Meeting the Needs of Older People?
A Comparative Study of Care Home Staff in England and Germany

by

Ingrid Anne Eyers

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Department of Sociology
School of Human Sciences
University of Surrey

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Abstract

The focus of this comparative research is on the interface between older people and the care staff employed to meet their needs. The aim was to establish how the policies and provision of ‘hands on’ care in English and German care homes impacts on the quality of life experienced by the older people who live there.

A multi-methodology was used to collect data in four care homes in Southeast England and four care homes in Northern Germany. Structured interview data was collected from eight care home managers to establish a profile of the care home residents and the staff employed to provide their care. Self-completion questionnaires were distributed to all care staff in the sample homes to establish a profile of how the respondents formally and informally developed and gained skills to work in a care home. To gain an understanding of every day care home work, semi-structured interviews incorporating care related vignettes were conducted with an average of three members of qualified staff and three care assistants in each of the eight sample homes. At the end of the interview detailed lifecourse data was collected from the interviewees.

The data from the home managers confirmed that the bodywork tasks undertaken in the English and German care homes were comparable. The interview data with care staff established the essence of care and provide a basis from which to investigate how and where in their lifecourse care staff develop the invisible, intangible and immeasurable skills that are essential in the care of older people living in a care home. Having gained an understanding of the interface between care staff and older people in a care home and the role of communication and time budgeting, the findings are related to the government policies that impact on institutional care in England and Germany.
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List of Tables and Figures

Table 2.1: Projected household situation of older population in 2010 (%) 21
Table 4.1: Overview of labour market statistics of 15-64 year olds in 1999 (percentages) 41
Table 4.2: Percentage of UK and German 25-64 year olds who participated in training in the last four weeks, by level of educational attainment in 1999 46
Table 4.3: Percentage of 25-64 year olds who participated in training in the last four weeks, by gender and country in 1999 46
Table 4.4: Overview of TOPSS Induction Training Programme 47
Table 4.5: The differences between formal learning and on-the-job workplace learning 48
Table 4.6: Outline of the German Red Cross training programme for care assistants 54
Table 4.7: Training to be an Older Person’s Carer 56
Table 4.8: Nurse training in Germany 58
Table 5.1: Characteristics of Sample Care Homes 80
Table 5.2: Summary of Data Collected 84
Table 5.3: Self-completion Questionnaire Response Rate 85
Table 5.4: Interviewee Profile 86
Table 6.1: Gender distribution of care staff in the sample homes (Data from care home managers) 90
Table 6.2: Care staff age distribution based on data from care home managers. (German qualified staff includes OPC’s) 91
Table 6.3: First job after leaving school based on data from self-completion questionnaires 93
Table 6.4: Skilled and unskilled route to care home employment based completed on lifecourse data set 97
Table 6.5: Number of NVQ qualified staff in the participating care home (Data from care home managers) 103
Table 6.6: Care Assistants who have completed NVQ training (Data from self-completion questionnaire) 104
Table 6.7: German care home staff who had participated in the ‘SHP’ by qualification level (Data from self-completion questionnaire) 105
Table 6.8: How much care staff perceived they knew about care of older people before starting to work in the care home (Data from self-completion questionnaire) 108
Table 6.9: Where qualified staff and care assistants gained experience in the care of older people (Data from self-completion questionnaire) 109
Table 6.10: How much learnt from colleagues (Data from self-completion questionnaire) 111
Table 6.11: How much learnt from attending courses (Data from self-completion questionnaire) 113
Table 6.12: Percentage of Care staff who have attended different types of courses related to health and safety training in the last three years 114
Table 6.13: Percentage of care staff who had participated in courses related to care of older people in the last three years
Table 6.14: Percentage of qualified staff and care assistants with parenting experience (Data from self-completion questionnaire)
Table 6.15: Percentage of care staff with care experience within the family, currently and in the past
Table 7.1: Percentage of English and German residents with medical conditions characterised in the care vignettes (Data from home managers)
Table 7.2: Percentage of English and German residents with care needs presented in the care vignettes (Data from home managers)
Table 7.3: Indicators that acknowledge medical conditions presented in the care vignettes
Table 7.4: Number of staff acknowledging the medical context of the vignette
Table 8.1: Edith’s communication needs acknowledged
Table: 9.1: Balancing ‘Maude and Derrick’s’ care
Table: 9.2: Respondents relating to not having enough time
Figure 5.1: Comparisons made between English and German care homes
Figure 5.2: Linking care staff’s lifecourse to care of older people
Figure 7.1: Vignette Edith (Frau Schmidt)
Figure 7.2: Vignette Phyllis (Frau Lembke)
Figure 7.3: Vignette John (Herr Böttcher)
Figure 7.4: Vignette Maude and Derrick (Frau Maier and Herr Töle)
Figure 10.1: The interface between older people and care staff
Figure 11.1: Framework surrounding the provision of care
<table>
<thead>
<tr>
<th>Chapter 11: Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
</tr>
<tr>
<td>2. Care home industry</td>
</tr>
<tr>
<td>3. Occupational training</td>
</tr>
<tr>
<td>4. Care home regulations</td>
</tr>
<tr>
<td>5. Funding systems</td>
</tr>
<tr>
<td>6. The interface between care staff and older people within the framework</td>
</tr>
<tr>
<td>7. Reflections</td>
</tr>
<tr>
<td>References</td>
</tr>
</tbody>
</table>

**Appendices**

Appendix 1: Home Management Interview questionnaire  
Appendix 2: Care home staff questionnaire  
Appendix 3: Semi-structured interview guide  
Appendix 4: Lifecourse grid for data collection  
Appendix 5: Map of England and Germany  
Appendix 6: List of respondents job after leaving school  
Appendix 7: Lifecourse Threads
Chapter 1
Introduction

The work undertaken for this thesis, which establishes how care staff develop the skills to meet the needs of older people living in care homes, actually builds on my own lifecourse. As with the care staff who participated in this research my lifecourse experience within my family and my occupational training and employment as a nurse in intensive care and later as matron/manager in English and German care homes form the basis from which the research was developed.

Extensive previous research has focused on informal carers, including comparisons between England and Germany. However, little research has examined those employed to care for older people living in care homes. Prior to my PhD research, there had been no comparative work between the English and German care home sectors relating to the acquisition of care skills in the two countries. The research aims are to compare how training is provided and skills are acquired throughout the lifecourse, and how they impact on the provision of care and on the autonomy of care home residents in England and Germany. In this research the aim has been to establish the blend of care skills used to provide care to older people living in English and German care homes. It was investigated and compared how in the two countries training is provided and skills are acquired throughout the lifecourse and consequently impact on the provision of care and on the autonomy of care home residents.

The initiative to undertake a comparative study between England and Germany was fuelled by an awareness of the contrasting policies surrounding the provision of institutional longterm care for older people in two countries with similar concerns about an ageing population. Having undertaken a small-scale comparative study of care homes in England and Germany for my MSc dissertation (MSc Gerontology: Policy, Care and Practice 1998) which indicated the role of formal and informal skills used in the provision of care, this research project was a natural progression. My background working in English and German care homes has been enhanced by my experiences as a relative of older people who needed to move into a care home in both countries.
As a young care home manager entering the care home industry from working as a nurse manager in intensive care, like many of the qualified nurses who participated in this research, I too brought my hospital-based knowledge and skills into the care home environment. Actions I took and decisions I made impacted on the lives of the older people living in the home I was managing. For example, within the first six weeks of my employment as a care home manager, the outcome of one of my actions was clearly brought home to me. The blood sugar levels of five older people who were diabetic were tested. On seeing the results, I was shocked to note that they were extremely high. The issue was discussed with the doctor, the chef in the kitchen and the care staff. My aim was to ensure that we provided a more suitable, controlled diet for these older people. As a qualified nurse, I did not want to be held responsible for not catering correctly for diabetic residents.

A few days later, a gentleman affected by the change in diet asked for an appointment to come and see me. He pointed out that he was now over 80 and had lived his life. He knew that sooner or later he was going to die. While he acknowledged and respected the fact that I had his best interests at heart, he asked could he please enjoy the rest of his life and personally take responsibility for the food he ate. There were certain foods he knew were not suitable for diabetics but he enjoyed eating them and could see no reason, why, at his age, he shouldn’t. It became obvious that he had covertly been eating the foods that, in keeping with the diet now being imposed, were not meant for him. Recognising that he clearly had a point and that it was better if we all knew what he was eating, I acknowledged that I should have included him and the other diabetic residents in my original meeting to discuss the problem and agreed that he should take responsibility for his choice of diet. That experience in my professional role of care home manager influenced my decision making process in the management of a care home. It taught me to recognise that the care of older people living in a care home differed from that of hospital patients, and I believe this incident influenced my approach towards the care of older people living in a care home for the following 23 years.
A second experience is that of a relative visiting my husband’s grandmother in a residential care home in the north of England. I had always known Gran as someone who was very aware of her clothes and took pride in her appearance. In conversation with the manager of the home, my husband and I were proudly told how the process of settling Gran into the home had included persuading her to no longer wear a corset and to wear ‘pop socks’. This process eased the provision of care. Gran expressed her displeasure by stating her dislike for ‘pop socks’. It was neither acknowledged nor recognised by care staff that this was an issue of any importance. However, for Gran it was a great loss of dignity and identity, taking away her corset was symptomatic of her disempowerment and total lack of autonomy now she was living in a care home. This experience in my private life also influenced my future attitudes towards the provision of care to older people living in a care home.

These two experiences took place before I embarked into academia but serve to present how my public and private lifecourse has informed the research I have undertaken. However, it is only in hindsight that I recognise the importance of these incidents. The fact that I remember them both so well indicates how powerful the experiences were as they entered the forefront of my memories during the analysis of the data collected for this thesis. Both relate to the interface between care staff and older people living in care homes and indicate the importance of how care is provided. In both instances, care was being provided to the best of the member of staff’s ability. My knowledge from hospital nursing informed my decision-making process when I saw the results of the blood sugar tests. The private experience with Gran influenced my assessment of situations I later encountered in the provision of care and it also exemplifies how care staff implement practical knowledge. Not having to assist Gran into her corset every morning saved time, and consequently influenced the decision made by the care staff looking after her. However, in neither case, did care home staff consider how the outcome might impact on the self-identity and everyday quality of life for the older person concerned. This research provides a more extensive, detailed insight into the interface between care staff and older people and into the knowledge base care staff develop from their public and private lifecourse which informs their thought processes and actions in the provision of care.
It also places the interface between care staff and older people within the context in which institutional care in England and Germany is provided.

The literature I have encountered over the last six years has further extended my knowledge and understanding of both the care home industry and the older people for whom they are providing a service. The blend of personal experiences as a care home manager and a relative, in conjunction with the knowledge I have gained as a student in gerontology and sociology, are reflected in this thesis in forming the research design, the analysis and discussion of the findings. The comparative element of the research has contributed towards identifying issues in the provision of care that could have otherwise be taken for granted and overlooked.

General consensus throughout the European Union (EU) is that community care is the most cost effective method to combat the need to meet the care costs of an ever increasing population of dependent older people (Jani-Le Bris 1993; Walker and Maltby 1997). However, within the EU it is recognised that each country individually has the prime responsibility and legislative competence to implement policies in the field of ageing (Social Europe 1995). As representatives of the conservative and liberal welfare system within Europe, England and Germany have approached the issues that arise from an ageing population in different ways (Esping-Andersen 1990). Both aim to ensure the best possible care for older people who for health and social care reasons live in a care home. Furthermore the two countries also present contrasting approaches towards occupational training (Roberts et al 1994). This consequentially provides the ideal constellation to undertake comparative research in order to challenge implicit assumptions that any one country's method and system of ensuring older people living in a care home, receive the best possible care. This thesis establishes how policies surrounding the provision of care relate to the interface between care staff and older people and how throughout their lifecourse care staff experience training and gain the skills and expertise required to care for institutionalised older people.

In the following chapters, after considering the implications of the World Health Organisations policy framework on 'Active Ageing' (WHO 2002) in Chapter 2, the
policies surrounding the provision of institutional long term care for older people in both England and Germany are compared. The comparison highlights the difference in the funding of care home placements and the diverging skill mix of care staff employed to provide care to older people living in care homes. The actual provision of care work based on the research literature to date is discussed in Chapter 3 and bodywork, emotional labour and communication skills are linked with the need for staff to provide care within an institutionally driven time frame.

Chapter 4 considers care homes as a place of employment and compares the diverging employment cultures in England and Germany. The routes to employment in the care home industry are discussed and the occupational training systems available to care home staff in both countries are reviewed and compared.

Having considered the issues surrounding the provision of institutional longterm care in England and Germany, Chapter 5 presents the aims and objectives of the research and the multi-methods used to collect data that would contribute towards establishing the comparability of the sample homes, the skills used in the provision of care and the lifecourse of care staff. The complexities of undertaking research in two languages are considered in conjunction with the design of the questionnaires and semi-structured interviews, including the vignettes used to collect standardised comparable data. The chapter includes a description of the pilot study and the experience of data collection and analysis.

The data collected provide a profile of the care staff working in the sample homes, which is presented in Chapter 6. After discussing the age and gender distribution, an overview of the diverging lifecourse experiences of English and German qualified staff and care assistants is provided. This contributes towards creating an understanding of how and where care staff acquire the skills to provide care to older people living in a care home.

The reality of care home work based on the research findings is discussed in Chapter 7. This sets the vignettes into the context of the care experiences and the daily
routine of the participating interviewees, thereby justifying the comparability of the English and German data and the appropriateness of the vignettes.

The responses to the vignettes and the description of the respondents daily routine provided rich data that are discussed in the following two chapters. In Chapter 8, the importance of communication as an instrument of power in the provision of care is considered. This chapter establishes how communication is used as an emotional labour instrument in the production of care. This is then related to the training the care staff have received and highlights their ability to enable an older person living in a care home to be empowered and actively participate in the daily decision making process when planning care. The focus in Chapter 9 is on the diverging contact time between older people and care staff experienced in the two countries. Here the emphasis is on the use of time as a valuable resource which impacts on the production of care and the resulting disempowerment of older people living in care homes in both countries.

The interface between care staff and the older people for whom they are employed to care is discussed in Chapter 10, identifying that caring for older people is by no means unskilled work and clearly calls for specialised skills from qualified staff and care assistants. In the discussion, the lifecourse of care staff is related to the development and use of care skills. It is then considered how the use of these skills impacts on the every day life experienced by older people living in a care home. In Chapter 11, the interface between older people and care staff is placed within the context in which institutional care in England and Germany is provided. The chapter concludes that it is the policy framework surrounding the 'hands on' provision of care which restricts the time available in which to provide care and also the further development of skills to meet the needs of older people living in care homes. Whilst the policy framework results in the disempowerment of older people it is the skills formally and informally acquired throughout the lifecourse of English and German care staff that enable them to provide care to older people within this framework. The research undertaken for this thesis therefore questions to what extent formal training and informal care skills influence the care experienced by older people living in English and German care homes.
Chapter 2
Policies, Care and Older People

1. Introduction

Amongst the countries of world, the United Kingdom (UK) and Germany represent developed countries with an ageing population. It has been projected that by the year 2025, people over the age of 60 in the UK and Germany will represent over one quarter of the population (WHO 2002). In both countries increased life expectancy is perceived to be linked to the risk of needing care, either at home or in a care home (Jani-leBris 1993; Walker and Maltby 1997; Naegele and Walker 2002). English and German health and social care policy makers aim to provide a framework that facilitates services to meet the needs of those older people who do need care. However, the framework does need to fit within the resources available in each country. Furthermore, active ageing and maintaining autonomy are seen to be key goals for both older people and policy makers, and an older person who is ill or living with a disability should be enabled to remain an active contributor to their family, peers, community and nation (WHO 2002).

In England and Germany, acts of parliament have been passed and policies were developed to address issues that impact on the provision of heath and social care services for frail, vulnerable older people. In England key legislation has been the ‘National Health and Community Care Act 1990’ (DoH 1990), the National Service Framework (DH 2001a), and the Care Standards Act 2000 (CSA). In Germany policies relating to the provision of longterm care relate to the ‘Sozialesgesetzbuch XI’ (SGBXI) [Social Legislation Book XI] which was passed by the German government in 1994. This led to the reform of social legislation in Germany resulting in a compulsory longterm care insurance system introduced in 1995 (Beck 1995; Goberg 1997; Klie 1997). To create an environment that could facilitate efficient, effective service to older people who need to live in a care home, in 1997 a revised version of the ‘Heimgesetz’ [Care Home Act] was passed.

Within the European Union (EU), longterm care is perceived to be a predominantly family orientated task (Walker and Maltby 1997) and it is the almost universal wish
of older people needing longterm care to remain in their own homes for as long as possible (Bebbington et al 1996; Peace et al 1997; Walker and Maltby 1997). Whilst the policies that enable older people to remain in their own homes are in place, there will, as Walker and Maltby (1997) point out, continue to be a need for institutional care, especially for dependent older people with special needs that cannot always be met in a domiciliary environment. Even with domiciliary care provisions, ‘staying put’ will not always be an option as it is often difficult to adapt accommodation to the needs of individual frail or disabled older people (Means 1997). The ability of spouses or children as informal carers (Arber and Ginn 1991; Askham 1995; Jani-leBris 1993; Lewis and Meredith 1988) even with the support of formal care systems also has boundaries and the physical abilities of an informal carer are not limitless even with the support of paid carers. The on-going need for institutional care will consequently lead to a continuing requirement for care staff with the skills to meet the needs of vulnerable older people in England and Germany.

Key elements in the provision of institutional longterm care are the policies on funding care home placements and the skill mix of the staff employed to provide this service. This chapter will provide an outline of the English and German policies that impact on the provision of institutional care and will present an overview of the literature relating to the autonomy, respect and dignity of older people living in care homes.

2. Institutional care in England
At the time of the research design and data collection for this thesis (1999-2000), the provision of institutional care in England was determined by the ‘Registered Homes Act 1984’ (DHSS 1984), which was interpreted individually by each supervisory local authority. For the majority of older people (97%), admittance to nursing home care was gained via their local authority social services who act as both gatekeeper and funder of longtermcare (Millard 1999). This is in accordance with the ‘NHS and Community Care Act 1990’ which was implemented in 1993.

Since implementation of the ‘NHS and Community Care Act’ in 1993, the National Health Service has reduced its capacity of longterm care beds and the independent
sector has taken over as the major provider of institutional care (Evers and Harding 1997; Peace et al 1997; Walker and Maltby 1997; Netten et al 1998). Within this profit orientated care home industry, the major providers are small business entrepreneurs, and many of these care homes are converted and extended family houses (Dalley and Dennis 2001). Such homes can be seen to facilitate care in a more homely environment (Barnes 2002). However, purpose built large facilities are being developed (Barnes 2002) and the corporate providers have established a keen interest in the industry and have control over approximately one third of the market (Peace et al 1997).

An indicator that the United Kingdom (UK) government policies are succeeding in fulfilling the undisputed wish of older people to remain in their own home might be surmised from the fact that, since 1996, an estimated 828 homes have closed with a loss of around 16, 600 longterm care beds (Laing 2002). However, this reduction of care home beds in the UK cannot purely be seen to relate to the success of government policy to enable frail older people to continue to live in their own home. It is also associated with the policies that impact on the funding of care home placements and the introduction of the Care Standards Act 2000 (CSA), implemented in April 2002 (DH 2000). These policies aim to improve the standard of the care home environment and the 'hands-on' provision of care across the country, and can be seen to have a significant impact on the predominantly profit making care home industry in England. To meet the environmental standards set by the CSA, many care home businesses established in the 1980’s and 90’s would need to invest money to make substantial changes to the building in order to meet the required minimum standards (Barnes 2002). In some instances it might not be possible to adapt the building to meet the requirements of the CSA and run a profitable business. Meeting the cost of environmental changes in conjunction with the increased staffing costs in keeping with National Minimum Wages and the increase in pay for qualified nurses, which is guided by NHS pay structures, may well influence a home owner’s decision to adapt to meet CSA requirements or close down the business. It would therefore be presumptuous to assume that the reduction in care home places in the UK was only related to the successful implementation of government policy to enable frail older people to remain in their own home.
2.1 Funding longterm care

The cost of longterm care in England is met either publicly or privately. Until October 2001, no distinction was made between accommodation and care in the weekly cost of a residential or nursing home placement. At the time of data collection, the cost of publicly funded care home placements were predominantly met by the Local Authority Social Services. In keeping with the NHS and Community Care Act (DoH 1990), the NHS would only fully fund the care home placement if the older person met the eligibility criteria of their Health Authority (Eyers 1997). Research undertaken by the Personal Social Services Research Unit (PSSRU) found that in 1996 nearly 70% of their sample, which accounted for 11,900 residents, were permanent publicly funded care home residents (Netten et al 1999). The sampled 618 homes were spread throughout 21 local authorities and at the time of the survey, the average weekly fee in a residential home was £237 (£1027 per month) and £333 (£1443 per month) in nursing homes. The survey established that nationally the NHS was covering the cost of only two percent of the publicly funded residents whereas the local authorities were covering the cost of two-thirds of the residents. All other placements were self-funded by the personal resources of the older person. The analysis of the cost and prices in the independent care home sector was, especially in nursing homes, not sensitive to the dependency of residents. However, the price of care was seen to be very sensitive to variations in local wages. The estimated mark-up rates of price over cost were around 10%. The competitive market for residential and nursing home care was further seen to be charging higher prices to privately funded residents (Netten et al 1999).

More recent data establish that in April 2002, the majority of care home placements in the UK were funded by the Local Authority (LA) and the NHS with 32.5 % of the placements being funded out of the resources of the individual resident (Laing and Buisson 2002). In this data set the NHS funding of a care home placement will be within the context of the eligibility criteria of each Health Authority as the NHS funding of nursing care was phased in as of October 2001 (DH 2001b). At the time Laing and Buisson (2002) collected data, the average cost for a nursing home placement in the UK was £422 per week and £302 for a residential placement. A comparison of the two data sets indicates an increase of £89 per week for nursing
home care and £65 for residential care from the NHS and Local Authorities over a period of approximately 5 years. However, with an increased provision of domiciliary care it is to be expected that the dependency of older people moving into care homes will have increased. This results in a changed work load for care home staff who need to gain more specialised skills to meet the needs of these frail older people, a factor which should be duly respected and rewarded.

At the time of finalising this Chapter (summer 2003) the funding of care home placements is undergoing a period of transition and government funding is ‘needs-tested’ for nursing care and ‘means-tested’ for social care. From October 2001 onwards the NHS undertakes a needs-test and if deemed necessary funds the nursing care element of a care home placement. This Registered Nursing Care Contribution (RNCC) is divided into three bands and funded as follows:

**The High Band** (£110 per week): People with high needs for registered nursing care will have complex needs which require frequent mechanical, technical and or therapeutic interventions. They will need frequent intervention and reassessment by a registered nurse through a 24-hour period, and their physical/mental health state will be unstable or unpredictable.

**The Medium Band** (£70 per week): People whose needs for registered nursing care are judged to be in the medium banding may have multiple care needs. This will require the intervention of a registered nurse on at least a daily basis, and may need access to a nurse at any time. However their condition is stable and predictable and likely to remain so if treatment and care regimes continue.

**The Low Band** (£35 per week): The low band of need for nursing care will apply to people who are self-funding whose care needs can be met with a minimal registered nurse input. Assessment will indicate that their needs could normally be met in another setting but they have chosen to place themselves in a care home.

(NHS 2001)

This demarcation of the RNCC territory within the provision of care to older people living in care home indicates the division of health and social care. It implies that once older people are living in a care home, they are marginalised as the NHS will only provide a minimum contribution towards the cost of institutional longterm care. This division between health and social care is further exemplified by the following statement:

‘...the NHS would meet the cost of registered nursing time spent providing, delegating or supervising care in any setting. This time does not include time spent by non-nursing staff such as care assistants. It does not cover personal or social care costs or the cost of resident’s accommodation’ (NHS 2001)
The wording of this NHS document indicates the clear division between means-tested social care and needs-tested healthcare services. Despite the government’s modernisation strategies to integrate health and social care services, this division continues to prevail (Glendenning et al 2002). Whilst an integrated service is in the process of being provided, there are clearly two diverging sources of funding available for the provision of longterm care. If a care home placement is totally funded from government sources and only limited funds are available the choice of care home is restricted. This is a major step towards restricting the autonomy of an older person moving into a care home. Such a funding system further predetermines the input of a qualified nurse in the provision of care and is consequently reflected in the provision of care to older people living in English care homes. The impact of this funding system on the actual ‘hands-on’ care which is predominantly delivered by care assistants will be exemplified in the findings from the data collected for this thesis.

2.2 Diverging provisions in English residential and nursing homes
Institutional care in England at the time of the data collection was provided in either residential or nursing homes. The key difference was that residential homes were intended to provide only ‘personal care’, in contrast to additional ‘healthcare needs’ which could be met in nursing homes. However, the Registered Homes Act (DHSS 1984) was ambiguous in its definition of ‘personal care’ as it may not necessarily include ‘assistance with bodily functions’ (Peace et al 1997) thereby leaving it open to the interpretation of each supervisory authority. In accordance with the Registered Homes Act (DHSS 1984), the staff employed in residential homes were required to be ‘suitably qualified and competent’ while nursing homes were to ‘provide adequate professional, technical, ancillary and other staff in relation to the size and type of establishment’. Consequently the ratio of qualified staff to unqualified staff encountered in nursing homes varies throughout the country, as does the ratio of care staff to residents (Millard 1999).

Since completion of the data collection, the implementation of the Care Standards Act (CSA) 2000 has been phased in as of April 2002. This has blurred the distinction between residential and nursing care within the policies framework. The terminology
'care homes' is prevalent. Care homes proprietors, in negotiation with the National Care Standards Commission (NCSC), define their target market and structure the environment and staffing to meet the needs of that market within the framework of the CSA (DH 2002). In their marketing material care homes must then in keeping with National Minimal Standard 1 (DH2002) outline the service they are able to provide so that the ‘service user’ can make an ‘informed choice’. However, invariably the cost of a care home employing qualified nursing staff will be higher than that of a care home employing care assistants. If cost is one of the main criteria in the selection of a care home then there is a danger of older people and their families selecting a care home that is not necessarily suitable for their individual health and social care needs.

2.3 Staffing levels and skill mix
Statutory staffing levels and qualifications differ considerably within the care home industry of the two countries. In England, at the time of data collection, the staffing levels were determined by the ‘Registered Homes Act 1984’ (DHSS 1984). This was interpreted and implemented individually by each registering authority. The quantity and qualifications of the care staff in nursing homes for example, was negotiated between the home proprietor and the Health Authority Care Home Inspectorate (DHSS 1984). However, the overall minimum standard of staffing in nursing homes required one qualified nurse to be on duty at all times. Residential homes were not required to employ qualified nurses at any time (DHSS 1984). Consequently the majority of staff employed to care for dependent older people in English residential homes were untrained care assistants.

The NCSC has been advised by the Minister of State for Health to ‘regard the staffing level required by the previous regulator as at 31 March 2002 as an appropriate level’ (DH 2002). This implies that the implementation of the CSA has to date not resulted in actual changes in staffing levels or the skill mix of care staff in existing care homes since the time the data for this research was collected. However, a major impact on care staff will be experienced when care home proprietors need to meet Standard 28.1 which states:
A minimum ratio of 50% trained members of staff (NVQ level 2 or equivalent) is achieved by 2005, excluding the registered manager and or/care manager, and in care homes providing nursing, excluding those members of the care staff who are registered nurses.

In order to achieve this goal set by the Department of Health the key issue for policy makers and the care home industry at present is to train and retain staff with National Vocational Qualifications (NVQ) to meet these requirements.

2.4 Terms and conditions of employment for English care home staff

In England there is no general body regulating the terms and conditions of employment for care home staff. The Royal College of Nursing (RCN) provides pay guidelines for qualified staff employed in the independent sector. However, it is not binding for employers. Research undertaken by the PSSRU established that in 1996 the majority of private nursing (89%) and residential homes (92%) were paying unqualified care assistants below £4 per hour (Netten 1998). These finding are supported by research undertaken by the Centre for Policy on Ageing who found that prior to the introduction of the minimum wage in April 1999, many care assistants were being paid below minimum wage (Dalley and Dennis 2001). As this fact indicates, the gross pay for care assistants is likely to have been influenced by the minimum wage act implemented in April 1999 (Department of Trade and Industry 1999). At the time of data collection, under the guidelines issued by the Department of Trade and Industry, the national minimum wage for a worker aged between 18-21 was £3 per hour and for workers over the age of 22 it was £3.60. However, if a worker over the age of 22 was participating in accredited training, then a lower hourly rate of £3.20 could be applied for the first six months of employment. During this time, a worker must have received at least 26 days training in the six-month period (Department of Trade and Industry 1999:17-19).

Research undertaken in three homes in South-East England in 1998 established considerable variation in the terms and conditions of employment for care staff (Eyers 1998). The average gross pay for a qualified nurse ranged very little and was from £7.65 to £7.87 per hour. The RCN 1998 guideline for pay in the independent sector for a scale ‘E’ nurse was £7.53 to £8.72 per hour. For care assistants, where
there were no guidelines, the hourly rate in the sampled care homes ranged from £3.60 to £4.50 per hour.

Under the umbrella of new government policies that aim to modernise and improve the standard of service, the care home industry in England is at present experiencing a number of changes. A key issue relevant to improving the standard of service and thereby the quality of life experienced by older people living in care homes is the input of qualified nursing time. Yet the funding of the RNCC described earlier in this chapter is in effect rationing the qualified nursing contribution an older person living in a care home will experience. It can be expected that an RN working in an English care home should now (excluding the recent increase in National Insurance (NI) contributions) earn around £8.50 per hour. Including the employers NI contribution this would be around £10 per hour. This would cover 11 hours per week, (approximately one and a half hours per day) of RNCC for an older person classified to be in the high band. For an older person classified to be in the medium band this would be 7 hours per week (one hour per day). In the Low Band the NHS funding would cover approximately 30 minutes of qualified nursing care per day. As much of this time involves the management and administration of drugs, and the maintenance of care plans and records it becomes clear that care assistants have an important role to play in the every day life of an older person living in a care home.

The resources to fund care home placements can be expected to remain restricted whilst the everyday work of care home staff will become more complex with the anticipated increase in the dependency level of older people who live in care homes. Consequently an important element in the provision of care to older people will be to respect and reward care staff in order to recruit and retain people with the skills needed to meet the government’s national minimum standards in care homes.

3. Institutional care in Germany

Institutional longterm care in Germany is provided in care homes that tend to be owned either by the local authority or by one of the five major voluntary organisations (Evers and Harding 1997; Walker and Maltby 1997). From sheltered housing to nursing care, large predominantly purpose built complexes often meet the
wide-ranging needs of older people within a local community. In total around 680,000 older people can be accommodated throughout the country of whom more than 50% have care needs (Evers and Harding 1997). The number of people receiving care fluctuates as the level of care provided to an individual is determined by the care assessment undertaken by the ‘medical board’ set-up by the longterm care insurance providers (Goberg 1997; Klie 1997; Schunk 1998). The board determines the level of care needed. This in turn determines the amount of funding a dependent older person receives from their insurance company, which ultimately determines the staffing level of a care home (Goberg 1997; Klie 1997).

The dependency level of an older person living in a German care home is divided into three basic categories. These are determined by the amount of time a care assessor deems is needed to meet the older person’s care needs and includes the provision of domestic services. On that basis, the categories are as follows:

- **Category I:** ‘Erheblich Pflegebedurftig’ [great need of care]. Daily at least 90 minutes of care to be required, of which at least 45 minutes are to be spent on basic care.
- **Category II:** ‘Schwerpflegebedurftig’ [severe need of care]. Daily at least 3 hours of care required, of which at least 2 hours are to be spent on basic care.
- **Category III:** ‘Schwerstpflegebedurftig’ [severest need of care] Daily at least 5 hours of care required, of which at least 4 hours are to be spent on basic care.


### 3.1 Funding longterm care

Older people in Germany who are independent when they move into a care home do not receive funding from the longterm care insurance system until their care needs arise which are then assessed and categorised by their insurance provider. As with all older people living in a care home, the cost of accommodation and the ‘hotel services’ are met from personal income. The actual care costs are funded separately by the insurance provider (Beck 1995; Goberg 1997; Klie 1997). At the time of data collection, the amount paid for each care category was laid down in the ‘Sozialgesetzbuch Elftes Buch’ [Social Law Book Eleven] §36-43 generally known as ‘SGBXI’ (Beck 1995; Goberg 1997; Klie1997; Schunk 1998). The set monthly amount to fund institutional care was:

- **Category I:** 2000 DM (*approximately £666*)
Someone who has been assessed to have exceptionally severe care needs will receive 3300DM (approximately £1100) to fund institutional care (Beck 1995; Goberg 1997; Klie 1997; Schunk 1998).

This funding system consequently determines the resources available to employ care staff. The German ‘Heimpersonalverordnung’ [Staffing Regulations for Homes] as part of the ‘Heimgesetz’ [Registered Homes Act] determines the number of staff employed to meet the needs of institutionalised dependent older people. The regulations stipulate that if there are more than four residents requiring nursing care in a home, then half the staff must be qualified care staff (Goberg 1997). The care category of the residents then determines the ‘Personalschlüssel [care staff to resident ratio] (Beck 1995; Goberg 1997; Klie 1997). When for example, a ‘Category III’ resident leaves the home, the next person admitted might not be in the same care-category and the resource for care staff could be expected to be reduced. This is a factor that needs to be taken into consideration in annual budgeting and business planning. However, the categories of older people’s dependency as defined by German policy makers does not lead to the distinction between nursing homes and residential homes experienced in England at the time of data collection. Whilst the German system differentiates between care and accommodation costs, it does not differentiate between health and social care costs. However, as with the English funding system, the actual provision of care that older people living in a care home experience is dependent of the government policies that determine how institutional longterm care is funded.

3.2 Staffing levels and skill mix

As stated earlier, the German ‘Heimpersonalverordnung’ [Care home Staffing Regulations] as part of the ‘Heimgesetz’ [Registered Homes Act] states that half the care staff must be qualified nurses (Goberg 1997). The qualified members of staff may have trained as a ‘Krankenschwester’ [general nurse], ‘Kinderkranenschwester’ [sick children’s nurse] or ‘Altenpflegerin’ [older person’s
These different groups of nursing qualifications will be discussed in the next chapter. However, what does stand out is the fact that in Germany the need to train nurses to meet the needs of older people has been identified and acted upon. Within the field of caring for older people in Germany, all three qualifications are valued in the same way and have broadly the same income and career opportunities (Goberg 1997).

The terms and conditions of employment for care staff throughout Germany are guided by the ‘Bundesangestelltentarif’ [Federal Employment Tariff] generally known as ‘BAT’. Within this system there are specific sections for qualified and unqualified care staff working in hospitals, in the community and in long term care institutions. The groupings range from Kr.I–Kr.XIII and are linked to the occupational qualifications and level of responsibility. For example, an unqualified care assistant will be in Kr.I and a qualified children’s nurse, general nurse and older person’s carer will be in Kr.IV (Klie 1997:242). Within each group there is also a grading according to age. This begins at 20 and increases every two years. Based on figures from 1994, a care assistant aged 38 would earn approximately £128 per month more than her 20 year old colleague who is doing exactly the same work (Klie 1997). The difference between the income of a 38 year old qualified nurse in group Kr.IV and a care assistant of the same age in group Kr.I would be approximately £194 per month. The hourly rate of pay based on a 38.5-hour week would be approximately £5 for a 38-year-old care assistant and approximately £6 for a qualified nurse of the same age (Klie 1997). These calculations do not include any fringe benefits and are based on an exchange rate of 3DM to £1. These figures indicate that a qualified member of staff in Germany earns, on average, £66 per month more than a care assistant of the same age.

The differing approaches to the terms and conditions of care staff employed in the care homes of England and Germany also reflect the divergence in general employment practices of the countries. An English qualified nurse earns twice as much as an English care assistant whereas a German qualified nurse can be seen to earn only 20% more than a care assistant of the same age. Based on the available figures, the difference between the gross hourly wage of a care assistant and a
qualified nurse in England was on average close to £4 an hour whereas in Germany the difference was under £1 per hour! This establishes a key difference between care home staff in England and Germany and reflects the different role of the qualified nurse in English care homes. Whilst the pay according to age in Germany makes a comparison more complex, on average German care assistants can be seen to be better rewarded for their work than their English colleagues.

The skill mix of staff in the two countries also reflects the diverging long term care funding systems between the two countries, where a distinction between health and social care is made in England but in Germany this differentiation is not made. In England, the qualified nurse has a more medically orientated supervisory and managerial role in the provision of care with little opportunity to provide 'hands on care', factors which, as described earlier in this chapter, can clearly be seen to be linked to the English long term care funding system. In Germany, the responsibilities of qualified staff are linked to both health and social care, and funding is distinctly related to the estimated time required to care for the older person needing care. Within the German funding policies no reference is made to the input of qualified staff in the provision of care. However, within the SGBXI it is clearly stated that 50% of the care staff must be qualified. This can be expected to result in an older person living in a German care home receiving 'hands on care' from a qualified member of staff on a more regular basis than someone living in an English care home.

4. English and German older people in care homes

Older people living in English and German care homes do so because, for health and social care reasons, they are no longer able to live independently in their own home. Whilst living with a potentially restrictive medical condition, maintaining autonomy and independence is a key element of their lives and should be the goal for both policy makers and service providers. In the course of maintaining a policy to enable older people to remain in their own homes, there are inevitably situations where a care home placement needs to be provided.
4.1 Medical condition and dependency of institutionalised older people

A national audit of nursing homes undertaken from 1995-1998 in England and Wales found that cerebra-vascular related illnesses, confusion, immobility and falls jointly accounted for over 80% of referrals to nursing home care (Millard 1999). The audit further established that the residents recorded multiple medical problems, ranging up to 10 per person. At the time of audit, 20% of the nursing home residents were highly dependent and 52% had substantial care needs, whereas 28% had lesser care needs and may have been suitable for residential or domiciliary care. The research literature indicates that in both England and Germany, the dependency of care home residents is increasing (Beck 1995; Evers and Harding 1997; Davies et al 1999; Millard 1999; Bebbington et al 2000; Nolan and Davies 2000).

Research undertaken in Mannheim, Germany, established that dementia was a key indicator for admission to institutional care (43%), whereas 14% had cerebra-vascular related illnesses and 8% had suffered fractures and injuries (Bickel 1996). These findings underline the evidence from the ‘European Observatory on Ageing and Older People’ who report that, amongst older people, the most prominent illnesses appear to be cardiovascular diseases and various forms of dementia (Walker and Maltby 1997). Cognitive impairment is an increasing issue in both England and Germany and can also be seen to be linked to the need for institutional care (Naegele and Walker 2002).

The risk of needing nursing care rises with age and whilst fewer than 5% of all people over the age of 65 are seen to be in need of domiciliary or residential care, this figure rises to about 40% for men over 90 and around 60% for women over 90 (Naegele and Walker 2002). In Germany, 30% of older people needing nursing care are living in care homes and the rate of institutionalisation is seen to increase with age. In England, 25% of people over the age of 85 needing care live in care homes or hospital thus emphasising the role of care homes in end of life care (Naegele and Walker 2002:7). Eurostat projections present data indicating that by 2010 for someone over the age of 80 there is the additional risk of living alone (Table 2.1). When someone living on their own has health problems and needs assistance with activities of daily living this is more likely to lead to the need to move into a care
home. In both countries, the percentage of older people aged 65-79 living with a partner is relatively high at 61% and 64% in England and Germany respectively especially in contrast to the over 80 age group where this drops to 31% in England and 29% in Germany (Table 2.1). Living with a partner provides mutual assistance and support with activities of daily living and as Arber and Ginn (1991) point out, the move into a care home is least likely for those with a marital partner. The 80+ age group indicates a marked difference in the percentage of the population living in institutional care. Whilst this is 8% in England and 10% in Germany, the total percentage is still relatively low and it is inappropriate to assume all older people end their life in institutional care. However, considering the medical indications and the predicted risk of living alone it can be expected that there will continue to be a need for care homes in England and Germany. A continuing need for care homes also means a continuing need for skilled care staff, especially in light of the increasing dependency levels of older people moving into care homes.

4.2 Loss of autonomy and independence

For an older person, the decision to move into a care home is not made easily. In this decision-making process the funding policies already described will impact on the actual choice of care home as the chosen home needs to be affordable either to the older person or the funding body. In both England and Germany, the funding can be seen to be key to the choice of home and this can represent the first instance where the older person experiences restrictions on their autonomy. The World Health Organisation (WHO) defines autonomy as:

'Autonomy is the perceived ability to control, cope with and make personal decisions about how one lives on a day to day basis, according to one's own rules and preferences' (WHO 2002:13)
An older person moving into a care home seldom has control of the situation. As Reed and Morgan (1999) have established, older people who are about to be admitted into a care home from a hospital setting, did not perceive themselves as being in control or able to make choices about their own future and expected to have to adapt to a regime in a care home. This in itself can be perceived as disempowering for an older person who is also coping with the loss of physical independence and privacy (Bounds and Hepburn 1996).

As Arber and Ginn (1993) argue, class is relevant to the likelihood of an older person becoming dependent and losing autonomy. As stated earlier in this chapter, the majority of care home placements in the UK are funded by the state. This indicates that many older people living in English care homes are from the lower classes and their financial, material and cultural resources will limit their ability to remain in their own home when they need regular assistance with their daily activities. Dependency on needs and means-tested state support results in a loss of autonomy as this is subject to an assessment procedure that is designed to operate within the framework of government policies. In Germany, an older person moving into a care home is also subjected to an assessment to establish the level of funding the insurance company will provide. However, this is needs-tested only. In both countries, the move into a care home is often not determined by the individual older person but by ‘well meaning’ relatives, friends or social workers (Bounds and Hepburn 1996; Reed and Morgan 1999). For the daughters and sons of older people it was primarily fear for their mothers and fathers that influenced the decision making process (DoH 1994).

The actual move into a care home usually means adapting to the daily routine determined by the needs of an institution. Personal rules and preferences have to be curtailed in order to adapt to the new living environment. Reed and Morgan (1999), who focus on dependent older people’s transition from hospital to care homes, establish the apparent stoic coping mechanisms of dependent older people, who forfeit autonomy and individuality and become passive and dependent when they move into a care home (Barder et al 1994; Bounds and Hepburn 1996).
The need to move is often linked to a loss of physical independence due to a medical condition. The ability to personally perform activities of daily living turns an independent older person as described by the WHO (2002) into a dependent older person. However, irrespective of dependency, it was established in English research that the ‘fear of being alone, the fear of crime, fear of falling, fear of not recovering from illness, fear of being a burden to others …’ (DoH 1994:5) was an aspect that contributed towards the decision of older people to move into a care home.

In conjunction with an anticipated loss of contact with family, friends, peers and the community, for an older person, the move into a care home is likely to signal the loss of autonomy, independence and dignity. It also has an impact on the quality of life, which is defined by the WHO (2002) as follows:

‘Quality of life is ‘an individual’s perception of his or her position in life in the context of the culture and value system where they live, and in relation to their goals and expectations, standards and concerns. It is a broad ranging concept, incorporating in a complex way a person’s physical health, psychological state, level of independence, social relationships, personal beliefs and relationships to salient features in the environment’. As people age, their quality of life is largely determined by their ability to maintain autonomy and independence.’ (WHO 2002:13)

This definition distinctly links autonomy and independence to the quality of life for older people. However, in its policy framework on active ageing the WHO (2002) undisputedly acknowledges the importance of professional caregivers in the lives of dependent frail older people. The organisation identifies the need for training and the development of practices that provide

‘Enabling models of care that recognise older people’s strengths and empower them to maintain even small measures of independence when they are ill or frail. Paternalistic or disrespectful attitudes by professionals can have a devastating effect on the self-esteem and independence of older people who require services. Information and education about active ageing needs to be incorporated onto curricular and training programs for all health, social services and recreation workers as well as city planners and architects. Basic principals and approaches in old age care should be mandatory in the training of all medical and nursing students as well as other healthcare professionals’ (WHO 2002:39)

The WHO framework further identifies the need to provide this female dominated area of employment ‘with adequate working conditions and remuneration with special attention to those who are skilled and have low social and professional status’ (WHO 2002:49).
This macro level WHO policy document provides excellent guidance to policy makers across the world. However, as national economics vary across the world, it does not appear to take into account the cost of developing and implementing the policies at the 'grass root' level.

5. Conclusion
In both England and Germany, policy makers only have finite resources and the needs of older people need to be seen within the context of each country's health and social care commitments. Both country's policies have been developed aiming to provide efficient and effective care within a society where older people are living longer and with an increasing likelihood of needing care. Whilst the need for care or assistance with everyday activities increases with age, the majority of the ageing English or German population will not need to move into a care home. However, those older people whose health and social needs lead to the move into a care home can be expected to be doing so with increasing dependency levels. This clearly calls for those who are paid to care for older people living in a care home to be provided with the appropriate skills. To respect and reward each country's care home work force can also be seen to be treating frail older members of our society with dignity and respect. Only then will it be possible to realise the guidelines set out by the WHO (2002) which aim to enable an older person who is ill or living with a disability to maintain autonomy and a good quality of life.
Chapter 3
Care Work

1. Introduction

As in most healthcare services, the workforce in care homes in both England and Germany is predominantly comprised of women with intermediate to low education (Becker and Meifort 1997; Lawler 1991; Ludvigsen and Roberts 1996). The work they undertake is perceived by society to be rewarding emotional work comparable to nurturing, comforting and protecting, all factors which are seen to be beneficial to the recipient (Lee-Treweek 1996). This positive view of care work conflicts with the 'goalless and ultimately unsuccessful' reality often encountered by care staff who are employed in a low status and low paid occupation (Jack 1994: 79; Lee-Treweek 1996). Whilst nurturing, comforting and protecting may be seen to be intrinsic to the provision of care they are not necessarily factors which can be seen to be enabling or encourage autonomy. In order to facilitate autonomy and quality of life of residents in a care home the knowledge, skills and understanding of care staff is crucial as their competencies become an integral part of the daily lives that older people experience.

Care work is perceived to be an extension of women's domestic role; it is described as being heavy, dirty and low paid work (Lawler 1991; Lee-Treweek 1997). The actual provision of care to older people living in care homes in England and Germany occurs within an industry aiming to provide effective and efficient care in a manner which has been compared with a production process in a factory (Lee-Treweek 1997; Ungerson 2000). In contrast to assembling the body of a car in the 'body shop' of a car factory, the 'product' in a care home is the body of an older person assembled to be 'a totally silent, lounge-standard individual' (Lee-Treweek 1997: 56). In order to achieve this 'bodywork' within the given time, the provision of care involves 'emotional labour' and the use of 'emotional tools' (Eyers 2000a, 2000b; James 1989; Lee-Treweek 1997).

This chapter will focus on the actual provision of 'hands-on' care to older people who need assistance to perform everyday tasks to look after their body. Based on the
literature to date, this chapter will establish the link between bodywork, emotional labour and the time available in which care is produced.

2. Bodywork

Occupations ranging from doctors to care assistants in the healthcare industry, and fitness instructors to shoe-shop assistants, are involved in bodywork (Wolkowitz 2002). The physical tasks in these occupations are related to the human body and often involve direct bodily contact. The actual bodywork undertaken in care homes involves the intrusion into the very personal and private sphere of older people who are also coming to terms with a medical condition that impacts on their everyday lives. Living with a stroke, Parkinson’s or dementia, for example, are medical conditions that have an effect on an older person’s ability to independently undertake everyday activities that most adults take for granted.

The very personal bodily function of using the toilet to excrete urine and faeces is a situation that often depends on the assistance, guidance or support of a second person. The situation of care staff on such an occasion is described by Twigg (2000b), who points out that care staff providing care to older people in their own home recurrently identified dealing with ‘shit’ (the term used by Twigg in her article) to be difficult as the smell was hard to bear and had ‘an all pervasive, stomach churning quality that lingered about the person’ (Twigg 2000b:396). This part of bodywork may be difficult for care staff but what about the dignity and personal concerns of the older person? As this is an area that is not discussed within ‘polite society’, it is not an issue that is easily researched from the perspective of an older person. However, such an intrusion into the personal sphere of bodily functions is an aspect of life that every adult can be expected to empathise with, as it relates to a natural bodily function that we all experience. Whilst coping with incontinence may be unpleasant for care staff it must surely be perceived to be degrading and undignified for an older person, who was possibly incontinent because they did not have the autonomy to determine when they could use the toilet. In this instance the loss of autonomy could be seen to be related to both the medical condition of the older person and the skills of care staff.
Much of the bodywork undertaken in care homes is collectively termed as 'basic care' in both England and Germany and involves tasks perceived to be rudimentary such as washing, dressing and toileting an older person. The staffing levels determined by policy makers in England result in 'basic care' being predominantly provided by care assistants, whereas German policies result in a more balanced skill mix and basic care is provided by both qualified staff and care assistants. The division of labour between qualified staff and care assistants replicates the division of hospital nursing care identified by Lawler (1991:30-31) where nursing is divided into basic nursing and technical nursing.

Basic nursing is seen to originate from the physical needs of the patient, whereas the technical needs result from the consequences of a disease and/or medical intervention. However, many older people living in care homes can be seen to require a blend of basic and technical care as the move into a care home is a consequence of a medical condition which impinges on their ability to personally and autonomously perform activities of daily living. This, therefore, could be seen to blur the edges within the hierarchy of care work, which Twigg (2000b) describes to be prevalent in bodywork where care assistants undertake the 'dirty work' and the 'clean/technical' tasks are performed by qualified staff. The German approach of having equal numbers of qualified staff and care assistants providing 'hands-on' care to older people living in care homes indicates an acknowledgement of this mixture of 'dirty work' and 'clean/technical tasks' in the provision of care to older people living in care homes. As outlined in Chapter 2, in England, qualified nurses would seem to be placed higher than their German counterparts within the hierarchy of care work, as their role is more supervisory and managerial. As such, it can be expected that bodily contact is minimal and at most related to the administration of drugs and other medical procedures.

