromise the standard of care. For example, instances where health and safety procedures are bypassed in favour of time saving short-cuts have been noted. In his study of a nursing homes in Michigan, Lopez, noted many instances where moving and handling a service user with the required equipment, method and number of people was by-passed in favour of unsafe actions that allowed workers to meet time targets (2006a: 56). However, not only does this pose a danger to the care worker, but the client is also at risk of physical harm or discomfort from these time saving actions. On the other hand care work does not merely entail physical tasks; time must also be made for affective labour to be conducted. This dimension of care is less amendable to time constraints and can potentially place care workers in frustrating and difficult positions of balancing the needs of the clients with the time constraints of the care home routine (England and Dyck: 2011: 212-213). Furthermore, within care work, quite often the outcome of care work is presented and emphasised (Twiggy: 2000: 145). So does this perhaps mean that one form of labour will be favoured or emphasised over another? For example because

the outcome of body labour is much more visible than that of emotional labour, will one be given more significance over the other?

Additionally, in order complete tasks in the allocated times, on occasion a client's needs and requests can be glossed in order to prevent disruption of the routine of the care home (Diamond: 1992: 77-79). Furthermore, if the clients do not have the ability to communicate their discomfort effectively they almost have to learn to cope with situations that many would regard as not only intolerable but degrading as well. Such situations can often be exacerbated in instances of unsatisfactory training programs and staff shortages (Cohen: 2011: 195). Still, it is not only the clients that could potentially suffer, academics like England and Dyck (2011) have noted that in over-running the allotted times on a care schedule, care workers can be reprimanded (212). As a consequence, it can be argued that by adopting a capitalist rationality within the parameters of the occupation of care, residents have invariably been transformed into a set of tasks to be completed within a manageable unit of time. However these manageable units of time are subjected to the mechanical expectation of routinized care work. But the reality of care work does not neatly fit into this structure of organising work, meaning that quite often residents are at risk of neglect or the time targets are not met. However is this scenario actually a reality? Do care workers actually feel the time pressures of care work? Is this impacted by other factors such as staffing levels? These questions will be kept in mind when the research is conducted, and the research findings will be used to provide answers to these questions and those which have previously arisen throughout the review of current and past sociological literature.

Now that the previous academic literature and theoretical concepts have been considered, this thesis will now state and discuss the research aim and chosen methodologies that were adopted within this research project.

Chapter Three: Methodology

Research Aim and Methods

The overall research aim of this project is to explore the perspectives and lived experiences of people who work in residential care homes for older people. Informed by findings from previous research into care work undertaken by the author, the aim of this project is to explore tensions associated with the commodification of care work and the notion of caring. In order to pursue this aim, this study will address the following questions: what has happened to care? What is the future for care? And finally, can you care for a profit?

As a qualitative investigation into care work, for this research I utilised my role as a bank care assistant to explore care work using the sociological imagination. In keeping with the qualitative tradition, the aim of this project is to provide an in-depth portrayal and analysis of what is actually occurring on the 'frontline' of care work from the perspective of those working in the contemporary care setting.

Having previously worked as a care worker; by conducting this research I was granted the opportunity to perceive, portray and examine the reality of care work from the perspectives of those included within the case studies rather than as someone who is external to the culture being studied (Yin: 2003: 94). Consequently this meant that the study adopted an ethnographic approach, but it was perhaps more akin to a micro-ethnographic study of working within contemporary care. Here, the term '*micro-ethnography*' (Wolcott: 1990: 64) is adopted, due to the time restraints and scope of the research undertaken. This research focused on three different settings and a relatively small number of workers who constitute a much larger group of workers at this particular time (Berg and Lune: 2012: 199). This narrowing of focus proved to be partly advantageous because it allowed specific aspects of care to become the focal points of this research. Keeping within an ethnographic and qualitative framework, a mixed method approach was adopted. Within this approach three methodologies were adopted; qualitative interviewing, participant observations and

secondary analysis. However before exploring the adopted methods, the sample that underpins the research will be briefly examined.

Sample

The sampling frame was based in three separate care settings; two were situated in the local area and the third setting was the care home in which I had previously been an employee for three years.

Various forms of sampling were utilised in different settings due to the differing level of access that I was granted. For the settings where observations and interviews were conducted convenience or accidental sampling was employed (Neuman: 2006: 220). The individuals who became participants were often those who happened to be scheduled to work on the same occasions when the fieldwork was conducted. In the first setting, the time and places in which the observations were conducted coincided with the times that I was scheduled to work. In contrast in the second setting, the time and places where the observations took place were agreed beforehand with the home manager.

However in the final setting, the manager only consented to interviews being conducted and not observations. Therefore, the form of sampling employed in this setting was more akin to snowball sampling (Bryman: 2012: 202), where a rapport was established with the manager of the care home who approached individuals on behalf of the researcher to be participants. Hence, this research does not claim to be representative of the whole population of care workers (Sarantakos: 1994: 137), but as a piece of qualitative research the main purpose of the findings is not generalisability, but rather to provide an illustration of the lived realities of care workers in the contemporary social context (Neuman: 2006: 219).

Finally the participants varied in age from late teens to early fifties and gender composition of the sample was predominantly female, but there were a few male participants within the sample. Now that the sample has been considered, the methods that were utilised within this research will now be analysed.

Micro-Ethnography and Observation

As mentioned previously, one of the methodological approaches utilised within this research was micro-ethnography and observation. These terms will now be defined and explored within the context of this study. Simply put, ethnography can be defined as the

'study of people in naturally occurring settings or fields by means of methods which capture their social meanings and ordinary activities, involving the researcher participating directly in the setting if not also the activities, in order to collect data in a systematic manner but without meaning being imposed in them externally' (Brewer: 2000: 10).

Quite often this is achieved through the use of various methods such as observations and interviews (Fielding: 2001:146). These actions allow a researcher to participate for a prolonged period of time in the everyday lives of those being studied. First the method of observations will be examined. Within this method what is said and what happens throughout this participation becomes the research data and is utilised to shed light on the issues that are the focus of the research (Hammersley and Atkinson: 1995: 1). As stated previously, a lot of ethnographic research is based on participant observations (Liamputtong and Ezzy: 2005: 169). Due to the differing levels of access to research settings, two forms of participant observations were adopted throughout this research process. These forms of observations will now be discussed.

The first form of participant observation that was adopted was the role of *'a participant-as-observer'* (Bryman: 2008: 140; Gold: 1958: 220; Walliman: 2006: 96), where I was fully engaged in the everyday activities and working lives of those whom I was observing but they were also aware of my presence there as a researcher (Walsh: 2004: 229-30). This form of observation was undertaken in Home A where I was an employee, and took place when I was scheduled to work. As mentioned previously, this meant that there was an element of chance with regards to the individuals who comprised the sample. This is because the research participants within the sample comprised those who also happened to be

scheduled to work on the same shift as me and agreed to participate in the research. This also meant that there was a mixture of staff and times when the observations were conducted depending on when I was scheduled to work. Each set of observations ranged from five to twelve hours, depending upon the length of shift that I was scheduled to work.

The other observational role that was employed was that of an '*observer-as-participant*' (Walsh: 2004: 230). My role as a researcher was common knowledge amongst both staff and residents, and it was understood that my presence in this setting was as a researcher, and that I was conducting interviews and some observations with very little participation in their everyday activities (Gold: 1958: 221; Walliman: 2006:95). As mentioned in a previous section, the times and locations in which the observations were conducted in the second setting were organised beforehand with the care home manager. In this setting, I would often be assigned to shadow a worker who was scheduled to work a morning shift on the designated dates. Each set of observations in this setting ranged from two to six hours in a single session, and were conducted under the supervision of managerial staff.

This approach to research has particular advantages. Notably this approach allows understanding of the implicit aspects of a culture that informs a part of everyday life and can allow access to experiences and perspectives of groups who can previously be difficult to engage (Harper and La Fontaine: 2009: 241). Also, as alluded to previously it allows cultures to be understood in their own terms rather than being subjected to the values of the more powerful cultures of society (Fetterman: 1989: 27-28). This outcome partially underpinned the rationality of adopting this methodological approach, because as stated previously, care work from the perspective of care workers is rarely featured in academic literature. Additionally, this method generates what is often referred to as '*thick description*' of cultures (Geertz: 1973: 5-6; 9-10). This is a detailed examination of social processes and the context in which they occur. An examination of this calibre enables a rich understanding of the views, actions and meanings that underpin a culture being studied (Harper and La Fontaine: 2009:243). Observations also have the additional advantage that unlike other methods of data collection it does not rely solely on the honesty, knowledge and memory of

its participants (Taylor: 2009: 227). Rather, it is what actually occurs that is recorded or contrasted with what people describe or perceive to have occurred.

Of course like many other pieces of research, there are limitations to this research approach. To gain the detailed material that can emerge from ethnographic work, takes a lot of time and few researchers are able to devote the required level of time to gather this data (Fielding: 2001:147). Also, although research was undertaken in more than one setting, this piece of research can make no claim to its generalisability. However as a piece of qualitative research, the generalisability of the findings is not the primary aim. Instead the aim is to consider the subjective meanings that underpin the behaviours and lived experiences (McCall: 2006: 8) of care workers. Another potential limitation of this research was that a total of only five months of observations were undertaken and arguably more observations could have been beneficial to the research process. Conversely because of the tendency to focus on one setting or group, quite often participant observation is criticised for a potential lack of objectivity and its limited generalisability (Taylor: 2009: 227).

However as stated previously, as this research is a qualitative investigation, it makes no claim to generalisability, the focus of this research is to convey the lived experiences of care workers in three different settings. Also because this method of data collection is non-standardised, quite often the results generated from the data collected relies heavily upon interpretation by the researcher and as a consequence it could be considered to be too subjective (Harper and La Fontaine: 2009: 242-243). Finally, another more practical issue is that of note-taking. What to include in the field notes, and how and when to record these field notes can generate other methodological issues. For instance trying to make notes covertly, away from the participant's gaze can arouse suspicion, and similarly making notes in their presence may also make them more wary and almost entail connotations that judgements are being made against their behaviour or attitudes.

Additionally, composing field notes after being in the settings can also give rise to bias because certain events may be forgotten, or misinterpreted as this relies on the researcher's memory. Furthermore, what is deemed to be noteworthy is another issue, because what is

judged to be relevant or irrelevant is left to the researcher's discretion. When undertaking this method as part of the research project, '*scratch notes*' (Bryman: 2008: 420) were taken in the first care setting whenever there was a chance, such as between tasks or during break times. These notes were basic, containing a few key words that were used as prompts and often written on pieces of tissue or scrap pieces of paper. They were written up into '*full field notes*' (Ibid) immediately after the shift had finished. However, in the second care home setting notes were taken when on the care floor, but they usually were written out of the site of the workers in order to prevent any discomfort and unease and thereby minimising the risk of bias.

However, it should be noted that although observations were undertaken and field notes were compiled, much of the content of the field notes will not be included into the discussion chapters. This is because the primary purpose of conducting observations was to build a rapport with the research participants, in an effort to reduce the possibility of '*reactive effect*' (Bryman: 2008: 265) during the interview process. However, the data gathered from the observations were also utilised to inform the interview schedule, and as points of reference when discussing particular questions or topics in the interviews. Therefore, although the observational data is not overtly present within the discussion chapters, the themes and data underpin and inform the interviews and the analysis of the prominent themes.

Now that the ethnographical and observational methods that were employed for this study have been examined, this chapter will now consider qualitative interviewing.

Qualitative Interviewing

As a qualitative piece of research, from a theoretical perspective the research approach was both inductive and deductive. Beginning with notions that were already present in grounded theory, the data collected in the interviews helped to establish a greater understanding of general patterns and issues that arose (Liamputtong and Ezzy: 2005: 57) from the observational data.

Interviewing is a form of questioning that employs verbal questioning (Sarantakos: 1998: 246), in order to obtain '*subjective theory*' (Flick: 2006: 155). In other words, interviewees have a '*stock of knowledge*' (Ibid) about a particular topic that is being examined; it is this knowledge that a researcher wants to access and collect. There are a number of different types of interview techniques, but the form utilized within this study was that of semi-structured interviews. This meant that in each interview there was a list or schedule of questions or specific topics that had to be covered, but there was a degree of flexibility within this interview schedule (Bryman: 2008: 438). This meant that the researcher could alter the sequence of questions or probe further for more information when needed (Fielding and Thomas: 2001: 124). This was in part the reason for choosing this form of interviewing, because although there was a degree of structure within the interview, answers were not limited to a schedule. This flexibility allows the interview to be less constrained, and flow more like an everyday conversation, potentially allowing participants to feel more at ease and more likely to disclose truthful information (Fielding and Thomas: 2008:245-248). This flexibility also allowed the questions to be adapted to suit the level of articulacy and competency of each respondent (Fielding and Thomas: 2001: 124), thereby lowering the possibility of non-response.

Furthermore, this approach values the perspectives and experiences of the interviewees and the flexible nature of this interview approach allows interviewees to speak in their own voices and with their own language (Byrne: 2004: 182). This approach can also generate very rich data. The use of open-ended questions allows the interviewees the space and freedom to elaborate on aspects of their answers or topics that they feel to be important or of particular interest to them (Leidner: 1993: 238). This gives a great depth to the interview data thereby allowing a greater understanding and exploration of the emotions, experiences and beliefs surrounding a particular topic that consequently enhances the validity of the findings (Coombes et al: 2009: 201).

However as with any other method there potential disadvantages for using this approach. As alluded to previously, there is a potential of non-response, either questions may not be fully understood or interviewees may not want to disclose anything that could have a

negative impact on them. This could lead to non-response bias within the interview data. Additionally there are other potential sources of bias, for instance in this study interviewer bias could affect the validity of the interview data, because interviewees may answer questions in a manner believed to be pleasing to the researcher. However, the flexible interviewing approach was adopted to minimise this form bias. Additionally, in accordance with the British Sociological Association's (BSA) guidelines, confidentiality and anonymity were stressed in an attempt to minimise non-response and bias. Furthermore, another potential disadvantage is the inability to generalise the research findings. The study was conducted on too small a scale and the findings therefore cannot be generalized to the population of care workers as a whole, but as mentioned previously this is not the purpose of qualitative research. As a qualitative investigation, the outcome is to provide an in-depth insight into the lived experiences of some care workers currently working within the private care industry. There was also a danger of having too much data that may not be useful, which could make a detailed analysis of the data more difficult. However in my role as a researcher, steps were taken to guide the conversations if it veered too much off topic.

