My home your workplace – the control and creation of risk in care homes for older adults

Abstract

In the past three decades the role of the public sector in providing residential care for older adults has diminished and there has been a corresponding growth in private and voluntary sector provision. At the same time, the Government's emphasis has shifted from one of employer, property-owner and long term care provider to one of purchaser and regulator (Hood et al, 2004, Holden, 2002). Against this backdrop public policy and rhetoric in relation to care homes has increasingly emphasized choice, rights and freedoms, whilst in reality it is also centrally concerned with the management of risk, a concept that does not always sit comfortably within the complex social world of the care '*home.*'

Drawing on an ongoing qualitative case study of care homes for older adults in England, this paper explores how the statutory management of risks and the risk control strategies adopted by care home providers may paradoxically cause new, hidden or unexpected risks to emerge. The paper argues that such emerging risks may be positioned within a theoretical transition phase of 'delicate equilibrium' that may be termed the '*metastable state*' (Cox and Cox, 1996). It is concluded that the existence and persistence of this state is a function of the culture of the home which determines the balance between rights and choice, risk and control.

Introduction

Historically the notion of risk was recognised as being either something 'good' or 'bad' which could involve loss or gain (Lupton 1999). The risks faced by those living in the early twentieth century were arguably greater than those faced today, yet the management of risk in contemporary society appears to have come to dominate the political and social landscape (McLaughlin 2007). Giddens (2000:52) suggests that: '*Our age is not more dangerous - not more risky - than those of earlier generations, but the balance of risks and dangers has shifted.*'

In contemporary society the meaning of risk has been transformed from being seen as a neutral term into something that is entirely negative and dangerous, indeed Douglas suggests that the term *risk* has become a decorative flourish on the term *danger* where high risk means a lot of danger in our modern Western culture (Douglas 1992:40). Whilst *risk* has been an area of enormous academic activity, Taylor-Gooby (2002:109) suggests that: '*the most striking aspect of risk research is that, despite numerous projects and programmes, it is difficult to identify the common themes in the mass of work*'.

At the same time a new institutional policy style has emerged, in which Government's role as a regulator of risk has been developed while its role as a direct employer, property-owner and long term care provider has declined through privatisation and downsizing (Hood et al 2004). Care homes for older adults operating within this mixed economy of care, represent an interesting 'case study' of how risk is both conceptualised and regulated. Care homes are at once a *home* for the people who live there and are highly regulated place of work for those who provide care. For care

professionals the discernable increase in regulatory presence has arguably resulted in the readily available expedient of 'regulation' as a fall back when explaining or justifying risk management practice. However, in managing risk, it is also possible to create risk. This paper will explore these themes by reference to some of the published literature. Additionally the paper draws on original qualitative data generated in a series of in-depth case studies of care homes for older adults. Part 1 of the paper will provide an overview of the policy and regulatory framework and the research methods, part 2 will briefly examine some of the empirical data in the context of the literature, whilst part 3 will discuss the theoretical idea of emergence and metastability in the context of examples drawn from the empirical work.

Part 1

An overview of the policy and regulatory framework

Over the last two decades there has been a paradigm shift in emphasis from 'welfare' to 'consumerism' in social care (Allen, 1992). In 1979 a Conservative Government drew what Peace et al (2003) called '*a dividing line in the history of residential care for older people*'. Local authority residential homes lost their dominant position, as policy makers gradually divested the public sector of its provider functions, believing that the move to a market would ultimately drive out poor quality services.

Unfortunately this has not entirely proved to be the case, leading to political demands for increasingly rigorous forms of public scrutiny and regulatory control. Since 1997 the New Labour Government has introduced a series of regulatory reforms designed to '*guarantee the public interest, even while ownership remains outside the public sector*' (Drakeford 2006:936).

Regulation has been defined as: '*a set of processes that aim to shape, motivate, monitor and modify the practices and technologies within organisations so as to achieve some desired state of affairs*' (Hutter 2001 in Macrae 2008:55). Within care homes for older adults there are two principal regulatory frameworks to consider, both of which have evolved separately and comprise their own unique statutory instruments, regulators and enforcement arrangements.

The first framework derives from the Care Standards Act 2000, the Care Homes Regulations 2001 and 38 National Minimum Standards (NMS) which are published under the Act. The Health and Social Care (Community Health and Standards) Act 2003 created a new regulatory body, the Commission for Social Care Inspection (CSCI) which had responsibility for ensuring the application of the Regulations and NMS in England and Wales.[1] Standard Thirty Eight of the NMS effectively requires care homes to comply with the second statutory framework comprising the Health and Safety at Work etc Act 1974 (HASAWA) and a large number of supporting Regulations. The second Act and supporting framework has its own, entirely separate regulator, the Health and Safety Executive with delegated support from Local Authority Environmental Health Officers. *Work*, in the context of the legislation and

[1] In April 2009, the Care Quality Commission replaces the Commission for Social Care Inspection, the Healthcare Commission and Mental Health Act Commission.

the care home is the way that the staff and residents interact with each other and with the building, its contents and services.