The 'dirty work' undertaken within care homes is identified to be low status work that is invisible (Lawler 1991; Lee-Treweek 1997; Twigg 2000a). The fact that it is invisible is not only because it happens behind closed doors or screens but also because it can be seen to be related to society's perception of traditional female roles where 'caring is central but poorly valued' (Lawler 1991:35). Furthermore, women
are often perceived to enjoy care work as it is seen to be an extension of their natural role (Lee Treweek 1997). This is further emphasised by the invisibility of the informal 'mothering skills' (Mason 1996; Ribbens 1994; Williams 2002), which are taken for granted and brought into the care home by a predominately female workforce.

Within the care home industry it appears to be assumed that women are naturally equipped to deal with bodily substances encountered in bodywork and that they are sympathetic and able to provide emotionally for others. The bodywork that is an intrinsic part of care work can be seen to be physically and emotionally taxing whilst being heavy, dirty and, as presented in Chapter 2, low paid.

The care services provided in a care home are, undeniably, mainly related to the provision of, at times, unpleasant bodywork to older people who are also living with a medical condition that impacts on their daily lives. Consequently it is to be expected that care staff need an understanding of these medical conditions such as stroke, Parkinson's or dementia and how they impact on an older person's everyday life. Only then can care staff be expected to adequately perform the bodywork to produce a 'lounge-standard product' within a given time as well as enabling older people to participate in the daily planning of their care and, where possible, undertake some tasks independently.

3. Emotional labour

The undertaking of bodywork as described earlier unavoidably evokes emotions in a care worker who is at the same time likely to be implementing emotional labour tools in the provision of care. This exemplifies the dichotomy encountered in emotional labour within healthcare. Hochschild (1983) identifies the fact that in order to survive in a job, such as that of a flight attendant for example, there is the need to detach oneself mentally from personal feelings that are defined to be similar to the sensory experience of hearing or seeing. As exemplified by the participant in Twigg's (2000b) research, this also includes smell. To detach oneself from the feeling of revulsion described earlier is a process that has to be learned and care assistants would appear to be expected to do this through experience at work. Care staff need to
learn to detach themselves from emotions such as the fear of death, which in healthcare is not perceived as a good outcome (Lee 2002). Yet death is to be expected within the working environment of a care home. Whilst, as described by Smith and Gray (2000), nursing students receive guidance and support from mentors and tutors in order to come to terms with the emotions experienced when in direct contact with patients throughout their training, care assistants have little to no access to training (Eyers 2000a) and can, at most, expect peer support. In contrast to student nurses, care assistants are not involved in an area of healthcare practice where the patient is expected to return home and the student to move on to other fields of healthcare. As Hochschild (1983) identifies, care home staff need to detach themselves from their own feelings in order to survive in the workplace. However, of all occupations in which emotional labour has been researched to date, it can be seen to be one of the few areas where a longterm interpersonal relationship between the ‘service user’ (older person living in a care home) and the ‘service provider’ (care staff) is unavoidable. Such a longterm relationship can be expected to involve a number of emotions including friendship, happiness, frustration, revulsion and sadness.

The dichotomy of emotional labour in care home work is related to the fact that whilst trying to detach themselves from personal emotions, care staff are also honing their emotional labour tools in order to meet the production targets set within the care industry. The daily routine for an older person living in a care home is as described by Valins (2002), who presents a very structured day which is determined by meal times and the shift patterns of care staff. Within this framework basic care is provided by a limited number of care staff and in both English and German care homes, the contact time between older people and care staff is restricted (Eyers 2000a). In order to meet the care needs of the people they are employed to care for within a tight time schedule, emotional labour skills are implemented (Eyers 2000a; 2000b; James 1989; Lee-Treweek 1997).

Emotional labour can be seen as demanding skilled work, as it is about ‘action and reaction, doing and being’ (James 1992:500). James defines it as ‘the labour involved in dealing with other people’s feelings, a core component of which is the regulation
of emotions' (James 1989:15). Within the care home as a work place, emotional labour tools are implemented as a means of manipulating an older person into being co-operative in order that care can be provided in the shortest possible time (Eyers 2000 a, 2000b). The 'emotional tools' used in care are identified to be; listening, gentle persuasion, firm direction, discomfort and force (James 1989:24) and represent a further development of Hochschild's (1983) groundbreaking work in emotional labour.

Emotional labour is perceived by Hochschild (1983) to be better understood and used by women and she makes the statement:

‘In general, lower-class and working-class people tend to work more with things, and middle-class and upper-class people tend to work more with people. More working women than men deal with people as a job. Thus there are both gender patterns and class patterns to the civic and commercial use of human feelings. That is the social point.’ (Hochschild 1983:21)

The established low status of bodywork indicates how the healthcare industry uses gender differences to its advantage but does not acknowledge the commercial value of such a gender difference. Staff who are able to facilitate and order emotions are seen to be of interest to commerce as such attributes keep customers happy and women’s emotional labour skills have become a sellable low priced commodity within the public sphere (Lee-Treweek 1996), a factor that is of great importance in the care home industry. The importance of this gender difference established by Hochschild (1983) is further researched within the healthcare industry by Smith (1992), Smith and Gray (2000), James (1989, 1992) and Lee Treweek (1996).

Smith’s work (Smith 1992; Smith and Gray 2000) focuses predominantly on the emotional labour and the training of student nurses and highlights the importance of acknowledging the role of emotions in hospital work. James (1989, 1992) based her research in hospice care and identified the use of emotional labour tools, developed throughout an individual’s lifecourse and in care work. This work has, for example, been expanded by Lee Treweek (1996) who undertook an ethnographic study of care home staff where she observed how order was created through kindness, nurturance and knowledge (Lee Treweek 1996:120). The relationship between older people living in care homes and care staff is seen to be reciprocal, intimate and to mimic
family bonds (Lee Treweek 1996; Caris-Verhallen 1999). Smith and Gray (2000) also report how student nurses referred to family relationships when relating their feelings about their experiences nursing hospital patients. This indicates how emotional labour skills developed within the personal family could be transferred to the work place ‘family’.

The outcome of emotional labour depends on how skilfully the care staff deal with encountered situations (James 1992). The constraints experienced by care home staff are compared to those of a factory worker as in both cases, it is about the process and order. Care assistants are seen to produce a clean, orderly, quiet resident without too much thought or personal input. Knowing the older person is seen to equate to knowing ones materials in the manufacturing process and care assistants consider their ‘product knowledge’ to be superior to that of the qualified nurse working in a care home. Care work was described as an ongoing production process rather than a set of person centred acts (Lee-Treweek 1997).

The use of emotional labour tools are undoubtedly central to the production process described by Lee-Treweek (1996, 1997) and can consequently be seen to impact on the lives of older people living in care homes. However, the ‘handle’ used to gain a firm grip on the emotional labour tools used by care staff can be seen to be connected to communication strategies in the provision of care.

4. Communication

Within care homes, the main function of communication is to ensure the smooth execution of care tasks (Sachweh 1999). Throughout the healthcare industry, communication can be seen to be important in service delivery, whether to establish a diagnosis, provide treatment or care. There would appear to be an acknowledged need for effective communication, which calls for an exchange of information between healthcare worker and patient. This is reflected in the literature on communication in the healthcare sector with a wide range of text books (e.g. Burnhard 1997; Silverman and Kurtz 1998; Wondrak and Robert 1998) aiming to provide healthcare staff with the skills needed to communicate successfully with both their colleagues and patients. Other literature on communication is based in
psychology (e.g. Rungapadiachy 1999) and linguistics (e.g. Coupland and Coupland 1995) and there is little reference made to the need to adapt communication to the specific needs of older people living in care homes. Lee-Treweek (1997) indicates that from the perspective of care assistants, communication with the older people they are employed to care for is perceived to be ‘useless’. However, Davies (2001) acknowledges the importance of empowering older people living in care homes by providing opportunities to make choices and decisions relating to their everyday lives.

Autonomy for an older person living in a care home may not mean they can wash their own face but it does mean that they have the autonomy to ask or indicate that they would like to have their face washed (Davies 2001:85). To indicate that they would like to have their face washed implies the need for communication between care staff and the older person they are caring for. In the interface between an older person living in a care home and care staff, communication can be seen to be very much part of meeting health and social care needs.

The literature review could not identify any publication clearly establishing the link between the use of emotional labour tools and communication skills. However, Sachweh (1999) undertook linguistics-based research in a care home in the Black Forest, Germany. Communication between care staff and older people living in the sample home were both observed and tape-recorded and the data collection was complemented by interviews with care staff. The analysis of the communication between care staff and the older people living in the home focused on the selection of words, use of dialect, construction of sentences and tone of voice. In this research, emotional labour was not perceived as an issue by the researcher, nonetheless, the report of her findings includes descriptions of communications that can be identified as emotional labour. This is exemplified by Sachweh’s (1999:113) statement that ‘it is undeniable that the main function of communication in medical institutions is to ensure the smooth execution of a care task’. It is further pointed out that communication strategies are used to ensure effective care and ‘routine’ and ‘ritual’ communication patterns are identified. The use of compliments and praise and how
this resulted in compliance were identified, thus implicating the use of the emotional labour tool described by James (1989:24) as ‘gentle persuasion’.

A thread that runs throughout Sachweh’s work is the concept of ‘baby talk’ and its effectiveness in the provision of care. ‘Baby talk’ is the description of the communication strategy psychologists and linguists have observed being used by care staff when providing care to older people, and is seen to have the following function:

‘In communication between adults, baby talk can reinforce the speaker’s own feeling of nurturance, communicate affection, indicate playful intimacy, suggest senility or sickness by signalling the childhood status of the adult and provide a wealth of possibilities for irony, humour and insult’ (Caporel, Lukaszewski and Cuthbertson 1983:747)

‘Baby talk’ is one of a range types of ‘talk’, and is seen to be used in communication with hospital patients, foreigners and pets. As such ‘baby talk’ can be linked to the use of emotional labour tools and the interface between care staff and older people requiring care. It further implies that care staff talk down to care recipients who are dependent on their assistance and support.

Sachweh (1999) makes reference to how care staff in the sample home behaved like mothers in both verbal and non-verbal communication with the older people living in the home. ‘Baby talk’ was observed to be used mostly by women aged around 40 and from interviews with care staff it was identified that the use of ‘baby talk’ was related to care staff’s lifecourse experiences, as the majority of female respondents had brought up children before taking up employment in the care home. To be perceived as a ‘good mother’ by the older people they cared for was one of the greatest compliments care staff could receive (Sachweh 1999:175). Male staff in the sample were seen to be less likely to use ‘baby talk’ in either their tone of voice or selection of words. The findings further indicate how the tone of voice can be used to be either friendly and supportive or fearful and threatening. Whilst not identified by Sachweh as such, the tone of voice used when communicating with an older person can be linked to the use of the emotional labour tools. The tone of voice can be encouraging or threatening and consequently be part of the emotional labour tools such as gentle persuasion, firm direction, discomfort or force. This is exemplified by
Sachweh's (1999) description of the tone of voice used to communicate with non-compliant older people living in the sample home.

The research undertaken by Sachweh can be seen to indicate the link between emotional labour and communication whilst also signalling the influence of the lifecourse of care staff on the skills they use in the provision of care to older people living in a care home. A further valuable finding from Sachweh's work is that she clearly points out that communication between care staff and older people can be seen to be predominantly task orientated (Sachweh 1999), which also indicates that the use of emotional labour in order to provide basic care within time limits disempowers an older person in the process.

5. Time to care
The policy framework surrounding the provision of institutional long-term care in England and Germany determines the contact time in which 'hands on care' can be provided to older people who live in care homes. This unavoidably calls for time management skills in care staff. Many of the women employed in care homes can be expected to have developed skills within the sphere of their family life that are useful within the care home environment. Within their own home, many multi-tasking women are accustomed to managing the household time budget and fragmenting their own time into 'time bites'. Jurczyk (1998:298) describes how women develop into 'time acrobats, negotiating a tightrope, performing risky balancing acts without a safety net'. These balancing acts are a crucial element of care work. In order to maintain their balance on the tightrope, care staff need to undertake emotional labour. In order to effectively use emotional labour tools, communication skills are invaluable. The combination of these skills are important to care home work in both England and Germany as budgeting time can be seen to be crucial to the successful production of care.

The policies relating to care funding in both countries (Chapter 2) indicate that the amount of time available to provide care to individual older people living in care homes is related to the funding available for an English and German care home placement. This in turn, determines the staffing levels, which in turn influence the
available contact time between older people living in care homes and the staff employed to care for them. In Germany, the fear has been expressed that the longterm care insurance system introduced in 1995 has had a negative effect on older people as care is seen to have become a product to be handled on the open market, where the service provider with the lowest price may be expected to gain the customer (Meyer-Kriechenbaum 1997). In order to provide care at a competitive price, Meyer-Kriechenbaum argues that the quality of care will be compromised as cost becomes the lead factor in the selection of a service provider and only minimal basic care can be expected to be provided.

The funding available to each individual in a German care home (Chapter 2) is determined by a care assessor who categorises an older person based on the amount of time it is assumed will be required to meet the individual’s needs. This can be interpreted to be care rationing, as only basic care needs can be met within the resulting contact time between care staff and an older person living in a care home. Within the framework of care provision under the German care insurance system, Meyer-Kriechenbaum (1997) points out that in order to be able to provide economical care, well trained care staff who can organise and prioritise care effectively are a prerequisite. This implies that the better trained the care staff, the more likely they are to be able to provide a minimal basic care within minimal time. However, Brüggeman (1997), also considered this issue in the provision of care, and indicates that no scientific evidence was available at the time to prove this hypothesis. The positive impact of qualified staff on the quality of care experienced in a care home is identified by Harrington et al (2000), although their research relates to the hours of medically orientated qualified nursing input. They do not relate to the issue of aspects of time to complete a care task, such as washing and dressing an older person who has suffered a stroke.

Later research reported by Wingenfeld and Schnabel (2002), where data were collected in 27 German care homes in order to provide further insight into the amount of time needed to provide care in Germany, makes no distinction between qualified staff and care assistants and relates generally to ‘care staff’ (Betreuungskräfte). Whilst this research does not indicate the difference that staff
training makes in the time required to provide care, it does indicate that the amount of time needed to provide care is greater than that stipulated within the framework of the German longterm care insurance regulations (Chapter 2). The findings from the sampled homes indicate that 83 minutes per care recipient per day was the average time needed to meet what was seen to be the absolutely necessary care needs. The data further indicated that there was little correlation between the care category (Chapter 2) an older person had been assessed to be in and the actual amount of time spent on their care, and in this article care needs are described as being ‘vast and complex’ (Wingenfeld and Schnabel 2002: 26).

Instruments to determine the care time for older people living in care homes have been developed and implemented, for example, in Canada, the United States of America and Switzerland (Tilquin et al 1997). These instruments are listed by Tilquin et al (1997:1) to be:

- CTMSP - Classification par types en milieux de soins prolonges = classification according to types in area of longterm care
- PLAINR - Planification informatisée des soins infirmiers requis = computerised planning of the care required (in longterm care facilities)
- RAI-RUG - Resident Assessment instrument – in connection with RUG-Resources Utilisation Groups - resident groups with the same use of resources

The development of all these highly refined instruments to measure the time needed to care for an older person living in a care home are based on the actual performance of the care task and would appear not to take the wishes of the care recipient into consideration (Tilquin et al 1997). The actual methodology appears complex, for example PLAINR, identifies approximately 70 subtasks and as Tilquin et al (1997) point out, in the case of PLAINR some elements are treated as ‘trade secrets’. The time budgeting that results from the use of these systems appears to result in the cost efficient production of care for the service provider i.e. the care home proprietor, the functional execution of care tasks by care staff and the total loss of autonomy for the older person living in a care home. The RAI-RUG system is under development and as pointed out by Tilquin et al (1997), in future the system must take the psychological needs of older people into consideration.
The RAI-RUG system has also been researched and developed in England to effectively differentiate between ‘standard’ and ‘enhanced’ qualified nursing time in care homes in order to form the basis of the NHS funding of a nursing element of a care home placement (Carpenter 2001). However, in the workload analysis, it was found difficult to take issues such as environmental factors associated with the care provision like case mix, facility size and services available into consideration. It would appear that following a single assessment to establish what is described as a ‘comprehensive evaluation of a resident’s clinical characteristics, such as functional ability, cognitive status, health condition and psychosocial well being’ (Carpenter 2001:3), a care plan can be devised. Once care staff are familiar with the system, it is claimed that it will take an average of four minutes to complete the assessment (Carpenter 2001:3). Undertaking an assessment within four minutes implies that little communication is expected with the care recipient and that the procedure is dependent on the knowledge of the assessor and could potentially be completed sitting at a desk reading the daily reports written about the individual older person. This system is task and cost orientated, aiming to produce as many ‘lounge-standard products’ as possible within the shortest period of time. Providing a service to older people in this manner clearly does not consider their individuality or autonomy and completely overlooks their social and emotional needs. It is a process that devalues the life of older people and implies that as little as possible should be spent on providing institutional care in later life.

The report on the research undertaken to establish the validity of the RAI-RUG system (Carpenter 2001) was funded by the Joseph Rowntree Foundation in order to contribute towards the development of the funding criteria for the NHS contribution for the qualified nursing input for a care home placement, introduced in October 2002. This intrinsically links the funding of care in England to time in a similar way to the German system. However, unlike the German funding system which differentiates between ‘care costs’ and ‘hotel costs’, the English system differentiates between nursing and social care incorporating the hotel costs in the social care costs and reducing the role of qualified nursing to pure management and supervision. In contrast to Germany, in England, the contact time between care staff and the older
people they are employed to care for is not overtly determined by the policy framework. Staffing levels are determined by the care home Inspectorate and the ratio of care staff to residents is influenced by the dependency level of the older people living in the home (Chapter 2, Section 2.3).

In Germany, the quality assurance of care provisions is included in the act of parliament which regulates the funding and provision of long-term care [§80 SGB XI] (Klie 1996). In England the Care Standards Act (DH 2000) has resulted in National Minimum Standards (DH 2002) being set and enforced since April 2002 aiming to improve the environment in which care is provided and the training standards of staff employed to provide care. In order to meet the set standards in many English and German homes, procedural guidelines have been established aiming to ensure 'best practice' by setting individual standard procedures to meet assessed needs and provide efficient, effective care to older people (Hurley 1995; Cook et al 1998; Klein 1998). This can be seen to be a result of the implementation of quality management in accordance with industrial standards (Frosch and Zimmerscheid 1995). Procedures that are developed within the quality assurance systems provide guidance on performing specific tasks within a given time frame and are exemplified in an article published in a German journal widely read by care home managers. In this article, an example on the procedure to assist a resident at mealtime is given; the task is to be undertaken by a qualified member of staff within an average time of 45 minutes (Frosch and Zimmerscheid 1995). Considering the time element in German care funding, this could result in nearly half of the daily care time being taken up by a single meal for someone in Category II (minimum of two hours for basic care) indicating a theoretical procedure that must in reality be difficult to implement.

Whilst not described in the procedure the task of assisting an older person with a meal will incorporate a combination of bodywork, emotional labour, communication and time management skills and would take place in what Davies (1994) describes to be 'process time' as opposed to 'clock time'. Davies relates the issue of process time in the provision of care to a mealtime and describes how an older person's brain and motor skills may not co-ordinate and that it takes time to chew and swallow food. How long that will take can not be predetermined and the 'process time' is therefore
variable and consequently difficult to measure, despite the fact that within an institutional setting, eating is an activity structured by actual clock time. The example of quality assurance procedures outlined by Frosch and Zimmerscheid (1995) indicates the conflict between ‘process time’ and ‘clock time’ within an institutional environment and indicates the importance of time in the provision of care.

6. Conclusion
The provision of care to older people living in a care home is clearly dependent on the skills of the staff employed to provide care. The combination of bodywork, emotional labour, communication and time management skills is key in this undervalued area of employment. The issue of social hierarchy is intrinsic throughout both bodywork and emotional labour and ‘hands-on’ care is closely linked to direct bodywork and the experience of emotional labour. Such direct ‘hands-on’ care would appear to be on the lowest scale of both the emotional labour and bodywork hierarchy, yet it involves the most important aspect of the care service provided to older people living in a care home and is an area where, within the restrictions of institutional life, autonomy could be facilitated. This indicates the importance of employing and training suitable staff who have the skills and knowledge to perform bodywork to a high standard within a given time whilst enabling older people to maintain autonomy.
Chapter 4
Employed and Trained to Care for Older People

1. Introduction
The care home industry of England and Germany represents a segment of a female dominated healthcare work force (Hugman 1991; Halford 1996). In accordance with the policy frameworks of both countries, the staff employed to undertake the bodywork required to meet the needs of older people are either qualified nurses or unqualified care assistants, respectively often seen as representing a skilled and an unskilled workforce, both of which comprise a high proportion of women in mid-working life (Eyers 1998).

In both England and Germany, educational attainment, family background, gender and place of residence determine the choice of occupation made by a young person (Callaghan 1998; Roberts et al 1994; Saunders 1995), which then influences their experiences in the workforce throughout their lives. However, there are fundamental differences between the experiences of younger people entering the English and the German workforce as there are historically rooted differences in the education and vocational training in the two countries (Roberts et al 1994). The selection of routes towards employment and consequently towards establishing an existence in the labour market of either country are described by Roberts et al (1994) to be: academic, skilled, non-skilled and the experience of unemployment.

The abilities of ‘skilled’ and ‘non-skilled’ care staff employed to work in care homes have an impact on the quality of life experienced by the older people who live there and the training of care staff is therefore of extreme importance. This chapter will consider the role of women in the workforce, compare the diverging cultures of occupational training through taking a focused view on the training available for qualified staff and care assistants working in English and German care homes.

2. Women in the workforce
Whether in England or Germany, as Arber and Gilbert (1992) point out, women’s lives are undeniably shaped by the composition of their family and their stage in the course of life. Contrary to Hakim’s theory that women choose early in their
lifecourse to be either career or family orientated (Hakim 1996), Procter and Padfield (1999), in their critical research on this theory, establish that women change and adapt throughout their lifecourse to meet the needs of career and family.

In the UK, 65% of women are employed, whereas in Germany 57% are employed, with a relatively high percentage in part-time employment in both countries (Table 4.1). Whilst within the EU there are no great differences between the proportions of economically active men and women in the age group 16-25, there are marked differences between men and women over the age of 25 as many women retract from the labour market to raise a family (Pollock 1997). Becoming a mother marks a transition many women make in the workforce. As mothers, women in England tend to adapt their role in the workforce and whilst some remain in full-time employment others reduce their hours of employment with the same employer or find alternative employment that enables them to work part-time (Himmelweit and Sigala 2002).

Table 4.1 Overview of labour market statistics of 15-64 year olds in 1999 (percentages)

<table>
<thead>
<tr>
<th></th>
<th>UK Total</th>
<th>UK Males</th>
<th>UK Females</th>
<th>German Total</th>
<th>German Males</th>
<th>German Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment rate</td>
<td>71</td>
<td>77</td>
<td>65</td>
<td>65</td>
<td>72</td>
<td>57</td>
</tr>
<tr>
<td>Part-time employment</td>
<td>25</td>
<td>9</td>
<td>44</td>
<td>19</td>
<td>5</td>
<td>37</td>
</tr>
</tbody>
</table>

Source: Eurostat 2001:119

Pre-existing social values, family commitments and domestic life occupationally restrict many women. This is in contrast to men who, irrespective of their family commitments are seen to be able to achieve their employment aims (Compton and Harris 1998). Hewitt (1993:4) states that the hours men work determines how much time they spend with their family, whereas the time women spend caring for their family determines how much time they have available to be employed.

Whilst women over 25 may leave the employment market when they have children, many also return at a later stage when their child care responsibilities allow. Both qualified staff and care assistants often return to work after taking a career break to raise a family. The age distribution of care staff (Becker and Meifort 1997; Eyers 2000b; Rainbird et al 1999) indicates that many women in this area of employment are in mid-working life and work part-time (Becker and Meifort 1997; Garner 1998). In her report on care assistants, Garner (1998) shows that the flexible working hours
offered in care home work are attractive to care assistants as they enable women to earn money whilst still meeting family commitments.

Within the care industry, women represent over 90% of the workforce (Hugman 1991; Halford et al. 1997). This places care home staff within the workforce of women who are over-represented in inferior post-industrial employment, especially amongst part-time employees (Dale and Bamford 1988; Fagan and Rubery 1996). Thus women, for whom intrinsic factors of employment, such as job satisfaction and a supportive peer group, are important (deVaus and McAllister 1991), play a vital role in providing a flexible workforce to the care home industry. The majority of employees in the care home industry can be perceived as part of the secondary labour market described by Dale (1985), since there is no job ladder, no promotion, very little training and the wages are low for care assistants.

Care staff in both England and Germany perform the same tasks in similar environments of institutional long-term care. However, the education and training experienced within the care home industry of the two countries differs. In England, in most occupations ‘on-the-job training’ focuses on younger rather than older employees and on full-time rather than part-time or temporary staff (Dale and Bamford 1988). In Germany, where vocational training is the standard prerequisite for employment in most occupations (Esping-Andersen 1993), there are no formal training provisions for care assistants employed to provide a service to dependent older people. This contrasts with the development of accredited training available to English care assistants in the form of NVQ (National Vocational Qualifications). Germany traditionally has strong vocational training policies whilst England has facilitated the development of a ‘large low-waged service proletariat’ (Esping-Andersen et al. 1993; Regini 1997). The picture presented for care assistants in the two countries is paradoxical and initially appears contrary to the standard comparisons of occupational training in the two countries.

Many qualified staff and care assistants chose to enter the care home industry in both England and Germany whilst combining work with raising a family (Eyers 2000b). However, it is an area of employment that, most markedly in England, is greatly
disadvantaged as the extrinsic rewards, such as pay and terms and conditions of employment, do not reflect the importance of care work to society. Training and rewarding care home staff adequately could not only potentially improve the image of care work and contribute towards retaining care staff it would be likely to also improve the care experience by older people living in care homes.

3. Diverging occupational training cultures
The route into the labour market for school leavers in England and Germany goes through contrasting terrain. The key differences are that in England the structure of the route is 'untidy' (Roberts et al 1994) and 'weak' (Evans and Heinz 1994), whereas in Germany the route is 'regulated' (Roberts et al 1994) and 'strongly institutionalised' (Evans and Heinz 1994). However, neither system can be seen to guarantee young women or men, a self-determined, future orientated preparation for the labour market (Evans and Heinz 1994). A further contrast between England and Germany can be observed in the training of healthcare professionals, which in England is governed by the individual professional organisations, such as the Nursing and Midwifery Council (NMC), and in Germany is determined by government legislation (Roberts et al 1994).

3.1 Formal occupational qualifications
Within European Union (EU) policies, vocational training is seen as an educational process targeting an existing labour market to create, alter or improve the skills of the workforce, and especially the unemployed. It is thereby directed primarily at prospective members of the workforce i.e. young people (Moschonas 1998). Vocational training is becoming an increasingly important issue within the English care home industry and it is implemented within the German educational system, which has encouraged the training of 'AltenpflegerInnen' (Older Person's Carer = OPC) over the last decade. Germany has expanded the number of training facilities for OPCs, encouraging both school leavers and mid-life adults to undergo vocational retraining (Brockschmidt 1993; Becker and Meifort 1997; Voges 2002). This illustrates how a relatively young profession has been encouraged to develop and take on the responsibility of care for dependent older people within Germany's well established culture of occupational training. In England new government policy to
improve care standards (Chapter 2) is leading towards more care assistants gaining NVQ.

A young person entering the world of employment in Germany will normally participate in a regulated and standardised occupational training programme which links employment with regular attendance at college, and will culminate in a certificate that will be the foundation for their further career. For example in 2002 over 530,000 young people were actively participating in such occupational training programmes, whilst 12,000 young people were still searching for a suitable placement and 5,600 training placements were vacant (Bundesarbeitsamt 2003). In a recent report, the Bundesarbeitsamt [Federal Department of Employment] expressed concern about the shortage of training places in 2002 and pointed out that it was actively developing policies to encourage employers to take on trainees.

The emphasis on occupational training for school leavers reflects the traditional German attitude towards occupational training, where formal qualifications are the standard prerequisite for employment in most occupations (Esping-Andersen 1993). These formal qualifications provide a clear structure through which to enter the world of employment. The tripartite school system in Germany, which has remained relatively unchanged for over 100 years, rigidly determines entry into class and status systems at all levels (Blossfeld et al 1993; Roberts 1994). This highly regulated vocational training system, which links education to the labour market, determines the career development for German employees (Blossfeld et al 1993; Esping-Andersen et al 1993). Vocational training combines theory with practice and establishes standardised learning conditions for clearly defined occupational groups, this enables the trained workers to have the opportunity to establish a career path. However, Germany has had to develop a degree of flexibility in the dual system of vocational training and education to accommodate 'sideways movement' and further career opportunities (Evans and Heinz 1994).

Access to employment throughout working life in Germany is determined by training certificates (Esping-Andersen et al 1993). Participation in continuing career training following the completion of vocational training is encouraged by German
government policies which entitle employees to paid 'Bildungsurlaub' [leave for continuing professional development]. However, participation in further education and training after gaining vocational qualifications is not regulated in Germany and is solely dependent on the initiative of individual employers and employees, consequently training tends to be reactive and ad-hoc and concentrate on specific occupational groups (Regini 1997).

As a consequence the importance of qualifications results in a clear distinction between unskilled, semi-skilled and skilled workers in Germany (Blossfeld et al 1993). Care staff are employed in a low status and low-paid occupation (Jack 1994), with employment as a care assistant perceived to be unskilled (Lee-Treweek1997) and as such it is easy to enter as a second career. This could, as Blossfeld et al (1993) point out, lead to an over representation of older workers from declining occupations joining the unskilled workforce of the care home industry. However, despite the occupational training culture that prevails in Germany, it is also acknowledged that many young people entering the labour market seek employment in unskilled work. The proportion of German women in unskilled jobs is high from school leaving age up to their early twenties and then decreases as women interrupt their employment because of family commitments (Blossfeld et al 1993).

In England, the current government's aim is to keep young people in education in order to gain primarily academic qualifications. However, whilst the aim of policy makers is to enable young people to stay in education and training, there is evidence that qualifications are reducing in value (Jones 2002). The erosion of traditional craft apprenticeships for men and clerical jobs for young women has led to many young people taking on employment in unskilled jobs, for example within retail. Such jobs are often seen to be insecure, part-time and low-paid (Jones 2002). This does not provide a clear entrance to the world of employment and exemplifies the weak and untidy route indicated by Evans and Heinz (1994) and Roberts (1994). In England, the qualified members of care home staff will have experienced a structured route into employment, via their training as nurses. However, the care assistants are likely to have experienced the untidy route into their employment.
NVQ training in England is gaining in importance in the English care home industry, whilst within the German educational and training system the training of OPCs has been greatly encouraged over the last decade. Germany has expanded the number of training facilities for OPCs, encouraging both school leavers and mid-life adults to undergo vocational retraining (Brockschmidt 1993; Becker and Meifort 1997; Voges 2002). This illustrates how a relatively young profession has been developed to take on the responsibility of providing care for dependent older people.

3.2 On-the-job training

The past lack of a ‘training culture’ in England has resulted in the development of systems, such as National Vocational Qualifications, that provide vocational training (Evans and Heinz 1994; Roberts et al.1994). Data from Eurostat (Table 4.2 and 4.3) indicate that in the United Kingdom, training courses are a more integral part of employment than in Germany, where employees over 25 are expected to have gained the required qualifications for their job. As Table 4.2 indicates, the likelihood of having participated in training within the last four weeks is greater in occupations that require upper secondary or tertiary education. Whilst the data does not relate to specific occupations, Table 4.3 shows the gender differences in training participation with a higher participation of women than men in the UK. The care assistants

Table 4.2: Percentage of UK and German 25-64 year old employees who participated in training in the last four weeks, by level of educational attainment in 1999

<table>
<thead>
<tr>
<th></th>
<th>UK</th>
<th>Germany</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than upper secondary</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Upper secondary</td>
<td>18</td>
<td>6</td>
</tr>
<tr>
<td>Tertiary</td>
<td>33</td>
<td>8</td>
</tr>
</tbody>
</table>

Source: Eurostat 2001:118

Table 4.3: Percentage of 25-64 year olds who participated in training in the last four weeks, by gender and country in 1999

<table>
<thead>
<tr>
<th></th>
<th>UK Male</th>
<th>UK Female</th>
<th>Germany Male</th>
<th>Germany Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participated in training</td>
<td>16</td>
<td>22</td>
<td>6</td>
<td>5</td>
</tr>
</tbody>
</table>

Source: Eurostat 2001:118

employed in the English and German care home industry can be expected to fall into the group with ‘less than upper secondary’ educational attainment. Whilst the percentage of 25-64 year olds employees undertaking some kind of training within
four weeks prior to data collection is higher in England than in Germany, the overall percentage of employees participating in training is low in both countries.

An important aspect indicated by these data is that there would appear to be a greater interest or availability of training courses in England than in Germany. However, as the data collection focuses on 'training in the last four weeks' it can be assumed that in Germany, for example, this excludes people who are undergoing a full three-year training program such as that to qualify as an OPC. On the other hand it will include English care staff who have participated in very brief training courses which may have lasted only a few hours, such as Health and Safety Training, or qualified nurses attending one-day seminars as part of their continuing professional development. Without further background information this data creates the impression that in England, employers provide more occupational training than their German counterparts. However, there is increasing emphasis on continuing professional development now being implemented by professional organisations, such as the Nursing and Midwife Council (NMC 2003), therefore the figures are likely to reflect a true picture.

Since April 2002, in keeping with national standards set for care homes (DH 2002), workplace training is being provided in English care homes as all newly employed care staff must participate in an induction program. This programme, outlined by the Training Organisation for the Personal Social Services (TOPSS), is set to take place

**Table 4.4: Overview of TOPSS Induction Training Programme**

<table>
<thead>
<tr>
<th>Induction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit 1: Understand the principles of care</td>
</tr>
<tr>
<td>Unit 2: Understand the organisation and the role of the worker</td>
</tr>
<tr>
<td>Unit 3: Understand the experiences and the particular needs of the service user groups</td>
</tr>
<tr>
<td>Unit 4: Maintain safety at work</td>
</tr>
<tr>
<td>Unit 5: Understand the effects of the service setting on providing services</td>
</tr>
</tbody>
</table>

Source: TOPSS 2002
over a period of six-weeks. It meets statutory Health and Safety requirements and provides care staff with a rudimentary understanding of the tasks they are expected to perform (see Table 4.4).

The induction program has a formal structure with learning outcomes but it takes place on-the-job and it does not provide any formal occupational qualification for care staff to work with older people. This, within itself, questions how employers and employees value the induction period. A high turnover of staff who are expected to be provided with induction training within the first six weeks of employment could be seen to place a considerable burden on a resource-restricted, profit-making care home industry. In Germany there is to date no formal requirement for care assistants to participate in an equivalent form of induction to employment in a care home.

3.3 Workplace learning

The skills to work in any workplace are not just related to theoretical knowledge, formal qualifications and statutory health and safety training. Much of the learning that takes place at work is in actual fact difficult to measure and accommodate, as it

<table>
<thead>
<tr>
<th>Table 4.5 The differences between formal learning and on-the-job workplace learning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Formal learning is intentional but work place learning is unintentional</td>
</tr>
<tr>
<td>2. Work place learning has no formal curriculum or prescribed outcome</td>
</tr>
<tr>
<td>3. During on-the-job training the learning outcomes are predictable whereas</td>
</tr>
<tr>
<td>workplace learning outcomes are much less predicable</td>
</tr>
<tr>
<td>4. On-the-job learning is largely explicit (the learner is expected to be able</td>
</tr>
<tr>
<td>to articulate what has been learnt e.g. in an examination) whereas workplace</td>
</tr>
<tr>
<td>learning is often implicit or tacit (learners are often unaware of the extent of</td>
</tr>
<tr>
<td>their learning)</td>
</tr>
<tr>
<td>5. In on-the-job training the emphasis is on the content and structure of what is</td>
</tr>
<tr>
<td>taught, whereas workplace learning the emphasis is on the learner as worker</td>
</tr>
<tr>
<td>6. On-the-job training tends to focus on individual learning. Workplace learning is</td>
</tr>
<tr>
<td>more often collaborative or collegial. Consequently workers invest much of their</td>
</tr>
<tr>
<td>personal identity in work and find these defined and redefined by the local work</td>
</tr>
<tr>
<td>culture i.e. by ‘the way we do things here’</td>
</tr>
<tr>
<td>7. Formal classroom learning is uncontextualised, while on-the-job learning is</td>
</tr>
<tr>
<td>somewhat contextualised e.g. training for general industrial standards. However,</td>
</tr>
<tr>
<td>workplace learning is contextualised as outlined in point 6 and includes emotive,</td>
</tr>
<tr>
<td>cognitive and social dimensions of workers experience in advancing their learning</td>
</tr>
<tr>
<td>8. Learning in formal education and in on-the-job training is seen typically in</td>
</tr>
<tr>
<td>terms of theory and practice. Workplace learning seems to be viewed as seamless</td>
</tr>
<tr>
<td>know how. In the Aristotelian sense of ‘phronesis’ or practical wisdom</td>
</tr>
<tr>
<td>9. In educational institutions and on-the-job training, learning is typically</td>
</tr>
<tr>
<td>viewed as more difficult than learning skills. Workplace learning, as the</td>
</tr>
<tr>
<td>development of competence or capability via a suitably structured sequence of</td>
</tr>
<tr>
<td>experience, does not operate with the knowledge skills distinction</td>
</tr>
</tbody>
</table>

Based on Beckett and Hager 1997:35-36

48
is 'invisible learning'. As Beckett and Hager (1997) have identified, part of lifelong learning is 'on-the-job' learning that is both informal and often invisible, their understanding of 'on-the-job' learning excludes the provision of on-the-job training described in the previous section. Nine key differences between formal learning and 'on-the-job' workplace learning (Table 4.5) have been identified by Beckett and Hager (1997).

These differences indicate the importance of on-the-job learning in an area that involves skills required in the care of older people. They imply the need to acknowledge the role and value of on-the-job learning. Workplace learning is, on the one hand, described to be undervalued by the formal education system, but, on the other hand, it is seen as an important learning process for professionals such as teachers, nurses, lawyers and surgeons who need to 'read' situations in order to make decisions 'when the action is hot' (Beckett and Hager 1997:34).

Qualified staff in England and Germany will have experienced formal learning whilst the care assistants, who require no formal qualifications, can be expected to have primarily learnt to care for older people at the work place. Both formal and invisible learning are likely to influence the quality of life experienced by older people living in a care home as they jointly inform the decision making process of both qualified staff and care assistants when planning and undertaking bodywork, and implementing emotional labour skills. However, since care assistants in England and Germany have little formal training, the invisible learning that takes place at work may be of greater importance.

4. Training Care Assistants in England
Care assistants in England at present (summer 2003) are not required to have any qualifications. However, by 2005, as part of implementing the Care Standards Act 2000, the Department of Health has set out the 'Care Homes for Older People. National Minimum Standards' (DH 2002) which aims to improve the provision of service in care homes. The document formally acknowledges the importance of training by setting Standard 28.1 which states: 'A minimum ratio of 50% trained members of care staff (NVQ Level 2 or equivalent) is to be achieved by 2005' (DH
However, whilst proprietors acknowledged the value of staff training, research undertaken in the late 1990's indicated a high turnover of care staff and low participation in NVQ training (Dalley and Dennis 2001; Eyers 2000a,b; Garner 1998).

The issue of training can be seen to be of value to care assistants, as for many women, training could potentially lead to better income and a career path. It could also provide care staff with the confidence needed to cope with difficult situations encountered in the provision of care to older people. Coping with confused older people or being confronted with someone dying is not a situation one can normally expect to experience in everyday life. However, on the basis of the medical condition of care home residents described in Chapter 2. Section 4.1 and the bodywork described in Chapter 3. Section 2, it is to be expected that within the working environment of a care home, difficult and unpleasant situations will be encountered. This calls for a training programme that enables care staff to develop skills that will enable them to deal with these situations.

The National Council for Vocational Qualifications was set up in 1986 and has established four NVQ levels. A participant in the first level is working towards the qualification classified as ‘NVQ Level 2’. However, this status is ambiguous as it is not clearly stated whether or not the trainee attends college on a regular basis or receives a set amount of ‘in-house training’ (Oulton and Steedman 1996). The overall length of the training period also appears to be undetermined. To achieve ‘Level 2’ does not require an externally set or graded examination. An assessment is undertaken either by the trainee’s own lecturer or the work-place supervisor (Oulton and Steedman 1996). Davies et al (1999) found that although qualified staff were acquiring qualifications to provide NVQ training in care homes in England, there were not many opportunities for unqualified staff to actually undertake NVQ training. This implies that in the everyday routine of care home work, there is not enough time to facilitate ‘in-house’ NVQ training and assessment.

The English NVQ training system that care home staff participate in was, as of 1999, under the auspices of the TOPSS. As the name implies this governmental
organisation outlines the training of staff who are involved in providing a social service to people and incorporates the National Training Organisation for Social Care. The training related to care home staff ranges from care home management to the induction of care assistants (TOPSS 2001).

Within the document ‘Care Homes for Older People. National Minimum Standards’ (DH 2002), NVQ training is key to the provision of service. To facilitate and ensure training in social care, the General Social Care Council (GSCC), which works together with TOPSS, has been established. Both organisations are expected to develop national training standards for care staff, ranging from induction competencies to management training (DH 2002 a:x). TOPSS is required to comply with any code of practice published by the GSCC, which is in the process of developing a register of social care staff. Whilst the content of the training modules can be seen to promote independence, the emphasis is on social care and excludes any material relevant to the specific needs of an older person or their medical condition.

The aim of NVQ training is to provide levels of competence within an occupation and an NVQ level 2 is defined by the Department for Education and Skills to be:

‘Competence which involves the application of knowledge in a significant range of varied work activities, performed in a variety of contexts. Some of these activities are complex or non-routine and there is some individual responsibility or autonomy. Collaboration with others, perhaps through membership of a work group or team, may often be a requirement.’ (DFES 2002:2)

The NVQ level 2 in care focuses on the delivery of health and social care to clients and includes both direct ‘hands-on care’ and ‘enablement care’ (TOPSS 2002). The award is aimed at a variety of occupations within social care ranging from care assistants meeting the needs of older people to midwifery support workers. To achieve NVQ competence level 2 candidates must complete four mandatory units, which are:

1. Foster people’s equality, diversity and rights
2. Promote, monitor and maintain health, safety and security in the work place
3. Promote effective communication and relationships
4. Contribute to the protection of individuals from abuse
(TOPSS 2002)

In addition, five ‘optional’ units need to be completed, selected from the following:
1. Promote communication with individuals where there are communication differences
2. Receive, transmit, store and retrieve information
3. Help clients to eat and drink
4. Contribute to the ongoing support of clients and others significant to them.
5. Support individuals experiencing a change in their requirements and provision
6. Enable clients to maintain and improve their mobility through exercise and the use of mobility appliances
7. Contribute to the movement and handling of clients to maximise their physical comfort
8. Enable clients to maintain their personal hygiene and appearance
9. Enable clients to access and use toilet facilities
10. Enable clients to achieve physical comfort
11. Promote communication with those who do not recognise language format
12. Monitor and maintain the cleanliness of environment
13. Support and control visitors to services and facilities
14. Assist in supplying and maintaining materials and equipment
15. Contribute to the effectiveness of work teams
16. Prepare food and drink for clients
17. Reinforce professional advice through supporting and encouraging the mother in active parenting in the first days of babies’ lives
18. Enabling individuals to maintain contacts in potentially isolating situations
19. Contribute to the support of clients during development programmes and activities
20. Enable individuals to manage their domestic and personal resources
21. Enable clients to maintain their mobility and make journeys and visits
22. Support individuals when they are distressed
23. Enable clients to participate in recreation and leisure activities
24. Contribute to the care of a deceased person
25. Care for a baby in the first ten days of life when the mother is unable to do so (TOPSS 2003:2-3)

Whilst the majority of tasks listed are relevant to the care of older people, at no time does any part of the core training programme or the selected optional modules relate specifically to the medical conditions that can be encountered among older people who live in a care home. Helping an older person to eat and drink for example can involve a variety of medical conditions that care staff need to be skilled to cope with. Notably module 24 relates to the care of a deceased person, there is however nothing relating to the care of someone who is dying, irrespective of their age. Whilst the very existence of the National Standard Framework for Older People (DH 2001) indicates that policy makers in one area of government accept the need to provide services focused on the needs of older people, this appears not to be followed through in other areas. The rhetoric refers to health and social care, however the NVQ level 2 modules do not appear to relate to specific medical conditions that impact on the health and consequently on the social needs of an older person. In the
provision of care for older people, either at home or in a care home, health needs cannot be divorced from social needs, as health needs influence social needs.

The NVQ training system provides a stark contrast to the structured vocational training experienced in Germany. In England, training is employer led and at most an employer will train their workforce for a particular job (Roberts et al 1994). As Regini (1997) points out, a low-skill, low-quality and low-waged workforce can achieve competitive prices and within the independent care home sector in England prices are competitive. It could, therefore, possibly be to the employer’s advantage not to encourage staff training. However, the implementation of the CSA 2000, the development of TOPSS and the GSCC can be expected to lead to a change in attitude towards training care staff in England as it is a legal requirement that 50% of care assistants must have NVQ level 2 competencies by 2005.

5. Training Care Assistants in Germany
Irrespective of their age, the majority of employees in German care homes will have undertaken this clearly defined route into formal employment as vocational training is the standard prerequisite for employment in most occupations (Esping-Andersen 1993). It is therefore surprising that there are no formal apprenticeship training provisions for care assistants employed to provide a service to dependent older people. There also appears to be no general statutory requirement to provide Health and Safety training in Germany. However, it can be assumed that it will be a subject included in any formal occupational training programme.

True to German tradition, most care assistants will have completed an apprenticeship after leaving school but this will have been in a different field, e.g. hairdressing, shop assistant or office clerk. It would have been normal for most women to have remained in employment in that field of work until they left the employment market to raise children. Care home employment is often considered in Germany after having a family, but prior to entering the care industry, many will have participated voluntarily in an auxiliary nurse training course (Eyers 2000a). These courses are run throughout Germany by the Red Cross and other similar voluntary organisations and include 110 hours of theory ranging from first aid to preparing injections and setting
Table 4.6: Outline of the German Red Cross training program for care assistants

<table>
<thead>
<tr>
<th>First Aid</th>
<th>Basic care</th>
<th>Work experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct at the scene of an accident or sudden illness; dealing with shock, dealing with someone unconscious; resuscitation; etc.</td>
<td>Bed making and positioning of patients, observing patients (taking temperature, measuring blood pressure etc.); nutrition; bandaging and changing dressings; basic therapeutic measures, handling medication and preparing injections; pre and post operative care</td>
<td>Two weeks on a hospital ward or in a care home for older people</td>
</tr>
</tbody>
</table>

Source: DRK Landesverband Rheinland-Pfalz 2003

up infusions (Table 4.6). The theoretical part is run as either a half- or full-day course over a period of three to six weeks and is followed by two weeks practical experience working full-time on a hospital ward or nursing home (DRK 2003). With the exception of First Aid, a qualified nurse provides the training. This training is government funded and is intended to prepare women between the age of 18 and 50 to work in hospitals in a national state of emergency. The completion of this training is not a formal occupational qualification in Germany and care assistants who have successfully completed the course will, like their English counterparts, be characterised as part of the unskilled labour force who develop their abilities to care for older people through on-the-job learning.

The care assistants in both England and Germany have access to training that provides them with some formal care skills. However, there would appear to be a paradox in that English care assistants have a more structured ‘tidy’ route towards gaining NVQ competencies as care assistants whereas in Germany care assistants have no equivalent training opportunities. This is contrary to Germany’s otherwise structured occupational training programmes. The one route to improve their personal situation for German care assistants is to undergo a three-year training programme and become a qualified OPC. Whilst many German care assistants make use of the opportunity to train as OPCs, the workforce of German care assistants remain ‘unskilled’. There is no equivalent route for English care assistants to become ‘qualified’ carer’s equivalent in status and remuneration to registered nurses.
6. Qualified Staff Training in Germany

The training of qualified nurses in Germany is governed by the Nursing Act passed by the Federal Government in 1985. Despite the ongoing debate over ‘post-basic education’, there is no formal requirement for nurses in Germany to undertake regular education or to update their nursing skills (Weinrich 1993). The care home staffing regulations in Germany encourage qualified care staff to keep up to date with professional developments (Goberg 1997; Klie 1997). However, the ‘Heimgesetz’ (Registered Homes Act), within its guidelines for quality assurance, actually stipulates that the employer has the duty to ensure the provision of training and further education to qualified care staff. Skills are to be regularly up dated and professional journals are to be accessible (Goberg 1997:531). This is in contrast to England, as it is the care home regulatory body that imposes further occupational development, not the governing body of a professional organisation. In accordance with the ‘Heimgesetz’ (Goberg1997), the qualified staff who work in German care homes will be qualified having trained as a children’s nurse, a general nurse, or an Older Persons Carer (see Chapter 2, Section 3.2).

Within the German care home industry, an important development over the last ten years has been the government’s policy to increase the number of qualified OPCs in order to meet the anticipated increase in the number of older people in residential care in the 21st century. For example, in 1993, the total number of OPCs in training was 194,000, while by 1995 that had increased to 213,000. In both years 87% of those participating were women (Becker and Meifort 1997). Whilst the occupation was made attractive to young people, government policies facilitated the provision of training to people in mid-life who were unable to find employment in the occupation in which they had originally undertaken an apprenticeship after leaving school and wanted to develop a second career.