In total 18 in-depth interviews were conducted over a two year period, eight were from a care setting that was analysed in a previous study. A further six were conducted in another setting and then the final four in the last setting. The interviews were often conducted during lunch breaks or when there were quiet periods on the respective shifts. The interviews also varied in length from seven to fifty minutes. In conducting the interviews, I attempted to adopt the role of a reflexive listener. This was so the care worker's lived experiences and the observational data could be grounded within the wider social context (Marvasti: 2004: 56-57), and into existing sociological literature.

Introspection and Secondary Analysis

In addition to conducting interviews and observations, in keeping within an ethnographic framework, I also drew upon my own experiences of being a care assistant as a foundation of knowledge and analysis, which this research project was developed upon. My experiences were considered throughout the research project, to complement and enrich the research data. However, my experiences were also referenced frequently when conducting

interviews with other care workers. This proved to be immensely helpful because I was able to give examples of my own experiences, to not only put the interviewee at ease but to allow the interview to flow more like an everyday conversation.

Alongside the aforementioned qualitative methods, a secondary analysis of a previous research project that I undertook as part of my undergraduate degree. This previous study was a micro-ethnographical study of care workers conducted in a private care home in the summer of 2011 (Wolton: 2012). This previous study not only provided one of the case studies for this research project, but it also provided a foundation on which much of the analysis of this study is built. Numerous themes arose from this previous study, but only a few of them were analysed due to the restrictions deriving from the academic requirements of the dissertation. This current study enabled these themes that had previously been excluded from the analysis to be incorporated and for the previously discussed themes to be re-examined in greater depth and developed using secondary analysis. The form of secondary analysis employed is what Heaton defined as '*supra analysis*' (2004: 38) in which the focus of the original study is extended. The existing set of data is analysed again using new '*empirical, theoretical or methodological questions*' (Ibid: 38), in an attempt to present any additional or differing forms of knowledge, interpretations or conclusions that were not presented in the primary analysis (Hakim: 1982: 1). Although this approach seems to offer little possibility for originality of ideas, it can actually offer more than a simple re-analysis of existing data and can open new research avenues that may not have been previously accessible to the researchers (Dale et al: 1988: 3), which was the underpinning rationale in selecting this methodological approach.

Additionally secondary sources were implemented into the interview schedule. This was particularly beneficial because, this allowed the interview questions and the collected data to be grounded into the wider social and cultural context. This was of particular importance because when this research was undertaken, institutional care particularly for older people was very topical and was high on both the political and media agenda. This was partly due to a few scandals that had occurred within care homes, but also at the time this research was conducted, health and social care within the United Kingdom was undergoing radical

reforms in response to the increasing costs and demands of care in a climate of austerity. Not only does this enable the research to be contextualised but this also supports the usefulness of research of this nature, because it can be asserted that the perspective of care workers need to be addressed and acknowledged in order to promote a good national standard of care in future years.

Thematic Analysis

In order to organise and narrow the focus of the research findings, thematic analysis of the empirical data was undertaken throughout the research process. The analysis of all of the data generated from this project was undertaken by hand without the assistance of computer assisted software package.

The first part of the empirical data derived from the observations that were undertaken in two of the care settings. While the observations were conducted, field notes were generated to record the everyday occurrences of the care settings. These field notes were written up by hand, and as this process ensued, some early themes were identified and considered alongside my own experiences of working in care and a previous study into care work that I conducted. These different data sets and any emerging themes were discussed with my supervisor in order to generate topics or points of discussions that would be used within the interview schedule.

Once the interview schedule had been agreed with my supervisor, interviews with the research participants were undertaken. As with the field notes, the interview data was transcribed verbatim by hand, and during the early part of analysis of the first few interviews, some preliminary themes became apparent. I then sought to tease out and develop these early themes as the interview process progressed. In this instance, although the interviews adhered to a schedule, in the later interviews, as the emerging themes became apparent, the interviews developed iteratively. Quite often the findings or themes from the earlier interviews were incorporated into the subsequent interviews and these early findings were validated or disconfirmed by the research participants. Furthermore, once all of the interviews had been transcribed by hand, the different forms of data were collated and the

prominent themes were identified. To aid this process, I utilised coloured highlighters to visually code the data and identify the prevalence of certain trends and themes.

A number of emergent themes arose. However, those that were considered to be the most prominent concerned time pressures, authenticity and perceptions of care work. The direction of the discussion chapters were guided by these themes, which were examined using previous and current academic literature. This action was undertaken with a view to ground theories and the data in the contemporary social context. Yet, as with most social research, the validity of the data and analysis can be questioned. The factors that could influence the validity of this research project and the actions taken to ensure the validity of the research process will now be examined.

Validity, Bias and Non-Response

As alluded to previously in this chapter, both bias and non-response can influence the validity of the research data. Therefore, a number of actions were undertaken to reduce the possibility of bias and non-response and to ensure the validity of the research data. The actions that were implemented along with a reflective account of my experiences of conducting empirical research will now be discussed.

The first action that was used to increase the validity of the research data was utilising a number of sociological research methods or a triangulation of methods. Using a mixture of social research methods meant that when interviews were conducted, the data derived from the observational field notes, secondary sources and introspection were utilised as sources of supporting data. This supporting data was used to help explain behaviours and attitudes of research participants in addition to verifying some of the details supplied in the interviews (Shenton: 2004: 65). This action not only ensured the validity of the research data itself but also aided to ensure the validity of analysis.

Additionally to ensure the validity of the observational data, I attempted to be objective when making field notes and record only what I observed without making any subjective judgements. Also as alluded to previously in this chapter, there is a possibility of *'reactive*

effect' (Bryman: 2008: 265). This is where participants are aware that they are being observed and as a consequence will alter their behaviour. However, in an effort to ensure validity and prevent reactive effect as much as possible, I attempted to establish some early familiarity with care workers and their organisations of work. For instance, before conducting observations in the first and second care homes, I would take time to be present in the care settings and have discussions with care workers without making any form of field notes. This action was undertaken with the intention of making my presence as a researcher less intrusive. This exercise also enabled me to build a rapport with the participants and put them at ease so that their behaviour would not be influenced by my presence when conducting observations. This notion will be revisited later in this section.

Another method employed in an attempt to minimise the possibility of reactive effect, bias and non-response was to primarily identify myself as a care worker and secondly as a researcher. For instance when being presented by the care home managers to the research participants, I would primarily be introduced as a care worker before any reference was made about my role as a researcher. Furthermore, I also utilised the period of time in which I undertook observations to become familiar with the research participants and answer any questions that they had about the research project and its underlying rationale. Moreover, in Home C in which observations were not undertaken, in a similar manner to the actions I undertook when conducting observations, I would take time before commencing interviews to speak about myself, explain my research and answer any questions that the participants had about the study.

In my experience, this open and overt research approach proved to be fruitful. I would contend that this very open and overt approach that was adopted when collecting the empirical data, reduced stigma towards my presence as a researcher, by almost bypassing an '*us and them*' (Bauman 1990: 41) barrier. This approach possibly made the research participants include me into their '*in-group*' (Ibid: 37-41) and view themselves as collaborators to the research project, rather than research subjects whose actions were being judged. This action not only allowed a rapport to be established, but it seemed to make the

research participants more willing to divulge information, and consequently reduced the possibility of bias within the research data.

Additionally the independent status of my role as a researcher was emphasised, and care workers were reassured of their confidentiality and anonymity as a research participant. Therefore, respondents were able to express ideas and present their subjective experiences and opinions that have arisen through working in the privatised care sector, without fear of losing any credibility in the eyes of their employers and managers. (Shenton: 2004: 65-67). This reassurance in my experience, encouraged participants to divulge more information, and consequently reduced the possibility of bias within the research data. For instance, in addition to describing the positives of the care homes in which they work, participants would also be willing to explain any negative issues or tensions that were apparent within their place of work. This action also meant that that non-response was not much of an issue during the data collection process; however, it cannot be wholly discounted as a limitation.

Furthermore, to make sure that the research findings were valid, strategies to ensure the honesty of research participants were utilised. For instance, each individual who was approached to participate were provided with a number of opportunities to refuse to participate or to withdraw from the study. These actions was undertaken with the intention of ensuring that participants were genuinely willing to take part in this research project and were therefore prepared to offer data freely. Also, before each interview was conducted, I reiterated that that there is no right or wrong answers to questions included in the interview schedule. Also, care was taken to exclude leading questions from the interview schedule, which could have influence respondent's answers. Although these actions were undertaken to ensure validity, there was still a risk that bias and non-response could influence the research data.

Finally, in addition to minimising the possibility of bias and non-response influencing the validity of the research data, actions were also taken to ensure the validity of the analysis of the empirical data. The method that I employed was to contact another researcher and my academic supervisor to look over a sample of the transcripts and a list of the emergent themes that were identified. Furthermore, I also sought a form of respondent validation

from the participants by discussing the early emergent themes as they arose during the interview process. Additionally, the themes that were identified after all the empirical data had been collected and merged were discussed with the home managers. These actions were undertaken to ascertain whether the categorisation of the themes depicted a true and fair representation of what had been observed and discussed in the interviews (Burnard: 1994: 114-115). This meant that the themes which were identified remained true to the texts being analysed without taking answers out of context. Once the categorisation of the emergent themes had been discussed and validated, I continued to explore the themes using sociological literature.

Settings

The methods employed within this research project have just been examined. This chapter will now provide a brief description of the three care home settings that were the case studies for this research.

I) Home A (Bakewell)

As mentioned in the section examining secondary analysis, this case study was the setting that was used in a preceding study. However the data gathered as part of this previous study was incorporated into this research project and many of these early substantive themes were developed upon.

This setting was primarily approached because this was the institution in which I had been employed for three years. This made the potential issue of access easier to overcome. Most care homes can appear to be quite closed settings (Bryman: 2008: 403-6; Silverman: 2005: 255). However, by working in this setting part time, I already had an established rapport with both the management and other employees. Most of the fieldwork in this setting was carried out over the summer months of 2011. This fieldwork was originally undertaken as part of a previous study (as noted on pages 40-42). Home A, was the setting in which the greatest amount of observations were conducted. Observations were carried out while I was

working on a care shift, and in this setting I adopted the role of a participant-as-observer (please refer back to page 35 for definition).

It is a privately owned care home located in the East of England. It is the largest setting and case study within this piece of research. It houses and provides services for up to 57 residents. The site itself used to be a rectory, but it had recently undergone extensive building work that extended the building and converted the site into a residential care home for older people. The care home is comprised of two separate units. The larger of the two, located in the older part of the building is primarily a residential care unit. In this unit most residents are quite mobile and fairly independent, requiring minimal assistance with personal care. The other section of the care home comprises a dementia unit; it is on this unit where the care is much more intensive, with many requiring a greater level of support both in terms of personal care and emotionally. The latter unit is where the majority of my research in this setting was undertaken; this was not a deliberate decision, it was actually a chance occurrence as this was where I was mainly scheduled to work. Additionally this care home has a kitchen on each unit, an onsite salon, laundry service and two activities coordinators. At the time this research was undertaken, the most recent assessment of this care home by the Care Quality Commission (CQC) was three stars; this is the highest possible rating from the CQC and indicates that the standard of care not only meets the national standards, but the services and facilities are considered to be excellent overall. This care home is also part of quite a big chain of care homes being one of eight care homes owned by this particular company.

The other two case studies were originally approached due to their proximity to my place of study. Initially, 10 care homes and companies were approached; however these two were the only ones that responded, indicating that they would be interested in participating. Although at some level this was due to chance, in researching prospective care homes to approach for this research, these appeared to be amongst the most desirable not only because of their relative proximity but also because as organisations, they varied from my other setting. This would generate data that would provide good comparisons and contrasts between settings that are slightly different in character.

II) Home B (Pavlova)

The second setting is slightly smaller in size compared to Bakewell. This second setting is located in the north-east of England. It has the capacity to accommodate about 37 residents and is affiliated with a charity. Therefore, this setting is in part a private care home where residents will pay for the use of care services, but within the fee the service users will also buy shares into the company. However, because this setting is associated with a charity, some individuals have their fees supplemented by the associated charity. In its' latest unannounced inspection from the CQC, it was declared that in various required criteria, all the standards were being met at the time of inspection. Again this indicates that the standard of care in this setting was of a good standard.

Research was conducted in this setting between January to May of 2013. This was the second setting in which observational research was conducted. However unlike Bakewell, because I was not an employee in this setting my role as a researcher was more akin to that of an observer-as-participant (please refer to page 36 for definition).

Although the home itself is one building, it has been divided into three sections. Each section contains twelve to thirteen residents, who are supervised by two to three members of staff. The first and most accessible section was located on the ground floor. It was on this section where residents who were more dependent on care were primarily placed. Due to the high level of dependency, many were limited in their mobility and required the use of mobility aids such as hoists. Quite often these limitations were a consequence of health related issues such as Parkinson's disease or stroke. The other section on the ground floor was where the care and service users were the most spread out logistically. Some residents had mobility problems but they were less dependent upon care than those in the previous section. Finally, the last section was located on the upper floor. This section was mostly residential, and most residents were fairly independent and mobile.

Each section was equipped with communal bathrooms and a small kitchen, in which care assistants prepared breakfasts and hot drinks and some snacks throughout the day. There is also a separate kitchen that prepares food for lunch and tea for all of the residents in the care

home, which was normally eaten within a communal dining room. This care setting also had an on-site hair salon, a small shop for residents, a television room, library, computer area as well as numerous sitting areas throughout the home. Additionally because some of the residents required nursing care, there was an on duty nurse present twenty four hours a day.

III) Home C (Honeycomb)

This setting was the smallest case study within the research, providing services for around 29 residents. This setting is classed as a care home with nursing services, and was a family run business, located in the north-east of England. Again like Pavlova, in its latest inspection, the CQC also deemed this setting to meet all the required standards. This again illustrates that the services delivered by this setting was considered to be at an extremely good level. For this setting, research was carried out from February to April of 2013. Unlike the other two settings, only four interviews with the staff were carried out, due to the limited access to this setting.