The basic framework of health and safety law comprises a relatively large and complex body of Regulations; however, the components of the framework are based upon a three stage process requiring employers (those charged with the management of care homes) to:

- Identify the hazards that are associated with work activities **- a Hazard** is something that has the *potential* to cause harm

- Assess the risk - **Risk** (in techno-scientific terms)is the *chance* or *probability* (high or low), that a hazard will actually cause harm

- Identify control measures – **Control measures** should be designed to reduce the risks to the lowest level that is reasonably practicable under the circumstances

It could be argued that it is this often complex framework that tends to be the focus of attention for proprietors and home managers and this has lead to accusations in the care press that: '*Regulations* [are] *stripping away choice and independence for older people*' (Community Care [online] September 8th 2004).

Cultural and organisational theorists have taken a particular interest in the way that risk is conceptualised within complex social worlds (Hood et al, 2004), thus, whilst the law might envisage one particular approach to understanding and applying the regulatory framework, it is likely to be done through the socio-cultural lens of *care* within the care home.

'Varieties' of risk

There is an extensive literature on *varieties of risk* (see Taylor-Gooby 2002). Risk has been classified into *techno-scientific*, *socio-cultural* (see Lupton 1999, Tansey and O'Riordan, 1999) and *psychometric* paradigms (see Marris et al 1997). Whilst there are important differences within and between these classifications, they can also be seen as complementary in many important respects. The psychometric paradigm theorises *an individual's* perception and interpretation of risk, which might for example be important when considering how a home manager perceives priorities in terms of risk management. The techno-scientific paradigm is most closely associated with the legal imperative (set out in HASAWA) to identify potentially harmful [work] activities. It is synonymous with probabilistic risk assessment where risk is a function of probability and the likelihood of harm. In a residential home this is likely to include all aspects of the building and the care and management practices that take place there, for example: gas and electrical appliances, chemicals, falling from height, scalding, burning etc. However, to view such hazards, risks and their perception in absolute terms is to ignore their social context and the cultural perspective of the observer. Beck (1994:11) suggests that society has a problem with notions of risk whereby: '*insurance experts contradict safety engineers…….. Politicians encounter the resistance of citizens' groups*'. Thus the *socio-cultural* conception of risk is

perhaps, whilst elusive, the lens through which risk is perceived and ultimately managed.

An overview of the research methods used

Case study research is not sampling research (Yin, 2002, Stake, 1995) and is therefore inconsistent with the requirements of statistical sampling techniques. The case study provides a means of studying multiple perspectives *within context*, with its unique strength of being able to deal with a wide range of evidence and data (Yin, 2002). Some authors assert that it is simply not possible to generalise from single or small scale case studies (Bowling 1997: 360), Gomm (2000) however asserts that *it is* possible for case study researchers to try to take into account probable and relevant heterogeneity within a population in two complementary ways: 1) by using theoretical ideas and information about the case and the population and; 2) by selecting cases for study on the basis of this information.

To these ends the sampling strategy involved identifying an *information oriented* sample of care homes for older adults located in an English city. An up to date copy of the Commission for Social Care Inspection report for all of the homes within the sampling frame was first content analysed in order to collect data on: the type, size and age of home; proprietor; and data derived from an overview of the inspector's findings / comments relating to relevant National Minimum Standards. This data was used to derive the case study sample of homes and to provide background and context in order to understand the circumstances within which the homes were operating. The research findings presented here are illustrations within a particular context and apply within that context. The reader is at liberty to draw parallels with their own experience and the probability or possibility that a particular empirical finding or observation might have wider significance.

The sample for the empirical research comprised:

- Private sector, owner managed homes
- Voluntary sector homes with local governance
- Voluntary sector homes with regionalised governance
- Corporate sector 'for profit' home
- Local authority homes

Part 2

The juxtaposition of home and risk

The meaning of home to older people has been the subject of extensive research (including Ahmed, 1999, Fox, 2002, Means, 1997). In housing related studies the home is one of the fundamental places giving shape and meaning to people's lives, indeed house and home *could* be the same place for some people, but these terms are not conflated and are indeed not the same (Mallet, 2004). From a sociological perspective, home is a physical and social space in which social interaction takes place. Peace and Holland (2001:397) paint a vivid picture of life at home where '*people can …make choices. They can light a fire, re-heat yesterday's dinner, re-decorate a room or dig up the garden.*' They may not expect someone from outside

the home to tell them how to do these things. Whilst this 'definition' of home will resonate with most people, it *may* also portray images of 'risk' and thereby the application of 'health and safety' laws.