Becker and Meifort (1997) identify that many people undergoing the OPC training had previously worked as care assistants in care homes. However, in keeping with the German ‘tidy route to employment’ (Roberts et al 1994), the occupations in which the participants had originally qualified ranged from teaching to hairdressing. The predominance of mature trainees also indicates that caring for older people was a
### Table 4.7: Training to be an Older Person's Carer

<table>
<thead>
<tr>
<th>Prerequisites</th>
<th>Course Content</th>
<th>Final Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| ‘Mittlerer Bildungsabschluss’ (equivalent to GCSE) or successful completion of ten years at school or basic school leaving certificate and the successful completion of a two year occupational training course. | **Theory** (approximately 2100 hours)  
- Medical care  
- Basic anatomy and physiology  
- Basic psychology and psychiatry  
- Basic physiotherapeutic and pharmacological treatments  
- Principals and methods of basic and needs orientated care  
- Care management and documentation  
- Medical conditions encountered in older people and how these can be prevented and treated  
- First aid and resuscitation  
- Health and safety  
- Nutrition  
- Legal framework  
- Social care  
- Sociology  
- Ethics, social policy, legal rights  
- How to assist and guide older people in personal and social matters and to encourage social contacts  
- Activities physical exercises to promote active ageing | **Written examination**  
Three exam papers related to theoretical subjects taught.  
**Viva**  
Only undertaken if the mark in a specific subject is unclear |
| Personal | **Practice** (minimum 2500 hours)  
Experience in putting theory into practice by caring for older people living in care homes or their own home | **Practical examination**  
Preparation, planning and execution of a social care task (in some ‘Bundesländer’ two social care tasks have to be completed) |


Second career. The needs of women with family commitments can be seen to be facilitated by ensuring access to part-time courses and part-time work experience was available (Becker and Meifort 1997). During the training period, trainee OPCs are financially supported by government employment policies designed to both reduce unemployment and to increase the number of OPCs (Voges 2002). A trainee OPC working in Lower Saxony would, based on the 2002 tariff for employees in public service, earn €591 per month in the first year, €638 in the second and €681 in the third year of training. A mature student who might for example need to support a family whilst undergoing retraining to become an OPC would gain additional funding in keeping with the ‘Bundesausbildungsförderungsgesetz’ [Federal legislation to promote training]. After qualifying as an OPC the basic monthly
income would increase to between €1,687 and €2,009 (Bundesarbeitsamt 2003). A trained OPC in Germany has the same status as a qualified hospital nurse and they are grouped in the same pay category.

The three-year training to become an OPC is a balanced mix of theory and practice as outlined in Table 4.7 and is concluded with a final set of written and practical examinations. Successfully passing the examinations enables the OPC to embark on a career in the care industry that, via further qualifications, could lead to unit management and then onto care home manager. The OPC qualification therefore provides older people living in a care home with staff trained to meet their health and social care needs and the care industry with skilled staff trained specifically for the task in hand. With the increasing number of qualified OPCs, it is to be expected that over the coming years, the majority of qualified staff in care homes will be OPCs, trained to plan and provide individualised, person-centred care that takes medical and psychosocial needs into consideration (Bundesarbeitsamt 2003).

Working alongside the OPCs, as qualified members of staff, are qualified nurses who will have experienced their training in a hospital environment. At present, the training programme for qualified general nurses in Germany covers a period of three years and takes place in hospitals that have an attached ‘Krankenpflegeschule’ [School of Nursing]. Unlike England, Schools of Nursing in Germany are not part of university education.

As outlined in Table 4.8, the training of hospital nurses in Germany focuses on medical conditions and although the needs of older people are explicitly included in the practical training, there is little preparation for the care of older people who live in a care home. The aim of training for hospital nurses is to provide them with the skills to be responsible co-workers in the prevention, recognition and therapy of illnesses (Universität Ulm 2003). Nurses with this form of three-year training who chose to work in care homes are able to participate in the further care management based training programs available to OPCs. However, there are no formal additional courses to provide them with the specialised skills to care for older people who need care in their own home or in a care home.
Table 4.8: Nurse training in Germany

<table>
<thead>
<tr>
<th>Course Content</th>
<th>Final Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>To be completed in a period of 3 years at a School of Nursing attached to a hospital.</td>
<td>Overseen by an exam board consisting of a representative from the regional medical authority, school management, course director, specialised subject examiners.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theory (minimum 1600 hours)</th>
<th>Written examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal framework (120 hours)</td>
<td>6 hours over two consecutive days covering: nursing care; health and illness; Anatomy and Physiology; Legal framework</td>
</tr>
<tr>
<td>Hygiene and medical microbiology (120 hours)</td>
<td>Viva</td>
</tr>
<tr>
<td>Biology, anatomy and physiology (120 hours)</td>
<td>10 minutes in: nursing care; psychology; social care, rehabilitation, hygiene</td>
</tr>
<tr>
<td>Medically focused physics and chemistry (40 hours)</td>
<td></td>
</tr>
<tr>
<td>Pharmacology (60 hours)</td>
<td></td>
</tr>
<tr>
<td>Health and illness (360 hours)</td>
<td></td>
</tr>
<tr>
<td>Basics of Psychology, Sociology and Pedagogy</td>
<td></td>
</tr>
<tr>
<td>Nursing care (480 hours)</td>
<td></td>
</tr>
<tr>
<td>Basic rehabilitation (20 hours)</td>
<td></td>
</tr>
<tr>
<td>Organisation and documentation in hospitals (30 hours)</td>
<td></td>
</tr>
<tr>
<td>Speech and literature (20 hours)</td>
<td></td>
</tr>
<tr>
<td>First Aid (30 hours)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice (minimum 3000 hours)</th>
<th>Practical examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical wards and units including the care of older people (900 hours)</td>
<td>6 hours spread over two consecutive days. Nursing a group of at most four patients on a hospital ward. To include the planning and administrative duties involved in the provision of nursing care.</td>
</tr>
<tr>
<td>Surgical wards and units (750 hours)</td>
<td></td>
</tr>
<tr>
<td>Obstetrics (including care of new born babies), Gynaecology or Urology (350 hours)</td>
<td></td>
</tr>
<tr>
<td>Psychiatry, Paediatrics, Community Nursing or similar (400 hours)</td>
<td></td>
</tr>
<tr>
<td>Night duty as from year 2, (120-160 hours in total)</td>
<td></td>
</tr>
</tbody>
</table>


Whilst in Germany both qualified nurses and OPCs have the same social status and earning potential, the training programme for both OPCs and hospital nurses in Germany highlights the difference between someone trained to work in a hospital and someone trained to work with older people in a care home. The content of the two types of training indicate the difference between care for a hospital patient and care for an older person whose health and social care needs have determined their move to live in a care home. An OPC gains an understanding of the medical conditions that older people living in a care home might experience and the psychosocial needs of an older person’s life is given equal consideration in the training programme. This balance of health and social care should ultimately enable OPCs to empower older people in their everyday life whilst living in a care home.
7. Qualified Staff Training in England

A further contrast between England and Germany can be observed in the training of qualified healthcare professionals, which in England is governed by the individual professional organisation and in Germany is determined by government legislation (Roberts et al 1994). In England, qualified nurses, trained to work in an acute hospital environment, are governed by their professional regulatory body, the Nursing and Midwifery Council (NMC) and only nurses registered with the NMC are allowed to practice in England (NMC 2002).

Whilst there is a growing understanding of the need to provide qualified staff in nursing homes with specialised skills, research on care home matron/managers has established that only one fifth of the qualifications held by the respondents were practice based (Johnson et al.1999). However, two-thirds of the respondents agreed that they should have qualifications to specifically meet the needs of older people (Johnson et al.1999). In contrast to problem-focused hospital nursing, the aim for qualified nurses working in care homes is seen by Nolan (1997) to be towards a more holistic model of care. Ford and McCormack (1998) describe the need for a 'gerontological nurse specialist' as a post-registration qualification for nurses working with older people. They see the gerontological nurse to be someone with the ability to demonstrate knowledge of rehabilitation, healthcare and clinical assessment and with a wide-ranging knowledge of the ageing process. This vision would provide care homes with qualified staff that suit the NHS funding of the nursing care element of a care home placement introduced in October 2001. The NHS outlines the role of a qualified nurse in a care home to be that of someone who delegates and supervises nursing care tasks (Chapter 2.2.1). However, such a policy can be seen to provide very little actual provision of 'hands-on care' by qualified staff and little opportunity to take a person-centred approach towards the health and social care needs of an older person living in a care home.

8. Conclusion

Hidden within the labour market of England and Germany is a little acknowledged sector of the healthcare industry that predominantly employs women to meet the requirements of older people living in care homes. The routes into employment in
England and Germany can initially be seen to differ. However, after taking a career break to raise children, the career path for many women in England and Germany can be seen to converge. It is at this time of life that many qualified staff and care assistants enter employment in the care home industry where the flexible hours worked may be attractive to women who have family commitments yet want to work (Becker and Meifort 1997; Eyers 2000b; Rainbird et al 1999). Consequently in both countries, this workforce has a strong presence of part-time workers. At present one main difference remains between the two countries. It is the fact that formal qualifications in Germany continue to be the key to employment throughout the labour market. In England a gradual change in culture can be observed. On-the-job training courses linked to NVQ competencies are being provided and young people are being encouraged to gain NVQ qualifications. However, these are undervalued in the labour market.

The policy makers in both countries have recognised that health and social care needs of older people determine the move into a care home. This calls for a workforce of care staff trained to meet the needs of increasingly dependent older people. In England, the split between health and social care policies has resulted in qualified nurses taking on the role of managers and supervisors of care, while the actual providers of ‘hands-on’ care are care assistants. This contrasts with Germany where a formal qualification has been developed to provide training to people who want to become qualified to meet the health and social care needs of older people by participating in a three-year programme to become an OPC. While the majority of care assistants in Germany will, at most, have participated in a training programme aiming to provide them with the basic skills to assist in hospitals in a national emergency. Contrary to the standard German culture of occupational qualifications no formal qualifications are needed to work as a care assistant. This could be seen to differ from England where, contrary to English employment culture, by 2005, it will be a statutory requirement that 50% of care assistants are qualified to a competence level of at least NVQ level 2 (DH 2002).
Chapter 5
Methodology

1. Introduction
With a focus on the formal training and informal acquisition of care skills, this comparative study of care home staff aims to establish how the lifecourse of care worker's influences their ability to care for dependent older people in English and German care homes. The data collection aims to gain an understanding of the skill and expertise required to care for older people and then establish how these are acquired. The comparison of a predominantly female workforce working in similar environments completing the same daily tasks will examine patterns of divergence and convergence in two countries with differing education and welfare systems. Research on four care homes in England and in Germany forms the basis of the empirical data collection. This chapter outlines the multi-methodology used to collect data that provide an understanding of the work undertaken by care staff and how their lifecourse has provided them with the skills required in this area of employment.

2. Research aims and objectives
Using a multi-method approach this research will compare qualified and unqualified staff in England with their counterparts in Germany (Figure 5.1). The difference between qualified and unqualified staff in each country will also be established and compared. As indicated in Figure 5.1 an additional dimension to this comparison is that in Germany many qualified staff working in care homes are OPCs (Older Peoples Carer) trained specifically to the care of older people living in a care home whilst in England it is NVQ training available to care assistants that aims to provide
the required skills. The intention is to establish the similarities and differences in English and German care worker's lifecourse experiences and the governmental policies that impact on the provision of institutional long-term care in order to ultimately identify key issues (Ragin 1994) that influence the autonomy and quality of life experienced in care homes meeting the needs of older people.

Comparable data will be collected from care home staff to provide a profile of the care staff who are paid to care for institutionalised older people and the daily tasks they carry out. This will be undertaken in the form of self-completion questionnaires and interviews using vignettes and a lifecourse grid. In order to link the data collected from care home staff to care home residents, data relating to the residents' dependency and the daily routine within a care home will be collected from the care
home managers. The more detailed description based on the daily tasks will be provided by care staff’s personal portrayal of care experiences during their interview.

The provision of long-term institutional care in England and Germany is influenced by government policies relating to health and welfare, employment and education and training. The actual policy content and implementation present considerable differences between the two countries. However, at ‘grass root level’ there is convergence between the two countries as the tasks required of care staff who provide the actual ‘hands-on’ care are similar and the ability to undertake bodywork is influenced by their lifecourse experiences (Figure 5.2). After establishing the skills required to provide care to care home residents this research will examine how and where care staff in England and Germany acquired the knowledge needed to work in a care home.

Government policies such as health and welfare, employment, education and training in England and Germany impact on both the institutional provision of long-term care to older people and on women’s lifecourse. The two contrasting groups of people encountered within the environment of a care home in both countries are the older people needing care and those employed to ensure that the quality of service expected by policy makers is provided. Individual care staff are meeting the individual needs of an older person living in a care home to the best of their ability. However, these abilities are determined by their lifecourse and the opportunities they have had to develop the skills needed to work with older people who live in a care home. Consequently the aims of this research are to examine the interface between women’s lifecourse and their skills to meet the needs of institutionalised older people (Figure 5.2). As outlined in Chapter 2 the government policies that impact on the provision of care in England and Germany result in a contrasting ratios of qualified staff to care assistants which is compounded by diverging ratios of care staff to residents. This indicates that a main difference in the everyday undertaking of bodywork between the two countries is related to the qualification and training of care staff and the contact time between care staff and residents.
Taking the quality of life experienced by older people living in a care home into consideration a key aspect of this study will be to research the interface between care staff and older people. Establishing the essence of care will provide a basis from which to investigate how and where in their lifecourse care staff develop the invisible, intangible and immeasurable skills that are essential in the care of older people living in a care home. Having gained an understanding of the interface between care staff and older people in a care home the findings will be related to the government policies that impact on institutional care in England and Germany.

3. Cross-national comparative research
The basis for a comparative study is to use the same systematic analysis of concepts in one or more units of two or more societies, cultures or countries and leads to a greater awareness and deeper understanding of social reality (Hantrais and Mangen 1996). The outcome of comparative research can draw out the significance of certain issues and as Mason (1996) points out, add more to an explanation than a simple statement of sameness or difference. In this instance it is also worth considering that comparative research can challenge implicit assumptions that our own method or system (e.g. the provision of vocational training) is the best or only way to develop a policy, organise, or solve a problem (O'Reilly 1996).

Comparative research is seen by Strauss and Corbin (1998) to be a ‘staple’ and ‘theoretical comparisons’ stimulate their thinking about the properties and dimensions of the theoretical sampling. The outcome of such research can draw out the significance of certain issues as it forces researchers to look at a total context which enables them to discover the greatest number of factors that are interactive and interdependent. The presentation of different perspectives in turn sharpens the focus of analysis.

Stimuli to undertake comparative research come from policy makers or managerial concerns on the one hand and theoretical interests on the other (O'Reilly 1996). Whilst managerial perspectives usually seek normative solutions, social sciences are more interested in analytical methods and theoretical implications and each perspective can be mutually informative. To seek and identify ‘best practice’, for
example, can impact on policy makers, management and in care homes ultimately on the ‘hands-on’ provision of care.

Cross-national comparative research adds another dimension to both the theoretical and organisational complexities of a study. Hakim (2000) points out that most cross-national studies are designed to collect quantitative data and that although the potential exists for qualitative research, it has so far been under-exploited. Underlining a key problem encountered in cross-national studies, Hakim highlights the problems of translation caused by national cultures and ‘taken-for-granted assumptions’. Consequently it can be extremely complex to design research tools which are equally understood in both countries and take both cultural and language differences into consideration. As Hakim (2000:207) points out ‘most researchers agree that the aim is never a literal translation but functional equivalence of meaning’. However, the time and effort spent on establishing a common basis may still result in data that is not truly comparable. Translation-related decisions may, as Birbili (2000) points out, influence the validity of the data and suggests that to ensure the collection of valid and comparable data both lexical equivalents and conceptual equivalents are necessary.

3.1 Collecting data in two languages
My own lifecourse, having grown up in England and Germany and as a routine speaker of both languages, provides me with skills to undertake this research without having to overcome cultural or language barriers and enables me to move between the two language without the aid of others. As Eyraud (2001:279) points out ‘translation is an operation using facts that are both linguistic and cultural’. Consequently designing research tools which were equally understood in both countries, taking both cultural and language differences into consideration was not without problems.

In order to ensure the collection of valid and comparable data both lexical equivalents and conceptual equivalents were used in the questionnaire design. In the design of the vignettes, conceptual equivalents were used. To prevent the problems pointed out by Birbili (2000), the translation of the interviews was undertaken by me. This was initially attempted with the help of voice recognition software.Whilst listening to the
German interviews over headphones, interviews were orally translated into English and transcribed with the assistance of 'Dragon Naturally Speaking 5' voice recognition software. However, the fact that the programme only recognises formally constructed, grammatically correct sentences proved to be problematic. This was particularly important as the intention was that formal sentence structures would be eliminated using this free method of translation and transcription, thereby ensuring the recommended collection of data which is conceptually equivalent (Birbili 2000). Low flying, honking geese and Chinook helicopters on manoeuvres also proved a problem in the transcription as the software program attempted to interpret and incorporate the sounds in the text. Ultimately I transcribed all the German interviews by listening to the tapes and writing what I heard in German down in English using colloquial language and conceptual equivalents.

4. Multi-methodology

The data collection for this research is undertaken in care homes where the skills needed to provide care will be identified and related to the lifecourse of the staff employed in this field of work. A multi-method approach using both qualitative and quantitative data were chosen. In contrast to Scheff (1997), who perceives quantitative and qualitative research to be increasingly separated, in this research the two forms of data are closely inter-linked. Scheff (1997:115) further describes qualitative methods to be like 'a wide angled-lens with little depth and quantitative methods are as narrow as using the wrong end of the telescope'. Again these observations are in contrast to this research where a more suitable analogy would be the use of a microscope. Here care home employment is under the microscope and the lens is regularly adjusted to view the finest particles. The interplay between qualitative and quantitative methods will also establish the validity of the collected data. Strauss and Corbin (1998) make the point that

'to build dense, well-developed, integrated and comprehensive theory, a researcher should make use of any or every method at his or her disposal, keeping in mind that a true interplay of methods is necessary'

(Strauss and Corbin 1998:33)

They further point out the importance of a researcher's ability to merge into their study and build on their own previous studies (Strauss and Corbin 1998). In this
instance my research builds not only on my previous academic work but also on my past employment as a care home manager in both England and Germany.

My approach, using both quantitative and qualitative forms of data collection, also results in the triangulation of the findings which will aid a 'more critical, even sceptical' (Fielding and Schreier 2001:46) approach towards the analysis. Kelle (2001:11) states that 'quantitative and qualitative methods have to be combined in order to produce sound sociological explanations' (Kelle's emphasis). The outcome of this quantitative and qualitative data collection should lead to a fusion of research methods that will provide an insight to the lifecourse of women working in the English and German care home industry at the beginning of this millennium. It will establish how women gain their care skills and whether their life experience provides them with the emotional tools and time management skills needed when working in a care home.

5. Research design
This research aims to provide a meaningful and holistic insight to the lives of women employed to care for institutionalised older people and to deepen the understanding of formal care work. The study is based on care staff employed in four English and four German care homes. Four homes were chosen in each country as it was judged that, within the resources available, this number would provide a comparable sample of quantitative and qualitative data from each country. The selected homes are comparable in ownership, size and dependency of their residents and are selected from different areas of Southeast England and Northern Germany. Quantitative and qualitative data were collected from care home management and care home staff in each home.

5.1 Data on the care home as a work environment
A diverse collection of documents and observations, plus a questionnaire (Appendix 1) completed by the home manager was used to establish a picture of care homes as a working environment. The questionnaire (Appendix 1) focuses on the residents' dependency and the qualifications and number of care staff employed in the home.
The ratio of care staff to residents is an important factor as this indicates the workload each care worker deals with during a shift. The actual work undertaken is indicated by data collected from the care home managers to establish the residents' dependency and care needs at the time of data collection. The number of female and male residents was recorded and, based on the German categorisation of residents dependency (see Chapter 2), the residents were grouped into four categories ranging from independent to highly dependent (Appendix 1). This however does not give a detailed picture of residents actual care needs. Based on research on care home residents' medical needs in England (Millard 1999) data were collected to establish the residents' medical needs. My past experience in care home management and my previous research (Eyers 1998) formed the basis for questions relating to daily care tasks undertaken (Appendix 1).

A factor which impacts on care home work is the design of the home and whether residents are in single or shared rooms. Data on room occupancy was collected from the manager and architectural plans were requested. To establish if care management set time limits in which a task was to be performed, homes were asked if quality assurance systems were in place. If so, copies of procedural guidelines to wash and dress a resident, to provide assistance at mealtime and toileting were requested. These procedures also related to the vignettes described in Section 5.4. My field notes kept in the form of a diary also provided a record of the observations and untaped conversations made during visits to the home.

Data collected from the manager also established a profile of the care staff employed in the sampled English and German homes. This was used to identify how representative the self-completion questionnaire respondents and interviewees were, thereby acting as a form of quality assurance and supporting the validity of the data (Fielding and Schreier 2001: 48).

5.2 Self-completion questionnaire for care home staff in England and Germany
To establish a profile of care home staff in the two countries a self-completion questionnaire was designed and distributed to all qualified and unqualified care-staff in the eight sample homes (Appendix 2). The collated data from these questionnaires
were intended to provide details of the family and work history of care staff and create a profile of the public and private life experiences of qualified staff and care assistants in the two counties. This provided information on how care skills used in care homes were acquired, acknowledged and financially rewarded.

Qualified and unqualified care staff in both countries were asked to complete the same questionnaire which, as far as possible, was the same in both countries. However they did differ in the following aspects:

1) The differing occupational training systems in the two countries led to a different set of questions in each country. For example as there is no German equivalent to National Vocational Training in Germany, therefore Questions 4-6 (Appendix 2) were omitted in the German version. The registration of qualified nurses is, as outlined in Chapter 4, an unknown concept in Germany and consequently Questions 8 and 9 were also omitted. In the German version, Question 3 asking about job titles has eight categories whereas the English version only has three, thus adapting to the cultural differences. However, both questionnaires sought to gain information about occupational training and qualifications.

2) Determined by the language, Question 15 in the English version (Appendix 2) was split into two separate questions for the German version in order to gain the equivalent range of responses

3) English respondents relate to hourly rates of pay and German respondents to monthly rates. Consequently Question 18 was adapted to meet the understanding of each culture.

5.3 Interviews with care staff

The tape-recorded interview data provided information on the actual work undertaken in care homes and the skills used to provide institutional care (Appendix 3). Interviews were undertaken with an average sample of three care assistants and three qualified staff in each home, resulting in 50 interviews. Consisting of three elements, the interview opened with general questions about work in the care home, this was followed by four vignettes relating to care home work and two relating to family life. At the end of the interview, questions were asked about the interviewee’s lifecourse, discussed in Section 5.5. Although the interview guide (Appendix 3) was
in front of me whilst interviewing, the actual interview was conducted less formally. However, all questions set out in the interview guide were covered.

In order to ensure the collection of comparable data, the vignettes included in the interviews (Appendix 3) were developed around situations encountered regularly in care homes and the family life of care staff in both countries. The vignettes aimed to establish how respondents would deal with typical situations involving the provision of care to 'difficult' residents. The interviews were concluded with the collection of more detailed lifecourse data collected in a lifecourse grid (see Section 5.5).

5.4 Vignettes
The use of vignettes focusing on an everyday occurrence in a care home and family life facilitated the collection of comparable empirical data without directly intruding into the daily contact between resident and care worker or directly asking personal questions about family life. For example to ask each participant to describe how they handled an incident they had experienced with residents that day would have resulted in the collection of qualitative data that would be difficult to categorise and may have resulted in data that was not comparable. Vignettes which present a familiar occurrence in the form of a very short story and ask interviewees to respond to the incident minimises such problems and enables a standardisation of the context (deVaus 1996). Crucial to the success of this form of data collection is that the conceptual elements of the stories were seen by the respondent to be plausible and real (Barter and Reinhold 1999, Bryman 2001). Here my own past experience of work in a care home was useful in creating scenarios that could be related to in both countries and by both qualified staff and care assistants.

This method of research minimised the interruption in the daily routine of a care home and enabled the collection of data without physically intruding into the one-to-one relationship between carer and resident or overtly examining care staff's knowledge and understanding of frail older people. It also enabled data collection from eight homes and 50 participants. It would not have been possible to gain this a breadth of data undertaking participant observation. Whilst the data could not document verbal interaction or use of body language between care staff and an older
person, the verbal responses to the written vignettes provided indicators to the actions and thought process in the provision of care.

The aim of a vignette is to 'elicit rich but focused responses from informants' (Schoenberg and Ravdal 2000: 63). A realistic vignette can be a useful research tool, which generates comparable data that enables an exchange between empirical findings and theoretical assessments (Soydan 1996). However, as Soydan (1996) points out, in cross-national comparative research to date, vignettes have not been widely used as it is a research method not widely known outside English speaking countries. The complexities of developing a vignette in two languages so that they understood in the same way may also contribute to the fact that they have not been widely used in cross nation research. However, being able to build on my professional and personal life experiences in both countries made it possible in this instance to design vignettes that presented the same care needs to the respondents in both countries. While adapting the surround issues such as the name of the older person and the time of day to one that reflected the actual situation encountered in both countries. Thereby creating a realistic situation for all the participants. The collection of data in countries with two different languages means that both lexical equivalents and conceptual equivalents need to be used in the design of the vignettes. My working knowledge of the colloquial language used in English and German care homes facilitated the design of the vignettes which utilised conceptual equivalents (Appendix 3).

The six vignettes (Appendix 3) aimed to research three distinct concepts:

1: the use of emotional tools and time management skills when undertaking bodywork with older people (the four vignettes in question 7)
2: the respondent’s awareness of older people’s needs (the four vignettes in Question 7)
3: the acquisition of emotional tools and time management skills within the family (the two vignettes in Question 8).

The common factor in the care vignettes (Question 7) used in this research relates to the daily bodywork undertaken by care staff providing institutional care to older people in England and Germany. Each of these vignettes was developed out of
personal experiences as a relative, former care home manager and visitor to care homes. The family based vignettes depict situations that could be expected to be experienced in either country. The responses to these vignettes in both countries were not as informative as the responses to the care vignettes. Considering the volume of data collected it was decided not to include the findings from this data set.

Each vignette was originally designed in English, then translation into German and is the conceptual equivalent. The German versions differ firstly in the choice of names:

- Edith (Vignette 1) became Frau Schmidt,
- Phyllis (Vignette 2) became Frau Lembke
- John (Vignette 3) became Herr Böttcher
- Maude and Derrick (Vignette 4) became Frau Maier and Herr Töle

In this way, I was able to accommodate the cultural difference in the use of first names between English care staff and older people and the more formal use of language in Germany where the use of first names would not be comparable. In the translation of the German responses in the analysis chapters the German surnames are used. In order to maintain continuity in the use of names when discussing the findings when referring to a German finding the English first names are used followed by the German surname in brackets. Secondly, the time of day is also amended to meet the reality of the day routine encountered in German care homes. The responses to the vignettes also enable a comparison between the approach qualified and unqualified staff take towards the same situations. As such the vignettes provide comparative data to establish the difference between the actions and understanding of qualified and unqualified staff in the two countries (Figure 5.1).

The ‘icebreaker’ recommended by researchers who have used vignettes to collect data in the past (Hazel 1995) is not required in this instance as the beginning of the interview takes over this function. However, as in other projects where vignettes have been used (Neale 1999), the main objective is to collect data related to a sensitive subject, in this instance, emotional labour and the care of older people. The aim here is to establish if emotional labour as described by James (1989) is initially used to create a routine which is then maintained by the occasional use of one particular ‘tool’ that has proved effective for the individual resident or member of
staff. The care vignettes present everyday situations at different times of a working shift and are related to a group of residents that the interviewee could be responsible for. A key element is that the ‘residents’ have been in the home for varying lengths of time therefore it can be assumed that there will be differing working relationships with the resident. The ‘residents’ also represent a variety of medical conditions and problems that can be expected to be encountered in care homes (Appendix 3).

The two family vignettes relate to children of different ages to establish if there are differing ‘emotional labour tools’ used on younger children than on older children. However, the initial piloted vignettes highlighted the fact that the similarities in the overall situation used were too great. Consequently the situation around the younger child in Question 8.2 (Appendix 3) was changed before the main study so that the mother was not under time pressure to get to work but to get to an important appointment with a young child at a time of day both countries could relate to. The tape-recorded responses to all the vignettes were designed to be open-ended and to allow the use of neutral probing questions. The use of Likert scale responses was considered but deemed too restrictive for qualitative data collection.

In order to focus the thoughts of the interviewee, the care vignettes (Question 7) asked how they would cope with the situation if it were to happen to them in the care home where they now worked (Appendix 3). In the ‘family life’ vignettes (Question 8) the respondents were asked how they thought the mother would behave, thus aiming to depersonalise the response. All the vignettes were also expected to be a stimulus to encourage the interviewee to provide more detailed information about similar situations that they might have personally experienced. The move into vignettes about family life also aided the transition into questions about lifecourse.

5.5 Lifecourse-grid

To establish in more detail how and if care home staff had had opportunities to formally or informally gain care skills throughout their lives, biographical data were collected from the interviewee. The aim was to gain an insight into the participant’s educational and occupational experiences providing information about the formal
acquisition of care skills alongside their family background, which would indicate their development of informal care skills.

The tape recorder was switched off for this final part of the interview especially as by this time rapport was established between interviewer and interviewee and the conversation was entering the personal sphere. It was important that the participant did not feel inhibited by the tape recorder. The information given was collated on a lifecourse grid (Appendix 4) and a note of interesting issues was kept in the margin of the sheet of paper used and/or included in the field notes. This lifecourse data were not the sole focus of the research, and from the outset it was clear that there would be a restriction on the amount of time available for the interviews. With this in mind, the lifecourse grid (Appendix 4) provided an effective tool to collect the relevant data in a short period of time. The lifecourse data from the interviews complemented the data on both public and private lifecourse issues collected in the self-completion questionnaire, thereby providing an overview of care staff’s lives that would otherwise have been complex and time consuming to collect.

The predictors of a person’s lifecourse were seen to be family background, level of education, gender and geographical location (Callaghan 1998, Roberts 1994, Saunders 1995). Data relating to these factors was collected before commencing the ‘grid’ (Appendix 4) which then follows five strands of the interviewee’s lifecourse. The data aims to establish strands of data that can be placed together in chronological order to reveal how the life events of an individual are inter-related and enable a comparison of interviewee cohorts in both countries. It also enables a comparison between same aged care assistants and qualified staff to contribute towards the comparison of differences between qualified and unqualified staff in England and Germany. As the focus is on key events which are meaningful in a person’s life and related to both age and year, the inaccuracy, identified as one of the main problems when using a life grid, should be alleviated (Parry et al 1999). In the grid used by Parry et al (1999) historical external events were used as ‘markers’ to help the participant remember when certain things in their own life had taken place. In this research, where it can be expected that the interviewees will cover a span of ages from 18 – 65, more personal events such as school leaving age, marriage and
childbirth represent important data which also act as 'markers'. Collecting this data in a grid format provides the facility to establish the link between public and private lifecourse.

6. Ethics
Whilst this research is related to a vulnerable group of society, the actual data collection had no direct involvement with older people living in care homes. The participants in the data collection were all care staff and did so on a voluntary basis. Informed consent was gained from the care home management and from each individual participant, and confidentiality was assured at all times. As the data collection was undertaken in the independent sector there was no requirement to submit the methodology to an ethical committee. However, the research was conducted in adherence to the British Sociological Association ethical guidelines. Before undertaking the data collection in each home, details of the methodology were submitted to the home management so they could make an informed decision as to whether or not data collection could be undertaken on their premises.

To protect the identity of the participants the homes in England are referred to as E1, E2, E3 and E4 reflecting the order the data were collected, similarly in Germany the care homes are referred to as G1, G2, G3 and G4. To find four fictional names in each language that could not relate to any care home in either country could have proved very difficult. Consequently the chosen format was both convenient and logical. In the design of the structured interview with the care home managers (Appendix 1) care was taken to protect the individual identity of care home residents and staff.

The interviewees were mainly those on duty at the time of my visit to the home. Prior to commencing the interview it was made clear to the participant that the aim was not to test their medical knowledge but to gather information that would enable me to describe the actual work undertaken by care home staff. A brief conversation about the research and the reason for the interview was given, any questions were answered, and the approval of the participant was requested before the tape was switched on. This procedure ensured that the interviewee gave informed consent to the interviewer. When transcribing, the interviewee was immediately given a 'new name', with names
chosen that did not relate to any known names of staff in that home. A list of 30 noticeably German male and female names was created from which ‘new names’ were selected. The English participants were given names that are noticeably English. This personalised the qualitative data and emphasised the comparative elements of this research. Whilst the selected names reflected the country the interviewee worked in, they did not reflect the participant’s country of origin. In order to maintain their anonymity, non-naturals were also given typically English or German names. When referring to the fact that the participant does not originate from England or Germany, for example in the lifecourse grid, the country of origin is not stated. Participants in the research were further protected by not relating the interview extracts or lifecourse data to a specific care home.

7. Pilot study
In summer 2000 a pilot study was completed in one care home in each country. This tested the design of the home manager questionnaire, the self-completion questionnaire and the interview guide including the vignettes and lifecourse grid. However, the first step was to collect data from the home manager and distribute the self-completion questionnaires to all care staff, which also sought for interview volunteers.

Despite its complexity, the home manager questionnaire (Appendix 1) did not need any changes. The questions about the residents asked for total numbers of particular groups of residents and consequently did not impinge on the English or German data protection acts. The design of the data collection focusing on care staff related to the standard staff roster and the information requested on all members of care staff was also in keeping with the requirements of the data protection acts as none of the information given could be linked to an individual employee. Neither the English nor German care home had set ‘procedures’ on how to undertake specific tasks. However, in both instances, it was stated that they were ‘working on it’. The architectural plan was only available from the English home.

The next sections discuss the changes made in the self-completion questionnaires and the interviews following the pilot study. Because only minor changes were made
between the pilot study and the main study the findings from the pilot study were included in the main study as one of the four homes in each country.

7.1 Self-completion questionnaire for all care staff

In the pilot study the self-completion questionnaire, in a self-sealing envelope, was distributed by the home managers to all qualified staff and care assistants in the two sample homes and a target was set to gain a response from a minimum of 20 members of care staff. In the English home, 22 questionnaires were completed and returned and in Germany the target of exactly 20 was achieved. At the time of distribution I was visiting the sample homes regularly to undertake the interviews and all care staff were aware of the research project.

In the pilot self-completion questionnaire, the last set of questions asks if the respondent had found any questions complicated and if so which questions (Appendix 2). The final question asked the respondent how long it took them to complete the form. In England only one respondent stated she found any question difficult to answer and this was not enough to warrant changing the format or the questions. German respondents found the questions relating to the acknowledgement of their work (Question 16) difficult to answer and in some cases did not respond at all. Following the pilot study in Germany this question was moved from the beginning to the end of this group of questions. After some consideration it was decided not to add 'don’t know' because it could in some instances be selected by respondents as the easy way out. Question 15 (divided into 2 questions for Germany) intended to encourage respondents to stop and think consequently providing a more reliable answer.

Considering the overall responses to questions 18 and 19 related to income (Appendix 2), deleting or rephrasing was considered as some returns from the pilot showed no response and some were obviously answered incorrectly. If the question were rephrased to ‘what was your take home pay last month?’, the data would be unusable as some of the German questionnaires are completed in December and January. In Germany most employees are entitled to a 13th months pay and a Christmas bonus. Consequently their take-home pay in December is considerably
higher than in the other 11 months of the year. In both countries the monthly pay is
variable because the number of hours worked vary in England, and in Germany
working weekends, nights and bank holidays also increases the monthly income.
However, pay represents a key difference experienced in the two countries. This
question presented a number of problems resulting from the wide range of possible
answers in both countries which meant that categories that are normally used to
collect data on income would not have been suitable. These factors also reflect a
part-time work force with a variable income. On that basis, questions 18 and 19 have
been retained as originally designed.

The responses to the question relating to school leaving qualifications (Appendix 2:
Question 22) were wide ranging and the pilot exemplified that not all respondents
were educated in England or Germany. The educational attainment in England and
Germany covered a wide age range where, especially in England, there have been
many changes in the education system. However, as this is also a key question
relating to care staff's lifecourse, the question was retained and the data coded and
entered into SPSS based on my knowledge of the respective educational systems.
Although some of the questions vary between the two counties both have the same
coding in order to enable comparative data analysis.

7.2 Interview with vignettes
In the English pilot home (E1), three interviews were conducted with qualified staff
and three with care assistants. In Germany four qualified staff and four care
assistants were interviewed in the pilot study. The overall structure of the interviews
worked well and in content the vignettes appeared to touch a note with pilot
interviewees (Appendix 3). This was noticeable in their facial expressions and verbal
responses, thus proving that the stories were seen to be plausible and real, elements
which are crucial to the success of vignettes as a form of data collection (Barter and
Reinhold 1999). The vignettes were initially intended to be read out to each
interviewee. However, this practice changed within the pilot, following the first two
interviews each vignette was printed out on one page in double spaced, Times
Roman, 14 point. This provided the interviewee with a better opportunity to think
through the vignette; they had the text in front of them while responding and could
refer back to the text if need be. The large print and spacing meant that text could be comfortably read by staff who needed to wear reading glasses but did not have them to hand. It also meant that the vignettes were presented in a neutral fashion. Following completion of the pilot in both England and Germany the fourth care related vignette of Maude and Derrick was added to gain a better insight into issues relating to time management and the second family related vignette was changed to those now in the interview guide (Appendix 3).

During the pilot interviewing it was decided to make a clear distinction between the two sets of vignettes. This was achieved by asking if the interviewee believed their family life had provided them with skills they used in the care home. The 'family life' vignettes were then read by the respondent (Appendix 3). Following the responses to the 'family life' vignettes the question was asked whether the interviewee thought the two mothers might have gained skills from bringing up their children that might be useful if they were employed in a care home. This alteration resulted in more informative and interesting data.

The lifecourse grid was initially divided into two columns, one for public life, the other for private life, with rows representing ages from 15 – 65 and years dating back from the time of data collection. During the pilot this was redesigned into five columns to each represent education and training, employment, geographical place of residence, family and living arrangements (Appendix 4). The decision to obtain lifecourse data was made after completion of four interviews in England. Following a number of phone calls and cancelled appointments it proved to be impossible to return to collect the additional data from three of these initial interviewees.

8. Selection of care homes
The selection of the participating homes needed to represent the range of care homes in each country whilst the characteristics of the homes also needed to be as comparable as possible. Yet it was also important to ensure that the working environment was comparable and that the home selection reduced the divergence of care home size and architecture between England and Germany. The participating homes were located in Northern Germany and Southeast England. The geographical
location was determined by my present and past places of residence linked to personal knowledge of care homes in each region in conjunction with the personal and physical accessibility of each home (Appendix 5).

Initially English homes were short-listed from the publicly available local authority listing of care homes in Hampshire and Surrey. The listing provided information about the ownership of the home, the number of residents it is registered to take and often includes pictures of the home. The German homes were selected out of a publication, which lists all care homes in Germany with information about ownership and number of residents and the services provided.

8.1 Selection and matching criteria

Whilst aiming to select homes that were typical of England and Germany, the attempt was made to also select homes with comparable features (Table 5.1).

Table 5.1: Characteristics of sample care homes

<table>
<thead>
<tr>
<th>Selection Criteria</th>
<th>England</th>
<th>Germany</th>
</tr>
</thead>
<tbody>
<tr>
<td>Profit making</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Profit making</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Number of residents</td>
<td>65</td>
<td>91</td>
</tr>
<tr>
<td>Purpose built</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>EMI* Unit on site</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Day care centre</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Close Care Flats on site</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Years of operation</td>
<td>3</td>
<td>45</td>
</tr>
</tbody>
</table>

* Elderly Mentally Infirm **recently moved into new premises

The home ownership reflects the differences experienced in the two countries and consequently the English sample is dominated by the independent sector and the German sample by the voluntary sector (Table 5.1). Predominantly purpose-built homes were also selected in each country, as this is an increasing trend in Southeast
England and is the norm in Germany (Table 5.1). However, the English sample includes two care homes that were converted manor houses (E3 and E4), typical of many English homes at the time of data collection.

The policy framework that made a clear distinction between residential and nursing homes in England at the time of data collection changed in April 2002 (see Chapter 2). Whilst conscious of potential change it was uncertain what the final policy framework would be and for that reason, the four sampled homes in England are dual registered care homes or nursing homes.

Selecting dual registered and nursing homes rather than residential homes in England provided a more comparable working environment as the distinction between residential and nursing home is not made in Germany (see Chapter 2). The provision of day care, specialised dementia care and care homes linked to 'close care flats' presents a growing aspect of institutional care of older people in both countries and consequently in each country newly opened homes providing these services were included in the sample (E1 and G4) (Table 5.1). The link to these facilities can mean that care staff develop a relationship with an older person before they permanently move into the care home.

In both countries the selection of homes evolved after completion of the pilot study. The matching criteria for the first homes in each country were the number of residents, nature of build and ownership. The German pilot home (G1) catered for 91 residents, was purpose built and was owned by one of the 5 leading voluntary organisations in the country (see Chapter 2) (Table 5.1). The English pilot home (E1) catered for 65 residents, was purpose built and was also owned by the voluntary sector. Characteristics of the care staff in the pilot German home, which had been in operation for over 40 years determined the selection of the second English home. Some of the care staff completing questionnaires and participating in interviews in the first German home had been employed there for over 20 years. This is an aspect that could impact on the research findings and it was considered important to gain access to similar respondents in England. This led to the selection of an English
home (E2) that would potentially provide comparable questionnaire respondents and interviewees as it had been operating for over 40 years.

A key feature of the pilot English home (E1) was that it had only been open for three years, a further factor that could impact on the data. Consequently this factor was then matched by the second German home (G2) which had also only been open for three years. Further characteristics of the second German home were that it was profit making and catered for 30 residents, as such it was comparable with many English homes (see Chapter 2). Like the pilot English care home (E1) it was purpose built and linked to sheltered accommodation. The main criteria for the selection of the third and fourth English homes (E3, E4) were that they should be representative of English care homes in ownership size and build. The proprietors of the third home (E3) only owned the one home whilst the fourth home was owned by an independent, market leading, national service provider (E4). Both these homes had been manor houses that were converted into care homes in the mid 1980's and extended over the last 20 years to meet market needs. As such these could be seen to be representative of the English care home industry at the turn of this century. The third and fourth German homes (G3, G4) are also representative of the German care home industry (see Chapter 2). Both are non-profit making, G3 is owned by a leading non-secular voluntary organisation whilst G4 is owned by a municipal organisation.

9. Gaining access to the sample homes

Care homes as organisations represent a closed setting and gaining access to research in this setting was a key issue. Negotiating access involved the use of ‘ordinary interpersonal resources, skills, and strategies that all of us develop in dealing with the conduct of everyday life’ (Walsh 1998:224). As described by Bryman (2001) the tactics used were based on the ‘use’ of friends within the care home industry of both countries. The home managers were contacted by phone and if they were willing to see me an appointment was made to visit. The phone call was followed up with a letter confirming the appointment and providing more information about the research.

After making the initial contact with a care home manager the tactic of gaining the support or ‘sponsorship’ (Bryman 2001, Walsh 1998) of someone within the
organisation was also used. This was usually the manager or head of care. The fact that I had in the past been employed as a home manager made me acceptable and trustworthy to both home managers and interviewees. Both matron/managers and care staff perceived me as a colleague, facilitating the collection of data that might not otherwise have been given.

9.1 Access to English homes
Using the selection criteria described, my contacts within the care home industry were very useful and eased access to all four English care homes. In two instances I happened to have informally met members of the board of governors and had been able to discuss the possibility of conducting the research in the particular homes. In one home I had known the matron/manager for many years and the home had participated in my MSc. research (Eyers 1998). Contact with one of the homes was made possible because the proprietor had been a fellow M.Sc. student. Attempts were made to gain access to homes where I had no personal contacts. Initially this appeared successful. However, in one instance when I phoned to confirm the arrangements for interviews and spoke to the proprietor I was informed that it would not be convenient or suitable for me to undertake the research. In another instance the care home I contacted had closed a few weeks before I phoned and I found myself talking to a building site manager.

Having secured access to the participating homes in England it was often problematic to organise the actual interviews. In all four homes I returned home from an appointment at least once having been told it would not be possible to undertake the interview that day. Ultimately the home managers allowed me to interview within the participants working hours and I was grateful that I was able to collect all the data I had planned (Table 5.2).

9.2 Access to the German homes
With the exception of one German care home where I had known the manager for many years, I ‘cold called’ the selected homes and asked to speak to the manager. After briefly introducing the research project and myself, either appointments were made for me to visit or details about the project with sample questionnaires and
interview guides were posted with a cover letter. In one selected home, access and
the organisation of the data collection was arranged over the phone and by email.
The home was only visited once and on that day six interviews were completed. The

Table 5.2: Summary of Data Collected

<table>
<thead>
<tr>
<th>Home</th>
<th>Home manager interview</th>
<th>Marketing material</th>
<th>Quality Assurance Principles</th>
<th>Self completion questionnaire</th>
<th>Care Staff Interview</th>
<th>Lifecourse grid</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1</td>
<td>1</td>
<td>1</td>
<td>22</td>
<td>6</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>E2</td>
<td>1</td>
<td>1</td>
<td>21</td>
<td>6</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>E3</td>
<td>1</td>
<td>1</td>
<td>15</td>
<td>6</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>E4</td>
<td>1</td>
<td>1</td>
<td>18</td>
<td>6</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Sub-total</td>
<td>4</td>
<td>4</td>
<td>76</td>
<td>24</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>G1</td>
<td>1</td>
<td>1</td>
<td>20</td>
<td>8</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>G2</td>
<td>1</td>
<td>1</td>
<td>11</td>
<td>6</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>G3</td>
<td>1</td>
<td>1</td>
<td>21</td>
<td>6</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>G4</td>
<td>1</td>
<td>1</td>
<td>26</td>
<td>6</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Sub-total</td>
<td>4</td>
<td>4</td>
<td>78</td>
<td>26</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>8</td>
<td>8</td>
<td>154</td>
<td>50</td>
<td>47</td>
<td></td>
</tr>
</tbody>
</table>

self-completion questionnaires were returned to me by post. All homes contacted in
Germany were willing to participate and all appointments went as planned. As in
England, care staff participated in the interviews during working hours. In one home
staff were even paid by their employer to stay on or come in and to talk to me. In one
home (G1) eight interviews were undertaken whilst the minimum of six were
achieved in the other homes, resulting in 13 interviews with qualified staff and 13
with care assistants in Germany (Table 5.2).

10. Data collection

The data collection from the home manager was largely uncomplicated. However,
only one home in each country was able to provide me with copies of procedures
related to washing and dressing, toileting or assistance at meal times (Table 5.2).
This was because they did not exist or were in the process of being developed. The
questionnaire providing data on residents and staff (Appendix 1) was provided by all
home managers without any problems.

The self-completion questionnaires were distributed individually to each member of
care staff by the head of care in each home. To maintain confidentiality each
questionnaire was put in an envelope that could be sealed after completion and
returned to me. The fact that the average of 20 questionnaires aimed for in each home
was not quite achieved was linked to the number of staff employed in each home. For example G2 only employed 14 members of care staff in total, of which 11 completed and returned the questionnaire. The overall average of returned English questionnaires was 19 per home and the average return of questionnaires in Germany was 20.5 per home (Table 5.2). The response rate in Germany was higher than in England (Table 5.3). However, the total number of respondents to the questionnaires in each country provides a comparable number with 76 respondents in England and 78 in Germany.

Table 5.3: Self-completion Questionnaire Response Rate

<table>
<thead>
<tr>
<th>Care Home</th>
<th>Number of Care staff</th>
<th>Number of questionnaire respondents</th>
<th>Response Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>E1</td>
<td>59</td>
<td>22</td>
<td>37</td>
</tr>
<tr>
<td>E2</td>
<td>21</td>
<td>21</td>
<td>100</td>
</tr>
<tr>
<td>E3</td>
<td>32</td>
<td>15</td>
<td>47</td>
</tr>
<tr>
<td>E4</td>
<td>31</td>
<td>18</td>
<td>58</td>
</tr>
<tr>
<td>Sub-total</td>
<td>143</td>
<td>76</td>
<td>53</td>
</tr>
<tr>
<td>G1</td>
<td>38</td>
<td>20</td>
<td>53</td>
</tr>
<tr>
<td>G2</td>
<td>14</td>
<td>11</td>
<td>79</td>
</tr>
<tr>
<td>G3</td>
<td>25</td>
<td>21</td>
<td>84</td>
</tr>
<tr>
<td>G4</td>
<td>40</td>
<td>26</td>
<td>65</td>
</tr>
<tr>
<td>Sub-total</td>
<td>117</td>
<td>78</td>
<td>67</td>
</tr>
<tr>
<td>TOTAL</td>
<td>260</td>
<td>154</td>
<td>59</td>
</tr>
</tbody>
</table>

The self-completion questionnaire distributed to all care staff in the participating homes asked for volunteers to participate in the interviews. However, ultimately the interviewee's were determined by their availability at the time of my visit although I was proactive in ensuring that I had a number of participants who had been working in care homes for over 15 years in each country. The age of participants and the mix of full-time and part-time staff were opportunistic. Men who volunteered were interviewed in both countries. In a German home a qualified nurse I personally approached and asked if she would participate refused. This full-time member of staff wanted to make the point to management that staffing levels were so low that she did not have time to spare for the interview and she was not willing to talk to me during her coffee or lunch break.

The actual interview data collection in England was fraught. Although I was welcomed by management when it came to making appointments to interview staff these became very difficult to organise. As staff were interviewed during working
hours I felt I should be as adaptable as possible. However, on occasions in E1, E2 and E4 I arrived to the appointment on time only to have to leave again without

**Table 5.4: Interviewee Profile**

<table>
<thead>
<tr>
<th>Home</th>
<th>England</th>
<th></th>
<th></th>
<th></th>
<th>Germany</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E1</td>
<td>E2</td>
<td>E3</td>
<td>E4</td>
<td>G1</td>
<td>G2</td>
<td>G3</td>
<td>G4</td>
</tr>
<tr>
<td>Form of Employment</td>
<td>f/t</td>
<td>p/t</td>
<td>f/t</td>
<td>p/t</td>
<td>f/t</td>
<td>p/t</td>
<td>f/t</td>
<td>p/t</td>
</tr>
<tr>
<td>Total number of Qualified Staff employed</td>
<td>7</td>
<td>8</td>
<td>5</td>
<td>0</td>
<td>3</td>
<td>6</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Total number of Care assistants employed</td>
<td>32</td>
<td>12</td>
<td>16</td>
<td>0</td>
<td>10</td>
<td>13</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>RGN Interviewed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>OPC Interviewed</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>NVQ Care Assistant Interviewed</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Assistant Interviewed</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Full-time = f/t Part-time = p/t

having interviewed any care staff. Rearranging the appointments was in two instances difficult as contacting the head of care, who was then my point of contact, was difficult. In E3, the planned three interview visits had to be extended to four as on one occasion it was only possible to interview one member of staff. In each English home the data collection stretched on average over a period of three months whereas in Germany the interviews were conducted on average in three days and the questionnaires completed and returned within a month.