This setting has its own onsite laundry and kitchen, there was also a visiting hairdresser and a member of staff had a dual role of being an activities co-ordinator as well as a care assistant. Quite often this staff member would arrange activities that would allow the service users to contribute towards the local seasonal fetes. Conversely, this setting unlike the previous two was not purpose built. Instead the setting had been converted from a house into a nursing home, and therefore spaces were adapted where possible to provide care services. As this setting is a nursing home, the type of care administered is a bit more intensive than the last two settings.

A summary of the main similarities and differences of the research settings and the methods employed are illustrated in the diagram on the subsequent page (see page 53).

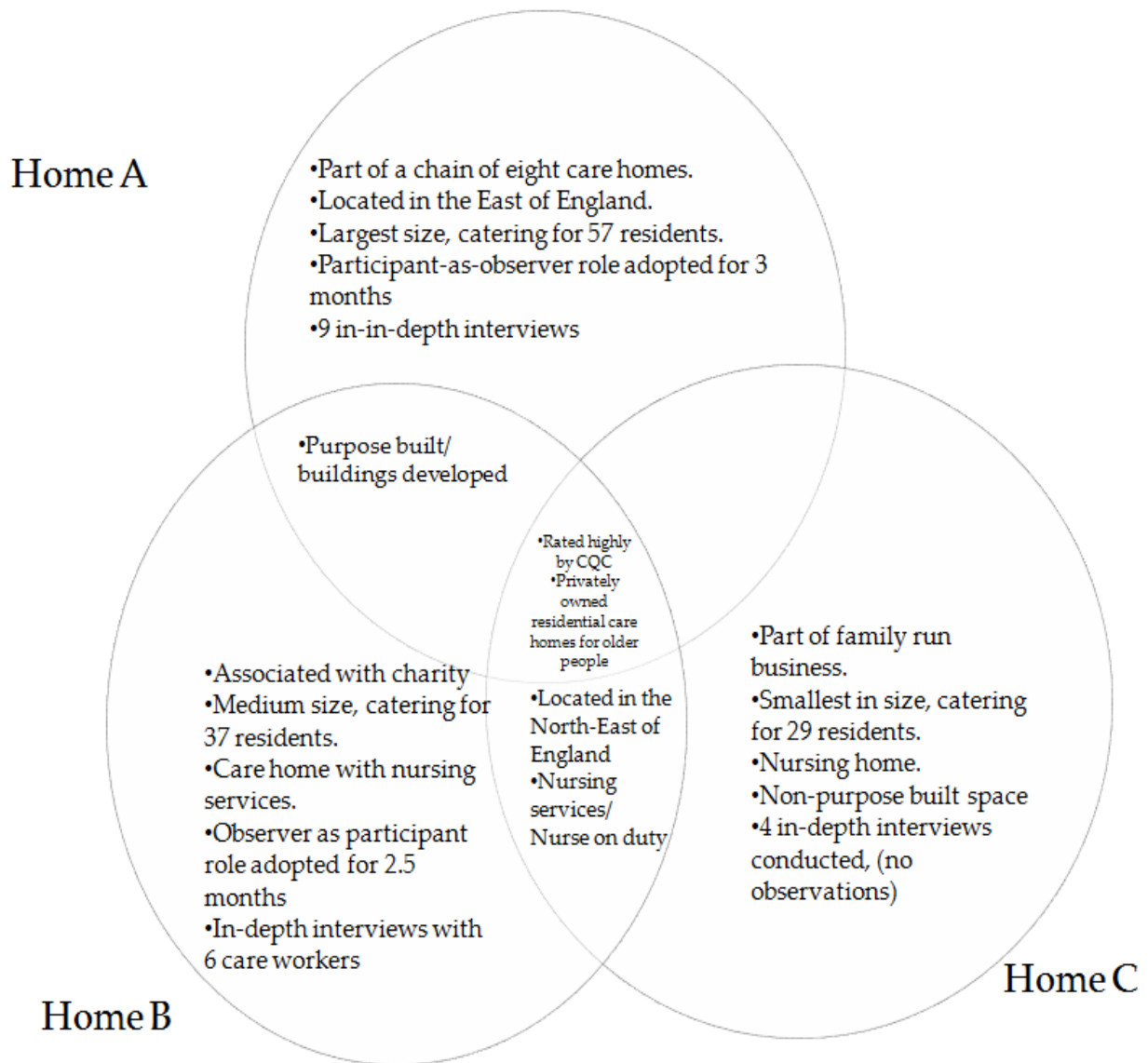


Diagram 1.0- Similarities and differences of the three research settings and the methods employed within each setting.

Although there was an element of chance in gaining access to the research settings, the differences and similarities noted in the diagram above have informed the analysis of this research project. For instance the three care environments within this project are rated highly by the CQC; therefore it can be determined that the standard of care is of a similar level throughout the three case studies. This infers that each setting is aiming to deliver and achieve the same standard of care, which allows for a good comparison of the possible issues and tensions that can arise as a consequence of attempting to achieve this level of care within the different settings.

However, the differences within these settings complement the similarities and enable this study to generate a more in-depth and informed analysis. For instance the differences in size of the care homes and services provided, allowed for a more detailed analysis. By using research settings that varied in the number of service users and the types of services provided enabled this project to examine whether the same pressures, frustrations and issues arise within an array of care settings that are all aiming to achieve a similar standard of care. This meant that the project could determine some of the more recurrent issues and themes that are faced by contemporary care workers currently operating within the privatised care industry.

Furthermore, although the different research settings were located in different areas of the U.K, this factor allowed for some diversity within the research sample. In particular this allowed some understanding of how the different priorities and actions of local authorities could potentially shape and influence the opinions and labour of care workers employed within different localities of the United Kingdom. Finally, even though the case studies are all privately owned care institutions, they vary slightly in form. For instance, Bakewell is part of a chain of care homes, Pavlova is affiliated with a charity and Honeycomb is part of a family run business. This slight difference within the economic backgrounds of the care homes allowed this research project to question whether the same profit ethos underpins and influences the working conditions and labour of care workers employed in different settings in the same manner. Consequently, this has allowed for a more in-depth and grounded analysis that will be used to answer the question as to whether contemporary society can care for a profit.

Ethics

Due to the nature of the topic that this piece of research explored, there were a number of ethical issues that arose which had to be addressed before any empirical data was collected. These issues will now be examined in some detail.

I) Permission

The first ethical issue that needed to be addressed was obtaining permission to undertake the research. In the Bakewell care home, gaining permission was less of an issue because I had previously worked in that particular organisation for almost three years. This meant that I had already established a rapport with both the management and fellow work colleagues. In the Pavlova and Honeycomb care homes, gaining permission was more of an issue. I arranged meetings with the managers in which I explained my personal motives for examining care workers, in addition to disclosing the intent and purpose of the outcomes of the research. As mentioned previously, my experience of working in care was immensely beneficial regarding this aspect of the research process. It almost bypassed a possible 'us and them' barrier, by illustrating that this research project was not a judgemental assessment of care workers. After fully informing the managers of the research, I sought and gained written permission from the managers of the care homes who each acted as gate keepers. Permission was also obtained from the Sociological Ethics Board at the University of York.

II) Vulnerability

The second issue that surfaced was that of vulnerability. All of residents within the care homes are vulnerable adults, especially those suffering from debilitating illnesses such as Parkinson's disease or forms of dementia. Therefore, the residents were not included in the research because some do not possess the mental capacity to be able to give proper informed consent. This could have been sought from family members or case workers, but because of the limited time span in which to conduct the research, the study only included care workers. Furthermore, instances of actual 'hands on' care work were omitted from the field notes in order to avoid recording interactions with the residents and to safeguard a resident's dignity.

Finally, there was a possibility that I could be both emotionally and physically vulnerable. Not only was part of the research carried out in my place of employment, but it involved my work colleagues. Additionally, as a consequence of some service users suffering from certain illnesses, there was a potential for some residents to become physically volatile. However

having worked part-time as a care assistant for over two years, I had undergone training in both how to prevent such situations from arising, or what to do in case such an incident occurred. Therefore, I did not feel as though this was of an issue, as actions had been undertaken to reduce the risk of situations of this nature arising.

III) Fear of Judgement

After commencing the research process, both my peers and workers in other settings expressed concerns about the process and the purpose of the research. There was also an element of fear that their behaviour would be judged or assumptions would be made about them in some capacity, or even potentially that I was acting on behalf of the management to check up on their behaviour (Bryman: 2008: 408). However, in adhering to ethical guidelines, the purpose and what the research process entailed was made transparent to all involved. Additionally, the matters of voluntary participation and their right to withdraw from the research at any point should they feel uncomfortable was emphasized.

IV) Informed Consent

A potent issue that had to be addressed was gaining informed consent. This is the reason why overt participation was the chosen methodology, because it would not be ethical to conduct research without informing the participants and gaining their consent. In an effort to raise awareness of my research, letters were sent to each care worker and notices were put up in communal staff areas. Also, in the settings where observations were undertaken, notices and letters were given to the residents, so that they would be aware of the reasons behind my continual presence within the care homes. Additionally, it was also made explicit that participation was voluntary, and in the event that any member of staff was uncomfortable and did not wish to participate, they should contact me either in person or on a given number, or communicate it to the manager. Those who agreed to participate in observations were asked to fill out consent forms before any observations took place on that particular shift.

Concerning the interviews, in the Bakewell and Pavlova settings, I approached eight and six care workers respectively to participate in interviews. Conversely in the Honeycomb home, the manager acted as a gate-keeper, arranging the time, place and who I would interview. However, in accordance with B.S.A guidelines, separate consent forms were signed and it was reaffirmed that participation was voluntary and that as a participant; they had the right to withdraw from the study at any point during the research process. Finally, to inform the residents and the families of my research, notices were distributed around the care home outlining the purposes and procedures of the research and reiterated that care assistants and not the residents, would be the focal point of the research.

V) Confidentiality

The confidentiality of those who participated had to be protected in accordance with sociological guidelines. The names of those who participated will remain anonymous and pseudonyms will be used in place of their real names on interview transcriptions and references within the research. Consent forms were also kept separate from the actual research data. The information was stored securely in multiple password protected safe places. Only my academic supervisor, those involved in the marking process and I will have access to the information. This information will only be stored for as long as is necessary for the purpose of the research.

Now that the chosen methodological approaches explored and the pressing ethical issues have been addressed, this paper will now discuss the themes that became apparent during the course of the research process.

Chapter Four: Is There Time to Care?

Routinization and the Commodification of Time

A distinctive theme that arose from the interview data concerned the pressures and tensions that can arise from the implementation of clock time onto forms of work in which individuals are at the centre of labour. An issue that was particularly common was frustrations that were experienced due to the incompatibility of trying to schedule care work. As with other forms of labour there is a certain necessity for a routine to be established and for workers to be efficient and complete the tasks they are given. This is in part acknowledged by care workers. For instance, when discussing what characteristics would make an individual suitable to be a care assistant, Bakewell worker Melody claimed that a good care worker needs to be

*'...kind and caring and obviously efficient because you have to make sure...
it's all very well being kind and caring but if you're not the sort of person
who gets things done then you still need to prioritise and everyone gets what
they want as soon as they can...'*

However within contemporary care work, it appears that the time given to complete caring tasks is at times unrealistic and does not tally with the actual times that individuals need day to day. In effect it could be asserted that care organisations have set unobtainable mechanical expectations within care work, which quite often does not match the organic actualities of caring labour. Indeed, quite a few care workers made comments about the difficulty of attempting to schedule care work through the strict manner described by Adam (1993). This was illustrated by Honeycomb worker Beatrice, who commented that,

'you can't put a time on how long someone wants to talk to you'.

Additionally, fellow Honeycomb worker Amelia claimed that some residents,

'are quicker than others, some are longer and others just go at one speed don't they?'

These comments, although brief support the notions forwarded by Twigg (2006), and indicate the difficulty in attempting to schedule work around people who are in themselves unpredictable. It seems that although there is great difficulty in organising care work in this manner, and it would appear that the increasing privatisation of care work continues to impose this often incompatible approach onto care work. Furthermore, as market principles of profit become increasingly enmeshed within care work, notions of efficiency and frugality pervade care work routines. Indeed as mentioned by Hochschild (1983), industries have been 'sped up' however in the same vein, the work also becomes intensified. This is possibly due to two factors which were identified in the interviews. The first factor identified by the participants was staff shortages, supporting the assertions made by Cohen (2011). At times staff shortages could arguably be due to cost cutting manoeuvres. Honeycomb worker Amelia summarised this notion by stating that

*'The bottom line is it is a business and it's all about the money.
They've cut the staffing levels so... I think standards of care will drop.'*

Pavlova worker Andrew, furthered this thought, claiming that

*'no matter where you work the staffing levels are never, never right
or satisfactory half the time...'*

Also Honeycomb worker Julia commented that,

*'sometimes if you just had one more [member of staff], you could do a
little bit more, d'you know?'*

Secondly, this was not aided by the care settings beginning to take on a greater number of highly dependent service users. Both Pavlova and Honeycomb are classified as care homes with nursing services, and Bakewell is classified as a care home that specialises in providing dementia care. Therefore, this gives a chance for the work to become more intense and

demanding, because service users could suffer not just from inhibited physical functions, but they also can suffer from debilitating mental illnesses such as various forms of dementia, stroke and Parkinson's disease amongst others. This issue was picked up by Pavlova worker Audrey who said that

'...we're getting more nursing clients now, with dementia and you know erm, they need more care and everything and you know we get people in that are needing more hoisting and just more nursing you know, and that takes your time up and you're just don't have the time for the interaction with the residents you know?'

Furthermore, this thought also indicates a much wider and more pervasive problem within contemporary care work. This is an issue that can impact on the sort of care that service users would begin to experience. It would seem that because of these external pressures placed on care workers and the labour they carry-out, there almost seems to be a trade off or battle between trying to balance a service user's physical needs with their emotional needs. When questioning the interviewees about what they found frustrating about care work or what they think could help improve the standard of care, the issue spending time with the service users was a common theme. The two listed below are just some of the many comments made around this issue.

Faye (Pavlova):

'you know when something's not quite right. If you had more time you could sit down with them and actually get to the bottom of it hopefully, and sometimes you just don't have that time to find. And you mean to go back later but then...you're more caught up with having to do your physical cares and then it's all like the paper work side of things, which is obviously, has to be done and I think that sometimes takes away from it but...'

Julia (Honeycomb):

'You're trying to help people in the morning but you're still, you're watching the clock because you've got so many to do...you're talking to people as you're going

*but it would be nice to sit down with... Betty or Fred or whoever and have a cuppa
and just sit and talk to them, because you haven't always got that time...
and to me that's precious time',*

Furthermore, the following two excerpts indicate the link between staffing levels and the sort of care clients can experience. For instance when questioned about how care could be improved, Bakewell worker Grace answered that having

*'more carers on shift... just so we have time to do more activities
and stuff rather than just basing it on their personal care and
like feeding them and everything. It would be nice to have more, so we could
take people out, erm just for like walks and stuff'.*

Fellow Bakewell worker Nora supported this notion stating that by

'having more staff... and having erm, a better staff ratio, so people can get one to one [care]'

All the above excerpts illustrate that there is a struggle to balance a client's physical needs and their emotional needs. In effect it appears that care workers have to choose to prioritise one aspect of caring labour at the expense of another. However perhaps what was the most striking, was that in total the interviewees in 12 out of the 18 (or two thirds) of the interviews conducted, mentioned that the lack of time to spend with the service users was a source of frustration or that care could be improved through greater staffing levels which could give carers the opportunity to give emotional support or one to one care. The findings suggest that in contrast to the assertions made by academics like Diamond (1992), rather than the clients of care work becoming dehumanised and reduced to the sum of the care tasks being carried out. Instead what actually seems to happen is that care almost becomes depersonalised. It almost seems as though the emotional needs are almost bypassed to cater to a resident's physical needs. This may be in part due to the relative invisibility of the outcomes of emotional labour whereas it is immediately apparent if an individual has not been fed, washed properly or not been taken to the toilet recently. This almost echoes

Twigg's (2000) assertion that quite often the outcomes of care are primarily focused upon, and it is much easier to observe the outcomes of the physical aspect of caring labour as opposed to the emotional side. This trade-off that seems to occur in care invariably has other consequences. For instance, as a means to meet the time targets imposed by the management, it could be asserted that quite often, workers will rush through their work in an attempt to meet with the imposed schedule. Additionally, because of the lack of staff and the schedule to which care work has to adhere to, if extra time was taken with one resident, quite often it is at the expense of another, which as stated by England and Dyck (2011) puts care workers in very difficult positions. This view is summarised in the following three extracts.

Judith (Pavlova):

'each person's got the right to have as much time as it takes but you know if you took sometimes the time that somebody might want to take, you're gonna have no chance to do anything else... other residents are going to be missing out because you have to be even quicker with them'

Beatrice (Honeycomb):

'You, you do feel it, people don't think you feel it 'cos you, you sort of do everything you know at the right speed, but if, if a resident's just taking like five minutes extra to pick a, to pick a top, you're thinking 'oh I've just lost that five minutes off somebody else' ... and then the residents starts to say 'don't rush me, don't rush me' and you're like 'I'm not trying to rush you but I need to get such and such up... But, no I think people could be more relaxed a bit, but you have to have everyone up by a certain time anyway, so I don't see how you could relax it a little bit. That's just the work...'

Freddie (Honeycomb):

'... we have quite a few residents erm, and obviously we can't have one to one care. Erm, and you do find that you know sometimes people are er trying to get your attention while you're doing something else or you're giving care to someone else.'

Erm you can feel that, you're not necessarily giving them the level of care that they want, but you are caring for someone else. So it's kinda, it's difficult to err...To balance that, I mean you can't be everywhere at once'.

So, the data suggests that not only does the intensification and the imposition of stricter time routines result in care workers having to attempt to balance a service users' needs within the parameters of schedules based around clock time. But it would also seem that in some instances, echoing the writings of Diamond (1992), care needs are either rushed through or glossed over altogether as a means of preventing disruption to the care home routine, in effect making care depersonalised for service users. It almost seems as though time is treated as the commodity and given precedence over actual care work which seems to be based on unobtainable mechanical expectations, and quite often the organic actualities of care work cannot be efficient and adhere to routines. These notions raise the question as to what care is now? If care is becoming increasingly depersonalised and more focused on time and profit, then what is the future for care? Will the essence of what care is be altered, or perhaps forgotten altogether? Is this still care work if aspects of the definition of care work are being glossed over? These questions will be addressed in chapter seven.

Chapter Five: Do We Still Care? Authenticity and Dramaturgy

Theoretical notions raised in chapter two questioned the nature of the relationships that are formed within care. Indeed, it would seem that previous academic writers such as de Raeve (2002) using the work of Hochschild (1983) and Goffman (1959) suggest that the relationships found within care could be deemed to be inauthentic, and that care workers are essentially acting out a series of emotions to comply with what service users expect to see and experience. This is because care workers are employed to form these relationships, and according to Ungerson (1983), such relationships are arguably not formed affectively but socially, and almost out of a sense of obligation. However, the findings from the

interviews and my own experiences of working in care portray a very different reality. It appears that the relationships formed within care are complex and cannot simply be reduced to a money and love dichotomy. This was summarised by the following excerpts,

Edith (Bakewell unit manager):

'yes I go to work because I need the money but I also do this job because I enjoy this job...'

Grace (Bakewell):

'you have to, obviously care about them, it can't just be a job because you want money, you have to care about the job that you are doing...'

Additionally, this notion was furthered by fellow Bakewell worker Melody who stated that a person should

'only do it [care work] if you care about the person, if you don't care about them, don't do it, do something else. There's no money in it. [Laughs]'

In considering this statement, it could be questioned whether a monetary incentive is strong enough to attract individuals into care. This is particularly resonant when considering that the status and pay of care work is not overly high. It would therefore seem that individuals or at least those who wish to have a long term career in care must enter into this occupation for reasons other than just an economic incentive. However in line with the assertions made by Ungerson (1983), it is true that at some level these relationships are formed out of a sense of obligation because the individuals involved find themselves in a very intimate environment where they are obliged to interact, but this does not necessarily mean that the relationships that emerge out of these interactions are insincere. This is particularly pertinent when considering the above excerpts. It would seem that at least for those who wish to have long-term careers in care work, there needs to be a genuine desire to help others and not just a monetary motivation. Therefore, it could be asserted that if care

workers are not just motivated by money then relationships could be considered to be authentic.

The authenticity of relationships found within care is demonstrated by the way that care workers described the difficulty of detaching themselves emotionally from the work in which they are immersed.

Carmen (Pavlova):

'You don't care for like robots, you care for humans, so you've got the same feelings as to what they're feeling, and you're gonna go home and you're going to feel like they are, and if you don't give that hundred per cent, or erm, yeah if you don't provide that hundred per cent care, you're going to go home, and you're going to beat yourself up about it.'

Marilyn (Pavlova):

'You're, you're looking after them, you're on seven hour shifts, you know doing a full time or more a week, so you do get attached to them you know, they become like a second family to you, in my eyes...'

Julia (Honeycomb):

'...being a smaller home, it's more like a big family...'

The above experts illustrate that at least some relationships formed in care are authentic, which seems to contradict the notions forwarded by writers like Bolton (2005) and William (2008). The data suggests that there is some level of emotional and at times an almost familial attachment made between workers and service users. As a consequence, workers cannot be fully detached and approach this aspect of care simply as a job requirement. This notion was approached from a slightly different angle by Honeycomb worker Freddie, who stated that experiencing service users passing away was his least favourite aspect of care work because

'...obviously you get to know people VERY well. You know they have intimate routines and then erm it does affect you, erm quite harsh, hard sometimes... and you know you've got to kind of got to get on with, got to get on with the rest of the job. And that, that was a little bit difficult for me at first, but erm, well it still is now...'

This illustrates that in line with the work of Wolkowitz (2002; 2006), due to the very nature of care work, care workers become intimately involved with service users and because the object of their labour are individuals, it is not possible to be completely detached for those who are being cared for. Some care workers, like Bakewell worker Valerie claimed that care workers should not be able to completely detach themselves from their labour,

'You can't just switch off; I mean you wouldn't be a carer if you could just switch off, you know?'

This thought was supported by Bakewell deputy manager Janet, who held a very strong and poignant view about emotional detachment

'If you don't leave here and think 'I have either done a really really good job and am really pleased or "oh I think I should have maybe have done more, maybe I should just phone and tell them to do that'. If you leave this building and completely forget what you have done and not think about the residents, you should not be in this job.'

This excerpt is extremely powerful and not only demonstrates the importance of the notion of care remaining in care work, but it also illustrates the blurring boundary between the home and work life of care workers. This quite often fed into how care workers conceptualised and approached care work.

Beatrice (Honeycomb):

'...they're just sort of like, 'oh it's just a job' but it isn't. You know you go home

and think 'oh god, I hope that lady gets better by...' you know and you're off until such and such a day and you think 'oh god, they've got a hospital appointment, oh, I hope everything goes alright'. And that's even on your days off, it's a 24/7 thing. You know, you can't switch off from it at all...'

Marilyn (Pavlova):

'I do try, try not to bring stuff at home... and I try to keep all that separate which I think I do very well...but yeah you do...think about[work] when you go home and things like that happen, yeah, because you're involved.'

But it's not just thinking about how care workers have conducted themselves and how to better deliver a service, but care workers also further blur the boundary between home and work by actually doing things or visiting service users on their day off. Furthermore, the sincerity of relationships was also demonstrated through the 'extra' actions that care workers frequently undertook for their service users. For instance, I would often observe times where care workers would conduct actions that would be considered to be outside or beyond their job requirements. As a consequence, care workers would blur the division between their work and home spheres. For instance care workers would often continue working beyond their contracted hours and spend time with certain individuals if they were ill or just to keep them company for a few hours. This observation was supported by Bakewell worker Alicia, who also commented that,

'I think yeah a lot of the girls do go out their way, when really they don't NEED to if you know what I mean'.

Furthermore when questioning care workers in Bakewell about this, they also were able to provide many examples of individuals going beyond the remit of their job title, and the excerpts below are just some of the responses.

Melody:

'...a colleague that I was working with noticed one of the residents had a

hole in her slipper, and then went out and bought her a new pair of slippers. The family said that she could not have, like they didn't want to pay for her to have new slippers. So the care assistant who's on min, not like minimum wage, not a lot of money, doing full time hours, went out and bought this lady a pair of slippers...'

Jennifer:

'One of our residents passed away and another resident was quite close to her and wanted to go to her funeral. But he had nothing to wear, so two other carers on their days off took him out to get him a suit to wear to the funeral.'

These extra small acts of kindness conducted by care workers indicate that a notion of care remains. Such examples demonstrate the difficulty of detaching oneself emotionally from care work, and also illustrates that individuals are making the boundary between their home and work lives more fluid. The rationality behind these actions can be questioned, and it could be asserted that this would not occur unless there was some level of genuine emotional attachment within these relationships. This is because there is little or no monetary incentive to do extra things outside of work, other than for the benefit of the service users. Furthermore, a prevailing thought underpins the above excerpts, namely; that there is a right sort of person for care. This is summarised in a quote from Janet's (Bakewell) interview in which she stated

'you can train someone on how to move and handle people, but, you can't train them to care'.

In speaking with and observing care workers, it was apparent that they had their own set of expectations about the sort of people who should enter into the care profession. For example when asked how the standard of care could be improved across the care industry as a whole Bakewell worker Valerie answered that standards could be improved by

'making sure they're, they're employing the right kind of people to do care you know. Erm, checking into their background properly and I mean I know they do

but the wrong sorts of people always slip through don't they'.

Also, in conversing about the qualities that makes a person suitable to be a care assistant Bakewell worker Nora stated that

'I don't think anybody realises the patience you do need and you need that more than anything. You need a very caring nature and it does not come naturally with some people...'

Additionally, when speaking to Pavlova worker Marilyn about how care standards can be maintained in the future she thought that

'it will be down to the homes as long as they get the right people in, I mean to do the right, and that are proper caring people, that's what it really revolves down to'.

This data reveals that care workers themselves have strong opinions about the 'type' of person or the kind of qualities an individual should possess before entering into care work. This demonstrates that care workers understand the importance of the notion of care remaining in care work. Therefore by having '*proper caring people*' within care, this could arguably feed into the authenticity of relationships. In this instance, by having individuals who enter into care for the wrong sort of reasons, could mean that authentic relationships are less likely to form.

Finally, returning to the notion of dramaturgy that was explored in chapter two. It would seem that the dramaturgical metaphor is applicable to care work but, not in the manner in which it is first presented. Utilizing a Goffmanesque approach along with the work of Hochschild (1983), it was asserted that care workers would adopt and act out an image of the idealized care worker, which differs from their authentic self that is only seen off-stage, in private spaces. Yet, in contrast to this notion it seems that the only time where care workers will actively adopt what Pisanello et al. (2012) describe as a professional front to

conform to an idealised company image is during times of great stress. For instance when asked if she thought about work when at home Bakewell worker Alicia replied

'I've learnt to shut it off, 'cos work's work and home's home.

When it gets a bit like, like when it goes to the death part of it, I take it home with me because I can't help it, because I'm keeping strong here and then going home and letting it out, that sort of thing'.

This theme of maintaining a professional veneer during times of great distress was also discussed by fellow Bakewell worker Janet.

'I've been doing this job for eight years now, and Sheila's

[the home manager] saying it gets easier oh you know it does get easier!

It doesn't get easier, it, what I have been able to do up until Ethel who passed away last week,

I have always been able to keep myself together until I got home, then I fell apart,

because I can't fall apart if I am supposed to be supporting the carers and

the residents as well. But, last week with Ethel, I did fall apart because I had to make the horrible phone calls to everyone saying she had passed away. That's the horrible part.'

These examples demonstrate that in line with the works of Mills (1951), Goffman (1959) and Hochschild (1983), the data suggests that care workers do in fact use feeling management and actively manage how they act and present themselves. However, the data suggests a 'professional front' is mainly adopted during times of great stress or distress such as a resident passing away. Quite often this is to support the team and other service users. Therefore, although the dramaturgical metaphor is apparent in this research it would appear that it does not necessarily impact on the authenticity of the relationships found within care.

The data suggests that on the whole care workers do still care and the relationships formed within care work are genuine. Care workers emotionally invest themselves into their labour and quite often strive to do more than is required of them, in an effort to aid service users as much as possible. Although dramaturgy can be observed in care work, it does not always

impact on the authenticity of relationships and most of the time the professional front is adopted to support the care team and service users in times of great stress. However, one should question how the authenticity of care work could be impacted by the time pressures discussed in chapter four. If there is less and less time to partake in the emotional aspects of care and care is becoming depersonalised, will there still be a space and time for genuine relationships within care to remain or even form? These notions will be discussed in a subsequent chapter.