The participating care staff in both countries were happy to be interviewed, often commenting that they enjoyed the interview even if it resulted in them staying at work longer than planned. The only problem I encountered in Germany was where I
went to G2 at the appointed time and neither the manager nor head of care were present to ease the introduction to the care staff. The nurse in charge of that shift originated from a former eastern block country and was understandably wary of my research, especially as I would be using a tape recorder. The problem was overcome by allowing her to sit in on the interview with her colleagues. This was done with the colleague’s permission. Whilst this might bias their responses, I did gain the impression that the interviewee was not influenced by the presence of her colleague who in the end was not able to sit and listen to the complete interview as the nurse-in-charge had to attend to the needs of the older people in the care home. Sitting in and listening to the first few questions where I was asking about the daily routine appeared to set her mind at rest and she did ultimately happily co-operate and that afternoon the planned three interviews were completed. The overall target of a minimum of 24 interviews in each country was achieved and in Germany this was exceeded by two (Table 5.2).

The participating interviewees ranged from head of care, including OPCs, General Nurses and care assistants with and without NVQ training. They represented a cross section of ages who worked full and part-time (Table 5.4). One head of care interviewed in each country was male and a further male qualified nurse in each country was interviewed. With the exception of a male in Germany, all the participating care assistants were female. The taped interviews lasted on average 30 minutes. However, the overall time spent with an interviewee averaged 45 minutes providing a rich source of data.

11. Data analysis
The analysis of each data set was undertaken separately and the findings linked, compared and contrasted. The home management data were analysed using Excel 97 and the self-completion questionnaire data were analysed using SPSS. The question in the self-completion questionnaire about the first occupation in which the participant was employed was coded separately. This question was not pre-coded, as it was difficult to anticipate what the responses would be. As the number of respondents was not expected to exceed 200 coding and analysis for one question could be done manually.
The data from transcribed and translated interviews was analysed with the assistance of WinMAX.98. The lifecourse data were initially collected in grid format (Appendix 4) and a method of analysis was developed to facilitate the link between the lifecourse threads of English and German care staff established from the collected data. This was achieved by establishing lifecourse threads (Appendix 7) in four different colours, one following private family life (red), a second following geographical location (green), a third following occupational training (blue) and a fourth following employment (purple). Events or a change in each aspect of an individual's lifecourse was indicated by a 'nodule' and change in structure of the thread. The data were grouped according to country, age and qualification. The four strands have been termed 'lifecourse threads' as they contribute towards weaving a colourful tapestry of people's lives. The 'nodules' in each thread indicate an event that has had an impact on the respondent's life in some instances the thickness of the thread then changes. The 'nodules' in a thread could then be related to another thread to identify how the course of one thread impacted on the other. For example it is possible to establish how the birth of children has impacted on a respondents employment thread. By bringing together the lifecourse threads of qualified staff and care assistants in the same age group in each country patterns could be established that facilitated the comparative element of this research project. The findings are compared and evaluated within the context of relevant research, literature and government policies, in particular focusing on women's life experiences and the care home industry in both countries. However, in the writing of the analysis chapters the findings from the lifecourse threads were not widely used as they proved not to fit into the conceptual framework of the thesis.

12. Conclusion

The multi-methodology used in this data collection makes it possible to establish the skills required to care for an older person living in a care home and relate these skills with the lifecourse of English and German care staff. This is then related to their ability to provide care within the policy framework of each country. The data from the care home managers and the interview data describing the tasks performed by care staff on the day of interview made it possible to create a picture of everyday
care home work and identified the skills needed by care workers in the English and German care home industry. The self-completion questionnaires established a care staff profile, which was enhanced by the lifecourse data collected in the interviews that provided information about the acquisition of care related skills throughout life. Using vignettes relating to everyday situations encountered in care work provided an insight into care work without intruding into the daily routine of a care home or involving vulnerable older people. The findings from the wide range of data collected data will make it possible to compare and understand the impact of English and German government policies on the everyday lives of both care staff and older people living in care homes.
Chapter 6
Profile of Care Staff in the English and German Sampled Care Homes

1. Introduction
The care that older people living in an English or German care home receive will invariably be linked to the people who regularly provide their 'hands-on' care. This chapter establishes the characteristics of care staff in the sample homes and identifies how lifecourse experiences in England and Germany have influenced the care skills of the participants in this research. After discussing the age and gender distribution, an overview of the diverging lifecourse experiences of qualified staff and care assistants are considered. This contributes towards creating an understanding of how and where care staff acquire the skills to provide care to older people living in a care home.

2. Gender and age
Research literature describes the care industry as a female dominated field of employment and this is reflected in the sample homes in both countries with 89% of the English and 91% of care staff in the German sample care home being female (Table 6.1). However, in both countries male staff were employed as both qualified staff and care assistants and are included in the empirical data collection.

<table>
<thead>
<tr>
<th></th>
<th>England (n=143)</th>
<th>Germany (n=123)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Staff Female</td>
<td>24%</td>
<td>49%</td>
</tr>
<tr>
<td>Care Assistant Female</td>
<td>65%</td>
<td>42%</td>
</tr>
<tr>
<td>Total Female</td>
<td>89%</td>
<td>91%</td>
</tr>
<tr>
<td>Qualified Staff Male</td>
<td>3%</td>
<td>5%</td>
</tr>
<tr>
<td>Care Assistant Male</td>
<td>8%</td>
<td>4%</td>
</tr>
<tr>
<td>Total male</td>
<td>11%</td>
<td>9%</td>
</tr>
</tbody>
</table>

In each country, one of the participating care homes employed a male ‘Head of Care’ and in each country one home had a male manager. One of the male care assistants in Germany was seconded to work in the care home to complete his compulsory ‘National Service’ in the form of ‘Community Service’ as he was a ‘conscientious objector’. The
presence of men working in all levels of employment in the care home sector does not deflect from the female dominance of this work force.

Whilst care work is related to gender it can also be seen to be related to age. The employees in the sampled homes in England and Germany provide an indication of the age profile of care staff which can then be related to the formal and informal skills developed throughout the lifecourse and used in this form of employment.

The divergence in occupational training policies between England and Germany can be seen in the age groups under 35 employed in the sample homes (Table 6.2).

Table 6.2 Care staff age distribution based on data from care home managers. (N.B. German qualified staff includes OPCs)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>English Care Staff</th>
<th>German Care Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>23</td>
<td>5</td>
</tr>
<tr>
<td>26-35</td>
<td>28</td>
<td>10</td>
</tr>
<tr>
<td>36-45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>46-55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>56+</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A noticeable difference between the two countries is to be observed in the 18-25 age group where there are 23 care assistants and no qualified staff in England. In contrast there are only five German care assistants in this age group, which does however contain three qualified OPCs. This trend continues on into the next age group where in England the number of care assistants in the 26-35 year old age group is 28 compared to 10 of qualified members of staff. This is in contrast to Germany where the qualified staff are more strongly represented than the care assistants. Whilst there is a contrast between

91
care staff employed under the age of 35 in England and Germany there is less divergence in age groups over 35.

The highest proportion of care assistants in both countries is in the 36-45 year age group. Whilst the highest number of qualified staff in England are to be found in the 46-55 age group, in Germany this is in the 36-45 age group. This indicates the strong presence of both English and German qualified staff and care assistants in mid working life and emphasises the importance of their lifecourse experiences in the provision of care.

3. Choosing care as an occupation
As described in the Chapter 4, the formal acquisition and certification of ‘skills’ in Germany has a very important role to play. The majority of young people who leave school at the age of 16 enter a three-year occupational training programme and continue to attend college on a day release basis until they have passed the final exam and gained the certificate which will be vital to their future employment. The fact that they have qualified to work in an occupation whether as a waitress, shop assistant or hairdresser identifies them as skilled workers and they will have a sound knowledge of the theoretical and practical aspects of their occupation. This is in contrast to England where a waitress or shop assistant would not expect to undertake an occupational training programme and the form of employment would be seen to be ‘unskilled’.

The care home industry of England and Germany, however, provides a comparable environment as in both countries the qualified staff are seen to be skilled and care assistants as unskilled. Qualified staff in both countries have participated in a training program in hospital nursing or as is the case in Germany in the care of older people and have successfully passed the final exams, they are therefore ‘skilled’ workers. At the time of data collection care assistants in England and Germany were not required to participate in formal training. Consequently they are seen to be ‘unskilled’ members of the work force. However, to actually define a care assistant as ‘unskilled’ is in reality unjustified, as special skills are called upon to meet the needs of an older person living in a care home.
The participants in this research have entered employment in a care home at varying stages of their lifecourse as either ‘skilled’ qualified nurses and OPCs or ‘unskilled’ care assistants. The aim of this section is to establish how the participants in this research entered employment in the English and German care home industry. This will create a better understanding of the aspects of their earlier lifecourse, which may have provided them with some of the skills needed to care for older people.

To gain an insight into the occupational history of care home staff, self-completion questionnaires distributed to all care staff in the eight participating homes included the question ‘What was your first job after leaving school?’. The resulting data shows that for 45% of the English and 46% of the German respondents the first job was care related (Table 6.3). In total 34 occupations were named (Appendix 6), these were then categorised into six core groups. The occupational group ‘Care’ ranged from working as a nanny to training to be a qualified nurse and included working as a care assistant. ‘Trade’ ranged from hairdresser to florist, whilst ‘Shop’, ‘Office’ and ‘Factory’ work are less complex categories. The ‘Various’ groups included nine different occupations that were named, ranging from a housewife to a teacher.

<table>
<thead>
<tr>
<th></th>
<th>Care</th>
<th>Trade</th>
<th>Shop</th>
<th>Office</th>
<th>Factory</th>
<th>Various</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>England RN (n=25)</td>
<td>60%</td>
<td>0%</td>
<td>8%</td>
<td>12%</td>
<td>12%</td>
<td>8%</td>
<td>40%</td>
</tr>
<tr>
<td>England Care Assistants (n=50)</td>
<td>38%</td>
<td>18%</td>
<td>16%</td>
<td>12%</td>
<td>2%</td>
<td>14%</td>
<td>62%</td>
</tr>
<tr>
<td>English Total (n=75)</td>
<td>45%</td>
<td>12%</td>
<td>13%</td>
<td>12%</td>
<td>5%</td>
<td>12%</td>
<td>55%</td>
</tr>
<tr>
<td>Germany RN (n=21)</td>
<td>71%</td>
<td>10%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>29%</td>
</tr>
<tr>
<td>Germany OPC (n=25)</td>
<td>56%</td>
<td>16%</td>
<td>8%</td>
<td>8%</td>
<td>0%</td>
<td>12%</td>
<td>44%</td>
</tr>
<tr>
<td>Germany Care Assistant (n=32)</td>
<td>22%</td>
<td>19%</td>
<td>16%</td>
<td>16%</td>
<td>13%</td>
<td>16%</td>
<td>78%</td>
</tr>
<tr>
<td>German Total (n=78)</td>
<td>46%</td>
<td>15%</td>
<td>10%</td>
<td>10%</td>
<td>6%</td>
<td>12%</td>
<td>54%</td>
</tr>
</tbody>
</table>

In both countries, training to be a nurse or OPC cannot commence until the age of 18 and training places are not always immediately accessible. However, as the lifecourse
data establishes, people who, like Enid, Sheila and Rowena, had decided as children that they wanted to be a nurse after leaving school tended to bridge the gap working as a nanny or care assistant. Sharon, one of the participating English care assistants in age group 18-25, was waiting for confirmation that she had been accepted to train as a nurse in London at the time of data collection.

Whilst the age profile of the English care staff shows a strong representation of care staff under the age of 25, this is not reflected in the interview participants. As indicated in Table 6.2 English qualified staff were not represented in the 18-25 age group yet 23 English care assistants were in that age group and only two participated in the interview. However, interview data from Kelly and Eileen (age group 26-35) provides a retrospective view of entering care work at a young age. They were two school friends who started to work in the care home at the age of 16 and 18 respectively (Appendix 7). When she was 18 years old Eileen joined her friend to work initially as a cleaner but very soon became a care assistant in the same care home. The following extract from the interview with Kelly exemplifies that for a teenager working as a care assistant, looking after older people did prove problematic at times and that the support and guidance of a mature care assistant, was essential. Kelly’s mother clearly not only guided and supported her daughter but also other young members of the care staff.

I: If you've been here for so many years, you obviously enjoy working in a care home.
Kelly, Care Assistant: Oh, I do. I've got a few friends - and I've got somebody who went to school with me and is my best friend and we work together as well so that's nice
I: Did you apply for the job together - or how ...?
Kelly: No, when it [the care home] first opened my mum came for a cleaning job and they didn't need anyone so she became a care assistant, then she got me a job. And there's about 10 of us that I've actually known from school that have been through the place - and other people - if my mum hadn't have started they wouldn't have got jobs here....
I: I'm surprised you started at 16.
Kelly: Oh yes - and came from school as well for work experience - I was 15 then.
I: And were you washing the residents and everything then?
Kelly: Yes
I: And how did the residents feel about being washed by a 16-year-old?
Kelly: They were fine actually - they were quite good. I think because my mum was working here as well, and she used to take me under her shoulder - and she knew the residents and she did introduce me to them.

I: Eileen’s mum wasn’t here?
Kelly: No but my mum’s not Eileen’s mum!

I: So your mum eased the way in for you and Eileen?
Kelly: Very definitely, yes. Made it a lot easier. If there was someone we didn’t like dressing in the morning my mum would go and do it for us.

I: What about the other residents?
Kelly: They didn’t really bother me - didn’t make any difference, tell you the truth. Just got on with the job.

I: Everything that needed to be done was done and that was it?
Kelly: Yes, I never thought about that. You just closed your eyes and got on with it. You just get used to some things.

I: And the residents didn’t mind?
Kelly: Didn’t mind at all actually, because at one point we had quite a few youngsters - now we’re all getting a bit older. They didn’t mind at all ...

Interview extract Kelly. My emphasis

It would appear that ‘Kelly’s mum’ at one time was the catalyst that enabled a number of young care assistants to work in one particular home. The overall impact of young care assistance on the work within a care home was for example raised by Penny (36-45 age group) who, as the following extract exemplifies, observed that young care assistants thought working in a care home would be an easy job.

Penny, Care Assistant: I think a lot of the youngsters think its going to be an easy ride looking after an elderly person - they go to the agencies they earn a lot of money and the agencies do tend to employ just anybody. We have had some awful ones here and I’ve refused to work with some of them – I’ve worked with them once and I’ll not do it again – They don’t seem to care about the residents they just sit there drinking coffee and reading the paper.

Interview extract Penny. My emphasis

Young care staff working in care homes clearly need to have an interest in caring for older people. Those who enter the care industry because it appears to be a good way to earn money are, as Penny’s observation highlights, soon disillusioned and become a burden to their colleagues which in turn can be expected adversely to influence the provision of care to older people. Both Sharon and Tracy in England and Sigrid in Germany clearly wanted to enter a caring occupation as they had attended college courses that could be seen to prepare them for this area of employment and all three clearly enjoyed their work. Eileen and Kelly also evidently enjoyed caring for older people at a young age and were successfully guided and motivated by qualified staff and
mature colleagues. This is indicated by the fact that they have both stayed in the same care home for over 10 years and when Eileen needed to earn extra money after her divorce she also registered with a care agency to provide care to older people living at home on her days off duty from the care home (Appendix 7).

The experience of young care staff entering the care home industry in England is in contrast to Germany where the development of OPCs vocational training facilitates the entry into the care home industry at the age of 18 and as Beate (Appendix 7, Figure 4) exemplifies, ultimately provides the individual with a qualification that will enable them to develop a career in caring for older people.

4. Route to employment in a care home

The routes towards employment and consequently towards establishing a position in the labour market in both England and Germany are described by Roberts et al (1994) to be: academic, skilled, non-skilled and the experience of unemployment. However, the routes to employment in care homes do not easily fit into these categories. This is related to the fact that being a care assistant is normally not perceived to require academic qualifications and the issue of unemployment is blurred by breaks in employment to raise a family. As such the route into employment in the care home industry can only be defined as ‘skilled’ for qualified staff and ‘unskilled’ for care assistants. However, as the data collected indicates, this basic definition is in reality more complex.

The majority of ‘skilled’ qualified staff who participated in the interviews in England (Table 6.4) indicated that their routes to work in care homes led from school to nursing training and experience in hospital nursing. This was similar for the qualified general nurses in Germany. A noticeable difference is found in the group of German OPCs who mainly entered care home employment in mid working life via work in another occupation or having worked as a care assistant. The data from the ‘unskilled’ care assistants identifies two routes, which are either directly from school/college to care home work or entry into the care industry after having worked in another occupation.
The interviewees only represent a small sample of care home staff in each country. However, the findings do indicate that the English qualified staff had a much more clearly defined entrance into care work than the German qualified staff. This can be seen to be contrary to other comparative employment studies where the entry into the work force in England is described as untidy and weak and in Germany to be regulated and strongly institutionalised (Chapter 4). This sample indicates a rigid structure in the English nursing occupation which has its main focus on academic hospital nursing at a young age and where caring for older people can be seen to be marginalised. The German data identifies the variety of pathways into caring for older people and can be seen to highlight the German government policies to create and develop a career path in the care of older people. Only three of the German interviewees were qualified registered nurses of whom two (Appendix 7 Figure 5, Ortrud and Hedwig) had entered nursing from college and the third had originally been a farmer who changed his career at the age of 20 (Appendix 7, Figure 5, Hartmut). The other 10 German qualified staff who participated in the interviews had, as their lifecourse data indicates, all trained to become OPCs in mid life. This is especially noticeable in the German 46-55 age group of qualified staff (Appendix 7, Figure 6).

Whilst the data from the care home managers indicates a high number of young care assistants, this was not reflected in the actual interview participants the selection of whom was determined by staff availability at the time of data collection (Chapter 5). Consequently the interviews may not be seen to be typical and more detailed research on the younger group of care home staff is called for. However, the data from the self-completion questionnaire does indicate that the majority of care assistants have worked in other occupations before entering care home work. This can be seen to be linked to

<table>
<thead>
<tr>
<th></th>
<th>Qualified Staff</th>
<th>Care Assistants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>via training after school</td>
<td>via training after work as care assistant</td>
</tr>
<tr>
<td>England (n=19)</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Germany (n=26)</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
Table 6.3 where 62% of the English care assistants and 78% of their German colleagues had started their working lives in non-care-related employment.

4.1 Skilled route in England
The skilled route towards employment in the care home industry of England and Germany presents diverging patterns that are linked to the differing structures for the training and regulation of the nursing profession in both countries (Chapter 4). In England the skilled route to employment in a care home is taken by qualified nurses trained to care for sick hospital patients. Such a working environment contrasts with work in a care home where older people with a medical condition live and seldom expect to return to the environment they lived in before moving into the care home.

Amongst the English qualified staff, Joyce (age group 36-45) was unusual as she had undertaken her training to be a nurse as a mature student because she wanted to work as a qualified member of staff in a care home (Appendix 7, Figure 2). This is in contrast to Thelma and Sheila who commenced their nurse training at the age of 18 and did not gain further qualifications after completing their training as qualified nurses and had no intention of a career path in caring for older people. Joyce had experienced care home work throughout her life as her parents owned and ran a care home where she also worked as a care assistant until her husband's army postings meant she lived too far away. Once her family situation allowed, Joyce trained to be a nurse and later found employment in the sample care home. As the extract from the interview with Joyce (Chapter 9. Section 4.4) exemplifies, her approach towards care home work is strongly influenced by the clinical decision making process and her managerial role as a qualified nurse. In this she is no different from her English colleagues who started their training to be a nurse as 18 year olds. This highlights the lack of training and a structured career in the care of older people outside the confines of NHS nursing.

The majority of female qualified staff in the English homes had been employed as 'skilled' care home staff after they had taken a 'career break' to meet family commitments. This is especially noticeable in the age group 36-45 and 46-55 (Appendix
7, Figures 2 and 3). Their formal skills will have been enhanced by their experiences within the family. Barry (RN), (Appendix 7, Figure 3) had spent most of his life in the Army as a nurse. In this environment he had also nursed hospitalised older people and had attended specialised courses focusing on older people’s nursing needs. His experiences within his family life as a father may also have enhanced his care skills. However, as Head of Care his main role as a skilled member of staff was managerial and his route to employment in a care home via the army and the training in nursing he received there, provided him with the nursing and organisational skills perceived to be required by English qualified staff working in care homes meeting the needs of older people.

In the age group 46-55 it is noticeable that all the skilled participants had attended further nursing orientated courses and gained further qualifications. Barry had originally trained as an ‘Enrolled Nurse’. In keeping with changing guidelines in the regulation of the nursing profession he had needed to ‘upgrade’ his qualifications so that he could continue to work as a nurse and participated in additional training to become a ‘Registered Nurse’. Rowena had attended a ‘back-to-nursing-course’, whilst Joan continued her training and gained midwifery and psychiatric qualifications. In their thirties, Enid and Joan also gained academic qualifications that related to nursing, thus reflecting how, within the last thirty years, nursing in England has become more academic. However, none of the academic qualifications they gained related specifically to the care of institutionalised older people or to the changing needs of an ageing society. The actual route to skilled employment in care homes undertaken by the English qualified participants in this project led via the route of skilled employment in hospital nursing.

4.2 Skilled route in Germany
In contrast to England the majority of German qualified staff have taken a different route. Whilst the three qualified nurses (Ortrud, Hartmut and Hedwig) had taken a route that is similar to that of their English counterparts, the ten participating OPCs have taken a different route. This is especially noticeable looking at the lifecourse threads of the
German qualified staff aged 46-55. This indicates that whilst the interview participants are employed as ‘skilled’ care staff, their route to care home employment could not always be clearly defined as ‘skilled’ because for example Dietlinde, Marlies and Doerte had commenced employment in the care home industry as care assistants.

With the exception of two of the three participating RNs in Germany, the qualified staff did not commence their training to become ‘skilled’ immediately after completing their formal school education. The German government policies to increase the number of OPCs available to care for an ageing population (Chapter 4) provided these interview participants with an opportunity to develop a career in the care of older people in mid life. Marlies (Appendix 7, Figure 6) for example had been working as a care assistant for 18 years before making the transition from ‘unskilled’ to ‘skilled’ care worker through training as an OPC. Like Roswitha in the same age group (Appendix 7, Figure 6), Marlies came to Germany from another country where she had gained educational qualifications that could have enabled her to attend University. However, as the lifecourse data shows, in both cases ‘love’ and marriage determined their lifecourse and they migrated to Germany. Roswitha married after leaving school and accompanied her husband who studied at a German university where she was a housewife and mother for 14 years. Marlies started to work as a care assistant because she wanted to live in Germany where her future husband lived and worked. At an early age these two women had made choices relating to marriage that meant they did not gain occupational qualifications. However in mid life, German government policies provided these two women with an opportunity to readdress their career prospects which both have successfully pursued. Not only are they qualified OPCs but they have also both attended extensive day release courses over a period of two years that provided them with the qualifications needed to take on a managerial position within German care homes.

Doerte and Hiltrud (Appendix 7, Figure 6) were the only two who had taken what is seen to be the standard route to employment in Germany. They both completed their occupational training programme, Doerte as a dental nurse receptionist and Hiltrud as a shoe shop assistant. Doerte then moved on to work as an administrator in a health
insurance company whilst Hiltrud stayed in the shoe shop where she had completed her occupational training programme. Both later took a break from employment in their twenties to raise a family, later gradually returning into employment. Doerte was asked by a local family doctor if she would help to care for a frail elderly couple in the neighbourhood. Although it could be seen as an informal arrangement, she was paid for the work she did. From these beginnings the doctor informally provided Doerte with a fairly steady supply of clients over a period of four years. Then Doerte started to work part-time as a care assistant in a care home and when the opportunity arose to participate in training to become an OPC, she did so whilst continuing to be gain practical experience on a part-time basis.

Dietlinde (Appendix 7, Figure 6) who left school at the age of 15 to work as an ‘unskilled’ seamstress until the birth of her child, re-entered employment as a cleaner once her child was at school. Like Doerte she also moved into caring for older people living at home, and commenced her training to be an OPC at the age of 40. Her training was funded by the government via the ‘Arbeitsamt’ (Department of Employment) and she also received a grant from the ‘Arbeitsamt’ during that time (Chapter 4). This will have meant that her participation in occupational training in mid life did not have a negative impact on the household income.

These examples of German OPCs exemplify the diverse educational backgrounds of the German skilled care home staff ranging from someone like Dietlinde who had minimal school leaving qualifications to Marlies and Roswitha with the highest school leaving qualifications achievable in their home country. However, only one of the participating OPCs could actually be seen to have taken a direct ‘skilled route’ into caring for older people. Beate (Appendix 7, Figure 4) worked as a housekeeper until she 18 and old enough to commence her training as an OPC. At the time of data collection, Beate was further developing her skills in care home work and attending a three year course on a day release basis to qualify in care home unit management. Such a course was also being attended by Detlef and Marlies (Appendix 7, Figures 5 and 6) whilst Roswitha had completed this course six years before the data collection (Appendix 7, Figure 6). As
Beate exemplifies, the German system enables either career development from leaving school or, as Marlies, Detlef and Roswitha exemplify, in mid life. Such an achievable career path can clearly be seen to benefit the care home industry, which has to operate effectively and efficiently to meet government standards. However, it can also be expected to impact on the residents as well as the personal development of the individual qualified member of staff. Despite being eligible to do so, none of the three participating German qualified staff whom had trained as general hospital nurses were participating in the care home management courses.

The lifecourse of ‘skilled’ German staff can be seen to be varied and to have provided participants with a mix of life experiences. This can be expected to influence their provision of care to older people. Whilst the German RNs route to employment in the care home industry was similar to that of their English colleagues, the OPCs illustrate more diverse routes, indicating the importance of providing occupational training to people in mid life. The majority of the participating OPCs embarked on the skilled route in which a training programme (Chapter 4) provided them with an appropriate blend of nursing and social care skills to meet the needs of frail older people either living in their own home or in a care home. The low number of RNs in the participating German homes indicates that OPCs dominate in the provision of institutional care to older people in Germany. This is further underlined by the fact that none of the participating RNs were in managerial roles or attending management courses. This is in contrast to the English ‘skilled’ participants whose work is, as the following chapters will indicate, mainly supervisory and managerial and builds on a hospital nursing culture. Contrary to the German qualified OPCs, the English qualified staff are not trained to meet the specific needs of older people living in a care home or to manage the staff employed to work in this industry.

4.3 Unskilled route England

At the time of data collection there was no legislation that impacted on the employment qualifications of care assistants in either England or Germany (Chapter 4). However, the route taken by the participating care assistants in this research does reflect basic
differences between English and German employment policies as it exemplifies the diverging governmental training policies experienced by women who work in the care home industry.

The lifecourse data of the 36-45 year old age group of English care assistants (Appendix 7, Figure 9) indicates that most interviewees entered employment in the care home industry in mid working life having worked in non care related occupations or taken a break to raise a family. Within this age group Audrey was exceptional, she was the only one who had gained 'A' levels, undertaken formal occupational training and had worked in that occupation for a number of years before starting to work in the care home industry which she enjoyed very much. However, she saw no value in participating in NVQ training to care for older people, as the time and effort to gain the qualification were not adequately rewarded. A factor which, in view of the National Minimum Standards (DH 2002), is relevant to English care home staff.

The data collected from English home managers (Table 6.5) illustrates how care homes E2 and E4 provided NVQ training, with 61% and 67% respectively of care assistants with NVQ competencies or preparing to gain the qualification. This contrast with E1 and E3 at the time of data collection where there was less interest in doing so and where only 7% and 17% of care staff had gained NVQ competencies. Across the participating four English care homes data from the care home managers indicates that 23% of the care assistants had achieved NVQ level 2; 5% had achieved level 3 with a further 8% were participating in NVQ training.

Table 6.5 Number of NVQ qualified staff in the participating care home (Data from care home managers)

<table>
<thead>
<tr>
<th></th>
<th>E1 (n = 44)</th>
<th>E2 (n = 18)</th>
<th>E3 (n = 23)</th>
<th>E4 (n = 21)</th>
<th>Total (n = 106)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NVQ 2 achieved</td>
<td>7%</td>
<td>33%</td>
<td>17%</td>
<td>52%</td>
<td>23%</td>
</tr>
<tr>
<td>NVQ 3 achieved</td>
<td>0%</td>
<td>19%</td>
<td>0%</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>Participating in NVQ training</td>
<td>0%</td>
<td>22%</td>
<td>13%</td>
<td>5%</td>
<td>8%</td>
</tr>
<tr>
<td>Total with or gaining NVQ competence</td>
<td>7%</td>
<td>61%</td>
<td>17%</td>
<td>67%</td>
<td>30%</td>
</tr>
</tbody>
</table>

Column %
The data from the self-completion questionnaires distributed to care staff in the sample homes indicates that for the care assistant’s age is not a relevant factor when participating in training. Whilst the 36-45 year old age group have the highest percentage of care assistants without NVQ training, their older colleagues in age group 46-55 are the age group with the highest percentage of care assistants participating in NVQ training. The fact that overall 45% of care assistants participating in the research claim to have NVQ competencies or are in the process of gaining the qualification, indicates that in England care assistants are being provided with opportunities to participate in NVQ training irrespective of their age1. The age distribution of care assistants who have gained or are in the process of gaining NVQ competencies indicates the role life-long learning has to play in training care home staff. This training can be expected to add to their lifecourse skills that contribute towards care assistants’ ability to meet the needs of older people living in a care home. It further indicates that at the time of data collection the care home industry was providing on-the-job training and preparing to meet the anticipated need to employ 50% of NVQ competent care assistants which will now need to be achieved in every English care home by 2005 (DH2002).

Table 6.6 Care Assistants who are participating in or have completed NVQ training (Data from self-completion questionnaire)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>In training (n=13)</th>
<th>Level 2 (n=9)</th>
<th>Level 3 (n=21)</th>
<th>No training (n=1)</th>
<th>Total (n=49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>15%</td>
<td></td>
<td></td>
<td></td>
<td>16%</td>
</tr>
<tr>
<td>26-35</td>
<td>23%</td>
<td>44%</td>
<td>24%</td>
<td></td>
<td>27%</td>
</tr>
<tr>
<td>36-45</td>
<td><em>11%</em></td>
<td><em>14%</em></td>
<td>20%</td>
<td></td>
<td>6%</td>
</tr>
<tr>
<td>46-55</td>
<td>8%</td>
<td></td>
<td>20%</td>
<td></td>
<td>6%</td>
</tr>
<tr>
<td>56+</td>
<td>54%</td>
<td>44%</td>
<td>67%</td>
<td>100%</td>
<td>55%</td>
</tr>
</tbody>
</table>

Column %, *includes one person training for level 3, who will already have achieved level 2.

Whilst the majority of the English care assistants entered employment in the care home industry without prior formal knowledge of older people’s care needs, participation in NVQ training during employment in care homes does provide care staff with on-the-job training in the basic skills required to work in a care home. Data from Tracy and Sharon, the two youngest English interviewees (Appendix 7, Figure 7), does establish that amongst the participants in this research, college students participated in training that would provide them with basic skills needed to care for older people. However, Tracy

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1 Due to the response rate to the self-completion questionnaire there were noticeable differences between Table 6.5 and 6.6.
did not complete the course and therefore did not gain formal qualifications and Sharon was waiting to be accepted to train as a qualified nurse aiming to specialise in nursing sick children. For the majority of the English care assistants, working in a care home was not their first job after leaving school (Table 6.3). Consequently, it can not be expected that they would have been interested in care related courses available to them before leaving formal school education. This does underline the need for policies in both lifelong learning and the provision of long-term care to develop and support a training programme that would meet the needs of potential care assistants, their future employers and the needs of older people living in care homes.

4.4 Unskilled route Germany

'Unskilled' entry into the care home industry in Germany presents a different picture as 72% of care assistants responding to the self-completion questionnaire (Table 6.7) had actually taken part in the ‘Schwesternhelferin Program’ (SHP), providing them with basic hospital nursing skills that could be called upon in a state emergency (Chapter 4, Section 5). However, it is not seen as a 'skilled' route into the provision of care to older people as this does not provide a formal German occupational qualification; nor is it formally a prerequisite to employment as a care assistant. Whilst attending the SHP training programme adds to the lifecourse skills of the individual and provides a basic understanding of how to undertake bodywork, it does not aim to provide training in the specific needs of older people.

<table>
<thead>
<tr>
<th></th>
<th>Participants</th>
<th>Non Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care assistant (n=32)</td>
<td>72%</td>
<td>28%</td>
</tr>
<tr>
<td>RN (n=20)</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td>OPC (n=25)</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>48%</strong></td>
<td><strong>52%</strong></td>
</tr>
</tbody>
</table>

Table 6.7 German care home staff who had participated in the ‘SHP’ by qualification level (Data from self-completion questionnaire)

Whilst this course in basic nursing skills does not provide an occupational qualification, it does informally appear to act as an 'entrance ticket' to employment as care assistants in the care industry, especially after taking a break in employment to raise a family.
(Appendix 7, Figures 13 and 14). This could be seen to be especially significant to the care assistants who, after leaving school, completed their vocational training in an occupation that is now obsolete or where a high rate of unemployment is experienced. The lifecourse data from the care assistants establishes that less than 50% of the participating care assistants had completed an occupational training programme after school. In Germany formal occupational qualifications are key to employment and women without such formal qualifications would only expect to find employment in areas such as assembly work in a factory or in some domestic employment.

Data from the lifecourse threads indicates how some care assistants who had undergone occupational training were unable to find employment that related to their training. Sigrid (Appendix 7, Figure 11) had trained as a children’s nanny but was not able to find employment in that field. Edeltraud (Appendix 7, Figure 14) had trained as a masseuse in the former German Democratic Republic and she was not able to find employment in that occupation when she moved to West Germany. Dagmar (Appendix 7, Figure 13) originally trained as a lathe operator but was never employed in that occupation because she married and had children soon after completing her training. Gudrun (Appendix 7, Figure 13) completed her occupational training as a hairdresser and stayed with the same employer until she was 25 when she chose to go and work in a factory for four years until the birth of her child. Subsequently, for three years she fitted her work as a part-time cleaner and childminder around her family commitments. She then worked as a laundress for four years at which time she found employment as a care assistant. Gunther (Appendix 7, Figure 12) undertook a three-year occupational training programme at a petrol station. His attendance at college on a day release basis will have provided him with the theoretical knowledge in legislation related to fuel sales and storage, stock management and basic book keeping. At the end of three years he will have taken an exam and become a qualified retail assistant and therefore be classified as a ‘skilled’ worker. However, he never took on employment in that occupation and with the exception of four years in the army, changed his employer almost annually until he found employment as a care assistant at the age of 29.
Despite having taken the standard German ‘skilled’ route into the work force, none of these five care assistants, for a variety of reasons, were able to develop a career and entered employment in the care home sector as ‘unskilled’ care assistants. Of these five, only Dagmar (Appendix 7, Figure 13) had taken part in the ‘SHP’ course. With the exception of Wiebke (Appendix 7, Figure 12) the other seven participating care assistants had all completed the SHP shortly before they took up employment in the care industry (Appendix 7, Figures 11-14). Wiebke attended the course a year after she started to work in the care home because she needed to be 18 to attend the course. The fact that eight out of the twelve female care assistants participating in the lifecourse data collection entered the care home industry after completing this government funded SHP course indicates its value to both the women and their employers. In contrast to English care assistants, their German counterparts who had attended the SHP course will have at least received the basic knowledge of how to bed bath and dress a hospital patient. However, as is the case with English care assistants they did not have formal occupational qualifications that provided them with an understanding of care home resident’s specific needs.

5. Acquisition of skills to care for older people living in care homes
The knowledge and understanding of older people and their needs when they live in a care home, are important aspects in the provision of their care. The data from the self-completion questionnaire provided an insight into where the respondents perceive they have acquired the skills to care for older people living in a care home and established their experiences in parenting and providing care within the family.

5.1 Understanding of older people’s needs prior to entering employment in the sample care home
Before entering employment in the sampled care home, the respondents in England and Germany can be expected to have had varying levels of knowledge about older people. In order to establish how the respondents themselves perceived their level of knowledge,
the self-completion questionnaire asked: ‘How much did you know about older people before you started work here?’.

Only one in five (18%) of the German qualified staff believed they knew a ‘great deal’ (Table 6.8) although just under half (47%) believed they knew a ‘fair amount’ about older people when they started work in the sample care home, and 36% stated that they thought they knew ‘a bit’. This can be seen to be linked to the fact that when the now-qualified OPCs commenced work in the care home, many were initially care assistants (Appendix 7, Figures 5 and 6) and were therefore very much aware of how much they have learnt about older people needs during their training.

In contrast, 65% of the English qualified staff who entered care home work after completing their training as hospital nurses believed they knew a ‘great deal’ about older people when they started to work in the sample home and 31% perceived they knew a ‘fair amount’, with 4% stating they knew ‘a bit’ (Table 6.8). The English qualified staff will have gained their knowledge whilst working in hospital during and after their training. This will then have been extended through experience working in care homes as 67% (Table 6.9) of the age group 18-35 and 63% of the 36-55 age group stated they had gained experience in caring for older people while working in care homes. These findings underline the role of workplace learning for qualified staff working in care homes and indicate the need to provide training for qualified staff that focuses on the skills required when working with older people who live in a care home. Amongst the care assistants in both countries, half of the respondents (49% in England, 50% in Germany) believed they knew a ‘fair amount’ about older people when they commenced

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Great deal</th>
<th>Fair amount</th>
<th>A bit</th>
<th>Nothing At all</th>
</tr>
</thead>
<tbody>
<tr>
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<td>31%</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
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<td>49%</td>
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<td>8%</td>
</tr>
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<td>50%</td>
<td>36%</td>
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<tr>
<td>German Total</td>
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<td>14%</td>
<td>48%</td>
<td>36%</td>
<td>3%</td>
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</tbody>
</table>

Row %
work in the sample home. Only 7% of the German care assistants believed they knew a ‘great deal’ about older people compared with 20% in England. The higher percentage in England could be seen to be linked to the fact that 46% of the care assistants had gained experience in the care of older people while working in other care homes compared to 32% of care assistants in Germany (Table 6.9). Furthermore 18% of care assistants in England had worked for a care agency where they will have worked in other care homes or provided care to older people living at home, and 8% had worked for Social Services providing care to older people living at home. The responses from the care assistants like those of the qualified staff highlight the importance of workplace learning.

Table 6.9 Where qualified staff and care assistants gained experience in the care of older people (Data from self-completion questionnaire)

| Age: 18-35 | 6 | 100% | 67% | 17% | 0% | 0% | 17% |
| Age: 36-55 | 19 | 95% | 63% | 21% | 11% | 0% | 16% |
| Age: 56+ | 1 | 100% | 0% | 0% | 0% | 0% | 0% |
| Total English Qualified | 26 | 96% | 62% | 19% | 7% | 0% | 13% |
| English Care Assistants Age: 18-35 | 24 | 12% | 46% | 10% | 12% | 0% | 8% |
| Age: 36-55 | 25 | 20% | 48% | 16% | 20% | 8% | 12% |
| Age: 56+ | 1 | 100% | 0% | 100% | 0% | 0% | 0% |
| Total English Care Assistants | 50 | 18% | 46% | 14% | 18% | 8% | 6% |
| English Total | 76 | 45% | 51% | 16% | 14% | 5% | 9% |
| German Qualified Age: 18-35 | 3 | 67% | 100% | 33% | 0% | 0% | 33% |
| Age: 36-55 | 29 | 31% | 38% | 7% | 0% | 14% | 21% |
| Age: 56+ | 4 | 25% | 0% | 50% | 0% | 25% | 25% |
| Total German Qualified | 46 | 37% | 43% | 13% | 0% | 13% | 9% |
| German Care Assistants Age: 18-35 | 4 | 25% | 25% | 25% | 0% | 25% | 0% |
| Age: 36-55 | 23 | 22% | 39% | 22% | 0% | 0% | 26% |
| Age: 56+ | 4 | 25% | 15% | 25% | 0% | 0% | 25% |
| Total German Care Assistants | 31 | 19% | 33% | 23% | 0% | 3% | 23% |
| German Total | 77 | 30% | 40% | 17% | 0% | 9% | 21% |

% do not add up to 100 as some respondents have worked in more than one area

In Germany, the care assistants who stated that they had gained experience in caring for older people elsewhere can be expected to be like Doerte and Dagmar, who prior to their OPC training were employed directly by the person to whom they provided care. As they were not employed via a domiciliary care or nursing agency to provide a home care service they will not have had an induction period, nor will their work have been
supervised by trained staff. Consequently they will have experienced workplace learning and developed their skills without the guidance of experienced colleagues.

From this data it can be concluded that the majority of care staff believed they knew a 'great deal' or a 'fair amount' about older people when they entered employment in the sample care home. This implies that they felt they had an understanding of older people and their everyday needs. However, the fact that a high percentage of respondents stated that they gained experience in caring for older people in care homes does indicate the importance of developing care skills in the workplace.

5.2 Developing care skills in the workplace

The participants in this research in both countries can be seen to have gained experience in the care of older people in a variety of ways before entering employment in the sample home. However, it would appear that much of this experience was gained at the workplace in hospitals, in care homes or in providing domiciliary care.

In response to the question 'How much have you learnt from your colleagues?' in both countries, qualified staff and care assistants say they have learnt a lot from the people they work with. Notably a high percentage of English qualified staff in the age groups 36-55 (Table 6.10) claim to have learnt a 'fair amount' or a 'great deal' from their colleagues (94%). This indicates that their hospital training had not prepared them to care for older people living in a care home. Amongst the English care assistants in the age group 18-35 and 36-55, around 80% state they have learnt a 'great deal' or a 'fair amount' from their colleagues. This would appear to highlight the importance of a skill mix amongst care home staff thereby allowing the transfer of knowledge from experienced staff to new members of staff. However, it also indicates how bad practice in the care of older people could develop if there is not an appropriate level of staff training and supervision of both care assistants and qualified staff.
Table 6.10 How much learnt from colleagues (Data from self-completion questionnaire)

<table>
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<tr>
<th></th>
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<th>Great deal</th>
<th>Fair amount</th>
<th>A bit</th>
<th>Nothing At all</th>
</tr>
</thead>
<tbody>
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<td>English Qualified</td>
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<td></td>
<td></td>
<td></td>
</tr>
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<td>Age: 36-55</td>
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<td>0%</td>
</tr>
<tr>
<td>Age: 56+</td>
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<td>0%</td>
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</tr>
<tr>
<td>Total English Care Assistants</td>
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<td>42%</td>
<td>35%</td>
<td>21%</td>
<td>2%</td>
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<tr>
<td>English Total</td>
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<td>28%</td>
<td>0%</td>
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<td>100%</td>
<td>0%</td>
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</tr>
<tr>
<td>Total German Qualified</td>
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<td>7%</td>
<td>52%</td>
<td>23%</td>
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</tr>
<tr>
<td>German Care Assistants</td>
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</tr>
<tr>
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<td>52%</td>
<td>37%</td>
<td>4%</td>
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<tr>
<td>Age: 36-55</td>
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<td>79%</td>
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<tr>
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<td>75%</td>
<td>25%</td>
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</tr>
<tr>
<td>Total German Care Assistants</td>
<td>35</td>
<td>18%</td>
<td>67%</td>
<td>15%</td>
<td>0%</td>
</tr>
<tr>
<td>German Total</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Age: 18-35</td>
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<td>20%</td>
<td>80%</td>
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</tr>
<tr>
<td>Age: 36-55</td>
<td>24</td>
<td>9%</td>
<td>79%</td>
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<tr>
<td>Age: 56+</td>
<td>4</td>
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<td>75%</td>
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<td>0%</td>
</tr>
<tr>
<td>Total German Care Assistants</td>
<td>33</td>
<td>18%</td>
<td>67%</td>
<td>15%</td>
<td>0%</td>
</tr>
</tbody>
</table>

During the interviews all participants were asked where they had gained their skills to care for older people. In keeping with the findings from the self-completion questionnaires, Wiebke, a German care assistant replied:

I: Where did you learn to care for older people?  
Wiebke: Here
I: You learnt everything here? Who taught you?  
Wiebke: Sister U, I started on Unit 1 with Frau H.[a care assistant] and Sister U. who took me round with her and bit by bit she showed me what to do until I started to work alone with the residents. U. is a trained OPC and she taught me a great deal. I thoroughly enjoyed myself. She is still pleased when I tell her that she taught me so much. It was such a contrast to Frau H. who had me cleaning mirrors until U came along and said that's not on. Then I really got to do things and learnt a lot, though I never imagined I would work in an old peoples home. I always wanted to be a hairdresser.

Extract from interview with Wiebke (Care assistant). My emphasis

Wiebke’s response illustrates the role of OPCs in providing German care assistants with guidance in their provision of care. This for example is in contrast to the experiences of Kelly and Eileen, described earlier in this chapter, who were clearly guided by fellow care assistants.
An example of how English qualified staff developed their skills to care for older people is exemplified by the following extract from the interview with Sheila who trained to be a qualified nurse during the late 1970’s.

I: Where did you learn your skills to specifically care for older people?
Sheila (RN): Well, other than, I mean everybody does a placement in elderly care when you’re training. I did that, and the majority of people that you’re looking after in hospitals are elderly especially on the medical side, and I was always more a medical person than a surgical person, and so that’s really where I gained my skills - obviously you just learn things as you go along, and you’re taught aren’t you. Or it was when we were trained, back in 1977, you were taught a lot of things, or then you picked up things when you were doing your placement. You’re training within the hospital environment on the wards in the traditional way. You don’t spend all this time in the university like they do at the moment. And then obviously courses that I’ve done since I’ve been trained, and all the experience you’ve had - it’s life experience isn’t it?

Extract from interview with Sheila (RN). My emphasis

This extract indicates the hospital-based knowledge that English qualified staff working in care homes have. It also indicates how skills are gained ‘invisibly’ on the job and taken for granted. A further aspect is that there is no recognition of the fact that an older person living in a care home might have different needs to an older person on a medical ward in hospital.

German qualified staff also stated in the interviews that they had developed their skills to care for older people ‘on the job’. However, the training programme for OPCs (Chapter 4) has strong links to practice based learning. Consequently it is to be expected that the acquisition of skills is linked to learning from colleagues. The key factor to be considered in this instance is the fact that learning from colleagues occurs whilst also attending college to gain formal qualifications.

Courses are made available to qualified staff and care assistants in both England and Germany and in both countries care staff claim to have learnt from their attendance (Table 6.11). In response to the question ‘How much have you learnt from attending courses?’ the English qualified staff are clearly the group most likely to state they have learnt a ‘fair amount’ from attending courses (Table 6.11). This could be related to the fact that in order to practice as a nurse in England, RNs are expected to maintain a
Table 6.11 How much learnt from attending courses (Data from self-completion questionnaire)

<table>
<thead>
<tr>
<th>Qualification</th>
<th>Age</th>
<th>N</th>
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<th>Fair amount</th>
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<td>83%</td>
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<tr>
<td>English Care Assists</td>
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<td>32%</td>
<td>46%</td>
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<tr>
<td></td>
<td>Age: 36-55</td>
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<td>29%</td>
<td>42%</td>
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<tr>
<td></td>
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<td>33%</td>
<td>67%</td>
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<tr>
<td>Total German Care Assistants</td>
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<td>17%</td>
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<tr>
<td>German Total</td>
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<td>74</td>
<td>20%</td>
<td>51%</td>
<td>24%</td>
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</tr>
</tbody>
</table>

Row %

portfolio of courses they have attended every year (see Chapter 4), whilst in Germany the SGBXI states that it is expected that care home staff keep up to date with the latest developments in care, but it is not a prerequisite to their continuing employment as a qualified member of staff (Chapter 4). Nonetheless nearly three quarters of the German qualified staff also claim to have learnt a ‘fair amount’ or a ‘great deal’ from attending courses (Table 6.11).

In England, governmental Health and Safety regulations determine that staff in any occupation that involves lifting are trained to lift in order to prevent injuries (Chapter 4). Lifting residents is necessarily a regular occurrence in the provision of care to older people. Consequently training courses on learning to physically lift and use lifting equipment is a basic legal requirement. Fire regulations also determine that staff need to know how to behave in the event of a fire. For English care staff who handle food, which the majority do (serving meals and assisting residents to eat), health and safety regulations require that food hygiene courses must be attended. Whilst these regulations in England are derived from EU regulation, which would also be relevant in Germany, there are no comparable German regulations.
Table 6.12 Percentage of care staff who have attended different types of courses related to health and safety training in the last three years (self-completion questionnaire)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>First Aid</th>
<th>Fire Drill</th>
<th>Food Hygiene</th>
<th>Manual Handling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total English Qualified</td>
<td>26</td>
<td>38%</td>
<td>92%</td>
<td>35%</td>
<td>92%</td>
</tr>
<tr>
<td>Total English Care Assistants</td>
<td>49</td>
<td>47%</td>
<td>71%</td>
<td>37%</td>
<td>84%</td>
</tr>
<tr>
<td>English Total</td>
<td>75</td>
<td>44%</td>
<td>79%</td>
<td>36%</td>
<td>87%</td>
</tr>
<tr>
<td>Total German Qualified</td>
<td>46</td>
<td>35%</td>
<td>46%</td>
<td>11%</td>
<td>52%</td>
</tr>
<tr>
<td>Total German Care Assistants</td>
<td>30</td>
<td>47%</td>
<td>43%</td>
<td>17%</td>
<td>30%</td>
</tr>
<tr>
<td>German Total</td>
<td>76</td>
<td>39%</td>
<td>45%</td>
<td>13%</td>
<td>43%</td>
</tr>
</tbody>
</table>

The difference between English and German care staffs attendance at fire, food hygiene and manual handling courses can be seen in Table 6.12. In England 79% of the English staff claim to have attended ‘Fire Drill’, 87% to have attended a ‘Manual Handling Course’ and 36% to have attend a ‘Food Hygiene Course’ in the last three years. In contrast in Germany, attendance percentages were around half the English level in each of these three courses. However, noticeably, 52% of the German qualified staff had learnt how to lift (Table 6.12). Such training courses aim to protect both care staff and the people they are employed to care for and have a significant impact on the daily provision of care. For care staff having gained skills to cope with an emergency such as a fire; to lift a heavy load and be aware of food hygiene adds to skills developed through out their lifecourse. For English care staff it adds to the portfolio of formal skills that are now part of the modern world of employment.