Chapter Six: How Can You Do It? Perceptions of Care and Media Effects

A final theme that became apparent throughout the research data centres on the perceptions of care work. It became apparent throughout the research that there are differing views of care work. The care workers involved had distinct views about how others perceived their profession; quite often it was in a negative manner.

The origins of this negative view of care could stem from the fact that care work is a low pay and low status occupation. This notion was touched upon by Bakewell deputy manager Janet, who stated,

*'I think that's one of the big issues with care, people think it's so low paid
it can't be an important job. When in actual fact it is...'*

This statement supports the assertions made by Ashforth and Krewer (1999), indicating that care is not only a low paid occupation; it is also not afforded a high or important status. However, another Bakewell worker Jennifer offered a contrasting view around the low rate of pay,

*'I suppose the rate of pay is as low as it is because you can come in,
straight out of school, without any qualifications
and get training for free.'*

This contrasting view also highlights another factor that can influence perceptions around care work. As noted by Jennifer, when entering into care work, a potential applicant does not require any formal qualifications and can receive on the job training. This was an issue that was also touched upon by Pavlova worker Andrew,

'...and in another way... it's not good that anybody can really apply. It seems easier to get a caring job than any other job, even though, I know you need your CRB but apart from that...'

The fact that care workers do not need any formal qualification to enter into care work, the low rate of pay and possibly care's connotation of being primarily dominated by women may result in stigma around care work to be established. For instance, when discussing how her family and friends view her role as a care assistant, Pavlova worker Faye responded,

'Um yeah, I think most people are quite positive... then you do get 'oh so what are you going to do?', 'How are you going to work your way up?' 'What else are you going to do?' You know whatever, actually I quite enjoy being a carer, for the moment I'm quite happy where I am so... yeah I think they view it, you know it's a good job but they think maybe I should have higher aspirations or something...'

This quote illustrates that even when individuals approach care work with quite a positive view, there is still an underlying stigma. This quote almost shows that individuals view care as a menial, low status job. Care work is a job that should be moved on or up from relatively quickly, and that to remain in care as a care worker is not thought to be highly regarded or desirable. Additionally, Pavlova worker Andrew claimed that he has experienced a more overt form of stigma,

'...what I've found in the eight years that I've done it as well, because

of the role of being a carer. Erm a few of the clients in the past and people outside think because you do this type of work that you're an idiot and this is all you can do because you've got no qualifications and I mean I've had it off a resident here before to be honest. ... There's more to it than people think.'

This notion was also addressed by Honeycomb worker Beatrice who commented that overall '... for what we do that, they [the general public] don't think of us that well. She went further to note that 'there's a lot of theory behind the caring'. But, it seems that not many individuals are aware that care workers need to be informed of the laws and procedure guidelines relating to care work for older people. National guidelines state that at least fifty per cent of staff needs to have formal caring qualifications, but not many are familiar with this guideline. In considering this assertion, it could be ascertained that the stigma surrounding care work derives from a widely held notion that care work is an 'easy' profession that any person can enter into because it requires no formal qualifications, and the low rate of pay reflects this and consequently also feeds into the low status of care work. This was an action that was a pervasive theme that appeared in 10 out of the 18 interviews. For instance the excerpts below reveal what care workers thought about this occurrence.

Valerie (Bakewell):

'...I don't think they [non care workers] understand how hard it can actually be, how difficult it can actually be and how different people actually are like... you might see them as your grand- Nan or your granddad but they are, they're different as to what they were when they were at home...'

Faye (Pavlova):

..., I think people don't necessarily realise how emotionally and physically hard it is and that you, you can be stretched to almost your limit and people just seem to think that you know maybe it's not good enough...

Similarly the stigma surrounding care work could derive from the actual labour requirements of the job role, namely having to work with bodily waste products. For

instance when conversing about how individuals react to care work, Honeycomb worker Carmen responded that

'...and then some people can say it like that 'oh basically you wipe bums and things like that' '

This notion was supported by Bakewell work Nora who commented that

'I think some people think 'oh you just clean them and feed them really'

These statements link into the theories fostered by academics such as Douglas (1984) and Hughes (1958). These theorists claimed that when occupations require dealing with matter that that is out of place, these occupations entail some form of disgust and are almost tainted. Care work is arguably among these occupations. In considering this perspective, it seems that there are a number of factors that contribute to the stigma surrounding care work. The low status of care work derives from the nature of the actual labour, the low rate of pay for care workers and the lack of formal educational or training requirements to enter into care work. From the interview data it appears that all these factors feed into the stigma and ignorance about the multi-faceted labour that constitutes care work. It appears that overall; care work is not a highly desirable occupation. But, interestingly, one care worker also discussed how this perception is shared and almost perpetuated by care workers, who actively degrade themselves.

Carmen (Pavlova):

' I think when you meet carers, people always say 'just' a carer. But I think we do, I think ourselves we do lower ourselves as being a carer, because people, some people might just see it as 'oh you wipe bums for a living' and stuff like that'.

This notion reflects how care workers tend place or describe themselves to other people. It could be asserted in line with what Carmen described, that care workers belittle themselves which could arguably be due to the longstanding stigma that has surrounded care work. Yet despite quite a lot of negative perceptions around care worker, many care workers also noted that there was also a level of admiration for care workers and the labour they partake

in. When questioning care workers about how those within their friendship and family circles react to their occupations, a common answer seemed to centre on the phrase *'I don't know how you do it'*. This has also been a common reaction throughout my experience of working in care and is reflected through the two excerpts,

Marilyn (Pavlova):

'The relatives and my family say 'I don't know how you do it but it's wonderful that there are people like you that do, 'cos if not then you know, where would the elderly be?' So, I know they think, they think it's good [laughs]'.

Andrew (Pavlova):

'Generally I think they're quite proud of me because quite a few of them couldn't do it themselves. And yeah, yeah they're quite proud.'

The above excerpts demonstrate that some individuals have a level of respect and admiration towards care work. However, this seems to derive from those who are at some level linked into care work, for instance family and friends of service users of care workers. Arguably, it is this link that changes the perception around care work, because they have a better level of understanding of the kind of labour and work environment that contemporary care workers are placed within. Yet it would appear that, at least from the perspectives of care workers, most individuals do not fully understand the complex nature of care work, which again can feed into the negative perceptions that seems to surround care.

Furthermore, the low status of care work could originate from the gender connotations associated with care work. When asked if they thought care work was gendered, many care workers replied that there was a dominance of women and this sort of work has traditionally been associated with the domain and responsibility of women. These answers supported the theories put forward by academics such as Mclean (2003), Wharton (2013) and Cancian (1987). This is possibly best summarised through the following statement from Honeycomb worker Beatrice,

'It's a shame really because we are the same and they can do the same job, and you know it is nice to see a male sort of you know just sort of involving themselves and that but, I spose it's, it's if they want to do as well because I mean, I spose when, if you if you go back to years and years ago, I mean they used to be, men used to be the main earners didn't they. And I spose in, in health and social care there, there's, there's not that sort of money there unless you're a doctor or a surgeon or something like that. I spose when you look at it like that there's not that much money in it so, I suppose, and I think it's more flexible care. Like, erm, you you'll get like you can go quite easily go from full time to part time because it's 24/7 care all the time. So it's more flexible for women who have a family as well so, I suppose, I mean it's changing now because obviously men, some men choose to stay at home, and the women goes out to work but I spose its all, all becoming modern in the care system now, like you are starting to see more men...'

This statement put forward by Beatrice illustrates a number of conceptual issues that influence the perceptions of gender within care work. For instance, she noted that in the past, male workers tended to be the main breadwinners in families and did not come to be associated with affective work. Additionally, because care work has been traditionally associated with women's labour, this could influence the status of care work. Due to these feminine connotations, care work could be given less prestige and importance. Furthermore, she stated that there is not much money in health social care, unless a worker was to enter into an occupation that carries a lot of prestige and status such as a medical doctor. These factors along with those that have been mentioned above could perhaps influence the perception of care work and perhaps provide a partial explanation as to why care work is not a highly regarded occupation.

Moreover, in noting the flexibility of care work, Beatrice illustrated that it would seem that females have remained the primary care giver within many families. Although they now participate in paid work, it would seem that an occupation within care work is ideal because there is a demand and a need for twenty four hour care. Therefore, this sort of work can fit around other commitments, which is advantageous in terms of child care. The flexible

nature of care work may have been appealing to women who needed to both work in addition to carrying out child care. However many participants noted that care work is undergoing a change. Despite the abundance of women in care, a few of the participants noted that it appears that an increasing number of men are entering the care profession.

Julia (Honeycomb):

... I've been here eighteen months and I was at the hospital for seven years... and there were quite a lot of males coming into care work. Whether they want to go into nursing or not I wouldn't like to say but there's quite a lot... yeah.

This may be because it is now becoming more acceptable for men to enter into more affective professions such as care work. Additionally as noted by Beatrice, family structures are changing. In some instances there can be single fathers, or fathers may undertake the majority of child-rearing. On the other hand, some other workers noted that care work could be viewed as women's work. For instance, when asked if he thought that care work was gendered, Freddie, a male care worker from Honeycomb answered

'Erm yeah, I would think so personally I think so yeah [clears throat]. I don't know many male care assistants personally... And I, I wouldn't really know why to be honest. Erm... I think er... generally women are seen as more caring than men'.

Although this seems to conflict with the traditional gender expectations, all the female interviewees that were questioned about this notion, indicated that they had not observed any form of bias towards male workers. However, the two male participants made comments that linked into the theories fostered by Gerstal (2000). Their statements alluded to the fact that women are seen to be more caring than men, and that at times there was an observable difference in approach or even prejudice towards male workers.

Andrew (Pavlova): *'Erm, because men aren't seen to be as caring as women, and you still see it now, erm, sexist people, especially people higher up like nurses erm that think you shouldn't be in*

this kind of work. And I've had it myself and I've been in situations where they're sexist about it and you get treated differently to the female carers'.

Interviewer: Is that quite, not common, but does it happen more than you think or is that rare?

Andrew: 'I don't, to be honest I don't think people are aware how much people, erm, kind of judge on it. I mean I've had it here quite a few times...'

An interesting notion that became apparent was that although many viewed care work as being traditionally associated with women's work, only the male participants actively communicated a difference in treatment or approach by others. Therefore, the validity could be questioned because of the mismatch of the perceptions of gender within care work.

The themes raised in the interviews also arose in my own experience of care work. I have known there to be differential treatment of workers based on their gender. But, as noted throughout the interviews, this is not always due to an overt prejudice but it's due to what makes a service user feel the most comfortable.

Audrey (Honeycomb):

'...some female care, er... residents prefer female carers and you know vice versa so I think it just depends upon each individual resident, how they feel, yeah... Like personally I'd prefer a female, you know?...Yeah, but that's not being prejudiced... It's just your own choice...'

This could be due to the association with what Evans (2002) described as a sexualised touch, which is not just limited to interactions with female service users and male workers. For many older individuals, care work involves intimate labour and exposing parts of themselves both emotionally and physically. This may have only been done previously to a partner and so there could be an association of a sexualised touch when a member of the opposite sex attempts to undertake a care task. But as stated previously, this is not just

limited to female service users and male workers. For instance, during the course of my participant observations in Bakewell, I have observed female residents to refuse care from male workers. Conversely, I have also witnessed and experienced male service users becoming very verbally and physically aggressive towards women workers. However, when they were in the presence of male workers, they had a much more positive reaction. Consequently, although quite a few participants noted that care work is changing in that more men are entering into care work; it is evident that a form of prejudice still remains both towards the men entering the profession and towards the profession as a whole.

However, there cannot really be any discussion about perceptions of care work without considering the role of the media in influencing public consciousness. As noted by academics like Hall ([1978] 2006), the media is the most pervasive force in informing public consciousness about particular issues. Yet, bearing in mind what Erikson (1966) describes as the tendency of the media to focus on the more negative aspects of care, what outcomes has this produced? In speaking to care workers themselves, some did consider that this attention could be viewed in a positive manner. For instance, Honeycomb worker Freddie claimed that reports about systematic abuse and neglect

'helps identify where there could be possible issues, not just in, in those particular places but er across the board. Erm brings in; helps bring in other policies and procedures, erm so that we can work better and more effectively'

This notion was also touched upon by Pavlova worker Andrew who answered

'It's scary really that that [abuse] goes on but, I suppose it's good that it's come out 'cos it opens people's eyes, 'cos the people haven't got a clue what's going on and it needs to be stopped. And I think it goes on a lot more than what people think'.

However despite these few positive outcomes, it can be argued that the coverage of abuse is at times exaggerated and rather than improving the standard of care, can actually serve to undermine the efforts of those working in the correct manner.

Nora (Bakewell):

'I think it's tied us all with a very bad brush, I think erm, they possibly think all care homes are like that and they certainly aren't'

It would seem that the media coverage of care homes and abuse seems to instil some level of doubt within the minds of the general public, at least from the perspectives of care workers.

Beatrice (Honeycomb):

'There's always a bit of doubt there. Erm, especially with families, but you see saying that I'd probably be the same...'

Additionally, other care workers also noted that there were some issues with doubt and trust. It would appear that the concepts of trust described by Mechanic (1998) and Giddens (1990) seem to be actively undermined and defied by the media coverage of instances of abuse. This is reflected in how families were quite often reported as being more vigilant and more inquisitive about events that had unfolded in their absence. It would appear that because of the power of the media, the emphasis on reporting the failures of the care system over the successes seems to instil a level of doubt that plagues contemporary care work. This would suggest that there is a lack of trust towards care work but this is possibly because care homes tend to be closed settings and to trust virtual strangers to care for their relatives. However, this is not aided by the media emphasis on the failures of the care system. Additionally throughout the interviews and in my own experience, families were reported and observed as being more vigilant, and would question care workers and the care home about procedures or actions that had been undertaken.

Furthermore, a more damaging outcome of the media scrutiny around care work is that care workers come to doubt themselves and the work that they do. This reflects the notions of Fox (1993); where trust is a two way process, but the extra media scrutiny around the failures of care can actually cause care workers to not fully trust their service users, the

organisation they work for and themselves. This first became apparent when asking Pavlova worker Marilyn if she felt trusted in her job role; she made an interesting response;

Interviewer: 'Okay... so do you feel trusted in your job role?'

Marilyn: 'What do you mean trusted? Do I trust myself or do I feel that everybody else trusts me?'