Table 6.13 Percentage of care staff who had participated in courses related to care of older people in the last three years (self-completion questionnaire)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Older people's health care</th>
<th>Mental Health</th>
<th>Terminal care</th>
<th>Manage ment</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total English Qualified</td>
<td>26</td>
<td>38%</td>
<td>35%</td>
<td>27%</td>
<td>35%</td>
<td>35%</td>
</tr>
<tr>
<td>Total English Care Assistants</td>
<td>49</td>
<td>29%</td>
<td>12%</td>
<td>16%</td>
<td>6%</td>
<td>14%</td>
</tr>
<tr>
<td>English Total</td>
<td>75</td>
<td>32%</td>
<td>20%</td>
<td>20%</td>
<td>16%</td>
<td>21%</td>
</tr>
<tr>
<td>Total German Qualified</td>
<td>46</td>
<td>39%</td>
<td>39%</td>
<td>15%</td>
<td>39%</td>
<td>24%</td>
</tr>
<tr>
<td>Total German Care Assistants</td>
<td>30</td>
<td>20%</td>
<td>17%</td>
<td>0%</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>German Total</td>
<td>76</td>
<td>32%</td>
<td>30%</td>
<td>9%</td>
<td>29%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Courses that related to the actual provision of care were overall much less likely to have been attended than courses related to statutory Health and Safety training (Table 6.12). The actual attendance of courses that relate to the provision of care over the last three years was overall low in England and Germany (Table 6.13). In both countries a total of
only 32% of all staff had attended courses relating to the health care needs of older people. Less than 40% of the qualified staff and less than 20% of the care assistants in both countries had attended courses relating to the mental health care needs of older people, yet all the sample homes catered for residents with mental health care needs (Chapter 7). The majority of the care home residents can be expected to die in the care home, yet only 20% of the English care staff and 9% of the German care staff had, in the last three years, attended courses related to terminal care. Noticeably in Germany none of the care assistants had participated in such a course (Table 6.13). Management related courses had been claimed to be attended by qualified staff and care assistants in both countries with 39% of the German qualified staff and 35% of their English counterparts participating in management related courses.

The findings relating to care staff training would appear to indicate that statutory training requirements result in a higher participation in training. However, in England the statutory training at the time of data collection was health and safety related and the NVQ task orientated. Neither of these two aspects of on-the-job training focuses directly on the needs of older people living in care homes. In Germany there was a low participation rate in training courses, a fact which could imply that the training received by OPCs is seen to meet the training guidelines identified by German policy makers. However, the guidelines for this three-year training programme, (Chapter 4, Section 7), does focus especially on training care staff to meet the health and social care needs of older people.

5.3 Acquiring care skills within the family
Care skills gained within the family can be expected to influence qualified staff and care assistants in English and German care homes alike. As care work is perceived to be an extension of the work women do within the family, the essential skills such as emotional labour, communication and time management can also be expected to be taken for granted by both the participants in the research and their employers. The skills developed within the family can be expected to have been gained as part of parenting and possibly providing care to a parent or grandparent.
The data from the self-completion questionnaires establishes that in Germany the experience of parenting is much more strongly represented than in England (Table 6.14). In England just under half (46%) of the care assistants had children although, English qualified staff had more experience in parenting (73%) (Table 6.14). This difference can be related to the data in the lifecourse threads which indicates that some of the English qualified staff working in care homes had taken a break in employment to raise a family. In the German sample a high percentage of both qualified staff (78%) and care assistants (84%) have gained experience in parenting (Table 6.14).

Caring for a frail older member of the family may provide a further opportunity to develop caring skills. The data from the self-completion questionnaire (Table 6.15) establishes that English care assistants and German qualified staff were more likely to have experience in caring for a member of the family than English qualified staff and German care assistants. Other than caring for their own children the majority of care staff in both countries had not experienced caring for a member of their family and it is the English qualified staff who were least likely to have experienced caring for a member of

Table 6.14 Percentage of qualified staff and care assistants with parenting experience (Data from self-completion questionnaire)

<table>
<thead>
<tr>
<th></th>
<th>English Qualified (n=26)</th>
<th>English Care Assistant (n=50)</th>
<th>German Qualified (n=46)</th>
<th>German Care Assistant (n=32)</th>
</tr>
</thead>
<tbody>
<tr>
<td>73%</td>
<td>46%</td>
<td>78%</td>
<td>84%</td>
<td></td>
</tr>
</tbody>
</table>

Table 6.15 Percentage of care staff with care experience within the family, currently and in the past (Data from self-completion questionnaire)

<table>
<thead>
<tr>
<th></th>
<th>Parents in-law</th>
<th>Grandparent</th>
<th>Other*</th>
<th>No experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>English Qualified (n=26)</td>
<td>19%</td>
<td>4%</td>
<td>0</td>
<td>77%</td>
</tr>
<tr>
<td>English Care Assistants (n=50)</td>
<td>28%</td>
<td>16%</td>
<td>2%</td>
<td>54%</td>
</tr>
<tr>
<td>English Total (n=76)</td>
<td>25%</td>
<td>12%</td>
<td>1%</td>
<td>62%</td>
</tr>
<tr>
<td>German Qualified (n=46)</td>
<td>26%</td>
<td>9%</td>
<td>3%</td>
<td>63%</td>
</tr>
<tr>
<td>German Care Assistants (n=32)</td>
<td>28%</td>
<td>9%</td>
<td>3%</td>
<td>60%</td>
</tr>
<tr>
<td>German Total (n=78)</td>
<td>27%</td>
<td>9%</td>
<td>3%</td>
<td>61%</td>
</tr>
</tbody>
</table>

*sibling, cousin, neighbour, % do not add up to 100 as some respondents may have cared for more than one relative
their family. The respondents who had experienced caring for a member of their family did so looking after parents, parents-in-law or grandparents (Table 6.15). The most influential aspect of caring within the family that impacts on the provision of care to older people would appear to be that of parenting. This indicates the role of parenting in the lifecourse skills that care staff bring into the workforce of the care home industry.

6. Conclusion

The profile of English and German care home staff working in the sample homes identifies a workforce of care staff that is dominated by women in mid working life. To the best of their ability they are aiming to meet the needs of older people for whom they are employed to care. However, a comparison of English and German care staff's route into employment in the care home industry and their acquisition of care skills provides a diverging picture.

English qualified staff gain their nursing skills within the context of training to nurse patients in hospital and then largely develop their skills to care for older people whilst working in the care home industry. Indicating the role of workplace learning in the acquisition of skills to meet the needs of older people living in a care home. The majority of the German qualified staff in the participating homes are OPCs, who have been trained to meet the social and healthcare needs of older people living either at home or in a care home. It would therefore be expected that German qualified staff will have a more resident centred approach towards their work than their English counterparts.

In both countries the work of care assistants is deemed to be ‘unskilled’, as it does not require formal occupational qualifications. However, in Germany many care assistants enter this form of employment using the certificate they gain from attending the ‘Schwesternhelferin Program’ course as an entrance ticket. Whilst this does not provide them with formal care qualifications, the home management will know that they can at least expect these care assistants to be able to carry out basic tasks such as giving an older person a bed bath. Once employed in the care home, German care assistants do not appear to participate in further training unless, like Marlies (Appendix 7, Figure 6) they
train to become an OPC. This is in contrast to the majority of English care assistants who enter employment in the care home sector without necessarily knowing how to wash an older person but are able to participate in NVQ training. In both countries for care assistant's workplace learning is key to their acquisition of skills to meet the needs of older people living in a care home. However, 45% (Table 6.6) of the care assistants in the four English sample homes participated in training or had gained NVQ competence. The data also indicates that the participation in NVQ is linked to the home ownership facilitating the training and assessment process. The divergence of the percentage of care assistants who had or were participating in the NVQ scheme in the four English sample homes (Table 6.5) indicates the importance of employers providing and motivating staff to participate in training. However, in view of Standard 27-30 of the National Minimal Standards for Care Homes (DH 2000) and the awareness of its potential implementation at the time of data collection also highlights the role of legislation to instigate a change of culture in occupational training.

Care skills gained from within the family can be seen to be similar in both countries. Caring within the family for a parent or in-law is experienced by a minority of care staff in both countries whilst the experience of parenting is common across qualified staff and care assistants in both England and Germany. It can be assumed that as the majority of qualified staff and care assistants in both countries are women in mid working life and many are parents, their lifecourse will have provided them with the invisible and intangible skills developed when managing a home and in family life.
Chapter 7
The reality of care home life in both countries

1. Introduction
To provide an understanding of what care home work actually entails, the data from the care home managers and care staff in the sample care homes aimed to establish the residents' dependency and the skills required to meet their care needs. After considering care work as an empowering or disempowering process and relating these factors to the care vignettes, this chapter examines how the vignettes relating to Edith, Phyllis, John, Maude and Derrick relate to the reality of care home work in the sample homes. Care home work in England and Germany is then compared to establish the differences between the work of qualified staff and care assistants in the two countries, and the skills needed to care for older people living in care homes. The respondents' understanding of the medical conditions presented in the vignettes is also analysed.

2. Empowered or disempowered care home residents
Despite government policies in both England and Germany aiming to promote the care of dependent older people in their own home, there is a continuing need for care homes. Here a service to meet the needs of dependent older people, who for various reasons cannot be cared for at home, is provided. Recent publications have described the provision of care in care homes as a production process (Lee-Treweek 1997; Ungerson 2000). The ‘product’ being produced has been described as ‘a totally silent, lounge-standard individual’ (Lee-Treweek 1997:56). Care homes in both countries are implementing quality assurance systems initially developed from manufacturing industry, thus emphasising the industrialisation of care. The four care vignettes used in this research aim to establish the impact of long-term care policies on the provision of care at grass-root level. Considering the importance the WHO (2002) places on maintaining the autonomy of older people at all stages of later life and baring Lee-Treweek’s (1997) works work in mind, the definition of an older person living in care as a ‘product’ or ‘disempowered older person’ in this research is:

A ‘lounge-standard’ individual who in the morning has been processed to become a clean and presentable care home resident who does not emit any unpleasant odours.
This has parallels to a care home study undertaken in Germany where a carer felt that she had time for the resident's body but not their soul (Dunkel 1994). It contrasts with the person-orientated focus called for in the British Royal Commission on Long Term Care Report (1999), which has a strong emphasis on 'respect' that in turn relates to the empowerment of older people in care homes. The definition of a care home resident as an 'empowered person' in this research is:

A person who has been able to participate in the decision making process, a person whose health and social needs determined this process and who was respected as an individual by the carer.

This definition also describes a person who is receiving person-centred care and is empowered to have control over everyday aspects of their life. The concept of an empowered or disempowered older person living in a care home runs through the analysis of the data collected in this research and is examined in relation to the care provided by care home staff in both countries.

In most cases, older people move into a care home because living an independent life in their accustomed surroundings, where they may have lived for many years, is no longer possible. The care home is now their home, it is where they live and where care staff work to earn money. Older people in such a situation expect knowledgeable, kind staff (Raynes 1999). However, the move into a care home may result in an older person having to forfeit autonomy and individuality and develop stoic coping mechanisms (Reed and Morgan 1999), consequently becoming passive and dependent (Bounds and Hepburn 1996, Davies et al. 1999). The verbal and non-verbal communications from care staff can be seen by Resnick (1999) to indicate to residents that they are unable to walk or dress themselves unaided, as a result many care home residents do not aim to achieve these activities independently.

Care staff are entering resident's private sphere as soon as they enter the resident's room. However, a dependent older person has to expect further intrusion into their private sphere in order to be assisted with their daily activities. The bodywork entailed in these activities ranges from bladder and bowel emptying in the morning to cleaning dentures at night.
The four vignettes in this data collection were designed to present a range of situations that can be encountered in care homes of both countries. They are intended to provide the respondents with a range of opportunities to discuss how they go about their care work and aim to establish how the knowledge and skills of care staff impact on their provision of care. The following section will present each vignette in turn in order to demonstrate how each one relates to the autonomy of an older person and the ability of care staff to meet their individual needs.

2.1 Edith

Figure 7.1: Vignette Edith (Frau Schmidt)

Edith is an 87-year-old widow; she had a stroke 6 months ago and was admitted to the home eight weeks ago. The stroke has affected her speech and she is not able to move her right arm. Her right leg has also been affected by the stroke. Edith uses a hearing aid and wears glasses and has dentures. However with help Edith is able to stand and hold onto her frame and with support and guidance she is for example able to transfer from bed to chair. Edith is frustrated by her condition and tends to be grumpy in the morning. Invariably Edith also needs help to go to the toilet. She no longer has a urine catheter. The night-staff sit her on the commode around 6am but then return her to her bed. You have come on duty at 8am and this morning she is in your group of residents. When you go into her room you find she is incontinent and has not touched her breakfast. You probably know someone like Edith – think about that person and tell me how that morning would have been, considering that you also have other residents to care for.

The stroke that Edith (Figure 7.1) has suffered impacts on her ability to communicate verbally. She also has dentures and a hearing aid, which are likely to have been part of her daily life for many years and could be seen as a part of Edith before she had the stroke and could therefore be seen as part of her identity. The fact that she had a wet bed could well be related to the stroke, especially as she previously had a urine catheter in situ, which could be a factor that needs to be considered in the provision of care. That she had not eaten breakfast could be approached by care staff from two different angles – she might have lost control of her bladder just after breakfast was served and subsequently lost her appetite. Alternatively breakfast could have been placed in front of her but the effect of the stroke meant that she was not enabled to eat her breakfast independently if it was not positioned correctly or care staff had not yet got round to assisting her and in the meantime she has lost control of her bladder. Edith was described as a person who was ‘grumpy’, a factor that could either be part of her personality or related to the fact that she was living with a Stroke. However,
with help and guidance Edith could maintain a degree of independence. Although she had difficulties speaking, she was able to speak and with her hearing aid in place and dentures in her mouth she should have been able to communicate with the care staff. With support from care staff she was able to transfer from her bed to a chair, this represented something that Edith was able to do. The vignette was placed in the busiest time of day thereby putting the interviewees into a time of day they would relate to as being very busy if not hectic at times. Care staff with an understanding of Edith’s medical condition and ability to provide person-centred care could empower Edith to participate in the planning of her care and provide her with choice that could impact on her quality of life. Encouraging Edith to be proactive would also help her towards regaining some independence.

2.2 Phyllis

Figure 7.2: Vignette Phyllis (Frau Lembke)

Phyllis is 83 and has had Parkinson’s for over 10 years. Her family are no longer able to care for her at home and she has now been in the home for a year. You have got to know her well and know her likes and dislikes, abilities and disabilities. Phyllis is one of the residents you care for this morning. Getting her up, washed and dressed went well this morning, however this lunchtime the picture has changed a bit and she is going to need a lot of help to eat her lunch as she can’t get a cup or spoon to her mouth. You probably also know someone like Phyllis, considering you also have other residents such as Edith to help, how do you ensure that Phyllis eats her lunch?

Phyllis (Figure 7.2), who had been living with Parkinson’s for over 10 years, presents a situation where the care staff know the resident well and are therefore more likely to be able to assess her needs. However, the complexities of someone living with Parkinson’s need to be considered in the approach towards assisting her at lunchtime. Here empowerment and independence would play an important factor in the provision of her care.

2.3 John

Figure 7.3: Vignette John (Herr Böttcher)

John is 76 and has Alzheimer’s. His wife could no longer cope with him at home and he has now been in the home for three months. He wanders around the home a great deal and tends to forget to use the toilet. It’s mid afternoon and you walk pass him and can smell that he has been incontinent. You probably also know someone like John, how do you go about getting him changed into clean dry clothes when he thinks that he has to go and check the boiler is working properly?
John (Figure 7.3) exemplifies many confused older people living in care homes. He was described to be living with Alzheimer’s because at present within everyday terminology this appears to be the blanket term used for a confused older person. It would appear to be more socially acceptable than ‘dementia’ and is a diagnosis all levels of care staff can be expected to be able to relate to. The key element of this vignette was to establish how care staff would cope with having to get him to change his clothes whilst maintaining his dignity and enabling him to be empowered to participate in the decision making process in planning the activity.

2.4 Maude and Derrick

Figure 7.4: Vignette Maude and Derrick (Frau Maier and Herr Töle)

Maude is a mentally alert 78-year-old lady who is wheelchair-bound because she had both legs amputated 6 months ago. She has been in the home for six weeks and is still coming to terms with her situation. Once she is in her wheelchair she is able to partially wash and dress herself. However, she is unable to dress the lower half of her body. You have helped her onto her wheelchair and left her to wash and dress herself as far as she can. You have gone on to Derrick intending to return back to Maude. This usually works well but to your surprise Derrick has been doubly incontinent, this has caused a lot of mess as Derrick has unsuccessfully tried to cope with the situation himself. You may well have encountered a similar situation, what would you do?

The vignette of Maude and Derrick (Figure 7.4) present a situation where the emphasis is on the care workers time management skills and conflicting responsibilities. The vignette described presents care staff with a situation where they need to make decisions that can influence not only the well being of the two residents but also the outcome of their mornings work. Maude is described as a mentally alert, semi-independent person who is still coming to terms with the facts that her legs have been amputated and that she is having to live in a care home. No reference is made to Derrick’s cognitive abilities; the only information provided is that he has been unexpectedly doubly incontinent. Caring for Derrick will be time consuming, yet Maude’s needs also have to be met. This vignette also presents a situation where respondents can refer to teamwork and communication with both residents and their colleagues in order to cope with the situation. The responses to this vignette can also be expected to indicate how empowered Maude and Derrick are in such a situation.
The responses to each vignette should not only identify the care skills used by qualified staff and care assistants in each country but also how empowering or disempowering the provision of care can be for the individual resident. Thus an analysis of the responses contributes towards identifying factors which need to be taken into account by policy makers when considering issues related to care home staff and the empowerment of older people living in care homes.

3. Profile of residents in the sample homes

In order to establish if the participating care home staff could relate to the vignettes, data collected from the care home managers in the sample homes provided information about the medical condition and care needs of residents. This provides an overview of the work the participating care staff were undertaking everyday. All eight homes had residents that could provide care staff with experiences that enabled them to relate to residents living with a Stroke, Parkinson’s or dementia (Table 7.1), which are the main medical conditions presented in the vignettes.

Table 7.1: Percentage of English and German residents with medical conditions characterised in the care vignettes (Data from home managers)

<table>
<thead>
<tr>
<th>Medical condition</th>
<th>E1 N=65</th>
<th>E2 N=40</th>
<th>E3 N=55</th>
<th>E4 N=30</th>
<th>Total N=190</th>
<th>G1 N=91</th>
<th>G2 N=36</th>
<th>G3 N=40</th>
<th>G4 N=90</th>
<th>Total N=257</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>25%</td>
<td>8%</td>
<td>7%</td>
<td>20%</td>
<td>15%</td>
<td>55%</td>
<td>8%</td>
<td>13%</td>
<td>22%</td>
<td>30%</td>
</tr>
<tr>
<td>Parkinson’s</td>
<td>14%</td>
<td>3%</td>
<td>6%</td>
<td>20%</td>
<td>10%</td>
<td>11%</td>
<td>11%</td>
<td>15%</td>
<td>11%</td>
<td>12%</td>
</tr>
<tr>
<td>Dementia</td>
<td>51%</td>
<td>0%</td>
<td>49%</td>
<td>23%</td>
<td>35%</td>
<td>88%</td>
<td>17%</td>
<td>43%</td>
<td>40%</td>
<td>54%</td>
</tr>
</tbody>
</table>

*Multi-diagnosis can be expected from some of the residents

The data presented in Table 7.1 show that home E2 did not care for residents with dementia, as it was not registered to care for older people classified as ‘Elderly Mentally Infirm’. However, conversations with the care home management, undertaken whilst collecting the data, established that the home had residents described to be ‘mildly confused’. In contrast, home G1 was stated to be caring for a high percentage (88%) of residents living with dementia. From the observation made during visits to the home and conversations with staff and management, this figure includes the ‘mildly confused’. The different interpretation of the question in the two homes can be related to the fact that in Germany there is no legislative requirement to establish specialist homes to meet the needs of ‘Elderly Mentally Infirm’ (EMI) older people.
Table 7.2 Percentage of English and German residents with care needs presented in the care vignettes (Data from home managers)

<table>
<thead>
<tr>
<th>Care Needs</th>
<th>E1 N=65</th>
<th>E2 N=40</th>
<th>E3 N=34</th>
<th>E4 N=37</th>
<th>Total N=190</th>
<th>G1 N=91</th>
<th>G2 N=36</th>
<th>G3 N=40</th>
<th>G4 N=90</th>
<th>Total N=257</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help to wash and dress</td>
<td>83%</td>
<td>90%</td>
<td>80%</td>
<td>83%</td>
<td>84%</td>
<td>97%</td>
<td>81%</td>
<td>90%</td>
<td>94%</td>
<td>93%</td>
</tr>
<tr>
<td>Help to eat</td>
<td>32%</td>
<td>30%</td>
<td>11%</td>
<td>63%</td>
<td>31%</td>
<td>54%</td>
<td>17%</td>
<td>45%</td>
<td>29%</td>
<td>39%</td>
</tr>
<tr>
<td>Help to toilet</td>
<td>77%</td>
<td>75%</td>
<td>45%</td>
<td>87%</td>
<td>69%</td>
<td>78%</td>
<td>33%</td>
<td>60%</td>
<td>44%</td>
<td>57%</td>
</tr>
<tr>
<td>Incontinence</td>
<td>40%</td>
<td>75%</td>
<td>31%</td>
<td>57%</td>
<td>47%</td>
<td>68%</td>
<td>53%</td>
<td>73%</td>
<td>64%</td>
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</tbody>
</table>

The care staff responding to the vignettes could be expected to be able to relate to all the care situations presented in the vignettes as they were accustomed to washing and dressing residents in the morning and assisting residents to eat at meal times. Dealing with incontinence and assisting residents to and from the toilet were also tasks that all participants could be expected to be able to relate to as these were situations that were dealt with in all eight care homes on a daily basis (Table 7.2).

4. The daily routine in English and German care homes

The four care vignettes were designed to suit the daily routine encountered by the participating qualified staff and care assistants in each country. To confirm this factor and to establish a picture of care home work, all interview participants were asked about the work they had done that day before the interview took place. If they had just come on duty or had come in especially to participate in the interview they were asked to talk about the last shift they had worked. This resulted in the collection of data relating to work in care homes over a 24-hour period. However, as three of the vignettes are clearly placed in the morning shift, the following examples present an insight into care work during a morning shift in a German and an English care home.

4.1 Qualified staff’s morning routine in England and Germany

The role of qualified staff in the English and German care homes have both similarities and considerable divergences. Whilst in both countries qualified staff are responsible for the medical needs of residents, the English qualified staff take on a more supervisory and managerial role whilst the German staff are more resident orientated and ‘hands on’ in their provision of care. The following descriptions from the qualified staff in both countries highlight the similarities and differences in their role in the provision of care to older people living in care homes.
Gail, an English RN, was responsible for the smooth running of a unit caring for 24 residents. However, because of the seniority system within the home, Gail was also responsible for the running of the home until a more senior person, such as the head of care or the home manager, came on duty. Gail’s managerial role dominates the pattern of her morning. Even the fact that she has assisted ‘a couple of residents’ to get up in the morning has a covert managerial role. As Gail points out, she wants to be seen to be able to relate to the tasks undertaken by care assistants by providing ‘hands-on care’.

I: Now, what I really want is a good description of the work you actually do - the more detailed the better. So the best would be if you could tell me what you have actually done this morning. You came on duty at -

Gail, RN: 8am, so you would like to know what I have done so far today

I: Yes

Gail: Right! When I came on I had 'hand-over' from the night RN. She also gave me a resume of what has happened on all the wings, so that I'm up to date with anything that has happened

I: At that time then were you responsible for the whole house?

Gail: Yes, I'm team leader so I'm responsible for the whole house until the manager or the deputy is on duty. Of course there is always the manager for the mental health unit, if I need anybody. So I give the carers a report because they come on a little bit later than I did this morning. Then we discussed the way in which we were going to tackle the routine of the morning - who was going to be bathed and in which order. So we then commenced our routine and eh I got a couple of residents up, washed and dressed before I did the drug round.

I: Do you always do that?

Gail: Yes

I: Do all the qualified nurses here do that or is that something specific to you?

Gail: I would hope that they always get at least one resident up before they start the drug round. So that everybody is up washed and dressed to be able to have their breakfast when they wish. I think it's important that they (RNs) keep their hands-on and are seen to be doing what the care assistants do. So I then proceed to do the drug round.

I: How long does that take you?

Gail: It depends if I have any interruption or not - ideally it should only take me about half an hour if I can get around without interruption.

I: So how long did it take this morning

Gail: This morning it took about three-quarters of an hour because I had a few interruptions

I: What were they?

Gail: Telephone mainly until the receptionist comes on. There was somebody needing to change their 'off duty' because of a family bereavement, which I then had to put on hold until I had finished the drugs, when we sorted it out at our leisure. Somebody wanted me to come and have a look at one of the residents who wasn't very well. So, that meant I had to lock everything [the drugs] up and go to see the resident and then recommence the round. So we got all that done and dusted, - sorted. After I'd finished the drugs I made sure that everybody was quite happy on my unit and went over to check on the other unit and check that everything was all right and everybody there and that they didn't need anything sorting out.
I: Wasn't there an RN on duty there?
Gail: Yes there is an RN on the other unit but I like to go round just to make sure that everything is going smoothly and that they don't need any help. Also to make sure that if we need a doctor's visit we only make one health centre call. So that they can plan their visits rather than then getting different phone calls from different units. I then went down to the third unit where I did exactly the same. Caught up with the girl who needed her off duty changing and sorted that out with the administration office and sorted out a few problems with off duty for the weekend and came back upstairs. I forgot to mention we have got some agency girls here for the first time - so they had to be taught the fire drill and be shown round the unit and be told where everything is, and to make sure they are working with somebody who knows the unit and they are not left to their own devices.
I: Were any of the agency girls qualified nurses?
Gail: No they were all carers -
I: So all the RNs on duty were from here?
Gail: Apart from one who is regularly sent here - so she does know the system quite well, that was the lady down on the third unit, ...ehm, I then had a coffee break.
I: Hurrah
Gail: It was at about quarter to eleven! Then had a quick chat to see what everybody was getting up to. The activities lady came up to try and arrange some activities. To see who I thought was most suitable to benefit from the tea-party she was arranging on Friday, and plan coach outings throughout the summer. Again discussing which residents throughout the building would benefit most, ...ehm, make sure all the residents have had their coffee. Help in general with toiletting before lunch if anybody needed to go. Did the lunchtime drugs, help with lunchtime feeds, help clear up afterwards. Went and got the report from one unit because I'm the RN covering both wings this afternoon. I listened to the hand-over the RN who was there this morning was giving to the care assistants coming on - told them where they could find me if they needed me. I then helped take people over to the church service, and just sat down and started doing the drug orders
I: Which is when I turned up!

Extracts from Gail's RN description of her work that day

Gail did provide some hands on care that morning. Of the twelve English RNs interviewed for this research only Joyce and Gail described undertaking bodywork, and it is not necessarily typical of all English qualified staff to do so. This is due to their management-orientated role within the care home and reflects the place of an English qualified nurse in the bodywork hierarchy. Within the four English sample homes, only the qualified staff in E2 did not appear to be involved in the organisation of staffing issues and focused on managerial issues related to the provision of 'hands-on care' with a focused input into the care of the highly dependent older people in their care. This can possibly be linked to the E2 management policy to only employ full-time staff which appeared to exclude the employment of agency staff. The data collected from the care home managers in the English sample homes indicates that whilst three English care homes employed agency staff at the time of data collection, E2 did not.
Similar to Gail, Beate, a qualified Older Persons Carer (OPC) in Germany, is responsible for the smooth running of a unit meeting the needs of 25 residents. However, the description of her morning is more resident orientated. During the busiest time of a morning shift between 6 and 8am on the day of the interview, Beate had assisted five residents to get up, wash and dress, she had also checked blood sugar levels, injected insulin, and prepared and distributed drugs.

I: Have you just come on duty?
Beate OPC: No, I've been here since a quarter to six.
I: Great, what I would like to do is establish a picture of the work done in a care home. On that basis could you tell me how your day has been so far?
Beate: Work starts at 5.45am we have a hand over and at 6am we start to get the residents out of bed and take them to the toilet, and provide the basic care. Some need help at different stages, in some instances you just need to wash their backs or and help them get dressed. Others will need assistance to wash the intimate part of their body and there are others where everything has to be done for them.
I: What do you consider to be basic care?
Beate: Right, well, washing and dressing, oral hygiene, do you want to know in more detail?
I: Yes please
Beate: OK, so first of all I remove the pad that’s been in the bed overnight from the bed, then I accompany the resident to the toilet and I help with oral hygiene. Then it depends, for some it might be a shower for others a wash at the sink. Then they need help dressing, pads need putting in place, creams applied. That’s not necessarily the right order. This morning I also did nail care and I stripped beds. Up to 8 o’clock the main job is to get people up, washed and dressed.
I: How many residents did you personally care for between 6 and 8 o’clock?
Beate: I did five before breakfast, normally I do six but we have one vacant bed. Time is tight when you do 6. It went well this morning; I felt that I could work in peace. I did not feel rushed as I often do when residents are half dressed and waiting for me to make sure they are dressed for breakfast. Those that can get out of bed should ideally come out of their rooms for breakfast. We have our own area where residents can sit and eat meals, so that they don’t eat alone in their rooms. Some eat there, others go to the main dining room. It also varies as to which meal they take in the company of others. Overall the dining area has a positive effect on the residents. A few months ago whilst I was on holiday it got closed down because the residents were arguing too much! But I reinstated it. There was a lot of fuss and bother, but it’s worth standing up for the residents! But to return to the work I did this morning, I checked blood sugar levels, injected insulin, prepared the drug round, and distributed drugs. At 8 o’clock the residents had breakfast.

Extracts from Beate's (OPC) description of her work

Beate is responsible for one of four care units in the home. Each unit provides care to an average of 25 residents in both single and shared rooms. That morning there was one care assistant on duty with her to care for 25 residents. Both are further assisted by a ‘runner’ in other words a care assistant who is designated to work on two units. This care assistant was a part-time member of staff and works from 6-8.30am on one
unit and from 9-11am on the other unit. Beate is responsible for the smooth running of her unit, her 'line manager' is the head of care who in turn is responsible to the home manager. Each of the other three units in the home is similarly staffed and overall this was a similar pattern to that encountered in the other three German care homes.

In a German home, each qualified member of staff is only responsible for the smooth running of their unit. When the head of care has a day off the deputy head of care, who would normally be responsible for a unit, would then be responsible for the care management throughout the home that day. However, on that day they would be exempt from 'normal' duties on their unit. Whilst the interview extracts show that both Gail and Beate provide 'hands-on care' and undertake direct bodywork it becomes clear that Gail also has a more managerial role. The extract from Gail's interview reflects the responses from all English qualified staff, whether employed full- or part-time. All provide a restricted amount of 'hands-on care' but were very much aware that they were working with an average of three care assistants to care for 25 residents in the morning. A key responsibility for both Beate and Gail was the dispensing of drugs to the residents. Beate is not concerned with off-duty issues nor does she need to concern herself with agency staff, which is an unknown concept in German care homes. All the German qualified staff were very much involved in the day to day provision of 'hands on' care. The administrative tasks of maintaining residents' care plans and records was observed to be undertaken by both qualified staff and care assistants in all four German care homes. In the four English homes this was observed to be entirely the task of qualified staff thereby emphasising the supervisory and managerial role of English qualified staff.

The description of the daily routine that qualified staff in Germany experienced was not influenced by their type of qualifications, and there was no discernible difference between the routine of the OPCs and the RN. This underlines the different ratio of qualified staff to care assistants in the two countries and can be related to both the diverging long-term care funding systems and pay structure for care staff (see Chapter 2). The English long-term care funding system places the qualified staff in a managerial role and the pay systems presents a stronger differentiation between
qualified staff and care assistants. However, this results in care assistants in England being the main providers of ‘hands on’ care and emphasises their role in the lives of older people living in English care homes.

4.2 Care assistants morning routine in England and Germany

The description of their morning routine made by care assistants in England and Germany presents not only the difference between the two countries but also the difference between qualified staff and care assistants.

The following extracts from Brenda’s description of a morning shift in England highlight the different starts of a shift and the impact that has on the morning routine. Whilst Brenda came on duty at 7.30am her counterpart Dagmar in Germany had started work at 5.45pm.

I: What time did you come on duty?
Brenda, care assistant, NVQ 3: Half past seven.
I: What did you do this morning?
Brenda: We make sure the night staff have got everybody sitting up for breakfast, if not out of bed and sitting up ready for breakfast and we just go round and check that and then about a quarter to 8 we go in for Report, and roughly about 8 o'clock we then start the breakfasts.
I: You distribute breakfasts?
Brenda: Yes, once they're all out we go and do all the feeds, and then we start to get our group up.
I: And how many did you have?
Brenda: I've got seven in my group, one lady gets herself up and dressed, the night staff got one of them up for me, so I had five to deal with this morning, averages between five to seven.
I: And what did you have to do for the five you did get up?
Brenda: The first lady I washed and dressed - she can't do anything herself. I had a bath to do for one of them, got her in the bath, once she's in the bath she will do her washing herself - leave her in there 5-10 minutes, whatever she wants, then go back, then bed making.
I: And the others?
Brenda: The same really, just get them up, wash them, dress them, if they can do it themselves, if not we do the bits they can't do.
I: Why had the night staff got one up for you?
Brenda: They often get one up in each group, if they've got enough staff on - it depends how many staff they've got on.
I: What determines which ones they get up?
Brenda: They usually will do one that takes a little extra time - they'll do one of those for us - perhaps one that needs the hoist - that sort of thing.
I: So the ones you did today you did entirely on your own?
Brenda: Yes, one lady uses a hoist - but otherwise you go and get somebody to help you.
I: Did you use the hoist today?
**Brenda:** I did use the hoist today, yes, on the lady that had the bath.
**I:** Do you use it other days?
**Brenda:** On that particular lady? Yes, I always use the hoist.

**Extracts from Brenda’s description of her work**

The description Brenda gives of her work is task orientated and the terminology she uses indicates a production-orientated approach towards the provision of care. The following description given by Dagmar is also production orientated as she is focused on getting the work ‘done’. The use of the terminology ‘done’ indicates the completion of a production process.

**I:** What time did you start work today?
**Dagmar, care assistant:** At 5.45
**I:** What did you do then?
**Dagmar:** First of all we did the hand over, then we discussed what will be important for the day. Then we each went off to our ‘sides’.
**I:** How many residents did you care for this morning?
**Dagmar:** 10, one is in hospital and another has just died. Because otherwise it would be 12.
**I:** What did you do in the first room this morning?
**Dagmar:** I started by giving a shower and washing the resident. Then I stripped the bed. It does need doing every few days!
**I:** Was the resident able to wash himself or herself?
**Dagmar:** No, no. The first four have to have everything done for them.
**I:** Did you do that all on your own?
**Dagmar:** I did it all on my own. I’ve got to have someone to help with bedridden residents. They are done in twos.
**I:** So you went from one room to the next washing and dressing residents then making their beds.
**Dagmar:** Yes, and then we have two gastric feeds to give on this side at about 8, then breakfast arrives.
**I:** What happens after breakfast
**Dagmar:** We have our breakfast.
**I:** and then?
**Dagmar:** At 9.30 we carry on, I don’t manage to get everybody done before 8!
**I:** How many do you manage before 8?
**Dagmar:** It varies, sometimes four sometimes five sometimes even more. It all depends.
**I:** But you always start at the same end of the corridor?
**Dagmar:** Yes, nearly always in the same room. When it’s ‘bowel opening day’ you have to check one or two residents first, some times the medication has taken effect at 5 so you have to start where you are needed.
**I:** and this morning, how many did you manage to do before breakfast
**Dagmar:** Four and the others were all done after breakfast.
**I:** What determines who is done before and after breakfast?
**Dagmar:** The bedridden residents are done after breakfast, the alert residents like to be done before breakfast.
**I:** So breakfast is at 8, when is lunch served?
**Dagmar:** at 11.30.

**Extracts from Dagmar’s description of her work**
Both Brenda and Dagmar describe bodywork based on a daily routine established around washing, dressing and assisting residents at meal times. For both of them their work is task orientated and they imply a production process. The key difference is the number of residents they care for and the time their shift starts. Their work is undertaken with a degree of autonomy as each one had a set group of residents to care for and did this without the help of others. In Brenda’s case the use of a hoist eliminates the need to ask a colleague for assistance and exemplifies the mechanisation of care, which in this instance is required to protect the backs of care staff. This was also encountered in the German care homes where in one home the hoist was nick named the ‘Eiserne Schwester’ (Iron Nurse). The description of an English care assistant’s routine did not vary between care assistants with or without NVQ training.

5. Understanding the medical conditions presented in the vignettes
A resident’s medical condition is a factor that impacts on many of their abilities to undertake daily activities independently. Understanding the medical condition in turn influences the approach care staff take towards the situations they encounter with residents, as their understanding facilitates their ability to empower a resident.

Not surprisingly the qualified staff in both countries generally presented an understanding of the medical conditions described in the vignettes. This was established by looking for specific indicators relating to each medical condition in the responses to the vignettes (Table 7.3). However, in both countries there appears to be a greater understanding for residents living with Parkinson’s than those living with Alzheimer’s or a stroke (Table 7.4). Only one out of twelve English RNs and two out of ten German OPCs presented an understanding of all three conditions. Of the German RNs two out of three presented an understanding of Alzheimer’s but did not relate to the other two medical conditions presented in the vignettes. Amongst the care assistants in both countries, there was very little understanding of the medical conditions presented in any of the vignettes. Care assistants who did present an understanding of the medical conditions in the vignettes actually related the situation to experiences they had had with residents they knew to have been living with a stroke, Parkinson’s or Alzheimer’s.
Table 7.3: Indicators that acknowledge medical conditions presented in the care vignettes

<table>
<thead>
<tr>
<th>Stroke (Edith)</th>
<th>Parkinson’s (Phyllis)</th>
<th>Alzheimer’s (John)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowing that the limited mobility requires rehabilitation</td>
<td>Knowing that Phyllis’ hands might be very shaky</td>
<td>Knowing that John might not be aware he has been incontinent</td>
</tr>
<tr>
<td>Knowing about the process of regaining bladder control</td>
<td>Understanding the fluctuation of physical abilities</td>
<td>Knowing John might be disoriented</td>
</tr>
<tr>
<td>Knowing that Edith might be able to understand what is said but could be unable to always respond appropriately</td>
<td></td>
<td>Knowing John might react aggressively</td>
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</table>

As the data indicates, whether or not a care assistant is NVQ trained does not appear to impact on their understanding of a resident’s medical condition. Within the German sample it is clearly the OPC who has the most knowledge about older people living with a stroke and Parkinson’s. German care home residents are more likely to be cared for by a qualified member of staff who has a deeper understanding of their needs than by a care assistant, whereas English care home residents are more likely to be cared for on a regular basis by a care assistant with little understanding of their medical condition (Table 7.4). The situation in England is compounded by the fact that care assistants are the main providers of ‘hands-on care’. However, with under 20% of the total sample specifically acknowledging the needs of an older person living with a stroke, fewer than 40% the needs of someone living Parkinson’s, and 30% the needs of a resident living with Alzheimer’s, the number of interviewees who acknowledged the implications of the medical conditions described in the vignette is very low in both countries.
5.1 Qualified staff responses to the presented medical conditions

In both countries the qualified staff, whether RNs or OPCs, can be expected to have undergone medically orientated training to provide them with a knowledge and understanding of the medical conditions the older people represented in the vignettes are living with. However, this was not always reflected in the responses to the vignettes. In England only one RN appeared to relate to all three medical conditions and in Germany only two OPCs did so.

Barry, the only English RN who related to all three medical conditions, presents an approach towards Edith, Phyllis and John which is very much to the point and orientated towards the clean 'lounge-standard product'. He takes the medical condition into consideration and questions medical and management factors that could impact on the situation. He does take Edith’s emotional state into consideration and considers her wishes regarding breakfast. In caring for Phyllis, Barry would consider her medical condition and relates this, amongst other things, to the consistency of her food. However, he does not consider what she might want to eat. This contrasts with the fact that he would help to maintain her independence by taking time to enable her to eat at her own pace, in her own way. His knowledge of the medical condition helped Barry to cope with John. With a ‘lounge-standard product’ in mind, Barry would negotiate with John in order to wash and change him into clean clothes. The responses Barry made are similar to that of the other English RNs who presented an understanding of Edith, Phyllis and John’s medical needs and reflect the managerial role of qualified staff in English care homes.

Barry, English RN: ...We would clean her [Edith] up and get her another breakfast, but we deal with people like her all the time. Her condition is, as anyone with a stroke, would be, she's frustrated, she can't do what she wants to do - she would be really upset about being incontinent as I think we all would be - so you've got the emotional side of things to sort out, you've got "why is she incontinent?" - has she been toiletted at 6 o'clock or not toiletted at 6 o'clock - has she got a UTI [Urinary Tract Infection]. But the thing here is reassurance and anything else she'd need. A lot of people would get worried about it - and the point would be to make her understand that fact - clean her up as you would normally clean her up - and then if she wished to have her breakfast - she might not wish to have her breakfast...

Interview extract from response to vignette 'Edith'

Barry: Does Phyllis want her lunch for a start? Yes she does, of course with Parkinson's it all depends on how bad she is. Would she be on a pureed diet? Why has she changed? I'd want to know why for a start. Could be the tremors and
everything else. Has she had her medication that morning? And of course we'd help her, assist her with eating, whether she wants us to - whether it's to get us to get the spoon or cup to her mouth or whether she wants to do it herself...

Extracts from response to Vignette ‘Phyllis’

Barry: Well, negotiation [with John]. I understand Alzheimer's. I understand the progression. He wants to wander round the home - fine - that's part and parcel of that. OK, it's negotiation - we're not going to frog-march anyone off to the loo or anything like that. Negotiate - if he wants to go and check the boilers - fine we can go to check the boilers while we're doing it - the boilers might be in the toilets. We can check the boilers after we've sorted him out. Change his clothes, change everything else - the boilers might be working properly - that'd be nice!

Extracts from response to Vignette ‘John’

Ilse, one of the two German OPCs who presented an understanding of all three medical conditions responded in a way that exemplifies how person-centred care takes the medical condition along with health and social needs into consideration. In all three situations, Ilse shows an understanding of the medical conditions presented in the vignettes, yet she also perceives Edith (Frau Schmidt), Phyllis and John as individuals with their own personalities which deserve to be respected.

Ilse: Well, as it says here Frau Maier is having difficulties in coming to terms with the fact that she is in the home; it needs to be acknowledged that she would take a while to settle in. To ease that process, we need to work together with her children, if she has any. If she's co-operative then we need to try and introduce her to the other residents in the home. That way she may be able to develop a small group of friends that might encourage her to look forward to the day and not be so grumpy. It's important not to leave her in bed but to encourage her to get out of bed and mix with the others. This doesn't have to be done every day. It might be wise to start off sort of every third day and then go on to every other day when she's ready, the next step would be to take her out of her room every day. If she doesn't want to eat, she needs to be encouraged and you just have to regularly offer her assistance to eat her breakfast. Maybe she will enjoy her breakfast more when she joins the others in the morning not only for breakfast but to take part in the other activities that are going on. Physiotherapy would also help her improve.

Interview extract from response to vignette ‘Edith (Frau Schmidt)’

Ilse: Well that's typical for Parkinson's, the person can change from one hour to the next. I think if she was co-operative and at times independent in the morning and the situation has changed over a few hours in the morning then there is no harm in providing some assistance so that she does realise yes I will be helped when I need it, its not a problem and I'd help her further. It is an illness where the picture is constantly changing and does not improve.

Extracts from response to Vignette ‘Phyllis (Frau Lembke)’

Ilse after reading about Herr Bottcher laughs
I: I often get that response
Ilse: Yes, I really do have to laugh. Well now, I take it that it will not be possible to convince him that he needs to go to the toilet. I would probably start by going along with him to let him do what he wants to do. Then I would talk him into coming along
with me to repair the damage. 'Cause I don't think you should boss Alzheimer patients around. They have their own world that they live in and we can't change that.

**Extracts from response to Vignette ‘John (Herr Böttcher)’**

There are similarities in the understanding of the medical conditions presented in the responses to the vignettes made by Barry and Ilse. However the knowledge is used differently. As Ilse exemplifies, the German qualified staff responses tend towards ‘person-centred care’ whilst the English qualified responses are orientated towards producing a ‘lounge standard resident’. This could be seen to reflect the different training that qualified staff have received in the two countries. The majority of the qualified staff in Germany are OPCs who were trained to meet the needs of older people living with a medical condition. In contrast the English qualified staff were trained to care for medical conditions of people irrespective of their age in a hospital environment where patients spend a relatively short period of time.

Qualified care staff who did not relate to the medical condition just wanted to get the job in hand done without any consideration of the medical condition or consulting the person they were caring for. The following responses that Joan RN, Ortrud RN and Gundula OPC made to the vignettes signal a focus on meeting the functional care needs, such as changing Edith’s wet bed and both Edith’s and Phyllis’ need to eat. This ‘lounge standard’ focused towards producing a comfortable person but not overtly considering the medical context of the situation by, for example, questioning or considering how and why the situation arose.

**Joan, RN**

Firstly, if she's wet, you have to make her comfortable. That's the basic thing. I'm sure that's the reason why she didn't touch her breakfast, because she was wet or uncomfortable. So you'd then help her to the chair, then you'd find out why she didn't want her breakfast, and give her another if necessary or make sure she has a good lunch.

**Extract from response to vignette ‘Edith’**

**Ortrud, RN**

Ortrud: In this case, I try to encourage her to pick up the spoon and attempt to eat on her own. If that doesn't work I would feed her. She must eat. I would ask her if she wants to carry on or if she has had enough. Because I've experienced that somebody has only been given a small portion and because of that I always ask if they had enough to eat. And of course I always ask what they would like to eat.

**Extract from response to vignette ‘Phyllis (Frau Lembke)’**
Gundula, OPC

Gundula: it is quite a normal situation, although we do try here to get everybody downstairs to the dining room for breakfast, which would mean getting her out of bed. But if that doesn't work out of course she could have breakfast in her own room. The fact that she is wet does not really matter.

Extract from response to vignette ‘Edith (Frau Schmidt)’

5.2 Care assistant responses to the presented medical conditions

The care assistants in both countries tended not to relate to the medical context in which Edith, Phyllis and John were presented. Gwen, who had been recruited from abroad to work in English homes, was the only care assistant with no previous training in the provision of care who presented an understanding of the three medical conditions. Before arriving in England, Gwen had worked in an office and had helped care for her mother. This care assistant did not have NVQ qualifications nor was she participating in NVQ training. Otherwise the general lack of understanding these medical conditions typically seen in care homes can be seen to reflect the task orientated NVQ training provided to care assistants. Whilst four of the seven care assistants who had undergone NVQ training did relate to at least one medical condition, their understanding was clearly derived from their care experiences as exemplified by Beverley’s response to vignette ‘Phyllis’.

Beverley, English Care assistant NVQ:

We've a lady here, sometimes she's very, very alert and she'll sit up and she will have her plate on her lap and can eat herself - but some days she's very shaky - and though she'll try to feed herself, the plate just ends up in her face. So what we'll do is sit her up with help, and lift her head up, not for long because it would hurt being held up like that and we help feed her because obviously she's going to be hungry.

Extracts from response to Vignette ‘Phyllis’

Tracy, an English care assistant, and Meta, a German care assistant, also presented an understanding of the medical condition by relating the situation to their work experiences. However, Meta also exemplifies how someone who has been working as a care assistant for just over ten years can establish inappropriate coping mechanisms. Meta appears to believe the best way to cope with John would be to raise her voice and take control of the situation, indicating that she does not understand the medical condition and its effect on John’s behaviour. Tracy relates the situation to her grandmother. Her first experiences of people living with dementia were family orientated and have influenced Tracy’s perception of such residents. Both exemplify how lifecourse experience determined how they provided care.
However, Tracy who is not yet 20 was influenced by family life whilst Meta, who was in her mid-fifties was influenced by her experience working in care homes.

**Tracy, English Care Assistant**

I: OK now the next one is John.

Tracy: Right, ...ehm, I don’t know.

I: I know it is a bit of a problem because here you have a separate mental health unit.

Tracy: I have actually done some shifts on the MHU [Mental Health Unit] so its not too bad and my Nan had Alzheimer’s – I used to care for her as well so I would – if he had to go and check the boiler – depending on where he was walking towards – if he was walking towards a toilet then I would go with him and encourage him to go into that toilet. I also find with a lot of Alzheimer’s they want to help a lot so I’d get talking to him, getting him to talk to me and changing the subject so that I could get him clean and fresh and everything. But if not, I’d get him as if he was helping me. I often find that works – may be not so much with Alzheimer’s but with dementia patients; if they think they are helping they are more willing to do stuff. So I’d hopefully get him to a toilet and get him clean, change his trousers, pad pants, whatever he had on. I mean I find communication normally one of the best things. When talking to them you can achieve anything really – not to be aggressive not to force him or come on too strong like say ‘John you’ve messed yourself now come along to the toilet.’ That would upset them more. To start with he doesn’t need to know that you know he’s been incontinent because he might know himself and feel quiet – and he sort of, you know, wants to get away from it. So I would talk to him, hopefully walk him towards the toilet, encourage and talk to him and try and persuade him. But basically, with communication, get him cleaned up.

**Extracts from response to Vignette ‘John’**

**Meta, German care assistant:**

We have somebody like that [like Herr Böttcher] who comes for respite care on a regular basis. He has Alzheimer’s and you have to be quite forthright with him. If you were to go along with him he wouldn’t really notice it. They always do what you don’t want them to do! So you just have to be forceful. Our gentlemen just follows around you even though he’s meant to go to bed and if you raise your voice he seems to understand things better.

I: Do you think everybody who has Alzheimer’s understands better if you raise your voice?

Meta: I can only go by what have experienced with this one gentleman. When you try and undress or dress him, he's fiddling here and fiddling there, he doesn't want to have his teeth in and you can't be having that so you just have to be forceful, friendly but forceful.

**Extracts from response to Vignette ‘John (Herr Böttcher)’**

The responses from English and German care assistants, with and without NVQ training, do recognise the tasks needed to meet Edith’s, Phyllis’ and John’s care. However, the data does imply that especially in Germany it in important to provide care assistants with basic training on focused providing care to older people living in care homes.
Overall, the majority of care assistants in both countries did not relate to the medical context that Edith, Phyllis and John were presented in, as exemplified by the responses made by Penny, Kelly and Helga. It can be assumed that the focus of their work is to produce a ‘lounge standard’ resident in the most effective and efficient way. Helga’s response also reflects Meta’s experience of learning to cope with unpleasant situations.

Kelly, care assistant with NVQ 2
Kelly: We’ve actually got a ‘feed’ table - certain people we always feed every day. So if somebody needed any help they could come over and sit with the feed table - where we make sure there’s people sat down so we don’t have to dish everything out - we’re just doing a feed - because sometimes it gets a bit aerated when they’re not sitting down and trying to give their lunches out to other people - and now we’ve got it so there are people sitting at all times - where they can feed them there.

Extract from response to vignette ‘Phyllis’

Penny, care-assistant
Penny: Well I personally would clear the incontinence up first ‘cause you can always remake the breakfast. So I would get Edith up out of bed make sure she was cleaned, if it was faeces I would bath or shower her then I would make her comfortable make sure her bed was stripped, dress her and remake her some breakfast. My prime care would be for Edith to make sure she was dry and comfortable. There is nothing worse than sitting in a pool of faeces or urine whilst eating your breakfast. My prime concern would be to make sure that she was dry, clean

Extract from response to vignette ‘Edith’

Helga, care assistant:
Helga: That sounds familiar! It happens quite a bit here, in time you learn how you must cope with the situation. Earlier today after we had finished making the beds we did the rounds again to check everybody and in the sitting area we could smell that somebody needed to be taken to the toilet. Some residents do find their own way to the toilet though

Extract from response to vignette ‘John (Herr Böttcher)’

By indicating the unpleasant smell and that not all residents need to be assisted to the toilet Helga’s response does not directly relate to John’s situation. However, she is implying that the situation and task described in the vignette is not unknown to her and is a situation that has to be dealt with and is not worthy of give to much thought to.

The lack of English and German care assistants understanding of the medical conditions presented in the vignettes can be expected to impact on the respondents approach to Edith, Phyllis, John, Maude or Derrick. This can be expected to result in
care assistants ‘playing safe’ and taking control of the situation and doing what they perceive has to be done to produce a ‘lounge-standard product’.

6. Conclusion

The vignettes facilitate the description of each respondent’s everyday work and how they relate to the same situation in their own individual way. The resulting data indicates how they would interact with the resident and provide care that could empower or disempower a resident. Information from the home managers provides an insight into the dependency and care needs of the residents in the sample homes and indicates that the respondents should be able to relate to the vignettes portraying older people with different medical conditions that result in diverse care needs.

The extracts describing the daily routine of care staff provide an understanding of the bodywork that care staff undertake in a care home on a regular basis and exemplify how the vignettes fit into the work environment of the interviewees. The description of care staff’s daily routine clearly establishes that there are differences in the roles of the qualified staff in England and Germany. The English qualified staff primarily take on a supervisory and managerial role whilst their German counterparts provide much more ‘hands-on care’ with a greater understanding of the medical conditions encountered in care homes. This can be expected to reverberate through the care staff and the residents and will be examined more closely in the responses to the vignettes.

The extracts from daily routine of the care assistant’s indicate the similarity in their everyday tasks in the two countries. However, it also clearly highlights the lower resident to care staff ratio in England in contrast to the higher ratio encountered in German care homes.

Despite the differences between the two countries the actual daily provision of care to older people living in a care home can be seen to be very similar. The data from the home managers in both countries indicates that the participants are accustomed to catering for the needs of older people like Edith, Phyllis, John, Maude and Derrick. However, the responses to the vignettes indicate that the medical conditions described are not greatly acknowledged by the interviewees thus signalling that for care workers the production of a lounge standard product is more important than
empowering an older person to be autonomous in their everyday life. How this relates to the skills used in the provision of care and the quality of life experienced by older people living in English and German care homes will be discussed in the following chapters.
Chapter 8
Communication as an Instrument of Power

1. Introduction
Within the environment of a care home communication could be seen to be pivotal to the provision of person-centred care and providing older people who live there with an opportunity to be empowered participants in the provision of their care. For care home staff, communication is an important instrument of care as it is used to clinically assess a situation and as an important tool in implementing emotional labour. However, communication between care home residents and care staff does not always incorporate reciprocity nor does it always result in a balanced exchange of information. Whilst this could be seen to be linked to the differing purposes behind the two parties' reason to communicate, it does indicate an imbalance within the relationship between resident and care staff and can be seen to be linked to the lack of empowerment older people experience when they move into a care home.

Within a care home communication takes place either via a communication system or face to face. The balance of power between resident and care staff is determined by the individual’s ability to control the communication system or verbalise their thoughts and wishes. It can be assumed that if Edith, Phyllis, John, Maude and Derrick were actual residents, they would appreciate human contact and that talking and chatting would be a pleasurable part of everyday life. This would establish and maintain an individual’s identity as an autonomous and valued person. However, communication for an older person living in a care home is linked to being able to hear, speak, see and control a communication system. This chapter considers the use of communication as an instrument of power, firstly from a resident’s perspective and then from the perspective of care staff.

2. Communication from a residents perspective
From the perspective of an older person living in a care home, communication could be seen to be a predominantly social activity. However, more importantly it can actually be seen as a method of empowerment to maintain their individual identity and to gain acknowledgement of their individual needs. A communication system
intended to provide residents with the facility to call for care staff as and when they need assistance can initially be seen to be empowering as it also provides older people living in a care home with the opportunity to initiate face to face communication with care staff.

2.1 Communication systems

Within care homes, the communication system used by residents to call for a member of staff in both countries is colloquially referred to as a ‘bell’ (Klingel). Although the ‘bell’ is more likely to buzz persistently rather than chime melodically, it contributes to the background noise and atmosphere of care home life for both care staff and residents. There is a wide-ranging variety of systems on the market. The majority of systems are connected to the wall and have a lead that reaches to the bed or chair. At the end of the lead there is usually a plastic box or a bell shaped device with at least one button to press to call for assistance. It is this button that is generally known as the ‘bell’, reminiscent of the bell systems used in both countries to call for domestic servants in days before World War I. Bathrooms and toilets have a lead hanging down from the ceiling that can be pulled when needed to activate the ‘bell’.

The important thing is that the ‘bell’ needs to be accessible to the older person, thus empowering them to call for assistance when it is wanted. It is often up to care staff to ensure that the ‘bell’ is within reach of the resident wherever they are in their room. The resident rings their ‘bell’ and in the corridor of the home, a display system will inform the care staff in which room someone has rung the bell. At a central point of the home or care unit there will also be a display system informing staff where a bell has been rung. Many systems also incorporate an intercom system so that from the central point a member of staff can communicate with the resident. Key to this communication succeeding is that the resident can hear the voice coming out of the wall and feels confident and able to reply. In some systems the ‘bell’ will only stop ringing if care staff physically enter the residents room and switch it off, in others it can be switched off from a central point. The sound of the bell in many homes can be heard throughout the building, in others it is only heard where care staff have turned on a switch that enables them to be aware of ‘bells’ ringing throughout the home or on their unit. Some modern systems now provide care staff with a receiver that they
carry around with them when they are on duty, this alleviates the sound of bells as background noise within the home. It is the older person who presses the bell to call for assistance. However, it is the care staff who determine how soon and when they respond to the call. Within most homes the nurse call system also enables staff to call for assistance from colleagues in emergency situations.

The use of the 'bell' is an aspect of care that was not overtly incorporated into the vignettes. However, in the context of the situation surrounding Maude and Derrick, it was an issue that could be expected to be raised. Whilst discussing the daily routine it was also an aspect of their work that was raised by respondents. The presence of 'bells' in care homes was invariably also observed during the data collection as the buzz of the communication system often interrupted the interviews in both countries.

2.2 Taking control of the communication system

It might be assumed that the 'bell' would provide care home residents with an instrument with which they could assert control and be empowered. After all, if you ring the bell you expect someone to respond and come and see to your needs. However, care staff determine when they respond to the call of a 'bell' thus defusing its power. This is exemplified by Hartmut, a German RN, who was representative of most care staff in both countries after they have been busy getting residents up, washed and dressed in the morning. During the interview he said the following whilst talking about the work he had done on the morning of the interview having started work at 6pm:

Hartmut RN: First of all I showered a lady and changed her bed. We do that once a week for her. During the rest of the week she washes herself. Once a week we have to make sure it's done thoroughly and her hair is washed. Then my normal routine continued.

I: What does that look like?

Hartmut: I put one gentleman on a bedpan and give him the urine bottle. Then I go to the next person where I wash and dress their lower body and then help them into their wheelchair, make their bed and wash their back. Then I return to the first gentleman who will have finished on the bedpan. I then wash his back and put out his clothes for his upper body. Then I go and hang up some tea to run through a gastric tube, so that he has had some fluids before breakfast. He won't have had anything since 10pm yesterday. Then I return to the first gent and wash him down below, his genitals, and dress him and assist him into his wheelchair and make his bed. Then I go to another gent. I have to plug his catheter, sit him in a wheelchair and then take him to the toilet. He sits there for a while and in that time I prepare the drugs and make the
bed, empty the urine bag and hang up a new one. Then I wash him whilst he sits on the toilet, but the head of care must not know that. Theoretically it is forbidden. He is supposed to sit on a chair in front of the sink.

I: So why do you wash him whilst he’s sitting on the loo?

Hartmut: It’s just not practical [sitting on the chair]. The chair is too low and there’s not a lot of space in the bathroom. He also can’t stand very well either.

I: Are you both happier that way?

Hartmut: I think so, yes. It’s the same for showering. Anyway he’s washed and dressed. His dentures are put in and he’s padded up then he goes into the wheelchair and is pushed up to the table where he shaves himself and has a drink. Then I go to Frau R. She has had a stroke. I sit her on the toilet so that she can pass urine, during that time I make her bed and I also make the other women’s bed. I then go to another woman and put her teeth in and pull her up in the bed and put her bib on and leave a drink within reach, basically have her ready for breakfast which she has in bed. Then I return to the women I had sat on the toilet and wash her and clean her dentures and so on. I also wash her sitting on the toilet for the same reason. I then dress her and sit her in a wheelchair at her table, put the bib on and comb her hair. Then it’s 8 o’clock. After breakfast I have two more to wash. Two gents though, one of whom gets up, but he’s showered twice a week. At 8, breakfast is served. Some need assistance with their breakfast. I need to check that one has drunk all her coffee and has eaten. She tends to fall asleep and forgets that she should have breakfast. That keeps me busy up to 8.45. Then, today, I had to get a duvet from the laundry because one had got dirty and there wasn’t another clean one on the unit. I also did the weekly blood sugar test on one resident. Then at 9, I have my breakfast break.

I: Do you stay on the unit for that?

Hartmut: Yes.

I: What happens if someone rings a bell?

Hartmut: Some one will go and answer it. Occasionally we do say [through the intercom system] we are having our breakfast, you have to wait’ if it’s someone sitting on the toilet. It does depend how far into the break we are and how well that person is able to sit. Some can’t sit for very long at all. At 9.30 I get going again. Taking people to the toilet, then I showered one gent and washed his hair and then dressed him and accompanied him to the table and assisted him to shave and comb his hair. Then he had a bit to drink. In between I’d also shaved the other gent in the room whilst the other was on the toilet. I also did his oral care, washed him, creamed him, put a clean ‘pampers’ on and made his bed. Just did all the things that are part of basic care. That takes me up to about 11. I’d also popped into the other woman to give her a drink. She needs to drink a lot but has to be reminded. I accompanied one gent to the dining room or should I say I sent him there.

Interview extract from Hartmut, Male Qualified Nurse. My emphasis

This extensive extract highlights how a member of staff believes he has done his best for the residents he is caring for that morning and that he is consequently entitled to a morning break. In both countries, care staff’s rest periods are often interrupted by residents ringing their ‘bell’, as it is not always possible to leave the care unit during a break. In some of the German care homes, there were comfortable staff rooms next to the nurses’ station on each unit for staff to retreat to. After completing the morning bodywork described by Hartmut, all care staff can be seen to need a break. In some instances the hub of the call system is actually positioned where staff take their break.
However, this also needs to be balanced against the residents need to maintain control over their own lives, even if only over their bodily functions. The importance of the nurse call system as a method of communication and a potential ‘power tool’ for residents cannot be underestimated. It is often the only means residents have to personally influence their provision of care, yet care staff do not always respond to the bell in the expected way. As the extract from the interview with Hartmut exemplifies, once it has been identified who has rung the ‘bell’, an assumption as to why it has been rung is often quickly made. This appears to accentuate the imbalance of power between residents and care staff although it could also be seen to illustrate the problems care staff face daily when attempting to distribute their time effectively amongst the residents they care for (see Chapter 9).

2.3 Giving control of the communication system

To be able to use the ‘bell’, a resident needs to be able to access it and it is not always physically possible for a resident to do so independently. Consequently it is up to care staff to place the ‘bell’ within the residents reach. The responses made by the English care staff to the four care vignettes show that of the care assistants, only Tracy and Gwen considered providing Maude with a call ‘bell’. Of the NVQ trained care assistants, Sharon, Helen and Brenda considered that it would, for example, be important that Maude has access to a bell if she had to be left when they go to care for Derrick. This is in contrast to the German care assistants where none of the respondents considered giving Maude a ‘bell’. This could be related to the fact that in a German care home, Maude would have been in an en-suite bathroom where there would have been a bell hanging from the wall. As Maude was sitting in her wheelchair it could therefore be assumed that she was able to gain access to the bell if it was not directly within her reach. In an English care home, the wash basin Maude could be sitting at would not always be in an en-suite bathroom, it could just be part of a vanity unit in her room and the bell would consequently not necessarily be within reach. In this instance the response to the vignette can be seen to be related to the divergence in the architecture encountered in English and German care homes.

The qualified staff in England took a managerial approach towards Maude and Derrick and would all have considered delegating some of Maude or Derrick’s care.
Only Thelma and Rowena also considered providing Maude with a 'bell' whilst coping with the overall situation. This response again highlights the managerial role taken by English qualified staff, whereas all the German qualified staff would have dealt with the situation in a very similar way to the German care assistants.

In both countries, empowering the resident by providing them with access to the 'bell' does not appear to be foremost in the mind of the respondents. It would appear that it is taken for granted that a care home resident does not have a choice in the provision of their care as care staff believe they know what the resident needs and have the best intention of returning when time permits.

3. Communication from care staff's perspective

For care home staff, communication can be seen to play a role in the clinical decision making process which enables them to work effectively and efficiently. It is also used as an emotional labour tool in order to complete a task as quickly as possible. Communication is clearly an important aspect in the provision of care by qualified staff and care assistants in both England and Germany.

3.1 Communication in the clinical and care decision making process

Communication with residents can provide care staff with clinical and care information that could impact on their decision making process and ultimately on the provision of a higher standard of care. Information gained from communicating with all five residents presented in the vignettes would impact on the care provided.

Communication with Edith (Frau Schmidt) would provide information about how the situation arose. The extract from Marlies’ (OPC) response shows it was important to her to have more background information before deciding what steps to take. That information could only be gained by communicating with Edith, and while the vignette describes her as having difficulties in communicating, she does have the devices that could enable her to communicate. Only if staff can communicate with Edith can they make a well-informed clinical decision and empower her by enabling her to participate in the planning of her own care.

Marlies: How would I cope with the situation?
I: You are bound to have encountered similar situations in the last twenty-eight years.
Marlies: I definitely have. What is it you want to know?
I: What would go through your mind? What would you do?
Marlies: I need to know if she went back to bed under her own steam or did the night staff put her back into bed? So I would ask her. Because she can't hear because she hasn't got her hearing aid in, I would make sure her hearing aid was put in. Then I would ask her if she needed to go to the loo again and if she'd like me to change her so that she could have her breakfast. Depending on her response, I would let her have breakfast. I would make her bed so that if she wanted, she could go back to bed and go back to sleep. I would then move on to the next resident.
I: So it wouldn't present a problem if she wanted to go back to sleep?
Marlies: No, not at all and if she didn't want to eat her breakfast it wouldn't worry me. She will have her reasons. The first thing I would definitely do is put her hearing aid in, otherwise I'd be wasting my breath 'cause she wouldn't hear me. There are lots of possibilities here but I am taking for granted that her teeth have been put into her mouth. Our staff here definitely would not forget to put somebody's teeth in or their glasses on.

Interview extract from response to vignette ‘Edith’ (Frau Schmidt). My emphasis

Whilst this extract provides an insight to the clinical decision process and how Edith is empowered, the actual number of participants who acknowledged the need to communicate with Edith was low in both countries (see Table 8.1). In England, two qualified staff and four care assistants identified Edith’s need to communicate with them whilst in Germany, three qualified staff and one care assistant acknowledged those needs. The majority of qualified staff and care assistants in England and Germany appear not to perceive communication with Edith to be an essential part of caring for her (Table 8.1).

Table 8.1 Edith’s communication needs acknowledged by care staff

<table>
<thead>
<tr>
<th>Communication needs acknowledged</th>
<th>RN England (12)</th>
<th>RN Germany (3)</th>
<th>OPC Germany (10)</th>
<th>Care assistant NVQ England (7)</th>
<th>Care assistant England (5)</th>
<th>Care assistant Germany (13)</th>
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</thead>
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<td>1</td>
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OPC = Older Persons Carer

The majority of staff in both countries appear to assume they know what needs to be done for Edith without communicating with her to gather further information to make a clinical decision or offering Edith the opportunity to be included in the planning of her care that morning. They therefore do not appear to consider the need for Edith to use her hearing aid or have her teeth in her mouth. These factors could also possibly
enable Edith to eat with a greater degree of independence, thus empowering her and providing dignity to her everyday life.

Of the twelve RNs interviewed in England, only four mentioned the need to communicate with the ‘residents’ in the vignettes in order to assess the residents situation and plan their appropriate care. One of the four was Barry (RN) who, as the extract from the response to the vignette on Phyllis exemplifies, considered it important to know more about the situation. His response was as follows:

**Barry RN:** Does Phyllis want her lunch for a start? Yes she does, of course with Parkinson's it all depends on how bad she is. Would she be on a pureed diet? Why has she changed? I'd want to know why for a start. Could be the tremors and everything else. Has she had her medication that morning? And of course we'd help her, assist her with eating, whether she wants us to - whether it's to get us to get the spoon or cup to her mouth or whether she wants to do it herself...

*Interview extract from response to vignette ‘Phyllis’. My emphasis*

Barry’s response starts with a barrage of questions that he would want to ask Phyllis. The answer to these questions would provide him with important information that would determine how he proceeds to care for Phyllis. Most of the questions could only be answered by Phyllis. He could find information about whether or not Phyllis had been given her drugs from the medical records. However, only Phyllis will know if she actually swallowed them. This extract exemplifies the importance of communication between care staff and residents as it highlights how further information can influence the care decisions made by care staff. However, without the appropriate knowledge base related to people living with Parkinson’s, it is doubtful that Barry would have wanted to ask these specific questions since they indicate his knowledge and understanding of this medical condition.

In Germany, of the thirteen qualified staff interviewed, none of the three RNs would have communicated with the ‘residents’ to gain more information about the situation with which they were confronted in the four vignettes. However, four of the OPCs in Germany would have wanted to communicate with the older person to find out more details of the situation. Like Barry (RN) in his immediate response to the vignette, the need for Roswitha (OPC) to ask questions was evident. Initially, she asked herself to consider what might have caused Phyllis (Frau Lembke) not to eat at lunchtime but
then she also considered communicating with Phyllis. After reading the vignette relating to Phyllis, Roswitha’s response was:

Roswitha (OPC): We have that here, well, you firstly ask yourself why? Often, if our people are confused, it’s because they have not been drinking enough. So I’d make sure she had more to drink and would observe her. If she’s not eating you find out why not. It is a normal situation
I: Yes, so what would you do?
Roswitha: I’d give her something to drink and if I have the time, chat with her to find out why she’s not eating

Interview extract from response to vignette ‘Phyllis’ (Frau Lembke). My emphasis

Barry, Marlies and Roswitha represent qualified care home staff who were accustomed to making clinical decisions and present a sound knowledge base of care home residents’ needs. They clearly do not represent the majority of qualified care staff in the English and German sample homes. Their responses, however, do emphasise the importance of employing knowledgeable staff as this research suggests they are able to empower older people living in care homes.

3.2 Unquestioning care in England

An unquestioning approach about the resident’s condition can be seen to be representative of most English care home staff irrespective of their training or qualifications. In all the English responses to the four care vignettes, only four members of qualified staff considered communicating with the older person in order to gain a better understanding of the situation they were confronted with. Eileen, a care assistant with NVQ training when responding to ‘Edith’ said that she would want to know more. Her response after reading the vignette was:

Eileen: I’d try to find out if that is like Edith.
I: Well you’d know wouldn’t you?
Eileen: If she usually eats her breakfast then there’s obviously something wrong - because we have got a lady like that here. And you’d spend whatever quality time you have to find out what is wrong and if there’s anything she’d prefer to eat - she’s obviously fed up because she’s had an accident - and just reassure her - "don’t worry about that - it’s just one of those things" and jolly her along really. Reassure them so they don’t get upset - it’s upsetting for them if they do have an accident and if you go in there huffing and puffing that you’ve got to strip the bed, they’re going to get upset - even with a stroke they know what’s going on and just reassure them that it’s not a problem. She probably doesn’t want to eat her breakfast because of what’s happened. Reassure her, jolly her along and get something to eat that she likes and if she doesn’t want to eat something then something like a milk.

Interview extract from response to vignette ‘Edith’. My emphasis

150
Tracy, another English care assistant also felt she wanted to know more after reading the vignette. However, she wanted to know about the staffing situation and clearly expected to gain all her information about the resident’s condition from the report she was given by a qualified nurse when she came on duty. Although in England, care assistants are the main providers of ‘hands-on care’, the picture gained from their responses to all the care vignettes is that it is not perceived to be their role to ask residents questions that could be related to the residents’ medical condition. A routine care task is identified, such as getting Edith washed and dressed or assisting Phyllis at lunch time, and the task is ‘done’ by the care assistants to the best of their personal ability. Most care assistants, including those with NVQ training, appear to be ‘doing care’ often without communicating with the residents to gain more background information about their present condition or including the resident in the decision making process whilst providing care.

In this instance the clinical assessment of care home residents in England can be seen to be the prerogative of the qualified staff. However, the fact that the majority of the qualified staff and care assistants participating in the interviews did not consider communicating with the resident to gain a better understanding of the situation leads to the conclusion that both qualified staff are providing care without considering the need to ask questions, thus disempowering older people living in care homes.

3.3 Unquestioning care in Germany

Amongst the thirteen German care assistants interviewed, only two considered communicating with Edith (Frau Schmidt) to help them assess the situation and determine the next steps to take. This is exemplified by Dagmar who also considers her sense of smell in the assessment of the situation. Her response to the vignette related to Edith (Frau Schmidt) was:

I: If you came into her room at 8.15 and found her like that what would you do?
Dagmar, care assistant: First I would check to see if she is conscious, if she is then I’ll have to see what else needs doing. I would get her into the bathroom and care for her. But first I have to be really sure she’s all right. I need to check her blood pressure and her temperature.
I: Let’s say you are here at work and you came across a resident who hasn’t eaten breakfast when you go to collect the tray, what would you do?
Dagmar: I would ask if she was not well. If the room stinks and she is wet, I would first of all prepare things in the bathroom. Then I would ask her if she wants to eat
There are two different aspects - if she is not well then something has to be done. If she needs to be cleaned up then it goes without saying that's what I do. I make sure she is clean before she has her breakfast.

Interview extract from response to vignette 'Edith' (Frau Schmidt)

The overall issue of communication of all care staff with residents to gain background information about an individual’s situation in both countries appears not to play a significant role in the provision of day to day care. Whilst in theory it might appear necessary and appropriate to communicate with residents in order to provide person-centred care, it would appear that in both countries care staff approach the older people with a preconceived idea of the care needed. This underpins the lack of person-centred care and the predominance of care staff focused on producing a 'lounge-standard' product.

4. Communication to implement emotional labour.

Emotional labour is an acknowledged part of care work. In their response to the vignettes, the emotional labour skills as described by James (1989) and Lee-Treweek (1996) are skills seen to be used by the qualified care staff and care assistants in both England and Germany. The responses to the vignettes based on Phyllis and on John highlight how communication is the main instrument used to implement emotional labour both to establish order and to achieve a goal in the provision of care.

In the vignette based on Phyllis, the outcome of the provision of care is to ensure that she ate lunch. For care staff the main method of achieving this goal, whilst maintaining her dignity, was to use emotional labour. It was clear from the responses made by all six groups of care staff that the respondents empathised with Phyllis and would take time and sit down with her. John's situation was less pleasant as he had been incontinent. Care staff who have in the past experienced care for older people diagnosed to be suffering from Alzheimer's disease would also be wary of the fact hat he might become aggressive, a factor which is reflected in the responses made to the vignette.

4.1 Encouraging Phyllis (Frau Lembke) to eat

Seven of the twelve qualified staff in England would have taken an organisational role in this situation and appeared not to consider communicating with Phyllis. Their
focus was on delegating, checking medication or making sure the correct utensils were being used to eat. However, five of the English qualified staff would have attempted the use of communication as part of emotional labour and would have coaxed Phyllis into eating her lunch. On the one hand, Joyce (RN) would tell Phyllis what she is eating, and on the other hand she offered Phyllis an alternative meal. Whilst assisting Phyllis, Joyce would also be chatting with her.

Joyce RN: I would sit with her for a while and try to help her eat her lunch. Obviously she can't manage it herself, so she's going to need assistance; make sure she's comfortable first, in her chair or in the bed. Wherever she is, make sure she's comfortable before we start, she's covered up and give her support, encourage her to eat her food, tell her what she's having to eat. Obviously she can see it, but sometimes it's pureed so you don't always know what it is. I would try and encourage her, help her. If she didn't want it, I'd ask if there's something else I could get for her. A sandwich or yoghurt or ice cream - they sometimes like ice cream if they're not wanting their main meal. We have a select menu - and if we want to we can order it at any time - help her with her drink, make sure that she's had sufficient, put her on a care chart if she needs it, and chat with her generally while you're doing that.

Interview extract from response to vignette 'Phyllis'. My emphasis

German qualified staff would also encourage Phyllis (Frau Lembke) to eat. Ortrud (RN) for example was concerned that Phyllis had had enough to eat. She would have both encouraged Phyllis to eat and asked her what she would like to eat.

Ortrud RN: In this case, I'd try to encourage her to pick up the spoon and attempt to eat on her own. If that's doesn't work, I would feed her. She must eat. I would ask her if she wants to carry on or if she has had enough. Because I've experienced that somebody has only been given a small portion and that was it, I always ask if they have had enough to eat and of course I always ask what they would like to eat.

Interview extract from response to vignette 'Phyllis (Frau Lembke)'. My emphasis

Thus both Joyce and Ortrud exemplify the use of emotional labour to ensure the orderly and successful completion of a daily task. The use of emotional labour in this instance can be seen to be an important part of the production process of care.

In a similar way to Ortrud, Sharon as a care assistant also exemplifies how the respondents did not directly talk about communicating with Phyllis but nevertheless did talk about encouraging, coaxing or motivating her to eat. As such this approach exemplifies the use of communication to perform emotional labour.

Sharon, care assistant NVQ: I'd probably try and encourage her - she's not eating very well. There must be a reason for it. I'd check whether she's been to the loo that day, she might be uncomfortable or in pain - I'd think back to how she was in the
morning - different - I'd just encourage her to feed herself - if she doesn't want to feed herself I'd see if she likes the food - or if there's anything else she'd like to eat instead of what is there. If she's happy to eat the food that's there, then I'd probably help to feed her, and that might get her motivated to feed herself, and encourage her.

**Interview extract from response to vignette 'Phyllis'. My emphasis**

Sharon, like Eileen earlier, would have also wanted to gain background information to have a better understanding of the situation so that the appropriate care could be provided, thus exemplifying how NVQ trained care assistants may use communication as a care instrument to assess and provide care. Their knowledge base can be seen to empower them to ask questions so that they can provide the best possible care.

All the German care assistants would have made sure Phyllis (Frau Lembke) was able to eat her lunch and like Uschi would have sat down, reassured her and assisted in enabling her to eat as independently as possible.

**Uschi, care assistant:** First of all I'd tell Frau Lembke that it's nothing to worry about. It can happen. May be she has done a lot that morning. Maybe she has taken part in ‘memory training’* and is now worn out. I would then offer to help her.

**Interview extract from response to vignette ‘Phyllis’ (Frau Lembke)**
* a group activity provided by occupational therapists to stimulate the brain

The provision of care for Phyllis was linked to communication and clearly presented the use of emotional tools in the provision of care by both qualified staff and care assistants in both countries. Directly or indirectly the majority of care assistants indicated the need to communicate with Phyllis to either establish her likes and dislikes or to encourage her to eat. Audrey was the only care assistant in both England and Germany who took a very task orientated approach to Phyllis’ situation. The approach Audrey has towards communicating with residents was as follows, short and to the point:

**Audrey, care assistant:** Sit with her and feed her - get her lunch into her.

**Interview extract from response to vignette ‘Phyllis’. My emphasis**

Amongst the qualified staff in England, it was noticeable that seven of the respondents maintained their organisational role which in this instance did not appear to include the need to communicate with Phyllis. This contrasted with the German qualified staff who would all have assisted Phyllis (Frau Lembke) to eat her meal and would not have considered delegating the task.
Communication was the key instrument used to implement emotional labour and as the extracts exemplify the communication was very one sided with little verbal response expected from Phyllis. As in this instance emotional labour was used to encourage Phyllis to eat and she would be expected to be concentrating on eating, it might not be expected that she participate in a conversation as there is an undeniable danger that she could choke if she attempted to speak whilst eating. Without encouragement, it can be expected that Phyllis would not have eaten. In both countries it is seen to be important that older people living in care homes are not only clean but also fed, elements that can be seen to be used as achievement ‘targets’ in the production of care in both countries.

4.2 Coaxing John (Herr Böttcher) to be a clean resident

Communication was a key element in the provision of John’s care. He has been incontinent and could be seen to need to return to his room, be washed and changed. Yet as far as he was concerned, the boiler needed checking and he was going to do it! From the outset it was clear to most respondents in both countries that ‘coaxing’ would be an important element of the task. The exception amongst the English care assistants’ was again Audrey who was focused on the efficient production of a clean, fresh-smelling product. John needed to be changed so that is what had to be done and Audrey expected him to co-operate without question.

**Audrey, care assistant:** Get him changed and then go and check his boiler!
**I:** How would you get him changed - if you met him in the corridor?
**Audrey:** I'd just get him back to his room - get him changed.
**I:** How would you get him back to his room if he was wanting to go somewhere else?
**Audrey:** I'd just tell him what we were going to do - get him changed and then he could go and look at the boiler.

**Interview extracts from response to Vignette ‘John’. My emphasis**

This contrasted with the other care assistants, both English and German who described how they would communicate, coax or divert John in order to get him washed and changed. Kelly, like the majority of the respondents, exemplifies how she would include the need to check the boiler in her attempt to divert John to the toilet.

**Kelly, care assistant:** Probably tell him you're actually going to take him to the boiler room - and then say "why don't you go to the loo while you're here before you check the boiler?" or something - just keep talking to him. They're the funniest ones actually - they think they're doing something like that and, I know you shouldn't, but it's the easiest way to do things sometimes is just to pretend - get into their world almost.
Interview extracts from response to Vignette ‘John’. My emphasis

Gladys, an English RN, stresses the importance of communication in her response to the vignette. Whilst she does not describe directly how she would communicate, she does highlight the emotional labour aspect of care by talking about coaxing and that coaxing is linked to communication.

Gladys, RN: I think obviously you'd need to approach John quite sensitively. If he thinks he's going to look at the boiler to make sure that's working, I think it's down to general coaxing back to his room, and talking him through it as you're doing it, you know communication is so important with them. You know whether they actually understand what you're doing or not, communication is so important, so talking through what you're doing and why you're doing it to make them more comfortable, and obviously get them changed and clean and dry. It's about communication.

Interview extracts from response to Vignette ‘John’. My emphasis

Detlef, a German OPC, exemplifies how he would take a down-to-earth approach using emotional labour tools by pointing out to John (Herr Böttcher) that it would be to his advantage if he were to be washed and changed.

Detlef, OPC: I would coax him into accepting the fact that he could go to the boiler room later on. Especially if it is quite obvious that his trousers are wet and dirty and smelly, then it is definitely to his advantage if he is cleaned too and changed as soon as possible. So I would make sure that he went to the toilet and I'd be able to convince him of the necessity. The fact that he needs to go to the boiler room is only in his imagination after all.

Interview extracts from response to Vignette ‘John Herr Böttcher’. My emphasis

Glen, an English RN, exemplifies how, by being assertive and using verbal force whilst communicating with residents, emotional labour tools are used to deal with an unpleasant situation. As a qualified nurse recruited from abroad Glen was a special case as he had not been expecting to be caring for older people. He was interested in acute medicine and had no interest or past experience in the care of older people. The response he made to the vignette is clearly indicating that as a qualified nurse he believes he knows best. However, he would have to overcome his revulsion of the situation he is confronted with.

Glen, RN: Well, I know better than him, which is important because you can smell him, so basically you have to change him.

I: How would you go about getting him to co-operate?

Glen: Yes that's a problem - difficult you know - you would have to argue that John had been incontinent and has to be changed. Like this man over here, sometimes you have to be more assertive because sometimes he's confused. He's insisting that he doesn't have a pill but we're the nurse and we know what we're doing, so we will insist that he has had his pill, and the same with John. "Well John you have to co-operate
with us because we're the ones looking after you. You're incontinent and you need to be changed." If he can smell it ...!

Interview extracts from response to Vignette ‘John’. My emphasis

Glen’s response to this vignette is similar to that of Meta who could also be seen to be expressing her fear of not being able to cope with the situation (Chapter 7). Both Glen and Meta are indicating the dichotomy of emotional labour where, whilst experiencing coping with their personal emotions of revulsion and fear, they are also evoking emotions by using emotional labour tools to undertake bodywork. In both instances communication is used to implement emotional labour tools such as firm direction and discomfort (Chapter 3).

The emotional labour tools used whilst communicating with John are varied and at times can be seen to be used inappropriately, for example by Glen and Meta who could potentially be seen to have been verbally aggressive. The responses made by both Meta as a German care assistant and Glen as an English RN highlight the need to train all care home staff, irrespective of their basic occupational background, to meet the specific needs of dependent older people living in care homes. This training would help them to come to terms with situations that evoke their own emotions of revulsion and fear they are confronted with and to use their emotional labour skills more appropriately and effectively. This can be seen to indicate the need to include an understanding of the various medical conditions encountered in the provision of care to older people in the NVQ training programme.

5. Conclusion

As the findings in this chapter show, communication is pivotal to the provision of care. However, the care staff are in control of the communication between themselves and the older people they are employed to care for. This ultimately can be seen to be disempowering and contributes to the argument that older people living in care homes are products of the care home industry in both England and Germany. The aim for the majority of care staff in both countries is to produce a clean, well-fed, pleasant-smelling, lounge-standard product.

Whilst older people living in care homes may well have an individual voice and be provided with a ‘bell’ to enable them to be heard outside of their room, the use of
their voice would appear to be controlled by care staff. The majority of care staff in both England and Germany appear not to communicate and do not consult with residents about their individual wishes or care needs. The majority of care staff in both countries also appear to believe they know what has to be done without gaining background information. This presents a picture of care staff who are mainly task oriented. Edith needed to be washed, provided with a fresh dry bed and given breakfast. Phyllis needed to eat her lunch. John needed to be taken to the toilet and be washed and changed. Maude and Derrick needed to be washed and dressed in the morning so that, like the others, they would become lounge-standard residents. The main use of communication by all care staff was as an instrument to implement emotional labour in order to successfully complete the care tasks.

Whilst English qualified staff usually delegated these tasks, the other respondents in both countries would have completed the tasks themselves. The English qualified staff present a picture of professionals whose main role within the care home is managerial and supervisory. Whilst they may at times provide 'hands-on care', this was the exception not the rule. When they did provide direct care the majority indicated that they did not need to communicate with the resident to gain background information, discuss the care needs or negotiate the care process with the residents.

Amongst the care staff interviewed in both countries there was a minority of care staff who presented a more person-centred approach towards the vignettes. The factor that these respondents had in common was that their lifecourse had formally or informally provided a knowledge base that helped them understand the social and physical care needs of older people living in a care home. The data indicates that of all six groups in the data collection it was the formal training experienced by the OPCs in Germany that provided the best knowledge base for care home staff. In England the NVQ trained staff did have a better understanding of the tasks they would be performing if providing care to Edith, Phyllis, John, Maude or Derrick. However, there was a lack of knowledge to place the task into its full health and social care context in order to provide empowering care.
Chapter 9
Time to Care

1. Introduction
Within the working environment of a care home, time is a finite resource which can be seen to impact on the provision of care in both England and Germany. The daily routine within a care home determines not only the rhythm of work but also the daily rhythm of an older person’s life. However, although a care home aims to provide a service to older people, it is the daily rhythm set by the institution that is more dominant than the daily rhythm of an individual older person’s life. This institutional dominance emphasises the loss of individuality and autonomy an older person experiences when they live in a care home. This chapter will present the daily routines experienced in the sample homes and then compare how the care staff in each country manage their contrasting time resources.

The quantitative data collected from care home managers and qualitative data from care staffs’ description of their daily work contributes towards establishing the temporal framework in which residents live and care staff work. How each occupational group of English and German care staff deal with the concept of time when undertaking bodywork will be compared by evaluating the interviewees responses to the care vignettes.

2. Temporal framework
The temporal framework of a care home is structured around the shifts of care staff and residents’ meal times. Care of the residents’ bodily needs is undertaken within the approximately two hour ‘time bites’ that these factors create during the day. The sample homes presented very similar daily patterns albeit with an hour and a half difference between the two countries. For example, the morning shift in the English homes started at 7.30/8am, in Germany at 5.30/6.00am. In the norm, the change of shift in England was at 2pm and in Germany at 12.30pm. The night shift starts at 8/8.30pm in both countries. In England, a number of care staff regularly worked 12-hour day shifts whereas in Germany the average weekday shift lasted 7 hours.
In the German home, breakfast was generally served to residents at 8am. In the English homes, practice varied. Breakfast in England was generally served between 7.30am and 8.30am, although unlike in Germany, English residents could not expect to be washed and dressed before eating breakfast. In England, breakfast was eaten in the resident's room and it was unusual for residents to eat breakfast in the dining room. In contrast, German residents were encouraged to take all their meals, including breakfast, in the dining room. Morning coffee was served around 10.30am in England, whilst in Germany generally there is no 'morning coffee culture'. The kitchen staff have lunch ready for 11.30am in Germany whereas it is ready at 12.30pm in England. An after lunch nap is taken by many residents in both countries. This is followed by afternoon tea and cakes in England and coffee with cakes in Germany. The evening meal in both countries is served between 5.30pm and 6pm, leaving the residents over 12 hours to the next meal. However, in both countries a 'drinks trolley' with water in Germany and 'Horlicks' or cocoa in England is taken round by the night staff when they go to settle residents for the night from approximately 8.30pm to 10pm.

The care staff's shift pattern and the routine of the kitchen create a temporal framework in which care staff become accustomed to working. This determines the rhythm of work and can consequently be expected to be a factor that care staff take for granted and are very much aware of in the provision of care.

3. Contact time
The staffing levels between English and German care homes differ considerably and in both countries are determined by the long-term care policies of each country (Chapter 2). Data collected from the home managers participating in this study provided a snapshot view of the staffing levels in each home on one day. When related to the number of residents in the home on that day this information illustrates the amount of contact time available between resident and care staff. In both countries the busiest time of the day is around breakfast time. This is also the time of day that relates to vignette 'Edith', as well as 'Maude and Derrick'. Vignette 'Phyllis' is at lunchtime and vignette 'John' is not placed at a specific time of day.
Based on the data collected from the home managers participating in this research, the average contact time between resident and care staff during the most labour intensive two hours of the day was established. This was achieved by multiplying the number of care staff on duty by 120 minutes and dividing the resulting figure by the number of residents in the home that day. Consequently in England (8-10am) each resident can on average expect a maximum of 29 minutes contact time with care staff. This time includes any distances staff may need to walk between the nursing station, residents, bathrooms, kitchen and laundry. In Germany each resident can on average expect a maximum of 16 minutes contact time with care staff from 6-8am. As in England this time includes distances staff may need to walk between the nursing station, residents, bathrooms, sluices, kitchen and laundry. However, the purpose build of a German home often means that the distances between all these facilities are shorter than they are in most English care homes.

3.1 Architectural layout of care homes

The actual contact time between care staff and residents in the two countries can be seen to be distorted by the architectural style and layout of the care homes. In England in the past, the trend has been to convert and extend large family homes into care homes which aim to establish an institution with a ‘homely atmosphere’. In contrast German care homes are built as institutions from the outset, but it was noticeable in the sample homes that management and staff did their best to create a ‘homely atmosphere’.

Many of the English homes were once large family houses that have been converted into care homes and have en-suite bathroom facilities which were seldom designed to accommodate care staff and residents at the same time. The philosophy in the design in a profit making English care home industry prior to the Care Standards Act 2000 (DH 2000), appears to have been that only residents who could independently use an en-suite toilet and wash basin or bathroom needed one. The architectural aim was to get as many bedrooms into the building as regulations permit. With the exception of E1, where a shower was included in the en-suite facilities, ‘en-suite’ facilities in the sample homes consisted of a toilet and wash basin. However, not all rooms had en-suite facilities and in some there was only a ‘vanity unit’ with a washbasin available
in the bedroom. If needed, a commode would be permanently placed in the room. The use of commodes invariably means that care staff have to regularly walk to and from the sluice to empty and clean the commode pans. There would also only be a limited number of bathrooms with hoisting facilities to bath or shower a dependent older person. Consequently care staff have to spend time transferring residents from their room to the bathroom which can be some distance from the residents room. This can be time consuming and use of the bathroom has to be organised or negotiated and is usually undertaken in the morning when most staff are on duty.

In contrast, the purpose built German care homes tend to have en-suite bathrooms which are spacious enough to accommodate a resident in a wheelchair and a member of care staff to provide assistance. In the oldest German care home building, some of the bathrooms were shared between two rooms. However, they were directly next to the two rooms. The en-suite bathrooms did not have a bath but they did all have a shower which was accepted by both residents and care staff. It appeared that the main bathrooms with hoists and baths that could be raised were almost superfluous as showers with ‘shower chairs’ were very much part of the daily routine. The fact that a resident could be transferred from their bed onto a shower chair and wheeled into the bathroom without having to be wheeled through corridors can be seen to be a time saving in Germany. This is further enhanced by the fact that to shower a resident is probably quicker than bathing as the hurdle of transferring the resident into and out of the bath does not have to be overcome. It also more dignified for the older person experiencing the procedure of being bathed or showered.

Distances that care staff need to cover to accompany or take a resident to a lounge or dining room also need to be considered. However, this was an issue that care staff in all eight homes had to contend with and cannot necessarily be seen to distort the comparative contact time between care staff and residents, whilst the use of bathroom facilities can be seen to be key to the provision of care in the morning.

3.2 ‘Making up the numbers’
In order to meet the staffing requirements laid down by the governing bodies in England and Germany, care homes must have a minimum number of care staff on
duty at all times (Chapter 2). In Germany, this is predominantly met by the number of staff permanently employed by the home. During the peak holiday periods, a German home may employ students who are looking for short-term contracts and are interested in working full-time in a care home for approximately four to six weeks. To meet the required staffing levels and consequently to provide the care staff-to-resident ratio expected by the supervising authorities, English homes tend to turn to nursing agencies for qualified staff and care assistants to 'make up the numbers'.

The deliberate use of this terminology indicates the reality encountered when English care homes need to use agency staff. On paper, the ratio between residents and care staff is improved by their presence; in reality this cannot always be seen to be the case. Whilst collecting the data, it was observed that negotiating with staff to do overtime and agencies to fill the gaps regular staff could not fill in was, in three of the English homes, a fairly standard and time consuming occurrence. In Germany staffing issues were dealt with by the manager and head of care only and there appeared to be a more clearly defined, shorter, line of management. Qualified care staff cared and undertook bodywork whilst management managed the running of the home, providing an environment that enabled care staff to provide care and not be involved with non-care-related tasks.

The following extract from the interview where Gail (RN) is describing her work that day provides an insight into how managing staff's 'off duty' and employing agency staff can be very time consuming. After being asked how long it took to do the morning drug round Gail responded as follows:

Gail RN: ...Caught up with the girl who needed her off duty changing and sorted that out with the administration office, and sorted out a few problems with off duty for the week-end and came back upstairs. I forgot to mention, we have got some agency girls here for the first time. So they had to be taught the fire drill and be shown round the unit and told where everything is and to make sure they are working with somebody who knows the unit and they are not left to their own devices.
I: Were any of the agency girls qualified nurses?
Gail: No they were all carers –
I: So all the RGN’s on duty were from here?
Gail: Apart from one who is regularly sent here - so she does know the system quite well. That was the lady down in the other unit...

Interview extract: Gail (RN). My emphasis
As the extended extract from the interview with Gail in Chapter 7 shows, whilst she did undertake nursing duties and dispensed drugs that morning, most of her work did not include direct contact with residents. The time Gail spent on organising ‘off duty’ issues and organising agency staff is in reality taking care time away from residents. Yet in the process of establishing the contact time between resident and care staff, the qualified members of staff in England were fully included as they are part of the team of staff employed to provide care to the residents. The following extract from the interview with Penny, an English care assistant, exemplifies how the issue of agency staff is also raised in the English care assistant’s description of her work on the day of the interview:

I: So how many patients were you looking after this morning? Or residents – what do you call them?
Penny: They’re residents, not patients.
I: Right OK
Penny: and they’re wings not wards.
I: OK
Penny: It’s just that this is their home – it is not a hospital. They like to have them as their homes, their rooms, every threshold is their home.
I: So how many were you looking after?
Penny: I’ve done two or three this morning. After that you look after all eleven residents or fifteen when we are full.
I: So that will be fifteen in one wing?
Penny: Yes, there’s fifteen in each wing
I: and how many of you?
Penny: There’s three carers in the morning, one RN and two carers in the afternoon and one RGN for our wing – upstairs there’s two and two, and one RGN over two wings.
I: So you had to get three up and dressed this morning?
Penny: Three and helped the other carers ’cause we had two agencies this morning
I: What did you actually do for your three residents?
Penny: Obviously go in there and gently wake them up, wash them, get them ready for the day – toilet them make their beds – make sure the rooms are tidy – the bathrooms, linen and towels are clean, make sure the pads are filled up, so...
I: Nothing special with those three
Penny: chm - it depends – ’cause they’re all frail – one of them has to have a leg brace put on – it depends – each day is different, one of them has got Parkinson’s and needs different care to the one who has had a stroke and things like that -
I: But you are told about all those different diagnoses and things like that
Penny: Well I’ve worked here for 18 months so I know what each individual needs you see, and that’s why when we have agencies on, we regular care workers have to sort of chase after them to make sure they are doing the requirements that are required
I: Which means more work?
Penny: Yes more work – and they get paid twice as much as us
I: But you do help each other and manage to work as a team?
Penny: Most of the time, yes, we seem to get on. There are some agency who think they are in for an easy ride
I: There is never an easy ride
**Penny:** No, and that's why we haven't got proper staff 'cause there are a lot of youngsters who come and think oh let's go and work in a nursing home we don't have to do nothing - just get the little old dears up and out of bed and sit and talk to them – but its not!

Extract from interview with Penny. My emphasis

As Penny exemplifies, her work was affected by agency staff. Time spent assisting agency staff was contact time that can be seen to have been taken away from a resident. This highlights how agency staff working in a care home do make up the physical numbers of care staff and maintain the required staff-to-resident ratio. However, as the extracts from Gail and Penny show, their presence can be seen to distort the actual contact time between residents and care staff in an English care home, as the regular staff members need to guide and supervise the agency staff. Penny also clearly expresses her disdain of agency staff who appear to cause discontent amongst care staff employed by the care home, as well as the perceived injustice that agency staff are paid more.

These extrinsic factors that impact on English contact time between care staff and residents in English care homes cannot be measured by the data collected in this research project. The basic formula used here to establish contact time can be considered as the only suitable method to establish a comparable figure of the ratio of residents to care staff in the two countries. The ratio indicates a considerably greater potential contact time that an English person, rather than a German older person, living in a care home can expect to experience with care staff. However, the various issues described that impact on the actual time available to provide care are factors that were observed during the data collection and need to be taken into consideration in the analysis of the research findings.

The limited time and the actual 'time-bites' in which bodywork is undertaken will be a factor that care staff take for granted and are very much aware of when dealing with residents. These will be factors that care staff from each country can be expected to have in the back of their minds when they responded to the care related vignettes.

4. Time as a commodity

In the responses to the care vignettes, it became clear that time within the provision of care is an important commodity. Concern about time was however only voiced by a
minority of the respondents who used terms such as ‘spending time’, ‘making time’ and ‘taking time’. These aspects can be related to the control the respondent perceives they have over the time available to care for residents. In turn, the time available to care can be seen to empower or disempower care home residents.

As stated earlier, time is a finite resource and invariably a day has 24 hours in each country. However, there appears to be a different approach to the concept of time in England and Germany. Whilst English staff spoke about, ‘taking time’, ‘making time’ and ‘spending time’, the German staff at most talked about ‘taking time’ (sich Zeit nehmen). Although there are available terms in the German language, they did not talk about spending time in the same way as English care staff and the concept of ‘making time’ appeared to be non-existent to German staff.