This notion was then expanded another interview with Honeycomb worker Beatrice who explained that in the advent of extra media coverage about abuse and failings of the care system,

'...you start to doubt yourself and start to doubt yourself and like how you're doing like 'ooh am I doing this right?' You know 'I've done it for ages but am I doing that right?' or 'do I know my job?' You start panicking yourself as soon as you watched it... and then you're like feeding someone and you're like 'oh have I just done that right?' And you're like 'oh dear, er is that too quick? Oh I think that was too quick, oh no'...and you start looking around the room as well. I've noticed a lot of people when they go in the room, they look around the room... and you start getting on edge and you start to pronounce your words a bit better when you go in a room, 'cos you're just thinking just in case there's a camera in there you know, I'll pronounce my words so it doesn't sound really bad [laughs].'

Additionally, this has not only made care workers doubt themselves but it can also make them dubious about doing anything as noted by Pavlova worker Judith,

'It's so difficult to do things, erm, knowing that you could be culpable if something goes wrong you know. Er, which we all are, and it's, it's, it does impact 'cos you've got to think twice sometimes you know. The best way of doing something's not the legal way, you gotta, you've no chance of doing it, you know what I mean?'

The data that emerges from this study seems to suggest that the perceptions surrounding care work appear to be disparaging towards the workers. It would seem that individuals outside the caring environment have preconceived notions about caring labour and the sort of individuals who enter into the care profession. It would also appear that to a certain extent, perceptions around care work are informed by media coverage. Although the effects may not be overt, through the interview data and through my own experiences in care, the media almost seems to subliminally make individuals doubt or not place full trust into care workers. Furthermore, it would appear that the negative perceptions around care, in tandem with the media representation of care impacts care workers directly. Not only do care workers begin to doubt themselves and their actions, but they also become reluctant to undertake certain actions due to the potential consequences if something was to go wrong. In considering this view, a few questions should be raised and considered. In line with the assertions made by academics such as Lupton (1996) and Misztal (1996), with trust being so fundamental to care work, what will happen to the future of care if public confidence becomes completely eroded from care work? How can care workers operate when their every move is scrutinised? What will happen to care in the future if it continues to carry this stigma and be regarded with such a low status? Finally, how can confidence in care workers and their labour be restored? These questions along those raised in previous chapters will be discussed in chapter seven.

Chapter Seven: Can You Care For a Profit?

A number of theoretical and practical issues have arisen throughout the previous chapters. Therefore, before addressing my overall research aims, a brief summary of the findings that emerge from the data will be stated. Once the conceptual questions have been addressed, this chapter will consider if society can really care for a profit.

What Has Happened to Care?

In answering the questions posed at the beginning of the substantive chapters, the interview data presents quite a vivid picture of contemporary privatised care work.

The first research question that this project aimed to address was if there is still time to care? This section aimed to explore the effect of imposing clock time onto care work. There was a particular focus on the care home routine and the physical and emotional needs of service users. From analysing the data, it appears that care workers face increasing time pressures which have a detrimental effect on the outcomes of their work. The imposition of a mechanically minded schedule onto care work is quite often incompatible with the organic actualities of the caring labour involved. As a consequence, supporting the view promoted by England and Dyck (2011), that the scheduling of care work in this manner places care workers in extremely awkward and difficult positions of attempting to balance all of their resident's needs alongside the care home routine. Furthermore, the interview data and my own experiences suggest that the imposition of a mechanically minded routine onto care work can almost transform the nature of care and how workers will approach service users.

However in contrast to the notion forwarded by Diamond (1992), service users are not simply dehumanised and reduced to a task that needs completing within a particular time frame. Instead, the data illustrates that care work is almost becoming depersonalised and not routinized. However Diamond's (1992) assertion that the needs of service users are overlooked is apparent to an extent. The interview data and from my own experience of care work, it seems that in order to comply with a care home schedule, the affective needs of service users are side-lined and physical labour is prioritised. This may be because the outcomes of physical labour are more visible than those of emotional labour, but while this is occurring it seems that the nature of care work itself is changing.

The second question to be addressed, asked if care workers were still able to care for their service users. This chapter questioned the nature of the relationships formed within care settings. Academics such as Ungerson (1983) claimed that care workers sense of obligation to care for service users is socially and not affectively constructed. Therefore, any

relationships that arise within these situations could be deemed to be inauthentic (de Raeve: 2002). Furthermore, the very nature of emotional labour could also be thought of as inauthentic. When considering theories such as Goffman's dramaturgical metaphor (1959) in conjunction with Hochschild's (1983) conceptualisation of emotional labour; how care workers conduct themselves is considered to be part of an act, employed to present an idealised image of a care worker that conforms to the company and service user's expectations. However, in contrast to these notions, the research data suggests that authentic relationships do exist within care work. But, it can be questioned if there will still be a place and temporal space to form these authentic relationships. Furthermore, considering that the time that can be given to this aspect of care is dwindling under the pressures of a care home routine.

The final substantive chapter explored the public consciousness and media representations of care workers. As a profession, care work is considered in a negative manner and entails low status and prestige. This is potentially due to three factors; the first is the low level of pay. As noted in the interview data, this could be because in part, importance is thought to be reflected in pay. Consequently, it could be stated that because care work is not a well-paid occupation, the public perception is that it cannot be an important job. This is possibly further influenced by the fact that no formal educational or vocational qualifications are required to enter into care work. Thirdly, the representation of care workers in the media is largely negative. Predominantly instances of abuse and failings of the care system are highlighted. This has in turn almost transformed care workers into a form of uneducated and non-compassionate pseudo folk devils. In presenting instances where care workers fail to meet their responsibilities as described by Mechanic (1998), the media serves to subconsciously place doubt around care. This has consequently undermined the confidence and reliability of the care system which Giddens (1990) described as fundamental for trust to be present.

Therefore, not only does doubt resonate with care work but this also causes care workers to doubt their own actions. As noted by Lupton (1996) and Misztal (1996), trust is fundamental to any caring relationship, but this seems to have been eroded meaning that the trust

described by Fox (1993) that is vital for both care workers to conduct their labour and for service users to feel safe. The constant undermining and questioning of care workers actions causes care workers to doubt themselves and their actions. It seems that a fundamental component of care work is being scratched away, making care work a highly controversial topic. In considering the pressures that have had an impact on care work in the contemporary context, this chapter will now return to the questions that were stated in the previous chapters and consider what faces the future of care if the pressures and stigma around care workers remain unchallenged.

What Is The Future For Care?

Numerous questions were raised in previous chapters that pertained to what would happen to care in the future if the present situation remains unchallenged. These questions will now be considered and addressed. Some of the questions that arose in the previous chapters concern the increasing depersonalisation of care through the implementation of a mismatched time schedule.

With the increasing removal of one of the fundamental aspects of care work will the essence of what care is be altered, or perhaps forgotten altogether? In this instance if care is becoming increasingly depersonalised and more focused on time and profit, what will care become in the future? Is this still care work if the emotional essence is removed? Should caring labour devoid of emotional labour still be regarded as care work? Debatably, if care was to continue in this manner, then the outcome could and should not be regarded as care work. This is because in order to meet the definitions of care put forward by academics such as Abel and Nelson (1990) in addition to the Department of Health (1993), care work not only constitutes the provision of assistance for instrumental tasks, but it also entails affective or emotional labour. However, if the emotional needs of service users are not being met or are glossed over in favour of the more physical aspects of care, then this form of care fails to adhere to the fundamental definition of care. Additionally, it could also be asserted that if care routines became too strict to a point where there is little or no room to establish and perform affective tasks, then care would become completely depersonalised as there would be no space to form genuine relationships because care workers will be unable to have the

space to emotionally invest in relationships with service users. Not only would this make care depersonalised, but care work would arguably become subjected to routinization because the person requiring care services could almost become forgotten and thought of as a job that needs to be completed within a specific time, rather than considered as an individual. Therefore, there is a need for this emotional essence to remain and underpin the ethos and actions of care workers and institutions, otherwise the service provided cannot be considered to be care, because the affective component and the individuals within care will be forgotten.

Furthermore, the stigma around care work needs to be challenged. In considering the widely held perceptions about care work, it could be asserted that if care work continues to be viewed in such a negative manner, it will not attract those who are deemed the right sort of people for care, or at the very least encourage suitable individuals to remain in the care profession. A notion put forward by some interviewees, is that a method of tackling this stigma could be approached through increasing the level of pay. A link between the level of pay and the status of care work is a pervasive thought and the low level of pay entails other connotations about care work. For instance, referring back to the notion that there is a particular type of person, who is right for care, a few interviewees made a connection between how the rate of pay can attract the right sort of people into care work. For instance Bakewell worker Nora thought that care work is,

'one of the hardest jobs, erm, I think one of the hardest jobs and to get the right kind of people I think you need to pay, you need to pay a good wage, a wage that values you, you know that values you'.

This notion was also addressed by another Bakewell worker Melody, who stated that,

'you've got care homes that pay minimum wage they're not going to have the best pick of the carers because if you've worked and done your NVQs and things like that or if you've been to college and university you want, you're not going to go and work for somewhere minimum wage, you're going to go where... you're going to be appreciated'.

Consequently, it could be argued that because care work is a low paid occupation, within the public consciousness this is associated with attracting a certain type of person. This not only feeds into feelings of lack of appreciation, but also contributes to negative stereotypes. These quotes show that some kind of value is reflected in the level of pay, therefore care work needs to be shown to be a valuable occupation. This could be shown through having an increased level of pay, and could also serve to attract what the care workers have described as 'the right sort' of people into care work. An increased level of pay could also challenge the long held stigmas surrounding care work because it would illustrate that care work is a worthwhile occupation that is matched by a decent wage. This would be difficult in the privatised sphere of care work because the industrialist attitude of achieving optimum profit through reducing costs and expenditure does not wholly match the perspectives held by many care workers. Perhaps a way to mitigate this is to adopt a similar approach to other occupations and have varying levels of wage that corresponds to a worker's level of qualification, so the higher the qualification held by a care worker, the more they could potentially earn. This was an approach that was suggested by Bakewell worker Jennifer;

'...I do think that once a worker has been trained, and is established in the job, and is known to do good work and is a hard worker, I think then, the rate of pay should increase. I think that the harder you work the more you should be paid.'

Additionally, if care continues to be illustrated in a negative manner by the mass media, and if the actions of care workers continue to be scrutinised and demonised in the current manner, it could possibly discourage potential workers and the confidence both within and around care will be eroded. Therefore, there is a need to restore confidence into care work for both the public and for care workers themselves.

Considering the notions that were identified in the research data, two methods of restoring confidence became apparent. Of course it could be asserted that the media should perhaps not just focus on the limitations and failure of the care system, but as identified by quite a few care assistants, it illustrates areas in which care is failing or could be improved.

Furthermore, one participant suggested that care workers also need to take some personal pride in their work. When discussing the possible future for the standard of care, Honeycomb worker Julia illustrated a very strong view;

'... well you should take pride in your job, no matter what you do, at what level. But to me, a nurse has got a pin number to keep. And it's not cheap, it don't come cheap, and you'd think 'it's your name' it's your good name... If you can't take pride in yourself and can't take pride in your work then you know like I said don't do it. But I think personal pride's got a lot to do with how you look after other people.'

In taking personal pride in their work as suggested by Julia could maintain or drive up the standards of care. Additionally, by having pride in their work, it could be asserted that this could make care workers more willing to whistle blow. This action could aid in restoring public confidence in the care profession. In addition to care workers taking some personal pride in their work, as a means of restoring confidence in care it was stated in the interview data that care institutions could undertake two actions.

The first action that was identified as a way of restoring confidence in care was organisations having longer inductions and initial training periods when a worker enters into care work. This notion was highlighted by Bakewell worker Valerie, who when questioned how the standard of care could be improved in Bakewell she suggested that new care workers needed

'a bit more intense training, erm more... more shadow shift I think. More...they need to actually learn... learn it more be involved more before they are actually thrown in and just told to like 'get on with it' if you know what I mean'

Following on from intensive initial training should be complemented by on-going periodic training and re-fresher courses. This can give care workers some form of reassurance that their actions are correct and conform to the emerging legislation. This was highlighted in

Honeycomb worker Amelia's Interview where she stated that the standard of care could be improved through

'...just on-going training really...as in, just training in what you're doing, whatever...because sometimes if you've done a course one year, then it's a year but when you go back on the course you think 'oh yeah' you haven't forgotten but it just brings it back up again.'

The second action that organisations could implement is to establish that greater systems of communication. This is to communicate what behaviour is acceptable and so workers will be willing to stamp out or report inappropriate behaviour. This concept was explored by Pavlova worker Faye, who commented that,

'with staff I think, if there's, they've done, I don't know misconduct or whatever, it does need to be stamped on straight away and nipped in the bud before it... attitudes kind of spread doesn't they? And it's like [those] who, may be good carers before, if you've got a good carer in an environment that's not so good, I think, they obviously do their bit but I think over time they wear down a bit...'

Not only does this mean care institutions, taking a more proactive and preventative approach before problems become too ingrained but if what Faye states is considered in tandem with what was asserted by Julia, it can be claimed that in order to restore public and worker confidence into care work both the institutions and care workers themselves need to be more culpable and be willing to report and stamp out unacceptable behaviour. In adopting changes of this nature then an ideal consequence is reducing the number of incidences of failures of the care system reported by the media and governmental reports. Finally, if these changes are also conducted in conjunction with regular on-going training then despite the reported instances of abuse, care workers can feel confident that their approaches and actions towards care workers are in no way abusive or neglectful.

To summarise, in considering how the contemporary problems and issues surrounding the contemporary care scene could develop into ingrained structural changes that can fundamentally cause the very notion of care to be altered. It can be ascertained that these actions need to be implemented at some level otherwise, if the pressures and changes that surround contemporary care work could become exacerbated and essentially change the principle of care work.

Can You Care For a Profit?

To conclude, this last section of the chapter will attempt to answer the question that has underpinned this research project; can you care for a profit? After considering the research data, it can be asserted that society can care for a profit. However there are certain pre-conditions that need to be met for this to be able to occur and to insure the longevity of high quality care work.

There is a place for privatised care work in contemporary and future society, because the increasing age of society is putting a strain on the state's ability to provide universal health and social care services for older people. The pressures and problems that are currently present are arguably only set to increase given the ever increasing life expectancy of the contemporary western population. Therefore, although there will always be a need for care services but, if this sector is to remain in society, the overarching ethos that underpins care work in addition to the attitudes towards care work needs to change.

Within the private caring profession, the drive for profit and market forces should not be the only factor underpinning policies and actions of care homes. Care work needs to be approached in a different manner than conventional occupations. What this project has illustrated is the need for equilibrium between generating a profit through increased efficiency and allowing care workers to be able to deliver a high quality service to clients. It is recognised amongst caring staff that care workers need to have a level of efficiency in their work and there does need to be some form of order underpinning the daily life within care institutions. However, the routines need to allow care workers to be able to perform their labour without having to cut corners and in some cases gloss over the needs of service users.

Furthermore, care institutions also need to ensure that they do not accommodate too many highly dependent clients in addition to having adequate staffing levels. In doing so care institutions can ensure that the services that they are able to provide for each service user is realistic and that each individual can receive the best possible care. By not limiting the number of high level service users and not having adequate staffing levels will serve to further increase the difficulties faced by care workers in having to juggle service users physical and emotional needs. This could possibly mean that the emotional aspect of care work could be further excluded and serve to depersonalise care even more than the current context, leading to a situation in which the meaning of care will become distorted.

Finally, care work should not solely be approached with the primary aim of making the optimum profit; due to the nature of care work the principles that have underpinned conventional occupations are not completely transferable to this sector. Care work entails difficult emotional and physical labour and so steps need to be taken to ensure that workers can complete the tasks to a high standard. Additionally, the way that care is perceived also needs to be altered. A more positive approach to care work needs to be established which should also be complemented by a decent wage. This will communicate that care workers are valued and will attract the 'right type' of people into care but to also incentivise them to remain in care long term.

In conclusion, it is possible to conduct care for a profit, but there are a number of pre-conditions that need to be fulfilled in order to secure the future of care in a form that still retains the initial principles of what care is and should be.

Chapter Eight: Conclusion and Critical Outlook for Further Research

Summary of Findings

Throughout this research I have aimed to address the academic deficit that surrounds contemporary care work from the perspectives of care workers. Using data derived from eighteen in-depth interviews and five months of participant and non-participant observations, this project has sought to provide an answer to the over-arching question; can you care for a profit? It would first appear that the future for care is extremely bleak. Contemporary care work is primarily being led by market forces and the drive for efficiency and profit has meant that an unobtainable schedule has been placed around care work. This action in tandem with some care homes accommodating greater numbers of highly dependent service users has resulted in the physical aspect of care work being prioritised over the emotional part of care work. Additionally with the intensification and speeding-up of care work, care workers report that it is becoming increasingly difficult for care workers to be able to establish genuine relationships with their service users; this process is of vital importance and should underpin caring labour. Furthermore, due to the negative public opinion which is partly informed by the media but has also stemmed from what the actual labour entails, care work is not a highly regarded occupation. These pressures resonate with care work and if they remain unchallenged, care as it is currently conceptualised will become distorted and eventually disappear.

Ultimately if care as it is currently conceptualised, is to retain its place in society there needs to be a cultural change within the privatised care industry. In addition to making profit, organisations also need to prioritise delivering a good quality service and creating a working environment that can facilitate care workers to do this. If care work in the future adopts approaches of this manner, there is a space for a privatised care industry as it is currently defined to remain within society.

Limitations

Like most other forms of research, this study does have limitations that should be addressed. The first limitation was that empirical research was only conducted in three care homes and as a consequence the findings cannot be generalised to the whole population of care workers and private care institutions within the United Kingdom. Arguably the findings are only representative to the localities in which they were conducted. Although there is some geographical variation within the data, because one setting was located in the south east of England and the other two were situated in the north east of England. Yet as stated previously, as a qualitative research project, this was not the primary aim of the research project.

Second in conducting the interviews and observations, bias cannot be discounted. This is because no research project can be completely excluded from sources of bias. There could have been some interviewer bias, namely that care workers produced answers in a manner that they believed conformed to what I wanted to hear. Additionally, because in two of the settings in which I was not an employee, the managers acted as gate-keepers. This could have influenced the interview findings and also they could have suggested participants that they know would have given particular types of answers to possibly portray the care home in the best possible manner. The potential for bias could also have been apparent when the observations were conducted. For instance care workers could have altered. Care workers could have altered their actions or censored some topics of conversation in order to portray a good image of themselves and of the care home in which they work.

Although steps were taken to minimise these fears, and I was quite often introduced or identified as being a care worker myself, the participants could still have underlying suspicions of my motivations for research and the potential outcomes of my research project. Consequently due to these internal pressures and biases the findings cannot claim to be completely reliable and valid.

A final limitation of this research was that many themes became apparent in the research data, but this project was only able to explore a few of these themes. For instance a theme that arose was bias and stigma towards care workers that was contingent upon their ages. However, due to the primary focus and limited scope of this research this theme was not explored in any great detail. Therefore, this inability to explore other emergent themes illustrates that there is a need for further research into this topic area. The need and space for further research will now be addressed in the final section.

Outlook for Further Research

As mentioned previously, there are a number of themes raised throughout this project that remain unexplored. This illustrates that there is a theoretical space where further and more current research into topics such as ethnicity, race and age of care workers and the care industry needs to be undertaken.

Furthermore, the conceptual notions that have been analysed and discussed throughout this project, illustrates why research of this calibre is important. By acknowledging that affluent societies are facing an increasingly aging population, the need for long term care is set to increase. Therefore in order to facilitate a continued high quality of care, the pressures and tensions within the contemporary care context need urgent scholarly and social attention. Otherwise these pressures and methods of coping with them could potentially become too ingrained into care work, which could ultimately alter future care cultures. Therefore, in order to pre-empt these possible outcomes a broad and intimate knowledge of care work and what it entails is from both the perspectives of both those who conduct the labour and those whom are the object of this labour becoming ever more imperative.

Appendix 1- Ethics Form

Department of Sociology
Graduate Student Ethics Form

Your name: Joanna Wolton

Supervisor: Professor Sarah Nettleton

Instructions/checklist

Before completing this form you should read the British Sociological Association Statement of Ethical Practice that you can download from the Sociology Department Webpage. If you are planning research with human subjects you should also look at the sample consent form available from the Sociology Office.

- A. [] Write your name and that of your supervisor above.
- B. [] Read section 3 that your supervisor will have to sign. Make sure that you cover all these issues in section 1.
- C. [] Complete sections 1 and, if you are using human subjects, section 2, of this form, and sign it.
- D. [] Ask your project supervisor to read these sections (and the draft consent form if you have one) and complete section 3 and sign it.
- E. Return the form to the Graduate Administrator in the Departmental Office.

Section 1. Project Outline – NOT USING HUMAN SUBJECTS IN YOUR RESEARCH) (to be completed by student)

(i) Title of Project: An exploration of formal care homes: a comparison of residential care and nursing homes from the perspectives of residents and formal care workers.

(ii) Aims of project:

To critically analyse to everyday experiences of care workers operating in private residential care homes. The primary aim is to gain an insight into the nature of their day to day work. Issues pertaining to caring for elderly clients will be identified and analysed from the perspective of those working within the care profession under the predominantly privatised care context. The perspectives of care workers operating within different care home settings will be compared and contrasted in order to examine the spatial-temporal differences and similarities between different settings of care. Additionally in order to complement the perspectives of care workers, the views of residents and service users will where possible also be included as this can provide a more balanced account of contemporary care work. Also other themes or issues that can potentially be found within both forms of care service can be identified and examined. Various methods will be adopted and data that has been gathered from a previous micro-ethnographic study of a care home for older people will be incorporated. As with my previous research, this current study will keep its aims broad and its

approaches flexible with the overall objective of gaining and presenting an insight into the everyday working life of those operating within the care profession, working with older individuals in both a residential and domiciliary setting. This research will be informed by existing literature on health care. As alluded to previously, the research will comment on the spatial temporalities found within different care environments. This will be complimented with literature focusing on routinisation and management of these care environments and strains that can arise as a result of this, especially in environments where care is a business and a mechanical mentality is applied to an occupation which is wholly unpredictable. This research will build on notions that have been established by writers like Julia Twigg, Steven Lopez and Leidner. Additionally perceptions of the performance and the reception gender will also be addressed. Furthermore, Goffman's dramaturgical metaphor may also be relevant here, especially his notions of front stage, back region and expectations of an audience. This study will examine the back regions notably the aspects of work that does not involve interaction with residents. How they manage their work, relations with their peers, adhering to a schedule and juggle their unpaid identity with their paid persona in addition to how and what they feel when partaking in care work. Furthermore the concepts bodywork and emotional labour that were examined in my previous study will be analysed further using notions of gender (particularly gendered work roles) and trust. This will incorporate the current media and political agenda where caring for an older generation is fast becoming a very prolific issue.

- (iii) Will you involve other people in your project - e.g. via formal or informal interviews, group discussions, questionnaires, internet surveys etc. (Note: if you are using data that has already been collected by another researcher - e.g. recordings or transcripts of conversations given to you by your supervisor, you should answer 'NO' to this question.)

YES NO

If no: you should now sign the statement below and return the form to your supervisor. You have completed this form.

This project is not designed to include research with human subjects. I understand that I do not have ethical clearance to interview people (formally or informally) about the topic of my research, to carry out internet research (e.g. on chat rooms or discussion boards) or in any other way to use people as subjects in my research.

Student's signature _____ - date _____

If yes: you should complete the rest of this form. Note that you **MUST NOT** begin research with human subjects until you have been informed that ethical clearance has been granted. It may take up to 4 weeks for the committee to review your proposal. If the committee is unhappy about any aspect of your proposal you may be required to revise and resubmit - which will mean a further delay before you will be able to start your research.

Section 2 – INTENDING TO USE HUMAN SUBJECTS IN YOUR RESEARCH) (to be completed by student)

NOTE: Ethics for internet research are not yet well developed. If you are planning an internet study, please read the downloadable articles available from the Department website and describe your study on a separate sheet.

(i) What will the participants have to do? (v. brief outline of procedure):

Those taking part in the research will be care workers and in some cases residents also. I intend to partake in non-participant observation of the everyday life of the care workers. The primary focus of my observations will be the interactions of care workers, so many of my observations will be conducted during handovers, coffee breaks and in between jobs. I will make 'scratch notes' (Bryman:2008:420) when possible and after leaving the care home I will then write up field notes regarding what I had witnessed during the time I visited the care home. I also intend to carry out interviews and potentially focus groups with members of staff that will be semi-structured in form. Other aspects of work relating to care work with residents will be explored further during confidential face to face interviews with the staff and potentially a few service users. The data gathered from these interviews would enrich the observational data. However, hands on care work will be excluded from the field notes so as to avoid observing interactions with the residents. Consequently this will limit the amount of data that is generated but this could be beneficial because if such instances were to be recorded the amount of data to be analysed could be overwhelming. While the interviews will maintain a level of flexibility to enable a conversation flow similar to that of an ordinary conversation.

(ii) What sort of people will the participants be and how will they be recruited, in the case of children state age range?

Primarily the participants will be care assistants and domestic staff within the care or nursing homes. Before commencing research, I will contact the managers of the care homes and establish a dialogue with them. Hopefully the care home manager will then act as a gatekeeper, and will aid me in accessing the care environment and arranging interviews. Letters will be sent to each worker that could potentially be included in the study. Posters will also be put up in staff rooms and kitchens of the care/nursing homes that grant access and permission. It will also be made explicitly clear that participation is voluntary and in the event that a member of staff does not want to be included or wishes to withdraw from the study, they should communicate this with myself either in person or on a given contact number that will be included on consent forms and given to the manager of the care home. Regarding the interviews of those in the care or nursing homes, I am aiming to ask up to 10 members of staff and 3-5 service users to participate. It will be made clear that participation is voluntary and in keeping with BSA guidelines it will be made explicit that they will have the right to withdraw at any point of the study.

(iii) What sort stimuli or materials will your participants be exposed to, tick the appropriate boxes and then state what they are in the space below?

Questionnaires []; Pictures []; Sounds []; Words []; Other [✓].

The participants will be exposed to a semi-structured interview schedule. These will contain questions that I would like them to answer or cover in the interviews. However in keeping with a flexible qualitative approach the order and wording of this schedule will be subject to change depending upon how the interview flows and how clear the question may be to the participant.

(iv) Consent: Informed consent must be obtained for all participants before they take part in your project. The form should clearly state what they will be doing; drawing attention to anything they could conceivably object to subsequently. It should also state how they can withdraw from the study at any time and the measures you are taking to ensure the confidentiality of data. Experiments carried out in schools will require the permission of the head-teacher and of parents if the head teacher recommends it. Children aged over 14 years should also sign an individual consent form themselves. If you are planning to carry out a project where you will be in contact with children, you must establish from the head-teacher or other responsible person whether the work proposed will require you to have the relevant disclosure from the Criminal Records Bureau. Please seek advice from your supervisor.

Who will you seek permission from?

I will seek written permission from the managers of the care and nursing homes involved, and also the regional managers of the community care companies. Permission will also be sought from all members of staff and the residents who participate in the study. Individual consent forms will be created for each method i.e. one for interviews (separate for staff and service users), one for observations. Additionally the residents and the families connected to the care or nursing homes within the study will also be notified that I am undertaking research. This will be done by placing notices around the care or nursing home outlining the purpose of my research and what will occur as I carry out my study (Please see attached form). This notice will also reiterate that the focus of the study will be the interactions of care workers and not the residents themselves, although some may be asked to participate in interviews.

If you are using one of the standard consent forms: say which one and write the "brief description of study" that you will give the participants before the study here.

If you are not using one of the standard forms please attach the form you will use.

(vi) What procedures will you follow in order to guarantee the confidentiality of participants' data?

Personal data (name, addresses etc.) should not be stored in such a way that they can be associated with the participant's data.

A list of all those who participate in the study will be compiled but only pseudonyms will be used. Consent forms will be kept separate from the actual research data and all information will be stored securely with password protection. After the interviews have been conducted they will be transcribed. Once transcription of interviews and field notes have been written up, no real names will be included in the final study. Only myself, my supervisor and those involved in the marking process will have access to the information. This information will also be saved in multiple safe places and will only be stored for as long as is necessary for the purpose of the research.

(vii) Special issues. Give brief details of other special issues the ethics committee should be aware of.