4.1 ‘Taking time’

Within the context of the vignettes ‘taking time’ is a term used by care staff in both countries and it is a factor that can be observed in the respondents description of how they would behave in the given situations. ‘Taking time’ can be seen to mean that someone is creating ‘process time’ to complete a task thoroughly and to the best of their ability. The use of the term ‘take’ however also implies gaining possession. This in turn raises the issue of the ownership of time. Does the resident own the time they need for their care because they are paying to receive care? In Germany the funding system is explicitly related to the timing of care. In England at the time of data collection, in the norm, the cost of a care home placement was not related to the amount of time needed to provide care (Chapter 2). However, care is one of the main services a care home is providing and therefore it is justifiable to state that residents pay for time as a commodity in the same way as they do for their meals and other ‘hotel services’ received in the home. As such the commodity ‘time’ is then controlled by the care home management and allocated to care staff to use to the best of their ability. They in turn are paid for the work they undertake to provide care. Consequently care staff can be seen to rightfully be in control of time as a commodity.
The responses to the care vignettes exemplify the impact of 'taking time' to perform tasks thoroughly, as they highlight how staff adapt to expected but not regular situations that arise within their daily routine. In both countries the respondents talk about 'taking time', however in their description of how they would respond to the 'Maude and Derrick' vignette, it becomes clear how time is taken from one resident to care for the other. This exemplifies the time management skills required when undertaking bodywork.

The 'Maude and Derrick' vignette was used in only three homes in each country (Chapter 5). From the data collected in these six homes it becomes clear that, in the process of 'taking time' for Derrick, care staff expected Maude to be tolerant and understanding. Maude was described to be mentally alert, consequently care staff appear to consider her able to evaluate the situation they were experiencing and be willing to wait until the staff had time free to support or provide for her care.

This particular vignette was actually based on a real situation observed in a home whilst piloting the research instrument. The lady here known as Maude was actually very distressed about having to wait until a member of staff was free to assist her to complete her morning routine of getting up, washing and dressing. The emotional problems she was encountering in coming to terms with the changes she was experiencing in her life made her extremely vulnerable and the incident caused quite a stir amongst staff that morning. The fact that the loss of her legs had led to her dependency on others was emphasised by her lack of power to control the everyday task of getting washed and dressed in the morning. This lady’s ability to verbalise her discontent provided her with the opportunity to voice her opinion, but it did not empower her to take control of the situation. However, within the working environment of a care home, all residents need to be considered and in the vignette Derrick’s care requirements also had to be considered. His dignity, discomfort and obvious inability to cope with the situation can be seen to have influenced care staff’s course of action.

In order to successfully complete the morning care tasks within a given time, decisions have to be made that can be seen to disempower some residents but
ultimately result in them receiving the care they need. In the response to the ‘Maude and Derrick’ vignette, interviewees did not specifically state that they would ‘take time’ to provide Derrick with extra care.

Table: 9.1 Balancing ‘Maude and Derrick’s’ care

<table>
<thead>
<tr>
<th>Qualified staff</th>
<th>Expect Tolerance from Maude</th>
<th>Try to be fair to both</th>
<th>Complete Maude</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN England (9)</td>
<td>7</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>RN Germany (1)</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>OPC Germany(8)</td>
<td>7</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Care assistant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NVQ England (6)</td>
<td>4</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>England (3)</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Germany (9)</td>
<td>6</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

The majority of their responses (Table 9.1) indicated that care staff expected Maude to understand the situation and be able to have the patience to wait until they themselves or a colleague were able to provide her with further assistance. With the exception of one German care assistant who would finish one task before moving on to the next, the respondents would all have informed and potentially discussed the situation with ‘Maude (Frau Maier)’. The extracts from Detlef’s response to the ‘Maude and Derrick’ (Frau Maier and Herr Töle) vignette exemplify how both qualified staff and care assistants in both England and Germany expected Maude to accept the situation:

Detlef, OPC: I would go to Frau Maier and explain that things might take a while longer, and I would cover her with a towel so that she doesn't get cold. I would expect Frau Maier to be able to understand the situation and then I would go and wash and change Herr Töle. That's the way I'd do it. But you cannot leave Frau Maier without letting her know what is happening. After all she is waiting. If she knows what's happening, then everything should be OK.

Interview extract from response to vignette ‘Maude and Derrick’ (Frau Maier and Herr Töle). My emphasis

Maude (Frau Maier) would have been informed about the situation and potentially the polite question ‘Do you mind?’ might have been asked. In reality a resident in such a situation would have little choice but to accept the situation. Derrick (Herr Töle) also had needs that had to be met and care staff needed to make an almost clinical decision to determine whose need was the greatest. For the majority of staff in both England and Germany, Derrick’s need was assessed to take priority and as Table 9.1 and the interview extract shows, in this instance time was taken from Maude to care for
Derrick. Of the qualified staff in both countries, only two English RNs and one German OPC would attempt to balance their time and be 'fair' to both residents. Amongst the care assistants in both countries, there appeared to be a slight tendency towards wanting to be 'fair' to both residents.

Mavis, NVQ: OK, if I'd just walked in on Derrick, and Maude was dressing herself. 
I: Basically you've got Maude to a certain stage and you can leave her for a while ... 
Mavis: OK it depends ..... if I'm working with another member of staff I'd ask them to either take over Derrick or go into Maude and help her. Or I'd pop back to Maude and say "look Maude I'm going to be a little bit longer, are you going to be alright?" and if she's fine with that then I'd go straight back to Derrick and clean him up.

Interview extract from response to vignette 'Maude and Derrick'. My emphasis

Exemplified by Mavis, it is clear that 'to be fair' the respondent needed to communicate and work with their colleagues to ensure that Maude was not deprived of contact time. In her response to the vignettes, knowing that taking care of Derrick would 'take time' and as a result she would not be able to give Maude the amount of time she usually would, Mavis assessed the situation. Mavis decided that to 'be fair' to Maude and give her the attention she was accustomed to, the shortage of time was best compensated by redistributing time amongst more members of staff. This approach was taken by both qualified staff and care assistants and can possibly be linked more to the teamwork within the care home than to care staff training. The respondents (Table 9.1) who aimed to be fair to both Maude and Derrick also saw the need to communicate with their colleagues. This is exemplified by the responses Sharon (NVQ care assistant); Thelma (RN); Heidrun (Care Assistant) and Marlies (OPC) made to the 'Maude and Derrick' vignette.

Sharon NVQ Care Assistant: I'd probably ring the call bell and call for whoever I'm working with that day to help me and there would probably be two of you to get Maude into a wheelchair anyway. If not, then you'd call for someone else to help you and then either you'd take over and do Derrick, or I'd probably go back to Maude and get the other person to take care of Derrick.
I: You wouldn't try to cope with the situation entirely on your own?
Sharon: No, I wouldn't.

Interview extract from response to vignette 'Maude and Derrick'. My emphasis

Thelma RN: Again, just try to get Derrick into a private environment, try obviously not to let him feel any worse than he possibly feels, and just try and quietly, and in a dignified way, sort him out.
I: What about Maude?
Thelma: I'd have to obviously go and check on Maude. If I can, probably I'd ask for help if I got into a situation like that. I'd hopefully get someone to give me a hand, so if I'm dealing with Derrick, hopefully somebody could go and check on Maude. If there's a problem with that, I'd try and reassure Maude that I have to leave her because
I'm doing something at the moment, and I'd get back to her as soon as I can, and have a call bell there so, if I'm not back in time she could call it, and hopefully someone else would attend.

**Interview extract from response to vignette ‘Maude and Derrick’. My emphasis**

**Heidrun, Care assistant**

I: What about Frau Maier?

Heidrun: You pop back to her, ask her to get on with as much as she can or you get hold of a colleague. Both are important. It depends on the situation and you need to arrange things with your colleagues, but it does depend who you are working with and how you get on with them. Team work is important.

**Interview extract from response to vignette ‘Maude and Derrick’ (Frau Maier and Herr Tôle)**

Marlies OPC: I would, of course, want to take care of Herr Tôle but I would go back to Frau Maier to let her know that it would be a while before I could get back to her. And that it will be best if she rang her bell when she was ready and that may be one of my colleagues would come to assist her if I wasn't ready. I wouldn't want her to be waiting for me for ages.

I: So one of your colleagues would go and answer the bell, even if they knew it was in your area?

Marlies: Yes they would. We have an intercom system where we can communicate with one another and with the residents, so we can find out what is wrong. So that if the colleague notices that the bell has been ringing for long time she can find out why by communicating with Frau Maier, who could then say that she's waiting for me and I still haven't got back to her. My colleagues would then go and assist Frau Maier. I must say the intercom system that we have has proved to be very useful...

**Interview extract from response to vignette ‘Maude and Derrick (Frau Maier and Herr Tôle)’. My emphasis**

Using the communication systems within the home clearly facilitates the communication of care staff with one another and supports the ‘teamwork’ mentioned by Heidrun. This method of coping with the situation could be seen to be spreading the loss of time so that not only one resident was disadvantaged and experienced a reduced contact time with care staff. In this instance, care staff could be seen to be consciously attempting not to take away time from one resident to care for the other. However, these members of staff in the sample homes of both countries are in the minority and serve to exemplify what is possible when there is an unexpected need to ‘take time’ (Table 9.1).

The data relating to care staff’s daily routine implies that the responses to the ‘Maude and Derrick’ vignette can be expected to reflect the reality of the care staff’s working day in both England and Germany. Whilst considering the fact that English staff potentially have almost twice as much contact time with residents at the busiest time of day, it is surprising that the issue of time presents no differing approaches in the
two countries. This is particularly indicated in the responses to the ‘Maude and Derrick’ vignette where most care staff in each country would budget time by ‘taking’ it from one resident to meet unexpected needs of another. In the responses to this vignette there appears to be little difference in this use of time in England and Germany. It can however be concluded that the control of time as a commodity is in the hands of care staff and although residents may be consulted, this is done more out of politeness than to incorporate residents in the decision making process.

4.2 Making time

‘Making time’ is a term used verbally only by English respondents. However, it is an aspect that can be observed in the responses to the vignettes and in the description of the daily work of the interviewees in both countries. It can be a term that describes forward planning to create ‘process time’. Whilst time is a restricted commodity, care staff in both countries appear to see how they can creatively use and take control of time.

Whilst there are cultural differences in the perception of time, Meta, a German care assistant, clearly describes how she made extra time for her morning shift by showering a resident the previous day. Meta also describes how the night staff create extra time for the day staff by preparing a resident for the day. This provides Meta with more time to care for other residents but could be seen to result in one resident being washed at a very early hour of the morning. However, interview data from another participating member of night staff in this home confirms that a resident actually asks the night staff to wash him, as they are potentially less rushed than the day staff. Meta relates to time in her response to the vignette ‘Edith (Frau Schmidt)’ and describes her actual situation as follows:

I: Within the last 12 years you’re bound to have experienced a similar situation
Meta, care assistant: Now, with the new building, things are quite extreme because everybody has to be down in the dining room for breakfast at 8:00. Breakfast is served from 8 to 9 and the residents all feel they have to be down at 8:00 on the dot and that is almost impossible for us to achieve. Yesterday I showered somebody in advance, so they didn’t need showering this morning. That way I only needed to give one resident a shower this morning. That made this morning bearable. But if you’re on your own and you’ve got seven people to look after - actually it is only six, because there is one who looks after herself. The night staff usually do one, it’s a lot of work if you’ve got to shower, wash and dress the residents in a short period of time. Then
there is Mr. N. who has a urine catheter, a colostomy and he's got a gastric tube. I usually take care of him at 9:00 when the others are all down at breakfast, poor man.

**Interview extract from response to vignette ‘Edith (Frau Schmidt’). My emphasis**

This extract shows how Meta creatively manages her allocated time and how she actually chooses to care for a highly dependent resident when she knows most others residents are preoccupied eating their breakfast and therefore less likely to use their ‘bell’ and interrupt her while she is caring for him. Whilst Meta would not use the term ‘making time’ she can none-the-less be seen to be in control of her work and is able to ‘make time’.

Mavis as an English care assistant exemplifies how she would ‘make time’ in her response to the ‘Phyllis’ vignette. Her response was as follows:

**Mavis, care assistant NVQ:** You help her!

I: Do you encourage her?

**Mavis:** That's part of her. You'd automatically make sure there was nothing actually wrong with her - was there a reason why she was being like this? Was she feeling alright? You'd just go through the process - you'd talk to her and help her.

I: What sort of process?

**Mavis:** Well for a start I'd make sure there wasn't actually a problem and if that wasn't the case I'd report it to the sister in charge anyway, and then I'd sit and help her, chat with her and feed her.

I: And you'd have time to do that as well?

**Mavis:** I'd make time. I'd try to keep as laid back as I can, because it can have a domino effect. If you start to get anxious with time it makes things twice as hard.

**Interview extract from response to vignette ‘Phyllis’. My emphasis**

By lunchtime, when Phyllis needs assistance, the bulk of the morning work has been completed and staff can assess how much time there is available before they have their lunch break or go off duty. The participating English care staff talked directly about ‘making time’ or presented a response that could be identified as ‘making time’. German care staff did not verbalise the concept of making time, however, as Meta exemplifies, they could be seen to be creative with their time management.

As described earlier Meta gained time by showering a resident a day early. What is not clear in this instance is what had to give way the previous day to enable her to do so. Whether or not the resident was a willing participant is also not clear. Mavis also appears to be in control of her allocated time. As Meta and Mavis exemplify, ‘making time’ can be seen to mean that the individual member of staff has control over time and can be creative in their use of time. It could therefore be assumed that the person
who has control of the commodity ‘time’ would be the more empowered person and in the relationship between care staff and resident this is most likely to be the member of care staff.

4.3 ‘Spending time’
The closest conceptual translation of ‘spending time’ in German would be ‘Zeit verbringen’. However, the German concept does not relate to time as a commodity in the same way as ‘spending time’ does. Whilst the Cassels (1976) English-German dictionary translates ‘verbringen’ as just ‘spending’, the word ‘spending’ is translated from English into German a number of ways. It is related to the spending of money and can be seen to be linked to the control of a commodity such as money, time and supplies. Whilst in the use of the English language money and time can be spent, in German the word ‘verbringen’ can be related to time but not to money. The English dictionary (Chambers 1993) defines the word ‘spend’ to mean:

‘to expend; to pay out; to give; bestow; employ, for any purpose; consume; to use up; to exhaust; to waste; to pass(time)’ Chambers 1993

As such the use of the concept ‘spending time’ in England can be seen to be related to a commodity such as time whilst in Germany this would appear not to be an issue. The English respondents also appear to use the phrase in the context of emotional labour such as spending time to motivate Edith in the morning or Phyllis at lunchtime.

The use of the term ‘spending time’ identifies time as a valuable resource that has to be controlled and budgeted. Time as a commodity can only be ‘spent’ if it readily available. In her response to the ‘Edith’ vignette, Helen clearly talks about ‘spending time’ whilst making it clear to Edith that unfortunately there are times when she might have to be patient and wait for someone to come and assist her. Helen made the following comment after reading the vignette:

Helen, care assistant, NVQ: You’ve just got to make sure when you get this lady up you’ve got time to make sure she has got her hearing aid in – so you can spend time talking to her and reassuring her that unfortunately in a home you can be left for a couple of hours before the next person comes on and does anything, is a normal situation. Give her time – her speech is obviously not going to be right but if you listen hard you might be able to get her to understand you and pick up on something she’s
saying – importantly making sure that her glasses, teeth and everything’s in place. It is very easy to walk out and leave something out which won’t make her feel like the old Edith, explain everything you are going to do and get her to help as much as she can. Hopefully do her several times in that week, so she learns to trust you. If you say you are going to go back you most probably find its easier to understand her more.

**Interview extract from response to vignette ‘Edith’. My emphasis**

On the one hand Helen is willing to ‘spend time’ yet at the same time she would be making it clear to Edith that in a care home time was a rare commodity. This exemplifies how time can impact on the quality of care and how ‘spending time’ is also part of emotional labour, thereby highlighting how emotional labour and time management are closely linked skills which impact on the care older people experience when living in a care home.

It could, for those who do not speak German be surprising that the term ‘spending time’ is not used, especially in light of the fact that German long-term care funding is closely linked to time (Chapter 2). The concept of time wasting (Zeitverschwendung) and the saying ‘Time is money’ (Zeit ist Geld) are however part of German time culture. Gunther’s response to the vignette ‘Phyllis (Frau Lembke)’ exemplifies both the issue of wasting time and the use of emotional labour to ensure Phyllis eats her lunch:

**Gunther Care Assistant:** … I would take my time and assist her. If there is a similar situation here, and I would just take my time. You have to and I believe the resident would be satisfied with that.

**I:** You wouldn't try to encourage her to eat independently?

**Gunther:** It depends on the residents, you know which ones are worth encouraging and you also know when it would be a waste of time. If I didn't know the resident very well, I would try to encourage her. first by putting the spoon in her hand to see if she could take it up to her mouth herself.

**Interview extract from response to vignette ‘Phyllis (Frau Lembke)’. My emphasis**

Gunther links his response to how well he knows the resident. His knowledge and understanding of the resident enables him to assess which emotional tools to use effectively and therefore not waste time. Whilst not using the term ‘spending time’, this response can be seen to link time as a valuable resource in the use of emotional labour tools. Like Helen, this exemplifies the role of emotional labour in the distribution of the valuable commodity ‘time’ in the provision of care in England and Germany.
4.4 ‘Shortage of time’

As already discussed within the context of the four care vignettes, care staff responses from both countries and all occupational groups related both overtly and covertly to time. Given the availability of time to English and German care staff, it was to be expected that the shortage of time would be an issue. This was however only explicitly raised by two members of staff in England and four in Germany (Table 9.2). Whilst the figures might be expected to relate to the contrasting available time to care in England and Germany, it is interesting to note that only one care assistant in each country overtly referred to a shortage of time.

Table: 9.2 Respondents relating to not having enough time

<table>
<thead>
<tr>
<th>Country</th>
<th>Not enough time</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td></td>
</tr>
<tr>
<td>RN (12)</td>
<td>1</td>
</tr>
<tr>
<td>Care assistant NVQ (7)</td>
<td>0</td>
</tr>
<tr>
<td>Care assistant (5)</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
</tr>
<tr>
<td>Germany</td>
<td></td>
</tr>
<tr>
<td>RN (3)</td>
<td>0</td>
</tr>
<tr>
<td>OPC (10)</td>
<td>3</td>
</tr>
<tr>
<td>Care Assistants (13)</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
</tr>
</tbody>
</table>

In Germany it was Wiebke who pointed out that there is never enough time and that time is limited, when she was asked about getting to know residents. In the following extract her responses indicate how for care staff there is limited time for bodywork but almost no time to get to know the older person being cared for:

I: What about the incontinence?

Wiebke, care assistant: Well it says here that she (Frau Schmidt) hasn't eaten her breakfast - that's probably why. Well, in that case I'd, as far as I could, wash her and get her onto a dry pad. Reading it now it's quite clear! Of course, once she was clean and dry I'd make sure she had breakfast. Then we would have our breakfast. Once we've finished I would go and wash her properly. That's what I would do. It's whilst you are washing somebody that you find the time to actually have a bit of a conversation with them before you have to move on to the next resident. Sadly that's the way it is.

I: Do you get to know the residents well?

Wiebke: There is never enough time. Time is limited. Whilst you are washing and dressing someone is about the only chance you have to talk to them, that's all you have time for in the morning. There is sometimes a bit more time in the afternoon.

Interview extract from response to vignette ‘Edith (Frau Schmidt)’
Whilst Wiebke could well be voicing what other German care assistants might say if the issue of time had been approached directly, she was however the only one to comment spontaneously on the issue.

In England, Audrey was the care assistant who was acutely aware of the lack of time. This is also reflected in the extracts already used from her interview (Chapter 8, Section 4). In her response to the ‘Edith’ vignette her first sentence was:

**Audrey, care assistant:** Perhaps the night staff didn't do it. It's lack of staff - it's terribly stressful - you just cannot do the job properly because you don't have time.

*Interview extract from response to vignette ‘Edith’. My emphasis*

In England, Joyce RN clearly pointed out the shortage of time by stating the following:

**Joyce RN:** Myself - and as I feel the majority of my staff would also like to say they'd give the appropriate care but it would have to be done quickly - we don't have the time to be spending an hour with this lady even though we would like to, and she is frustrated by her condition but we also have the time factor to think of. I would want to help her with her breakfast - make her a fresh cup of tea, perhaps make her fresh toast or a sandwich - to encourage her to have something to eat - not just leave it until the coffee round at ten. I would also want to make sure she had a very thorough wash all over, so she's comfortable in her pad or whatever she uses during the day, and that she's being stood up or moved so that she's relieving all the pressure areas, and obviously I'd check that her teeth, her hair, that they'd been cleaned thoroughly as well. You can't always take it for granted that these things have been done by the night staff. If she's grumpy I'd try to cheer her along; "Hello, it's a lovely day, did you sleep well? Oh you haven't eaten your breakfast, is there something else I can get you? Would you like a nice hot cup of tea? Do you take sugar? Can I make you a sandwich or would you like some fruit?" That sort of thing - just try to encourage her to eat something at least - and obviously whilst she's doing that, I could be making the bed at the same time - that cuts down the time spent. She's been returned to bed - I'd want to get her out and onto the commode, so she could use it if she needed to. It's also much easier for me to give her a thorough wash when she's on the commode because I can take the commode pan from beneath so I can wash her thoroughly below, but I would be talking and chatting to her all the time, trying to get her into a better mood because it would make her day much nicer and then, once she was ready I would try to encourage her to sit in one of the lounges with a couple of the other residents so that they could communicate, even if it's not verbally, just to show her that she's cared for, that she's had some attention, that we do realise she's there, and that she has her needs.

*Interview extract from response to vignette ‘Edith’. My emphasis*

In her response to the vignette, Joyce starts by pointing out the shortage of time. She then exemplifies her position as an English qualified member of staff who supervises the care Edith receives. Joyce also exemplifies the use of emotional labour tools and how she would potentially budget the commodity ‘time’ by multi-tasking and not
only talking to Edith but also by making the bed whilst encouraging Edith to eat. This example highlights the importance of time as a commodity in the provision of care.

Qualified staff in Germany also related to the shortage of time. Whilst not formally participating in the data collection, one member of care staff in a German care home did highlight the shortage of time to care. Chatting to her whilst she was sorting laundry a qualified nurse pointed out that she wanted to make it clear to the home management that there was not enough time to give residents the care they needed. Consequently there was no way she could have time to participate in an interview with me. This approach is further highlighted by the response Roswitha made to the vignette Edith (Frau Schmidt):

Roswitha, OPC: It can happen. It’s quite normal that someone wets their bed. There is no sense in getting cross, shouting and telling people off. I always work in accordance with the resident’s wishes. Then they respect what you are doing. She could also have breakfast later. Breakfast is not important, she's got all day to eat it! Our residents have plenty of time, we don’t. Then I would ask the lady if I could get her clean and dry. If she would agree to being washed and dressed, if she agrees then I would do that, and then bring her a fresh breakfast that she can take her time over. The bed is soon stripped and remade. There is really no sense it getting cross and telling people off. They don’t like it.

I: So you would go into the room, wash and dress her, and give her another breakfast.

Roswitha: Exactly

Interview extract from response to vignette ‘Edith (Frau Schmidt)’. My emphasis

The statement made by Roswitha pointing out that care staff have no time whilst residents have plenty of time highlights how the daily routine of care home staff dominates the rhythm of a resident’s day. It further exemplifies the conflict between the 24 hours of a day experienced by an older person living in a care home and the limited contact time they have with care staff.

In Germany, Beate (OPC) is aware of the need to let residents gain more independence. However, she clearly acknowledges the conflict between residents’ potential empowerment and her need to have all residents washed and dressed within a ‘time bite’. Her following statement makes it clear that to get a resident washed and dressed within a given time, it is best to do it yourself:

I: In that case how do you get Frau Schmidt to co-operate?

Beate: I think the main thing is to stay calm, take it easy and try and let Frau Schmidt do what she can for herself. But I would actually help, because that would speed things up. I would possibly help more than I needed to. I can imagine that because I
just wouldn’t have the patience. I wouldn’t do it all but possibly most of it, because that would be the quickest solution.
I: But normally you would try to maintain the resident’s independence?
Beate: Yes.
I: Do you have the opportunity to do that?
Beate: Yes, but it is sometimes difficult. It does often mean you have to sit a resident in front of the sink while you go off to the next resident, you can’t be standing over them. It’s not dignified for them, nor is there the time.

**Interview extract from response to vignette ‘Edith (Frau Schmidt)’. My emphasis**

This interview extract exemplifies how the shortage of time can disempower a resident, even when a member of staff has a sound knowledge base of care home residents’ needs and in theory appreciates the need to empower care home residents.

5. Conclusion

The contrasting amount of time available to provide care to older people in English and German care homes has contributed towards identifying time as an important issue in the provision of care. As the responses to the vignettes and descriptions of the daily routine indicate, time is clearly an important commodity in the provision of care. Older people living in a care home are in an environment that potentially bears little resemblance to the surroundings in which they have spent most of their lives and the 24 hours of a day may well seem endless, marked mainly by meal times and the appearance of care staff to assist them with their daily activities. In contrast, as the interviewees indicate, for the care staff employed to undertake bodywork in this environment, time is a limited resource that calls for careful budgeting.

At first sight, in England care staff appear to have more potential contact time with residents than German staff. However, various external factors impact on this contact time, which are difficult to measure as they vary from home to home and from day to day. The architectural layout of homes varies, as do the problems related to meeting required staffing levels and the role of qualified staff in the ‘hands-on’ provision of care. These issues in the provision of institutional care potentially call for further research, as they are central to the provision of care. Considering the importance of the role of contact time this research has identified in the provision of care, the reduction in contact time caused by these factors in English care homes, deserves to be taken into account in the policies relating to the provision of institutional care in England.
In both countries, time is highly relevant in the provision of care. As these findings indicate, limited time results in the disempowerment of care home residents as time is key to successfully meeting production targets of clean, sweet-smelling, lounge-standard older people. The skills to work within 'time bites' are not formally taught, a factor which is underpinned by the lack of distinction between the findings from the different occupational groups participating in the research. It can therefore be assumed that the ability to 'take time', 'make time', 'spend time' and cope with a shortage of time form part of the essential skills that care staff develop throughout their lifecourse and bring with them when they enter the care home industry. Intrinsic to the skill of working within 'time bites' imposed by institutional clock time is the creation of 'process time' by 'taking time' when the need arises and 'making time' by planning ahead or 'spending time' if it is available within the allocated time budget.
Chapter 10
The Essence of Care

1. Introduction
The focus of this research has been on the interface between care staff and the older people for whom they are employed to provide care. From the perspective of an older person, the contact with care staff is strongly influenced by their individual needs whilst from the perspective of care staff the contact is influenced by their skills and the requirement to accomplish the tasks they are employed to do. The individual needs of an older person are linked to their medical condition, care needs, social needs and the desire to maintain autonomy. The ability of care staff to meet these individual needs is determined by their knowledge and understanding of older people, their ability to undertake bodywork, their use of communication and their emotional labour skills (Figure 10.1).

Figure 10.1: The interface between older people and care staff

In this research, older people living in care homes were represented in vignettes about Edith, Phyllis, John and about Maude and Derrick. The situations presented in the vignettes were developed out of my personal experiences as a relative, former care home manager and visitor to care homes in England and Germany. The responses care home staff made to these vignettes contributed towards gaining an insight into the interface between care staff and the people they are employed to care for. The
care staff who participated in the research cannot be seen to be representative of all care staff encountered in English and German care homes. However, the sample selection of care homes was aimed to be typical of the English and German care home industry at the time of data collection (Chapter 5). The data collected from the care home managers provided an insight into the needs of the older people living in the homes and the data from the lifecourse grids and the self-completion questionnaires provided a comparison of the care staff working in the sample homes in England and Germany.

Taking the quality of life experienced by older people living in a care home into consideration a key aspect of this study has been to research the interface between care staff and older people. Establishing the essence of care has provide a basis from which to investigate how and where in their lifecourse care staff develop the invisible, intangible and immeasurable skills that are essential in the care of older people living in a care home. Having gained an understanding of the interface between care staff and older people in a care home the findings are related to the government policies that impact on institutional care in England and Germany. This chapter will discuss these issues and relate them to existing sociological concepts and theories relating to care in conjunction with the acquisition and use of skills needed in the provision of care.

2. Skills needed to provide care

The skills needed by care staff in the sample homes of both countries were linked to the needs of the older people they were employed to care for. The data collected from the care home managers established that the participating care staff were undertaking comparable tasks in each country and were able to relate to the medical conditions encountered in the care vignettes (Chapter 7). The semi-structured interviews with qualified staff and care assistants provided a more detailed picture of the actual skills used in the provision of care. This was based on a description of the daily routine which provided an overview of the everyday tasks undertaken, whilst the responses to the vignettes indicated the skills used in the provision of care to individual older people.
Previous research has identified that older people living in care homes expect knowledgeable and understanding staff (Raynes 1998). However, to date, little research has been undertaken to identify what knowledge and understanding is needed in the provision of institutional long-term care for older people. The term ‘knowledgeable’ as used by Raynes (1998) can be seen to be related to practical skills; Chambers Dictionary (1994:929) defines ‘knowledge’ to be ‘that which is known; …practical skill’. The findings from this research indicate that the knowledge, understanding and skills required of care staff can be grouped into four categories: medical; bodywork; communication; emotional sensitivity and time budgeting. Together these categories can be seen to present the essence of caring for older people living in a care home and the first three will be discussed within this section, and time budgeting will be discussed in the following section on ‘time to care’.

2.1 Medical knowledge and understanding

The qualified staff in both England and Germany can be expected to have knowledge of older people living with medical conditions such as a ‘stroke’, ‘Parkinson’s’ and ‘Alzheimer’s’. Whilst this was not always explicit in the responses to the vignettes it is to be expected that during their training to become a qualified healthcare worker, they will have been taught about neurological and cardio-vascular illnesses that include the medical conditions described in the vignettes. Their occupational qualification implies medical knowledge of such diagnoses. However, in England this does not imply an understanding of an older person who has suffered a ‘stroke’ or is experiencing ‘Parkinson’s’ or ‘Alzheimer’s’ and is living in a care home, as opposed to receiving treatment in hospital. In Germany, the qualified staff who trained as general nurses are in a comparable situation, whereas the OPCs can be expected to have both knowledge and understanding of such a situation (Chapter 4). Like the English qualified staff, the German qualified general nurses took a task-orientated approach to the situation presented in the vignettes. However, the OPCs tended to take a more person-centred approach in their responses (Chapter 8 and 9), an approach which can be expected to have a more positive impact on the quality of life encountered by the older people for whom they are employed to care. This difference can be linked to the diverging foci of the training they have experienced (Chapter 4).
In contrast, care assistants from both countries, at most, presented an understanding of the medical condition based on their personal experience either within the family or from their work caring for older people (Chapter 7). This indicates a need to provide training to both qualified staff and care assistants in order to develop an understanding of the medical conditions prevalent amongst older people living in a care home. Such a knowledge base would potentially enable care staff to ultimately empower older people living in a care home as they would be more confident in knowing what an individual with a particular medical condition can be expected or encouraged to do independently. It would also provide a better understanding of the frustrations older people living in a care home might be experiencing. Knowledge of a medical condition would also inform the care decision making process that forms part of the bodywork conducted by both qualified staff and care assistants. This, in turn, would then be a step towards meeting the request for knowledgeable and understanding care staff made by the participants in the research undertaken by Raynes (1998).

2.2 Bodywork - Understanding and knowing how to provide care

Understanding and knowing how to provide care is key to the undertaking of bodywork for older people in a care home. As the research findings (Chapter 7, 8 and 9) indicate, the provision of care in English and German care homes is task orientated towards the completion of a ‘lounge-standard product’. To date, the literature on the actual ‘hands on’ everyday provision of care to older people living in a care home is sparse. Lee-Treweek (1997) discusses the fact that care work is physically heavy, dirty and highly repetitive. However, which care tasks this might relate to or their relevance to the lives of an older person living in a care home is not considered. The issue of bodywork in the context of employment to care for older people is addressed by Twigg (2000a, 2000b, 2002) who focuses particularly on bathing in the provision of domiciliary care. In Twigg’s research, the environment in which bodywork is conducted differs from that of my research, and an older person living at home may initially be perceived to be more empowered because they are in their own household. However, both in my research, and within the provision of domiciliary care, it has been identified that care recipients are disempowered (Twigg 2000a, 2000b).
Older people needing care, either living 'at home' or in a care home, seldom have the opportunity to determine when they receive assistance to have a bath or get up, wash and get dressed. Irrespective of the environment in which they live, older people dependent on the support of care workers to have a bath are unable to choose either how often or when they can have a bath. In both instances older people are dependent on the availability of care workers, who in turn are restricted by procedures they need to adhere to and the limited time they have in which to provide assistance or undertake bodywork. As the description of the daily routine in care homes indicates there is little room for care staff to enable older people to self-determine when they have a bath (Chapter 7). The responses, especially to the vignette 'Edith', indicate that care staff also see little need to establish the actual wishes of the people they are employed to care for. This lack of self-determination experienced by older people living in a care home is indicative of the disempowerment encountered in everyday life.

Research on the provision of care in care homes indicates an acknowledgement of the need to provide person-centred care but makes little reference to the actual bodywork entailed or the acquisition of the knowledge and understanding needed to perform individual tasks related to such bodywork. The use of vignettes in this research has provided an insight into the actual undertaking of bodywork and the accompanying thought processes of care staff. This in turn has provided indicators of the understanding, knowledge and skills needed by both qualified staff and care assistants in providing care for older people living in care homes.

In both England and Germany the bodywork required to meet the needs of Edith, Phyllis, John, and Maude and Derrick involves tasks that are defined to be 'basic care' (Grundpflege) such as washing and dressing or assisting at mealtimes. The term 'basic', used spontaneously in both English and German literature and by care staff, implies simplicity and devalues the importance of the task to an individual older person. How a care task is performed could be fundamental to their wellbeing. For all care staff, this calls for knowledge and understanding of how to effectively and efficiently provide the required care, especially to somebody who may have physical limitations or be cognitively impaired.
The care-task-orientated responses to the vignettes in both countries and in each occupational group, indicated the need and importance of enabling care staff to formally acquire skills that will provide a sound knowledge and understanding of how to undertake bodywork tasks in a variety of circumstances within a care home. For example, washing and dressing Edith, who has suffered a stroke, calls for a different knowledge base of care skills from those required to care for Maude, a wheel-chair bound amputee or John, living with Alzheimer’s. Yet the initial task to get someone up, washed and dressed can be seen to be the same.

Knowing and understanding how to care for someone who has had a stroke could result in care staff who, for example, would be able to work together with Edith to improve the situation they encountered when they walked into the room and found she had not eaten her breakfast and was in a wet bed. Working together with Edith, by inviting her to make choices and perform tasks such as washing parts of her body herself, would not only improve the physical situation and maintain her dignity, but would also contribute towards her rehabilitation and empower Edith, consequently adding to the quality of life she was experiencing in the care home. Knowing and understanding issues surrounding Maude’s amputation and subsequent loss of independence would contribute towards her adaptation to a changed lifestyle and dependence on a wheelchair and on care staff to perform some of her everyday life activities. This, in turn, would help Maude regain dignity and quality of life. Knowledge and understanding of an older person, who like John, has been diagnosed to have Alzheimer’s would result in care staff being able to cope effectively with his behaviour and change his clothes whilst maintaining his dignity. Understanding the varied ability pattern that is related to Parkinson’s disease would enable an understanding of Phyllis’ individual situation and provide the knowledge to provide her with the appropriate assistance to at lunchtime. Thus knowledge and understanding of the needs of older people living in a care home is essential for the conduct of bodywork which would improve not only the quality of care provided but also the job satisfaction of care staff.
2.3 Emotional labour skills

The emotional labour involved in the provision of care has been discussed by James (1989, 1992) who identified the use of emotional labour tools to negotiate the organisation of day-to-day care in hospice work. Her theoretical framework was taken into care home research by Lee-Treweek (1997:57) who argued strongly that care work 'consists of acts performed on objects within the shortest possible time'. She therefore takes the theory developed by James (1989) that emotional labour undertaken by healthcare workers creates order out of the hospice environment, by researching emotional labour from the perspective of care assistants working in a residential home caring for older people. A flaw in Lee-Treweek's (1997) research is that it is one sided and focuses only on care assistants, thereby overlooking the role of qualified staff and excluding the health and social care needs of the older people they are employed to care for. Her approach fails to situate their work in the context of older peoples’ quality of life and contributes to the devaluation of care work.

My own research aimed to redress the balance and focus on the interface between care staff and older people and the use of emotional labour tools in the context of bodywork within the care home as a place of employment. The data clearly indicated that emotional labour tools would be used to care for Edith, Phyllis, John, and Maude and Derrick. However, the analysis of the data also identified a dichotomy in the emotions experienced and evoked in the provision of care. In his response to the vignette 'John', a qualified member of staff in England, Glen indicated a potential revulsion against the smell he might encounter if John were doubly incontinent. Meta, a German care assistant, also indicated that she could be fearful of John becoming physically aggressive. Glen and Meta are experiencing emotions of revulsion and fear which they know they need to overcome. At the same time they need to evoke emotions that will make John co-operate with the actions they need to perform in order to undertake the bodywork needed to change his trousers. Experiencing revulsion and fear calls for Glen and Meta to use emotional labour skills to cope with their own emotions. At the same time they are also using emotional labour tools, such as firm direction, in order to complete a care task (Chapter 8, Section 4.2). This presents an indication of the dichotomy within what is deemed to be emotional labour in healthcare and potentially calls for further research. Establishing a dichotomy in
the emotional labour experienced by care staff was not an expected outcome of the data analysis and the existing data did not facilitate further exploration of this aspect of emotional labour.

The qualified staff in both England and Germany had received training that assisted them in developing strategies to cope with the emotions they experience when encountering situations in the conduct of bodywork that are initially unpleasant. As Smith and Gray (2000) indicate, student nurses in England are provided with support from tutors and mentors to deal with the emotions they experience during their training (Chapter 3). An understanding of the medical conditions encountered in care homes can also be expected to provide qualified staff with a knowledge base that will result in the appropriate use of emotional labour tools. Student nurses in England may be provided with a support system that enables them to cope emotionally with stressful and upsetting situations they may encounter during their career. However, care assistants in both England and Germany cannot be expected to have the support of tutors or mentors whilst they are developing their care skills and will, as the research findings indicate, learn from their colleagues how to deal with situations that arise. For example, a better understanding of Alzheimer’s would have alleviated Meta’s fear of ‘John’s’ potentially aggressive behaviour (Chapter 8) and she would have been enabled to suggest the use of more appropriate emotional labour tools in her response to the vignette.

Neither qualified staff nor care assistants formally acquire the skills to use emotional labour tools in the provision of care to older people living in a care home. The findings from this research indicate that for qualified staff and care assistants in both countries, these skills are initially gained within the family and further developed within the working environment of a care home (Chapter 6). This can be linked to the high number of qualified staff and care assistants in both countries who state that they have learnt a ‘great deal’ or a ‘fair amount’ (Table 6.10) from their work colleagues. Consequently the use of emotional labour tools such as listening, gentle persuasion, firm direction, force or by causing discomfort to the care recipient, will have been observed and potentially copied. This indicates the need to acknowledge the dichotomy of emotional labour within the provision of care and to include this within
the training available for qualified staff and care assistants. Only then can care staff be expected to cope with the emotions they personally experience and appropriately use emotional tools. This ultimately could be expected to have a positive impact on the quality of life experienced by older people living in a care home.

3. Time to care

The comparative element of this research highlighted the importance of time as a resource in the provision of care (Chapter 9). Time to care has been an issue identified in the provision of domiciliary care by Ungerson (2000) and Twigg (2000a). Ungerson (2000) identifies how the shortage of time results in care tasks being fragmented so they can be performed at speed. This can be seen to reflect Lee-Treweek’s (1997) observation that care is provided in the shortest possible time. However, neither Lee-Treweek (1997), Twigg (2000a) nor Ungerson (2000) follow through the issue they have highlighted to relate time to governmental long-term care policies. In her discussion on bathing older people within domiciliary care, Twigg (2000a) considers the differing perceptions of time for older people and service providers. Her findings that older people receiving care in their own home have a great deal of time in contrast to their care workers, draws parallels to the finding in my research where, for example, Roswitha (Chapter 9, Section 4.4) points out that older people living in a care home have plenty of time, care staff do not. Whilst Twigg (2000a) relates the provision of domiciliary care to emotional labour no direct link is made between the use of emotional labour tools and time.

My research has identified the link between policies that influence the time available to care in both England and Germany and relates the commodity of time to the use of emotional labour tools to create and maintain order in a care home as a workplace. In both countries, the time available in which to provide care is initially determined by the ratio of care staff to residents and is further influenced by the knowledge and understanding of care staff and the dependency of the older people they are employed to care for. In the direct interface between care staff and older people illustrated by responses to the vignettes in this research, care staff interviews identified that emotional labour tools are used in order to assist in the provision of care within a limited time (Chapter 8 and 9). Thus relating the issues of time in the provision of
care to long-term care policies, to care staff’s emotional labour skills and to the quality of life experienced by older people living in a care home.

3.1 Governmental policies that impact on time
The research findings indicate that in England there is a higher ratio of care staff to care home residents than in Germany. However, a lower ratio of qualified staff to care assistants was identified in the English homes. This contrast between the ratio of staff to residents and the skill mix of staff encountered in the English and German sample homes highlighted the issue of time in the provision of care. The data established that English staff potentially had almost twice as much time in which to provide care at the busiest time of the morning shift than their German colleagues (Chapter 7 and 9).

The time aspect in the provision of care was traced back to the policies that impact on the provision of long-term care in each country and it was identified that in Germany the time related funding system of a care home placement was key to the contact time between older people and care staff (Chapter 2). In England it is the legislation governing care home staffing levels and consequently the ratio of care staff to older people living in the home, that determined the time available to provide care. Since conducting the research, new policies have been introduced in England. These policies relate to the NHS funding of the nursing element of a care home placement which can be seen to be related to the interface between qualified staff and older people living in care homes (Chapter 2 Section 2 and Chapter 3 Section 5). However, to date, the actual number of care staff employed in a care home has not been affected by the introduction of the Care Standards Act 2000 implemented in April 2002 (Chapter 2 Section 2) and the NHS funding of nursing care can only be seen to reflect the pre-existing input of qualified nursing in care homes. The NHS contribution towards the funding of a care home placement now being implemented has resulted in the role of a qualified nurse in an English care home being more clearly defined and stresses their managerial and supervisory role. This prevents them participating in the ‘hands-on’ provision of care and reduces the contact time between care staff and residents. This is in contrast to Germany where qualified staff are intended to be fully involved in the hands on provision of care. Whilst German policies result in a
potentially lower amount of time in which to undertake bodywork the policies do result in a greater participation of qualified staff in the ‘hands-on’ provision of care.

3.2 Institutional time

Within the context of childcare in Swedish nurseries, Davies (1994:279) argues that ‘care requires process time’ which she further sees as encapsulating the ‘hidden’ aspects of care giving. Davies (1994) defines ‘process time’ by focusing on the task of feeding and draws parallels between the care of an infant and a person who is senile, pointing out that it is difficult to pre-determine how long it will take to complete the task. In this instance it is acknowledged that an older person’s brain and motor skills may co-ordinate less well and that it takes time to chew and swallow food. How long that will take cannot be predetermined and the ‘process time’ is therefore immeasurable, despite the fact that within an institutional setting eating is an activity structured by actual clock time. Davies (1994) consequently questions the quality of life experienced by both an older person or child in such a situation.

Whilst personally inherently disapproving of linking the care of older people with childcare, there are parallels between the finding Davies (1994) has made and my research. However, the parallels do not directly relate to the actual ‘hands on’ provision of care but to the temporal frameworks in which care is provided. In both instances the institutional routine is dominant and knowledgeable staff are restricted in their ability to empower either older people or children by enabling the use of ‘process time’ over actual clock time. The aspects of ‘taking time’, ‘making time’ and ‘spending time’ identified by this research indicates how care staff attempt to create ‘process time’ so that to the best of their ability they are meeting the individual situations they encounter in the provision of care. The shortage of ‘process time’ in the care homes participating in my research and the nurseries participating in Davies’ (1994) research is linked to staffing levels and ultimately the available contact time between care staff and older people/children. In both cases restricted time also resulted in theoretical knowledge not being put into practice.

The findings from my research indicate that the use of time needs to be evaluated in the context of knowledge and understanding of care, and consequently the ability to
enact care within a given time frame. This is best exemplified by Beate (Chapter 9), who is a very motivated, well trained OPC who acknowledges the need to empower older people living in a care home. Yet if the objective is to wash and dress an older person within a very limited time she does not have the opportunity to enact her knowledge, whilst her power as the carer enables her to take control and undertake the task as quickly as possible in order to ensure she produces a ‘lounge-standard product’. This unavoidably disempowers the older person and indicates the conflicts that care staff encounter in the provision of care. This is an indicator of the use of power in the provision of care and exemplifies the importance of having time to enact care so that theory can be put into practice within an institutional setting.

3.3 Caring within ‘time bites’

The findings from my research indicate that time in the provision of care is a finite resource to be controlled and budgeted by qualified staff and care assistants in both countries. Twigg (2000a) clearly states that time is not a currency in the provision of care. However, as the findings from my research indicate, time is a commodity that can be seen to be controlled by the use of emotional labour tools and can be budgeted by ‘taking time’, ‘making time’ and ‘spending time’ (Chapter 9). As discussed earlier in this chapter, emotional labour tools are used in order to conduct bodywork within the shortest possible time. The temporal framework and its resulting ‘time bites’, in conjunction with the average time available for each older person living in the English or German sample care homes (Chapter 9), indicate the importance of time in the provision of care.

In the process of budgeting time, if the respondent considered there was a need for extra time to complete a task with one older person, time was taken from another older person (Chapter 9). This implies that ‘process time’ was for example facilitated for Derrick at the expense of Maude in order to work within ‘clock time’. Considering the German funding system is based on the formally assessed time needed to provide care for an individual (Chapter 2), the situation described in the vignette could mean that facilitating ‘process time’ actually results in overspending the time that policy makers allocated for Derrick’s care. German care staff do not appear to be consciously aware of how much time is available for an individual older
person. However, they can be seen to be aware of the need to complete a number of care tasks within a ‘time bite’. This is similar to the situation that English care staff are in. They too are conscious of the requirement to meet the care needs of a set number of older people within a ‘time bite’. To achieve this, both qualified staff and care assistants in both countries are constantly assessing a situation and having to make care decisions. Key to this process is communication which is also key to the use of emotional labour tools (Chapter 8 and 9) and indicates the importance of communication as an instrument of care.

4. Communication

Lee-Treweek (1997) identified that care assistants considered communication to be pointless, whilst Sachweh (1999) identified verbal communication between care staff and older people to be task orientated. This research identifies how communication is used as an instrument of care to create order but not to empower older people (Chapter 8). In the provision of care, communication can be seen to be pivotal not only to gather information in order to make a care decision but also to implement emotional labour in order to control time.

This research has identified how communication is pivotal to the provision of care. Even the use of the nurses call ‘bell’ system by older people living in a care home can be seen to be used to budget the valuable commodity, time. As exemplified by Hartmut (Chapter 8), it is care staff who determine when they respond to a communication initiated by an older person when they use the bell, thereby disempowering the older person who was initially empowered by having access to the nurse call system, which would potentially enable communication to be instigated. Taking control of the nurse call system is also physically taking control of time to maintain order in the production process of a ‘lounge-standard product’. Time is then further regulated by the use of emotional labour. Key to order in an institutional environment is that tasks are completed within a set timeframe and as James (1992) has indicated, emotional labour is used to create order.

Asking Edith, Phyllis, John, and Maude and Derrick questions to gain background information about the situation they are confronted with would have enabled care
staff both to make care decisions and to empower the older person. However, as the research findings indicate, the clinical decision making process undertaken by the majority of care staff was based on their personal knowledge and understanding of the medical condition and situation they were confronted with. This lack of communication indicates the importance of providing care staff with a sound knowledge base of medical conditions encountered in care homes and therefore to enable the skilled completion of bodywork. It further indicates an insufficient understanding and knowledge of the link between health and social care needs of older people living in a care home and how disempowering the lack of communication can be for an older person in this situation. However, the research findings do indicate that communication was clearly used to implement emotional labour tools by care staff in both countries. This was most evident in the responses to the vignette ‘Phyllis’ where respondents would use communication to coax her into eating lunch, and the vignette ‘John’ where communication would have been used to coax him into changing his trousers (Chapter 8).

Care staff skilled in providing care that combines the effective use of communication with medical knowledge and understanding, and the ability to perform bodywork, could be seen to empower older people living in care homes. These skills are key to the interface between care staff and the older people they are employed to care for. The findings from this research indicate that the group of care staff most likely to present this skill mix are the OPCs in Germany where the three-year training programme enables them to acquire the knowledge and develop the competence to work in this field of employment.

5. The acquisition of formal care qualifications

This research highlights how in both England and Germany, the work of care assistants was taken to be an extension of a woman’s role within the family as it is a form of employment that, at the time of data collection, did not require any formal qualifications. This, for Germany, can be seen to be exceptional, as vocational training is the standard prerequisite for employment in most occupations (Esping-Andersen 1993) and contrasts with the development of accredited training available to English care assistants wanting to gain NVQ competencies (Chapter 4). The
findings from this research indicate that the care assistants who have gained NVQ competencies are more likely have a better knowledge and understanding of how to perform bodywork than the care assistants who have not formally participated in the development of social care competencies (Chapter 8). However, NVQ competencies are employer-led (Eraut 1994) and consequently task orientated so that care can be provided efficiently. They are not aiming to provide a knowledge base to take a medical condition into consideration in the provision of care to older people living in a care home. This is in contrast to the OPCs in Germany whose three-year, full-time training program (Chapter 4) enables them, in theory, to take older people’s health and social care needs into consideration. The research findings indicate that whilst time limits might have restricted OPCs from putting theory into practice, they did have a more sound and rounded knowledge and understanding of older people living in a care home than either English qualified nurses or care assistants with NVQ competencies (Chapter 8 and 9).