The residents of care homes are vulnerable adults but they are not the primary focus of the research in this instance, the care workers are. Although some service users will be asked to participate in interviews they will not be included in observations. Only those who can give full informed consent will be interviewed and participation will be voluntary, and in line with BSA guidelines if they change their minds they do not have to participate. I will also inform the families of the residents of the care homes by putting notices around the care homes and will also ask the managers to communicate this through other mediums (i.e. newsletters and e-mails). This will also serve to inform the residents.

Also there is a possibility that some workers may feel as though I am judging them and making assumptions about and their behaviour. I think the best way to combat this is to communicate effectively and ensure that participants are completely informed that if they are uncomfortable at any stage of the research process, they have the right to withdraw from the study. Additionally I would like to adopt a more inclusive approach. This will enable a greater level of input from the care workers as I would like to make it clear that this research is about them and will allow their perspective to be heard.

(viii) Tick any of the following that apply to your project

- it requires participants to give information of a personal nature;
- it involves children or other vulnerable individuals;
- it involves paying participants or giving them some other incentive to participate
- it could put you or someone else at risk of injury.

A Completed Informed Consent Form must be submitted with this form. Your project ethics will not be considered without it

Student's signature: **date:**

Supervisor's assessment (supervisor to complete)

Supervisor's signature: **date:**

**This project is designed to include research with human subjects
(circle yes or no)**

Yes/No - The design of this study ensures that the dignity, welfare and safety of the participants will be ensured and that if children or other vulnerable individuals are involved they will be afforded the necessary protection.

Yes/No - All statutory, legislative and other formal requirements of the research have been addressed (e.g., permissions, police checks)

Yes/No - I am confident that the participants will be provided with all necessary information before the study, in the consent form, and after the study if necessary.

Yes/No - I am confident the participant's confidentiality will be preserved.

Yes/No - I consider that the risks involved to the student, the participants and any third party are insignificant and carry no special supervisory considerations. If you circle "no" please describe the problems as you see them.

No/Yes - I would like the ethics committee to give this proposal particular attention. (Please state why below)

Supervisor's signature: **date:**

Appendix 2- Letter to Care Home Managers

THE UNIVERSITY *of York*

Department of Sociology
Heslington
York
YO10 5DD
Tel: 07826959748
Email: Joanna.wolton@york.ac.uk

Dear (write as applicable),

My name is Joanna Wolton and, I am a post-graduate student currently studying for an MA in Sociology by Research at the University of York, which involves me carrying out a yearlong research project. My chosen topic concerns the everyday life of care workers within private care institutions. I am writing to you today as I would like to arrange a meeting in order to discuss whether it would be possible to carry out the research in your care home. However, I think it may be best to state a little bit about myself and why I chose this area for a research topic and what the research could potentially entail.

My interest in the topic stems from my experience of being a care worker for the past three years. When attempting to find sociological literature about care work, I mainly found articles about service users, and I think it is important to redress this balance by examining the perspective of care workers. After completing a similar project for my undergraduate dissertation, my University tutors were impressed with the quality of my work and encouraged me to develop the research further. This positive encouragement, along with the knowledge that I have gathered over the years, has given me the impetus to continue with this research. I also believe that research into this is of utmost importance. As a society we are living longer and so there is a greater chance that more and more people will require care services, and therefore the only way to improve standards of care is to not only give a voice to those whom the service is dedicated to, but to those working behind the scenes as they are the backbone of an increasingly privatised long-term care system.

If it is possible to carry out research in your establishment, I would like to conduct observations on agreed times and dates. This would possibly entail shadowing workers when on shift, so that I can get a feel for the home and observe its daily rituals. I would also like to conduct interviews with both staff and residents so that I can understand the experience of being in the care industry from both the perspective of workers and service users. Of course this would be subject to ethical approval from the University of York and consent from both your employees and service users. Again these will be conducted at agreed times so as to not disrupt the routine of your home. My presence as a researcher is to be non-intrusive and please do not feel that I would be there to make judgements on the behaviour of the staff and running of the care home. I only wish to research what it is like to be involved in the care industry using the experiences of those who are already in it.

A high standard of ethical practice will be adopted as the University's ethics board will review my research proposal and only approve it if it meets all of the required ethical considerations and practices outlined by the University of York and the British Sociological Association. A big part of the ethical requirements relates to the issue of confidentiality, especially in the context of caring for

vulnerable people. Therefore in order to meet the ethical standards, the identity of those who participate and the location of your care home will not be included in the study. The study will be supervised by Professor Sarah Nettleton, who is an experienced social researcher

This letter is just to ask if you and your staff would be willing to perhaps arrange a meeting to discuss the possibility of being involved in my study. If you could please respond either via e-mail, letter or telephone to the addresses and number listed above, this would be greatly appreciated.

Thank you for your time and I look forward to hearing from you

Yours sincerely,

Joanna Wolton

Appendix 3- Letter to Staff Members

THE UNIVERSITY *of York*

Department of Sociology
Heslington
York
YO10 5DD
Tel: 07826959748

Date to be added

Email: Joanna.wolton@york.ac.uk

Dear Staff Member,

This is a letter to inform you that over the next few weeks I will be undertaking research at (write as applicable). This letter will explain the reasons, purpose and process of the research.

I am a post-graduate student studying for an MA in Sociology by Research at The University of York. Over the next few weeks commencing [dates to be added] I will be undertaking research contributes to my research project, and I would like you to be part of this study.

My research will entail observing only interactions between care assistants and nurses within the work place and interviewing certain workers. This will require me to occasionally shadow a few workers and observe the routine of the care/ nursing home, in conjunction with conducting interviews with various members of staff. I will personally undertake the research, and the information gathered will contribute to my Master's thesis.

As a potential participant it should be noted that you have no obligation to take part in the study and should you choose to take part, you have the right to withdraw at any stage of the research process. Please be assured that your behaviour is not being judged in any way but is merely being observed.

As a participant your identity will remain anonymous, no real names will be used and the location of the care home will also be excluded from the final report. The gathered information will also remain confidential in accordance with the British Sociological Association (BSA) guidelines, and this research has been cleared by the University of York, Department of Sociology's Ethics Committee. Appropriate measures will also be taken to ensure that all information will be protected against unauthorised access, accidental loss and damage. The information will also only be kept for as long as is necessary for my project.

My contact information and that of my academic supervisor will also be given to the manager to the care home. Therefore if you have any further queries regarding the purposes, intent or the process of my research please feel free to contact me, or my supervisor for further information. Alternatively you can also approach me in person to discuss my project.

This letter is also to reassure you that your behaviour is not being judged in any way. My aim is not to make you feel uncomfortable, but merely to portray what it is like to work in the care industry.

If you wish to take part in my research project could you please fill in the consent forms, hand one to your manager or to me in person and retain the other copy for your records. If you do not wish to participate then please do not feel obliged to fill in and return a copy of the consent form.

Thank You,

Joanna L. Wolton

Appendix 4- Poster for Staff

To All Staff

To All Staff,

I am a post-graduate student studying for an MA in Sociology by Research at the University of York. Over the next few weeks I will be undertaking research that will provide the foundation for my Master's thesis, and I would like you to be a part of this.

My research entails observations of only the interactions between care assistants and nursing staff in the work place and interviewing certain workers. This requires me to potentially shadow a few workers in order to get a general feel of the everyday working life to a care worker. These issues will then be explored further by conducting interviews with various members of staff. I will personally be undertaking the research and the information gathered will contribute to the thesis that constitutes my overall degree mark. This information will mainly be seen by my supervisor and those involved in the marking process.

There is no obligation to participate in the research. Should you choose to take part, please note that you have the right to withdraw at any stage of the research process. Also please be assured that if you participate your identity will remain anonymous, no real names will be used and the name and location of the care home will remain anonymous in line with the British Sociological Association (BSA) guidelines.

The information gathered will also remain confidential, in accordance with the BSA guidelines. Appropriate measures will be taken to ensure this information will be protected against unauthorised access, accidental loss and damage. The information will also only be kept for as long as necessary for my project.

My contact information and that of my academic supervisor will also be given to your manager, so in the event that you have further queries regarding the purposes, intent or process of my research you may contact me, or my supervisor for further information.

Thank you

Joanna L. Wolton

Appendix 5

Consent Forms for Observations

PROJECT TITLE:

An in-depth exploration of the labour of formal care workers: a comparison of residential and community care for older people

Name of researcher: Joanna L. Wolton
Telephone: 07826959748

Name of Supervisor: Dr. Sarah Nettleton
Telephone: 01904 323062

Please initial box

1. I confirm that I have read and understood the statement of intent for the above study. I have had the opportunity to consider the information Ask questions and have had these answered satisfactorily.

2. I understand that my participation is **voluntary** and that **I am free to withdraw at any time**, without giving reason.

3. I understand that any information given by me may be used in future reports, articles or presentations by the research team.

4. I understand that my name will not appear in any reports, articles or presentations.

5. I agree to take part in the above study.

Name of Participant

Date

Signature

Researcher

Date

Signature

When Completed please retain a copy for your records, and return the other in the envelope provided. Thank you for taking part.

Appendix 6



INFORMED CONSENT FORM FOR INTERVIEWS

(To be read out by the researcher/moderator before the beginning of the session. One copy of the form to be left with each participant; one copy to be signed by each participant and kept by the researcher/moderator).

My name is: **Joanna L. Wolton**

I am doing research on a project entitled: **An exploration of the labour of formal care workers: a comparison of residential care and nursing homes for older people.**

My tutor/supervisor **Dr. Sarah Nettleton** is directing the project. Should you have any questions she can be contacted at:

Department of Sociology
Wentworth College
University of York
Heslington
YORK
YO10 5DD
Tel: 01904 323062

Thank you for agreeing to take part in this project. Before we start, I would like to emphasise that:

- Your participation is entirely voluntary
- You are free to refuse to answer any question
- You are free to withdraw at any time

The interview will be tape-recorded, but the data will be kept strictly confidential and will be available only to members of the research team. Excerpts from the results may be made part of the final research report, but under no circumstances will your name or any identifying characteristics be included in the report.

Please sign this form to show that I have read the contents to you.

(signed)

(printed)

(date)

Researcher/ moderator to keep a signed copy and an unsigned copy should be left with each participant. Thank you for taking part.

Appendix 7

To All Residents and Family Members *From Joanna Wolton*

This is a notice to inform you that over the next few weeks I will be conducting sociological research. I am a post-graduate student studying for an MA in Sociology by Research at the University of York. Over the next few weeks I will be conducting some research into the everyday life of care workers.

My research will entail shadowing workers in order to observe their daily routine. Additionally I will be observing other daily events such as tea time and I will also be conducting interviews with some members of staff and some residents.

I will personally be undertaking the research, and the information gathered will provide the basis of my thesis. Confidentiality will be upheld in line with the British Sociological Association guidelines, and the research had been reviewed by the Sociology Ethics committee at the University of York.

The focus of my research will be on the everyday working life of care assistants and nurses, and in particular the social interactions of those working within residential care settings. This notice is to inform and assure you that no residents will be the focus of the observations. Although where possible I would like to interview a few residents who would be willing to participate in this manner. If you have any further questions please do not hesitate to contact me or my supervisor to discuss this matter further. Details will be held by the manager of the home in the office should you require them.

Thank you

Joanna L. Wolton

Appendix 8

(Preliminary) Interview Schedule for care assistants

1. How did you find yourself working as a care assistant/ nurse?
2. Do you view your role as a care/nursing assistant to be a long term career or more of a short term profession?
3. What character traits do you think makes a person suitable to work in the care industry?
4. What would you describe as good care that gives you satisfaction?
5. Do you think that care work is widely thought of as women's work? Why?
6. Do you think that people approach or react to male care workers in a different manner than female care workers? If so how, is this a positive response or negative one?
7. What would you say is your favourite aspect of care work?
8. What would you say is your least favourite aspect of care work?
9. Is there anything that you find particularly frustrating about care work?
10. How do people react when you inform/tell them that you are a care worker?
11. Given the recent media coverage about abuse and neglect within care homes do you feel that this has had an impact on your occupation? If so in what way? (Notions of trust)
12. Do you ever feel pressed for time when administering care?
13. Do you think ever find it difficult to separate your home and work life? That is do you think you sometimes take work home with you are vice versa?
14. Have you ever been in a situation where a resident has been uncooperative? What

would you normally do in these situations?

15. Do you feel as though you are emotionally at risk? How do you avoid such risks?

16. Do you feel that communication is important in care work? Can you think of any instances where a lack of communication or too much communication has been a detriment to care?

17. What factors do you think could improve the standard of care?

18. After working in the care industry and seeing how it operates, would you feel comfortable placing a family member in care?

19. Considering the reforms in health care now, and seeing a lot of state funded care homes closing down or receiving a loss in funding, how do you think this will affect the standard of care or the care industry as a whole?

Appendix 9- Letters of Permission from Care Home Managers

7th December 2012

Dear Joanna

Thank you for your visit on Thursday 6th December about your research project 'the everyday life of care workers within private care institutions'.

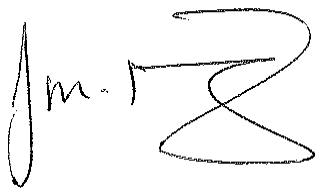
I believe that this would be a very worth-while topic to cover and I am very happy to allow you access to our home to help with your research.

As discussed I am more than happy to allow you to talk to staff members and our client's providing they are happy to talk to you. When we next meet I think that it would be helpful to discuss in what format you would like to speak to these groups, as individuals or as a group. If you wish to speak to staff to explain what you are doing I could allow you air time at a staff meeting.

Due to your own work in the care sector I know that you have an excellent understanding of confidentiality and I feel assured that the survey will be conducted in both a confidential and ethical manner.

I look forward to meeting with you again in the new year.

With regards,



Home Manager

[REDACTED]

[REDACTED]

2nd January 2013

Dear Joanna,

Further to our conversation this letter is to confirm we are happy for you to continue with your interviews with staff [REDACTED] to support your research.

If I can be of any further help please do not hesitate to contact me.

Yours Sincerely,

[REDACTED]

Manager

[REDACTED]

Dear Joanna

Following on from our recent telephone conversation, I am pleased to confirm that [REDACTED] [REDACTED] will assist you in your university work in order to enable you to complete your dissertation.

Please give me your availability so that i can ensure appropriate levels of staff are on duty and are able to assist you whilst off duty.

Kind Regards

[REDACTED]

Home Manager

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