The most notable difference in the qualifications of care staff in England and Germany is the fact that in England there is no equivalent to the OPC. Similarities are found between the English RNs and the German qualified general nurses. In both instances these nurses have undertaken three years of training to meet the needs of hospitalised people. This training was not intended to provide nurses with a full understanding of the health and social care needs of an older person living in a care home. The research findings indicate that the English qualified staff had a more managerial and supervisory role than the German qualified staff and provided very little actual ‘hands-on care’. This is an issue that is also linked to the low ratio of qualified staff to care assistants encountered in England which results in care assistant’s being the main providers of ‘hands-on care’. The data does show that in Germany, the OPCs had a broader understanding and knowledge base of the requirements of older people living in care homes and made a considerable contribution in the actual daily provision of care.

Davies (2002) discusses the issue of skill mix in English care homes and comes to the conclusion that qualified staff do not necessarily improve the quality of care experienced in a care home. This argument is possibly made because qualified staff
have been trained in hospital nursing and are seldom directly involved in the actual physical provision of care. Recently published research on care home staff in America (Polivaka et al 2003, Wiener 2003) indicates that the quantity and quality of care staff impacts on the outcome of care. Wiener (2003) points out that with the increased dependency of older people living in care homes, a possible reason for poor quality care is linked to a lack of care staff training.

The findings from my research indicate that qualified OPCs working in the German care homes had a positive impact on the provision of care. As they provide 'hands-on care', their knowledge base informs the care and clinical decision making process that results in better care for older people living in the care home. OPCs also provide role models for the care assistants with whom they provide 'hands-on care' to older people on a daily basis. These findings indicate that both qualified staff and care assistants working in care homes should be enabled to gain qualifications that provide them with a sound knowledge and understanding of older people's health and social care needs as this could improve the quality of life experienced in a care home.

6. Skills gained within the family

Having identified the skills that form the essence of care for older people living in care homes, my research aimed to establish how these skills were gained. In addition to the formal acquisition of care skills experiences from an individual's family life also inform and establish skills used in the care of older people living in English and German care homes. Caring is seen to be part of a woman's role in the home (James 1989; Williams 2002; Ungerson 2000). Time-budgeting skills are seen to be part of the multi-tasking skills many women develop (Davies 1994; James 1989; Jurczyk 1998) and the acquisition of emotional labour skills is seen by James (1989, 1992) to be developed within the family and transferred to the work place.

The profile of care staff in the English and German sample homes indicates that in both countries, the qualified staff and care assistants are predominantly women in mid-working life (Tables 6.1 and 6.2). In the process of raising a family, women in mid-working life will have developed and honed the emotional labour tools that they indicated they would have used in their provision of care to Edith, Phyllis, John, and
Maude and Derrick. Communication and time-budgeting skills are also part of the 'hidden' skills that form the essence of care for which there are no formal qualifications.

The findings indicate that women in mid-working life are a valuable resource to the care home industry and this raises the issue of how the skills they may have established as housewives and mothers might contribute to the provision of care. The lifecourse data from the interviewees (Chapter 6) indicates that many qualified staff and care assistants in England and Germany had taken a break in employment to raise a family before entering the care home industry as an area of the labour market. Women in mid-working life could be expected to cope well with care work as their experiences as a mother are likely to have taught them how to deal with the situations they encounter. Similar to Williams' (2002) description of mothers who are in conflict between being responsible and enabling the autonomy of teenage children with chronic illness, knowledgeable and understanding care staff are potentially in conflict between meeting their employer's requirements to produce a 'lounge-standard product' and their knowledge that rehabilitating and empowering an older person would improve their quality of life. In the relationship between mother and child, power is seen to be indicative of caring (Ribbens 1994) and my research findings indicate that, irrespective of their training, care staff tend to use power via emotional labour tools in the process of caring for older people. Whilst a mother can be expected to be committed to developing her child into an independent adult (Williams 2002), this cannot be seen to replicated in the commitment between care staff and the older people they are employed to care for. This indicates the how the interface between care staff and the older person they are employed to care for is influenced by the service provider, who in turn is regulated by government legislation. In this instance, the commitment of care staff can be expected to be to their employer with whom they have an employment contract rather than to the older person, and the provision of care may unavoidably become task orientated.

These informal care skills which can be likened to 'mothering' are clearly indicated to be important to the provision of care yet they are invisible, intangible and immeasurable. In a day and age where targets are set and outcomes are measured,
judged and placed in rank order, these vital skills are taken for granted and overlooked. As Davies (1994) indicates, they are hidden within the 'process time' in care giving. Within the context of 'mothering', Williams (2002) discusses the invisible elements of for teenage children care and within family care, Mason (1996) discusses 'sentient activity' and 'active sensibility', attempting to make these elements of care more visible. By using these terms Mason is turning an intangible and immeasurable concept, such as thought and feeling, into an activity. As an activity, sentient care takes time and theoretically the hidden elements of care become measurable, as they are absorbed in the 'process time'. However, as discussed earlier, within the provision of institutional care, 'process time' often has to give way to 'clock time'. On the other hand the findings from this research indicate that invisible, hidden elements of care such as emotional labour are very much part of the essence of care, which itself includes the budgeting of clock time. This emphasises the important role of informally gained, invisible, intangible and immeasurable skills in the provision of care.

Considering the concept of the care production process, these skills could be compared with a lubricant used to keep a conveyor belt running smoothly. Without lubricants in the form of emotional labour and time management, the production of care could be seen to grind to a halt. Similarly within a family, such invisible, sentient, lubricating actions are pivotal to successful relationships and the flourishing development of children. The lubricating formula used within family life can be seen to be transferred and adapted by care staff to provide a lubricant that is invaluable in the production of care by both qualified staff and care assistants.

7. Skills gained at the workplace

The dominance of care assistants working in English care homes and the fact that 50% of German care staff employed in care homes are care assistants, provides a clear indication that many of their skills are developed 'on the job'. Beckett and Hager (1997) identify that much informal learning occurs within the work place. Within the context of life long learning they describe this form of learning to be invisible and consequently of low status. My research indicates that by providing English care assistants with the opportunity to gain NVQ competencies in the
workplace, this situation could be seen to be improved. The findings from care assistants participating in this research indicate that alongside ‘invisible learning’, care assistants are participating in ‘on the job’ programmes that will provide them with formal NVQ competencies in social care (Table 6.6).

As the lifecourse data from England and Germany indicates, care staff enter this field of employment in mid-working life and in Germany many of the OPCs undertook their training after the age of 30 (Chapter 6). In Germany, where vocational training is the standard prerequisite for employment in most occupations (Esping-Andersen 1993), there are no formal training provisions for care assistants employed to provide a service to dependent older people. This invariably means that care assistants in Germany develop their skills to care for older people ‘on the job’. As the findings in Table 6.9 indicate, a high percentage of care assistants in both England and Germany say they gained their skills to care for older people in care homes and Table 6.10 indicates they learnt ‘a great deal’ or a ‘fair amount’ from their colleagues.

The ratio of qualified staff to care assistants in England implies that for care assistants, much of this learning from colleagues will be from fellow care assistants. The daily routine of the English qualified staff (Chapter 6) indicates that there is little opportunity for qualified staff to be a role model in the provision of ‘hands on’ care to new care assistants, a factor which is indicated by the extract from the semi-structured interview with Kelly (Chapter 6). In Germany, the ratio of qualified staff to care assistants indicates that this is less likely to be the case and is exemplified by the German care assistant Wiebke (Chapter 6) who indicates that she learnt a great deal from ‘Sister U’, who was a qualified OPC.

The profile of English care assistants indicates a strong representation of women under the age of 26 (Table 6.2), which is in contrast to Germany where 84% of the care assistants had parenting experiences compared to only 46% of the English care assistants (Table 6.14). This invariably raises the issue of how younger care assistants develop emotional labour tools and time management skills. The findings from the self-completion questionnaire identify the care home itself as a place where care skills were developed (Table 6.9). This indicates that women in midlife who are so
dominant in the profile of care home staff also pass on their skills to younger members of staff and this is exemplified by the interview extract from Kelly (Chapter 6) who clearly described how much both she and Eileen had been guided by her mother who also worked as a carer in that care home.\footnote{It might initially appear to be unusual to have a mother and daughter working in the same home. Although this was not an aspect that was formally included in the data collection I am aware that in at least one other English sample care home a mother and daughter were employed and in one German sample home a mother and her son were employed. From my personal experience working in care homes I can state that in every home where I have worked there has been at least one mother and daughter.}

The high percentage of English qualified staff who stated they had learnt a ‘great deal’ or ‘fair amount’ about the care of older people from work colleagues or from working in care homes (Tables 6.9 and 6.10) also indicates the ‘invisible’ learning process they undergo when working in a care home. This can be seen to signal the need to provide English qualified staff with training to meet the needs of older people living in a care home. The German qualified staff also stated that they had learnt a great deal from colleagues. However, this needs to be seen in the context of the German training programme for OPCs (Chapter 4), which has strong links to practice-based learning. Consequently it is to be expected that the acquisition of skills is linked to learning from colleagues.

The invisibility of the ‘on the job’ acquisition of skills to care for older people living in care homes can, in general, be seen to go unrecognised and be taken for granted for many care assistants and qualified nurses entering employment in care homes. This can be seen to indicate the importance of the six-week induction period for care staff in England that the new National Minimal Standards (DH 2002) has set out for new employees. During this time new members of staff will not only receive the statutory Health and Safety training but also have a brief period in which to extend and further develop the skills that form the essence of care.

In England, NVQ training can be seen to be improving the provision of care and in Germany the training of OPCs is an acknowledged blend of theory and ‘on the job’ learning. In turn, OPCs are also passing on their knowledge and skills to care
assistants. The invisible learning and skill development that clearly takes place in English and German care homes needs to be formally acknowledged. In Germany this could be achieved by introducing a six-month induction period for care assistants. Similarly in England where both qualified staff and care assistants need to gain a greater understanding of care home life for an older person the newly introduced six-weeks induction period (Chapter 4. Section 3.2) needs to be extended to six months. This is especially important as the invisible learning process involves the acquisition and development of the ‘invisible skills’ that are vital in the provision of care.

8. Conclusion
The findings from this research indicate that the interface between care staff and older people living in a care home is strongly influenced by an amalgam of invisible skills that form the ‘care production lubricant’. It is clear that care staff in both England and Germany provide care to older people living in care homes with the best intentions and to the best of their ability. However, these abilities need to be acquired, developed and acknowledged. As the findings from this research indicate, caring for older people is by no means unskilled work and clearly calls for specialised skills from qualified staff and care assistants.

The comparative methodology used in this research has contributed towards establishing that well educated and highly skilled care staff who have enough time to meet the needs of individuals are key factors in the interface between care staff and older people. In this research the training OPCs receive and the role they play in the provision of care in Germany contrasted with that of the qualified nurse in English care homes. On the other hand the NVQ training system in social care in England contrasted with the lack of formal training for care assistants in Germany. These contrasts contributed towards establishing the importance of training both qualified staff and care assistants to meet the needs of older people living in a care home. All care staff require an understanding of older people’s medical condition. This needs to be accompanied by attributes that include an understanding and knowledge of how to provide care, an accomplished use of emotional labour, the skill to work within ‘time bites’ and the ability to communicate to enable empowerment. Only if these attributes are acknowledged, enhanced and rewarded by policy makers and facilitated by all
service providers, can older people living in English and German care homes hope to experience a good quality of care that facilitates quality of life by enabling autonomy and empowerment in their daily activities.
Chapter 11
Conclusion: Implications of the National Policies

1. Introduction

The interface between older people and care staff in England and Germany cannot be judged in isolation, but needs to be considered in the policy context in which care is provided. Four key aspects, namely the care home industry, occupational training policies, legislation setting care standards, and policies that regulate the funding of a care home placement, establish a context that forms a frame around the provision of care in both countries (Figure 11.1). Whilst the frame consists of the same elements the actual building materials differ and contribute towards establishing the issues this comparative study has focused on.

The care home industry of both countries provides accommodation and care for older people and is an employment sector for healthcare workers operating within parameters set by government legislation, ranging from employment laws to health and safety regulations. The skills and expertise of care staff employed by the care home industry are linked to their occupational training. In turn the skills and expertise influence the interaction between care staff and older people. The training available to care workers is consequently linked to government legislation relating both to occupational training policies and the qualifications that care home regulators expect of care staff. In both countries, the legislation regulating care standards further impacts on the relationship between care staff and older people living in a care home by influencing the environment in which care is provided and the time available in which to provide care. As the arrow in Figure 11.1 indicates, care home regulations cut through the interface between care staff and older people and impact on the care home industry. Furthermore these regulations directly effect both care staff and older people living in care homes. The final side of the frame surrounding the interface between older people and care staff is the long-term care funding system which is situated between the care home industry and the care standards. Significantly, there is no link between the care standards and the funding system. Funding however, is key to the provision of care and completes
### Care Home Industry

<table>
<thead>
<tr>
<th>England</th>
<th>Germany</th>
</tr>
</thead>
<tbody>
<tr>
<td>Predominantly profit making</td>
<td>Predominantly not-for profit</td>
</tr>
<tr>
<td>Many building are conversions with extensions</td>
<td>Mainly purpose built</td>
</tr>
</tbody>
</table>

### Occupational Training Policies

<table>
<thead>
<tr>
<th>England</th>
<th>Germany</th>
</tr>
</thead>
<tbody>
<tr>
<td>NVQ competencies</td>
<td>OPC qualifications</td>
</tr>
</tbody>
</table>

### Funding Systems

- **England:** NHS nursing care + self or social services for care + social care and accommodation
- **Germany:** LTC insurance for all care + self or social services for social care and accommodation

### Care Home Regulations

- **England:** Care Standard Act 2000, National Minimal Standards
- **Germany:** SGBXI (Social Law Act XI), Heimgesetz (Home Act)

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**Figure 11.1** The framework surrounding the provision of care
the framework which both English and German care homes (Figure 11.1). In England and Germany the care home industry is dependent on the funding of a care home placement as the income determines the budget and consequently, the available resources to accommodate older people and employ care staff (Figure 11.1).

The care home industry in both countries is primarily focused on the production of a 'lounge-standard product'. However, this outcome is not in keeping with the aims of the WHO (2002) policy promoting active ageing and maintaining autonomy for all older people. Nor is it in keeping with the Care Standards Act 2000 (DH 2000) or the National Service Framework for Older People in England (DH 2001). This comparative study has contributed towards identifying how and why this divergence occurs. Relating the research findings to the care home industry, occupational training policies, care home regulations and the long-term care funding systems provides a greater understanding from which to develop policies that would enable older people to be autonomous and be empowered in their everyday life in a care home. The four sides of the frame illustrated in Figure 11.1 represent the boundaries in which older people living in care homes experience everyday life and in which care staff are employed to provide a service. This chapter draws conclusions from the research findings to show how the framework in which care is provided impacts on the autonomy that English and German older people experience in care homes.

2. Care home industry

As this research has identified, there are clear differences between the English and German care home industries. These differences impact on the interface between care staff and the older people for whom the industry is providing a service. The historically rooted differences relevant to this research are based in the development of long-term care institutions for older people and their ownership. This has resulted in differing care environments and the fact that, in England, the care home industry is predominantly profit-making, whilst in Germany the voluntary, not-for-profit service providers take the lead (Chapter 2).
2.1 The environment in which care is provided

English care homes to date have very often been developed out of old manor houses or large family houses that have been adapted and extended. The intention has been to develop a profitable service industry that meets the health and social care needs of older people who are no longer able to remain in their own homes. As such the design of two (E3, E4) of the sample English care homes was aimed to accommodate as many beds as possible within the guidelines of the Registered Homes Act 1984 (HMSO 1984). The internal layout of such homes consequently can not be expected to consider facilitating an environment in which care staff work efficiently and do not lose valuable care time walking long distances to and from the kitchen, laundry, sluices and bathrooms. Nor did the lay out take into consideration that, where available, en-suite bathrooms need be large enough to accommodate a resident in a wheelchair and at least one member of care staff. All these factors add considerably to the amount of time needed to provide care. Only home E1, a relatively recently planned and purpose built care home, appeared to take these aspects into consideration. This is in contrast to the purpose built German care homes that provided care staff with an environment in which care could be provided efficiently. It was not necessary to walk long distances to any of the facilities required in the daily provision of care and the en-suite bathrooms provided space to comfortably accommodate both an older person in a wheelchair and at least one member of staff. However, the purpose build of German care homes did result in a more institutional environment in some of the sample homes. The four German sample homes were all divided into care units where the rooms had direct access to toilets, washbasins and showers. The environmental differences between the German homes were observed to be determined more by the atmosphere created by the management style and interior decoration.

As the research findings presented in Chapter 9 indicate, time is a finite resource in the provision of care and the layout of a care home can contribute to the amount of time available to provide 'hands-on' care by each member of care staff. The environment in the German care homes enables staff to work more efficiently. It would appear to be short-sighted of English care home proprietors not to take these issues into consideration as ultimately this has an impact on the standard of care.
provided and consequently on the quality of life experienced by the older people who live there. The Care Standards Act 2000 (DH 2000) and the resulting National Minimum Standards for Care Homes (NMS) (DH 2002), which have been introduced since the data collection, can be seen to be acknowledging some of these factors.

2.2 Home ownership
The differing forms of home ownership between England and Germany also impact on both the skills of care staff and the contact time available between care staff and older people living in a care home. Terms and conditions of employment could potentially influence the selection of staff employed in a care home. However, this was not a focus of the research. In both countries, care has to be provided within a set budget and the fact that English care homes are predominantly profit orientated could, in the first instance, be seen to influence the training made available to care staff and the number of people employed as this might affect profit margins. Differing levels of NVQ training were found across the four English sample homes, but this could not be related to the nature of the home ownership as, for example, one voluntary sector home provided NVQ training at the time of data collection whilst the other did not. The skill mix of care staff in the English sample homes also did not indicate that care home proprietors reduce their standard of service in order to increase their profit. However, it is primarily the national regulatory bodies who influence the skill mix and training provided to care staff in both England and Germany. This demonstrates the importance of the standards being set by the regulatory bodies of both countries and the consequences they have for the autonomy experienced by older people living in care homes. Whilst there are differences in the types of care home ownership in England and Germany, from the findings of my research this factor does not appear to impact on the interface between care staff and older people living in care homes.

3. Occupational training
England and Germany present two countries with contrasting occupational training policies. As outlined in Chapter 4, Germany has a strong well-structured
occupational training culture whilst in England it is seen to be weak and untidy (Esping-Anderson 1993; Evans and Heinz 1994, Roberts et al 1994). The findings from this research present a picture that does not fully conform to this description of occupational training. Care assistants make a considerable contribution towards the provision of care in both countries. In England, they are able to develop formal competencies in their occupation as care assistants and by 2005 there will be a statutory requirement for all care homes to employ 50% of care assistants with a minimum of NVQ level 2 competencies (DH 2002). In contrast, Germany has no formal requirement or provision of qualifications for care assistants. However, in Germany 50% of the care staff have to be qualified nurses or OPCs, indicating some parity of qualified and unqualified care staff in each country, but there is a considerable difference in the content and structure of the training experienced in the two countries. On the other hand, in England there is a greater difference in status and pay between qualified staff and care assistants than there is in Germany where an OPC has the same status as a qualified nurse. Although many of the German care assistants in the sample homes had participated in the voluntary training as nursing assistants for state emergencies (Chapters 4 and 6) this is not a statutory prerequisite to employment as a care assistant in a German care home. In the provision of care, the lack of specialised training for care assistants can be seen to be counterbalanced by a higher proportion of qualified staff, many of whom are trained to be Older People's Carers who, as this research indicates, pass on their skills to the care assistants.

The NMS (DH 2002), implemented in England in April 2002, indicates that policy makers are aware of the need to train staff to meet the needs of older people living in care homes. However, the NVQ competencies that English care assistants can gain are task orientated and as the findings from this research indicate, do not place the tasks within the context of the specific needs of older people living in a care home or the range of skills identified to be important in the provision of institutional care. The task orientation of care work training can only contribute towards furthering the production process of care, which invariably deprives older people living in care homes of their autonomy.
The qualified general nurses in both England and Germany have undergone a similar, hospital-based three-year nursing training programme. As the research findings indicate, this leads to qualified staff in England having a medical-dominated approach towards their work in a care home. In contrast, the three-year occupational training experienced by the German OPCs provided them with a knowledge base and the opportunity to develop the skills and expertise needed to meet both the health and social needs of older people. In theory this enables them to provide person-centred care that empowers older people living in a care home and enables them to be autonomous in their daily lives.

In both England and Germany, policy makers acknowledge the need to train care staff working in care homes. This reflects the WHO (2002) recommendations to train all employees providing a service to older people. However, in England, the occupational policies focus on care assistants and in Germany on establishing a workforce of qualified OPCs. In England, the occupational training of qualified staff and care assistants appears not to fully address the health and social care needs of older people living in care homes. In Germany, the training needs of care assistants appear to be overlooked although it should not be forgotten that, as the data from this research indicates, care assistants are given the opportunity to train to become qualified OPCs. Whilst the individual German care assistant may gain from the training opportunity, the fact remains that 50% of care home staff in Germany are care assistants who, like many of their English counterparts, develop their skills and gain expertise ‘on the job’. The invisible, immeasurable, intangible skills that care staff have, are valuable assets in the provision of care and contribute towards the provision of care within a restrictive framework. The use of these skills is key to the quality of life experienced by older people experiencing the provision of care in England and Germany. It is therefore important to identify the use of these skills and acknowledge how they are invisibly developed within the working environment of the care home. This underlines the need to provide all care assistants in both countries with training that acknowledges these skills and provides a basic understanding of both the health and social care needs of older people. Incorporating these issues into the training of care home staff could
contribute towards enabling care assistants to empower older people in their everyday lives in a care home.

The findings from this research indicate that the occupational training policies available to both qualified staff and care assistants have clear implications for the ability of care staff to adequately and effectively use all the skills required to meet the needs of older people living in English and German care homes. English training policies need to incorporate the training of qualified nurses working in the care home industry. In both countries qualified nurses entering this form of employment require an understanding of care home residents' social needs. Induction courses incorporating teaching sessions aiming to emphasise the difference between hospital nursing and the care of older people living in a care home could contribute towards improving this situation. Further training sessions need to include an introduction to their role as managers and supervisors of care assistants who are providing 'hands-on care'.

It is important that qualified nurses working in the environment of a care home have and awareness and understanding of the role of the invisible, immeasurable, intangible skills used in the provision of care. This could be developed through day courses providing information on these issues. Discussions following role-play exercises or the critical analysis of a film vignette that presents the interaction between older people and care staff could be used to complement theoretical lectures on these issues. An awareness and understanding of these aspects of care provision would provide qualified nurses with the expertise to guide care assistants accordingly and consequently contribute towards improving the quality of life experienced by older people living in a care home. An understanding and awareness of the impact a stroke, Parkinson’s or Alzheimer’s, for example, has on the everyday life of an older person living in a care home would contribute towards enabling care staff to undertake informed care planning. A care assistant with an understanding of Edith’s medical condition would be aware of how Edith could be encouraged to participate in the planning of how she is helped out of her predicament and how Edith might be able to actively be involved in the process (Chapters 7 and 8). Such an understanding and awareness would enhance the
quality of life experienced by older people living in an English or German care home.

There is a need to extend the now compulsory six-week induction period for all new care staff entering the care home industry (Standard 30.2 of the NMS) to facilitate a formal basic training qualification in the care of older people (Chapter 4). This could then form a basis from which qualified nurses and care assistants would be enabled to be included in the register of social care workers now being developed by the General Social Care Council (GSCC). German occupational training policies need to acknowledge that there is a requirement to provide a brief course resulting in a formal qualification for care assistants meeting the care needs of older people.

4. Care home regulations

The development of occupational qualifications in the health and social care of older people has to be linked to the policies that regulate the staffing requirements of care homes in both countries. The legislation in both countries is wide ranging and aims to ensure that older people living in care homes receive a minimum standard of care. However, the guidelines set up in both countries in order to regulate and implement institutional long-term care for older people can be seen to enforce the development of care homes that produce ‘lounge standard products’ to a high standard. The standards relating to the care staff employed in English and German care homes leave little leeway for older people to be empowered to be autonomous in their daily lives. They result in limited time in which to meet both health and social care needs. Whilst the required skill mix in Germany is better than in England, as discussed above, the lack of training for care assistants needs to be addressed in both countries. In England, the new legislation requires a skill mix of qualified nurses and care assistants with and without task orientated NVQ competencies. As the findings of this research indicate, there is a need for care staff training to be addressed in order to enable the provision of appropriate training for both qualified staff and care assistants to meet the health and social care needs of older people living in a care home.
The regulations that are relevant to this research relate to the skill mix of care staff and their ratio to older people in care homes. The staffing requirements differ considerably between the two countries. In England there is a higher ratio of care staff to older people living in a care home than there is in Germany. This implies that older people in England can expect more direct contact time with care staff than their German counterparts. However, as discussed in Chapter 9, the environment in which care is provided in Germany enables care staff to work more efficiently and therefore results in proportionately more contact time with the older people they are employed to care for.

A further difference between the two countries is linked to the role of qualified staff in the provision of care. In both countries, it is the role of qualified staff to administer drugs and, for example, to change wound dressings and to provide guidance to care assistants. However, there the similarity ends, as English qualified staff appear to take on organisational and administrative tasks, such as those described by Gail (Chapter 7), who was involved primarily in staff related organisational issues. While the tasks described by Gail are relevant to the running of the home they are not related to the actual undertaking of bodywork within the care home. However, the qualified staff in home E2 were not distracted by such issues as all care staff worked full-time and agency staff were seldom needed. The administrative support available in the German care homes freed qualified care staff in Germany of such tasks whilst the keeping of daily records in the care plans was undertaken by both qualified staff and care assistants (Chapter 7). The fact that agency staff are not used in German care homes, in conjunction with the comments made by Penny as a member of permanent staff (Chapter 6 Section 3), indicates that the employment of agency staff is controversial and contributes to the distortion of the actual contact time care staff have with older people. As the research findings indicate, in both countries time was a finite resource that all care staff were directly or indirectly aware of (Chapter 9). The time available to provide care in both English and German care homes is ultimately determined by the national policies that regulate staffing levels, the abilities of the workforce, and the use of short-term agency care staff. Lastly the layout of care homes has, as the
observations made in this research indicate, an important role to play in the interface between care staff and older people.

Qualified staff in both countries can only assess the work of the care assistants on duty with them by the presentation of the lounge-standard product. Within English and German care homes, bodywork is undertaken behind closed doors in the one to one relationship between a member of care staff and the older person they are employed to care for. Consequently, there is in reality little opportunity for qualified staff to supervise the work of care assistants. If care staff are not trained to meet the health and social needs of older people living in a care home this could be seen to be risking the standards of service provided.

The findings from this research establish a close link between the time available to care and being able to implement skills that have been acquired to provide care. These two factors are undoubtedly linked to the care home regulations in both England and Germany. Germany needs to increase the ratio of care staff to residents in order to fully meet the health and social care needs of older people living in care homes. In England, policy makers need to consider the role and funding of qualified nursing in care homes and re-evaluate the training needs and provision for both qualified staff and care assistants. In order to instigate such training programmes, the English care home regulators need to expand Standards 27-30 that regulate staffing in the National Minimal Standards (DH 2002). Only if care staff have a sound knowledge base, are skilled in the provision of care, and have enough time in which to provide care, can older people living in English and German care homes hope to be empowered to be autonomous in their daily lives.

5. Funding systems
The funding systems for a care home placement in England and Germany present considerable differences that, as this research indicates, also have implications for the provision of care. In England the government funding available for a care home placement is needs-tested for the so-called nursing element, and means-tested for the social care element. In contrast, in Germany the compulsory long-term care insurance system funds the care element and the ‘hotel costs’ are means-
tested. A further element of the German care funding system is that it is based on the time, according to dependency level, that has been assessed to be required for the provision of care. In neither country is the funding system related to the care home regulatory system which sets standards that have to be met by the service providers. However, the English NHS funding of nursing care which has been introduced since the data for this research were collected, appears to enforce the organisational and supervisory role of qualified staff described in this research. The NHS contribution towards care home funding was introduced in October 2002 and assessment of self-funding older people living in care home is ongoing. It would not appear that this funding system will increase or improve the quality of qualified nursing experienced by older people living in care homes as it represents only a small contribution towards the overall cost of a care home placement. The dominance of social care funding for a care home placement emphasises the role of care assistants in the provision of care in English care homes and underlines the necessity of ensuring that care assistants are skilled in their occupation. The German system of funding according to the time needed to provide care can be seen to prohibit well trained staff from putting theory into practice and needs to be reconsidered to enable older people living in care homes to be empowered in their everyday lives.

6. The interface between care staff and older people within the framework
The interface between care staff and the older people for whom they are employed to care is strongly influenced by the four macro-level structural factors discussed above, which together represent the framework within which care takes place (Figure 11.1). As this research has identified and discussed in Chapter 10, the medical knowledge of qualified staff and care assistants’ understanding and awareness of the medical conditions experienced by older people living in a care home is as relevant to their work as the ability to competently undertake bodywork, effectively communicate and manage time. This combination of attributes provides care staff with the essential skills required in the provision of institutional care as it enables them to empower older people living in a care home whilst working within the confines of the policy framework of each country (Figure 11.1).
This research has contributed towards identifying the importance of the ‘invisible’, ‘intangible’, ‘immeasurable’ and consequently undervalued care skills that are major contributors to the essence of care required in the relationship between care staff and older people. The description of everyday work in a care home and the responses care staff in England and Germany made to the care vignettes, contributed towards establishing the spectrum of skills used by the interviewees in their provision of care.

Relating the skills required in the provision of care to the lifecourse of care staff has identified how care staff were trained and developed their skills and expertise throughout their public and private lifecourse as well as in the regular ‘hands-on’ provision of care for older people. The findings imply that many women enter employment in the care home industry with basic skills that are taken for granted. However, both qualified staff and care assistants in England and Germany acquire and develop the skills and expertise to care specifically for older people ‘invisibly’ on the job. The ‘invisible learning’ that takes place in care homes can incorporate both ‘good practice’ and ‘bad practice’ and needs to be accompanied by theoretical knowledge that enables care staff to differentiate between good and bad practice.

Comparing the responses made by qualified staff in both countries indicated the different approach OPCs took in their provision of care thereby highlighting the importance of training qualified staff to meet the needs of older people who live in a care home in contrast to older people in hospital. The training of OPCs in Germany, which combines theoretical knowledge with the experience of providing everyday care for older people over a three-year period, exemplifies how ‘best practice’ can be developed. It is good practice in the provision of care that will empower older people in the daily lives in a care home.

The comparison between the care assistants responses where it was the English care assistants who were more likely to have participated in formal NVQ training indicated the importance of including all English and German care assistants in induction and training programmes. A further comparison between OPCs and care
assistants with NVQ competencies highlighted the task orientation of the NVQ social care programme that does not relate to the specific social and health care needs of older people living in a care home. For the NVQ competencies of care assistants in England to have a positive impact on their ability to empower older people living in care homes the training programmes in social care need to consider providing an awareness of the medical conditions and understanding of the resulting situations that care assistants working in care homes are confronted with on a regular basis.

The findings from this research indicate that the regulatory and actual framework in which care is provided for English and German older people, who for health and social care reasons need to live in a care home, is severely restrictive. If the quality of life for older people set out by the WHO (2002) is to be provided to older people living in English and German care homes, the policies relating to long-term care funding need to be reconsidered. Only if care staff are enabled to empower older people in the provision of care will the quality of life experienced in English and German care homes improve. To achieve this, care staff need time to provide care that is based on a sound knowledge and understanding of older people living in a care home and need an opportunity to develop the invisible skills needed in the provision of high quality person-centred care. The English and German governmental regulatory structure aims to improve the quality of care encountered in care homes. However, as the findings from this research indicate this does not equate to an improved quality of life experienced by older people who find they need to live in a care home.

7. Reflections

This research was undertaken at the turn of the millennium and establishes a benchmark from which further research into care homes in England and Germany could be undertaken. In England, the data collection took place in 1999/2000 prior to the introduction of sweeping changes in the legislation surrounding the provision of care. Both the Care Standards Act 2000 (DH 2000) with the resulting ‘National Minimum Standards’ (DH 2002) and the ‘National Service Framework for Older People’ (DH 2001) acknowledge the need to empower older people and train care staff. Consequently some of the issues raised in this research have been
addressed and first steps towards improving the situation for older people in English care homes are being taken. In German care homes, standards set by government legislation are gradually being implemented and being met. The data was collected in 1999/2000, prior to the final deadline set for quality assurance systems to be implemented in all German care homes. At the time, none of the sample homes in Germany actually had quality assurance systems in place and they were, to some extent, resentfully preparing to do so. Whilst at grass root level English and German care staff were providing care to the best of their ability, above them, managers were having to adapt to a changing culture of care. This research did not take these issues into consideration in the methodology. In-depth interviews with care home managers discussing how they were adapting to the changing legislation could have potentially contributed towards providing an insight into these issues. However, the data collection was already complex and multifaceted.

The breadth of data collected was a necessity as it was important to establish that the participating care staff worked in comparable environments and were able to relate to the vignettes designed to establish the skills used by staff in the provision of care for older people living in care homes. The self-completion questionnaires were fundamental in establishing a profile of care home staff and contributed towards establishing how care skills were acquired throughout their lifecourse. The lifecourse data collected in the interviews with care staff provided a more detailed picture of care home staff and both data sets together contributed towards establishing how women's lifecourse influences their ability to care for older people. A key aim was to interview equal numbers of qualified staff and care assistants in each country. It would however have been useful to include age in the selection criteria of the care staff who participated in the interviews. Consequently the lifecourse threads are not used to their full potential in the thesis. Funding for further research has been awarded to address this issue which will also increase the total number of respondents in each country. A larger sample will give the data set greater reliability and validity.
Whilst the attempt was made to include full-time and part-time employees working day and night shifts, the age of the interviewee was not considered. Subsequent analysis of the data indicated that age seemed to be an issue that impacted on care skills. However, the imbalance in the number of interviewees in each age group prevented a comparative analysis of the data from this perspective.

Given more time and resources to transcribe the interviews, the research could have benefited from a larger sample of care homes, allowing greater diversity in types of service provision. However, in the circumstances, I do believe that sufficient data was collected to identify key issues relating to the skills used in the provision of care to older people living in English and German care homes. This comparative research contributed towards identifying the issue of time in conjunction with knowledge and understanding of older people, bodywork, communication and time management in the provision of care. The comparison of the diverging skill mix between the care staff in each country highlighted the implications training care home staff has on the autonomy of older people living in a care home. Whilst the research findings are not fully representative, they do provide a better understanding of the key factors influencing the provision of long-term care for older people in England and Germany at the beginning of the millennium.
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Home Management Interview Questionnaire

1. Information about the Home

Ownership:

Present Registration:

<table>
<thead>
<tr>
<th>Number of beds registered:</th>
<th>Single rooms:</th>
<th>Shared rooms:</th>
</tr>
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</table>

2. Information about Residents:

2.1 Number of Resident

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<tr>
<th>Men</th>
<th>Women</th>
<th>Total</th>
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2.2 Care levels

In order to establish comparable dependency levels in the two countries please could you state how many residents you have in each of the following levels:

- **Care level 0**: Needing no assistance
- **Care level 1**: Daily at least 90 minutes of care to be required, of which at least 45 minutes are spent on basic care
- **Care level 2**: Daily at least 3 hours of care required, of which at least 2 hours are spent on basic care
- **Care level 3**: Daily at least 5 hours of care required, of which at least 4 hours are spent on basic care.

<table>
<thead>
<tr>
<th>Care-level</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
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2.3 How many residents have any of the following diagnosis:

1) ‘Stroke’  2) Cardio-vascular dysfunction
3) Parkinson’s 4) Multiple Scleroses
5) Dementia  6) Severe Arthritis

2.4

a) How many residents need assistance to eat?

b) How many residents are fed via gastric tube?

c) How many residents need assistance to attend the toilet?
d) How many residents are incontinent?  

e) How many residents have a urine-catheter in situ?

f) How many residents are unable to wash and dress independently?

g) How many residents are bedridden?

3. Do you implement a quality assurance system? Yes □ No □

3.1 If yes could I please have a copy of the procedure guidelines for: washing and dressing, meal times e.g. assistance with eating, coping with incontinence e.g. assistance with toileting

4. Information about care-staff:

4.1 On average how many shifts are covered by qualified agency staff per week? □□□□

4.2 On average how many shifts are covered by agency care assistants per week? □□□□

4.3 Is unemployment in your catchment area
a) High □ b) Average □ c) Low □

4.4 Is qualified staff recruitment
a) Very difficult □ b) Difficult □ c) Not a problem □

4.5 Is care assistant recruitment
a) Very difficult □ b) Difficult □ c) Not a problem □

5. Could you please provide me with information about your staff using the following abbreviations in the grid on page 3

Qualifications:
RN = Registered Nurse  EN = Enrolled Nurse  C = Care Assistant

Type of employment:
FT = Full time (at least 38 hours per week)  PT = Part time

Gender
F = Female  M = Male

Age Group:
2 = 18-24  3 = 25-34  4 = 35-44  5 = 45-54  6 = 55-64  7 = 65+
The first line is completed as an example. To maintain confidentiality the numbers replace names. Joan is a care-assistant who works part-time, she is 38 years old.

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<th>Qualification</th>
<th>Type of Employment</th>
<th>Gender</th>
<th>Age Group</th>
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6. Staff training
6.1 Do any of your qualified staff have specialised nursing qualifications? No □
   If yes how many and which?

6.2 How many of your staff have or are participating in NVQ training?
   a) Have NVQ qualification

   

   229
Level 2:  

Level 3:  

b) Participating in training for  
level 2:  
level 3:  

7. Ratio of residents to care staff over 24 hours  
Please complete the following grid to demonstrate how the home was staffed on a  
week day to care for the residents described earlier.  
For example: 2 care-assistants worked from 1pm – 7.30pm  
Please include agency staff that might have been on duty yesterday, identifying them  
with an A. For example: an agency RGN did night duty from 8pm-8am  

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<th>Time</th>
<th>Qualified Nurses</th>
<th>Care-assistants</th>
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Thank you for your help  
Ingrid Eyers MSc, RGN  
Department of Sociology  
University of Surrey  
Guildford GU2 5HX
In completing this questionnaire you will be helping to gather information to establish a picture of the people who actually provide the ‘hands on care’ for old people in nursing and residential homes. The intention is to heighten the awareness of the important work undertaken in care-homes and underlining the need to give this form of employment more acknowledgement. Please tick or fill in the answers that best describe you, your situation or your experience. The information you give will be treated confidentially.

1. a) How long have you been working in this residential/nursing home?

b) Are you employed by an agency to work here? a) no  b) yes

2. Did you have experience in looking after older people before you came to this home? a) yes  b) no  move to question 3.

If yes please tick the boxes that describe where you gained that experience

a) within the family  b) home-care agency  c) social services

d) hospital  e) care-home  f) other

b) Qualified Nurse  go to question 10.
c) Matron/Manager  go to question 10.

4. Are you participating in NVQ training? a) no  b) yes  for level 2  level 3

5. Have you achieved NVQ’s? a) no  b) level 2  level 3

6. Have you done some NVQ training but not gained a qualification? a) no  b) yes

7. Did you once start training to be a qualified nurse? a) yes  b) no
8. Are you a SRN/MN but not on the UKCC register? 
   a) yes  b) no

9. Are you a SEN but not on the UKCC register? 
   please move to question 12.

10. Please state which of the following qualifications you have:
    a) RGN  b) RM  c) RMN  d) EN
    e) when did you qualify? 
    f) do you have other nursing qualifications please state:

11. 1. Are you involved with NVQ training for care-home staff? 
     a) yes  b) no

     2. Have you been involved in NVQ training in the past? 
     a) yes  b) no

     3. Are you a NVQ Assessor for care-home staff? 
     a) yes  b) no

     4. Are you training to become a NVQ assessor? 
     a) yes  b) no

12. In the last 3 years have you attended training in any of the following subjects

    a) Food hygiene  b) Lifting
    c) First aid  d) Fire drill
    e) Care-home management  f) Health-care needs of older people
    g) Mental health of older people  h) Terminal care
    i) no training received  j) other, please state

13. Do you work: 
    a) full-time  b) part-time

14. a) How many days do you usually work per week? 
    b) How many hours do you usually work per shift?
15. Please answer the following questions with
   1 = a great deal  2 = a fair amount  3 = a bit  4 = nothing at all

   a) How much did you know about
   older people before you started work here?
   b) How much do you now know
   about looking after older people?
   c) How much have you learnt from your colleagues?
   d) How much have you learnt from the residents?
   e) How much have you learnt from attending courses?

16. Please answer the following questions with
   1 = strongly agree  2 = agree  3 = disagree  4 = strongly disagree

   Would you say
   a) your work is acknowledged by the residents
   b) your work is acknowledged by the management
   c) your contribution is acknowledged by fellow workers
   d) work in a care-home is like being in a big family
   e) your job is typical women’s work

17. How long have you been in jobs relating to the care for older people?
   _______ years

18. What is your average hourly rate of pay before tax and NI: £
   _______

19. What is your average monthly ‘take home’ pay
   £

20. Are you the main breadwinner in your household?  a) yes  b) no

21. Do you do any other paid work?  a) no  b) yes
   If yes please state where
   b1) care agency  b2) other care-home  b3) other

22. Did you leave school with any qualifications?  a) no  b) yes
   If yes, which qualifications
23. Please state any (non nursing) employment related qualifications:


24. What was your first job after leaving school?


25. Please list other paid jobs you have done during your adult life


26. Are you: a) single □ b) married □ c) living with partner □
    d) separated □ e) divorced □ f) widowed □

27. Do you have children a) yes □ b) no □
    27.1 If yes in what year(s) were they born?

28. Are you currently caring for a dependent relative?
    a) yes □ b) no □ go to question 29.
    28.1 If yes who are you caring for?
        a) parent □ b) in-law □ c) partner □ d) brother or sister □
        e) child □ f) grandchild □ g) other

29. Have you in the past cared for a dependent relative (other than bringing up your children)? a) yes □ b) no □ go to question 30.
    29.1 If yes who have you looked after?
        a) parent □ b) in-law □ c) partner □ d) brother or sister □
        e) child □ f) grandchild □ g) other

30. Are you a) female □ b) male □

31. Which age-group do you belong to
    a) 18-25 □ b) 26-35 □ c) 36-45 □ d) 46-55 □ e) 56-65 □

If you are willing to participate in the interviews that also form part of this research please fill in your name:

How many minutes did you take to complete the form? 5 □ 10 □ 15 □ more □
Did you find any if the questions complicated? Yes □ No □
If yes which ones?
Thank you for helping.
Appendix 3

Semi-structured interview guide

Interview guide: The aim of this interview is to gain a picture of care work and the people who provide the care.

1. Do you enjoy your work?
2. When did you come on duty today?
3. How many people were you looking after today?
4. What did you have to do for them?
5. Did anybody help you at all?
6. How did you gain your skills to care especially for older people?

7. Vignettes
My research is being undertaken in a number of homes in England and Germany, to gather comparable data I would like to ask you to imagine the following situation: within the home Edith, Phyllis, John Derrick and Maude each have a single room. Please imagine that all five are part of the group of residents you are caring for.

7.1 Edith is 87 year old widow; she had a stroke 6 months ago and was admitted to the home eight weeks ago. The stroke has affected her speech and she is not able to move her right arm, her right leg has also affected by the stroke. Edith uses a hearing aid and wears glasses and has dentures. However with help Edith is able to stand and hold onto her frame and with support and guidance she is for example able to transfer from bed to chair. Edith is frustrated by her condition and tends to be grumpy in the morning. Invariably Edith also needs help to go to the toilet. She no longer has a urine catheter. The night-staff sit her on the commode around 6am but then return her to her bed. You have come on duty at 8am and this morning she is in your group of residents. When you go into her room you find she is incontinent and has not touched her breakfast. You probably know someone like Edith – think about that person and tell me how that morning would have been given that you also have other residents to care for.

7.2 Phyllis is 83 and has had Parkinson’s for over 10 years. Her family are no longer able to care for her at home and she has now been in the home for a year. You have got to know her well and now her likes and dislikes, abilities and disabilities. Phyllis is one of the residents you care for this morning. Getting her up washed and dressed went well this morning, however this lunchtime the picture has changed a bit and she is going to need a lot of help to eat her lunch as she can’t get a cup or spoon to her mouth. You probably also know someone like Phyllis, considering you also have other residents such as Edith to help how do you ensure that Phyllis eats her lunch?

7.3 John 76 and has ‘Alzheimer’s’. His wife could no longer cope with him at home and he has now been in the home for 3 months. He wanders around the home a great deal and tends to forget to use the toilet. It’s mid afternoon and you walk pass him and can smell that he has been incontinent. You probably also know someone like John, how do you go about getting him changed into clean dry clothes when he thinks that he has to go and check the boiler is working properly?
Maude is a mentally alert 78-year-old lady who is wheelchair bound because she had both legs amputated 6 months ago. She has been in the home for six weeks and is still coming to terms with her situation. Once she is in her wheelchair she is able to partially wash and dress herself. However, she is unable to dress the lower half of her body. You have helped her onto her wheelchair and left her to wash and dress herself as far as she can. You have gone on to Derrick intending to return back to Maude. This usually works well but to your surprise Derrick has been doubly incontinent, this has caused a lot of mess as Derrick has unsuccessfully tried to cope with the situation himself. You may well have encountered a similar situation, what would you do?

Do you think that your experiences within your family have influenced your ability to care for older people? If so in what way

Again to collect comparable data I would like to read you two brief vignettes

8.1 Joe and Mary have a daughter, Sophie aged 8 and son Jason aged 11, they are experiencing a hectic morning getting up and off to work and school on time. The son is not co-operating and the daughter is refusing to eat breakfast. Please describe the morning from Mary’s point of view, she wants to make sure the children get the 8.30 school bus on time whilst their father needs to leave the house at 8.15 and she has to leave for work by 8.40.

8.2 This morning Emma needs to take her 2 year old daughter, Julia, to see their GP at 9.30am. This appointment is important and the time is ideal because it should still be possible for Emma to collect her son from nursery school on time. However, Julia is playing up this morning and has poured the contents of her cereal bowl over her head and down her front. Emma needs to change her before going out. What do you think Emma did in this situation?

9. Do you see any of the skills used in these situations also being used in your job in the care home?

10. Life-course Grid
10.1 Public life course
1. School leaving age,
2. Employment after leaving school
3. Occupational training
4. Employment relative to birth of children
5. Employment as children grow up

10.2 Private life course
1. Living with parents until
2. Cohabiting with partner or house sharing (from to)
3. Marriage, divorce, widowhood, break-up of partnership
4. Moving house
5. Moving geographical location
6. Birth of children
7. Birth of grandchildren
## Life Course Grid for data collection

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Appendix 6

List of respondents’ first job after leaving school as stated in self-completion questionnaire

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Appendix 7: Lifecourse Threads

As described in Chapter 5, Section 11 data focusing on four strands of the interviewees life-course was collected in the form of a life-course grid. The strands were colour coded and the following ‘Key’ presents the indicators identified to be relevant to establish a picture of the life-course experienced by care staff in England and Germany. The four strands have been termed to be ‘life-course threads’ as they contribute towards weaving a colourful tapestry of people’s lives. ‘Nodules’ in each thread indicate an event that has had an impact on the respondents life in some instances the thickness of the thread then changes. The explanation to these changes is also found in the ‘Key’. The ‘nodules’ in a thread could then be related to another thread to identify how the course of one thread impacted on the other. For example it is possible to establish how the birth of children has impacted on a respondents employment thread. By bringing together the lifecourse threads of cohorts of qualified staff and care assistants in each country patterns could be established that facilitated the comparative element of this research project.

The ‘key’ is on page 2, however the following example aims to provide an understanding of the system. Gwen, Eileen and Kelly are English care assistants. At the time of data collection all three belonged in the 26-35 cohort. The blue ‘educational thread’ shows that all three left school at the age of 16/17. Eileen initially started but did not complete her training in a non care related occupation. At 27 she gained her NVQ in care as did Kelly at 24. The pink ‘employment thread’ presents how Kelly commenced work in a care home after leaving school, Eileen when she was 18 and Gwen when she was 29. At the time of data collection Gwen was with her second employer in the care home industry. The green thread indicating ‘place of residence’ shows how Gwen came to England from abroad whilst Eileen and Kelly have always lived within a 20 mile radius of the sample home. The red ‘family thread’ shows how Gwen and Eileen are both divorced and Kelly and Gwen have children. The link between family and employment can for example be made looking at how Eileen’s divorce coincides with the change in her ‘employment thread’ and NVQ qualifications. The dark blue cross bar at the end of all lines indicates the age at the time of data collection.
Education:
- Formal schooling ended
- Attend college to gain formal school leaving qualifications
- Undertaking care orientated occupational training
- Other occupational training
- Training completed

# Schwesterhelferin Lehrgang (Nursing assistants course)
** NVQ level 2 for care assistants
*** NVQ level 3 for care assistants

Employment:
- Fulltime employment in care home of older people
- Fulltime employment in hospital nursing
- Part-time employment in care of older people
- Part-time employment in hospital nursing
- Fulltime employment other occupation
- Part-time employment other occupation
- Unwaged
- Training Grant
- Changed employer

Place of Residence:
- In area (within a twenty mile radius of sample care home)
- Outside the twenty mile radius of present care home
- In another country
- Moved into or out of area

Family:
- Single
- Cohabiting
- Marriage
- Divorce /separated
- Widow
+ Birth of child
+sc stepchild/ren
- Year 2000/01
Figure 1: Life Course Threads – English Qualified Staff - Age Group 26-35

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Figure 2: Life Course Threads – English Qualified Staff - Age Group 36-45

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Figure 3: Life Course Threads – English Qualified Staff Age Group 46-55
Figure 4: Life Course Threads - German Qualified Care Staff Age Group 26-35

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Figure 5: Life Course Threads - German Qualified Care Staff - Age Group 36-45

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* Qualified Nurse

Detlef and Hartmut are male names
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Figure 8: Life Course Threads – English Care Assistants Age Group 26-35
Figure 9: Life Course Threads – English Care Assistants Age Group 36-45
Figure 10: Life Course Threads – English Care Assistants Age Group 46-55

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Figure 11: Life Course Threads - German Care Assistants - Age Group 18-25
Figure 12: Life Course Threads - German Care Assistants - Age Group 26-35

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Gunther is a male name.
Figure 14: Life Course Threads - German Care Assistants Age Group 46-55