The right to take risks or the responsibility to control them

Over the last two decades there have been a number of policy and practice documents (Avebury 1984; Avebury 1996; DoH: SSI 1989) that have stressed the importance of allowing people in residential care to take reasonable risks, linking responsible risk-taking with independence. In 2006 the Department of Health (Ivan Lewis DoH 2006) launched its *Dignity in Care* campaign which included the goal of enabling people to maintain the maximum possible level of independence, choice and control. More recently the Green Paper *Independence, well-being and choice* encouraged a debate about risk and consulted on the right balance between protecting individuals and enabling them to make decisions about their lives including risk. In May 2007 the English Department of Health published *Independence, Choice and Risk: a Guide to Best Practice in Supported Decision Making*, described as a *best practice guide for the use of everyone involved in supporting adults* [18 and over] *using health and social care within any setting*. Any setting includes community or residential care, in the public, independent or voluntary sectors.

Manthorpe (2007:237) suggests that the publication of such a risk framework highlights Government awareness of the problems of managing risk in a climate of criticism and risk aversion. Whilst the framework talks in terms of viewing risk 'proportionally and realistically', and distinguishing 'reasonable' risks from others, distinguishing between 'reasonable' risks and risks requiring management control, may prove a real challenge.

Whilst Manthorpe (2007:237) argues that this apparent turn away from the risk management of everything '*is to be welcomed*', she also acknowledges that the apparent culture of 'risk management', perhaps based upon a fear of litigation, is likely to be difficult to unseat. Robinson et al (2007) suggest for example that the balance in favour of risk management by care professionals was the fear of litigation. This observation resonates with the author's own research where one participant in particular clearly articulated concerns about a perceived culture of apportioning blame:

> '*We have a culture of attaching blame to somebody, you know, I've often said the word accident should no longer be in the dictionary, because you cannot have an accident anymore, you've got to find somebody that's responsible and put them up as a scapegoat almost……….there is a very severe cultural factor to apportion blame to somebody or some organisation, and obviously riding on the back of that there's a lot of litigation going on, and therefore companies and organisations become terrified of being litigated against*' (care home manager – voluntary sector).

Despite the written rhetoric of privacy, dignity and choice espoused in Government publications and care home literature, a very practical example, and arguably one cause of these fears, can be readily demonstrated in prosecutions following accidents

and incidents in care homes for older adults with their subsequent press attention. For example, when in 2006 an 81 year old resident fell from her bedroom window, the home owner was prosecuted for 'failing to secure the health and safety of residents'. The prosecuting District Council claimed that the risk had been '*brought to the proprietor's attention as early as 2000, but that he had felt a 'home from home' environment was important to residents*' (Mid Devon Star, first published Friday 23rd Jun 2006).

Such headlines with their accompanying fear of censure are perhaps more likely to promote 'risk aversive' practices by care home proprietors, managers and staff at the expense of individual residents' freedoms. Figure 1 illustrates how Robinson et al (2007) conceptualised the factors that determine how carers are likely to determine the balance between the rights of the individual and the application of risk reduction measures.

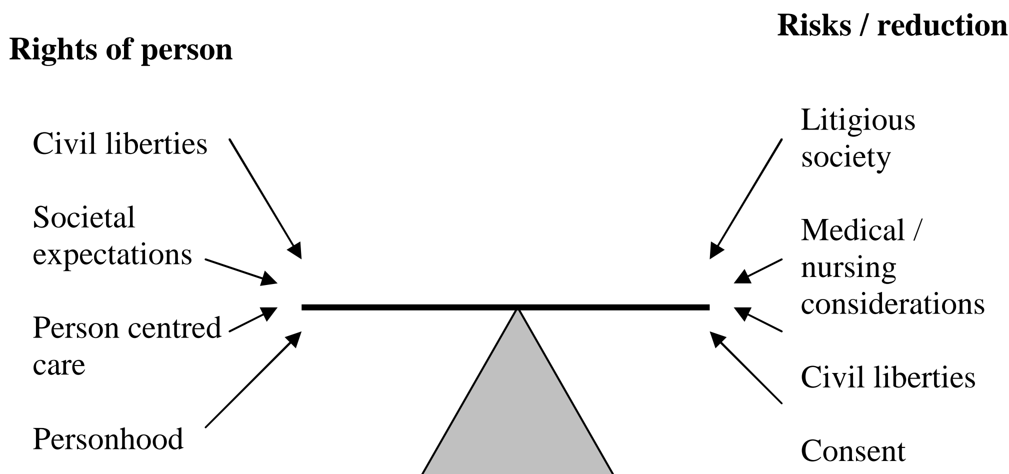

Figure 1: Factors affecting the balance between rights and risks (Diagram adapted from Robinson et al 2007:395)

For residents and their relatives the balance is likely to be in tipped in favour of quality of life and independence, based on the established values of liberty, personhood and society's expectations of equality and the rights of the individual to person centred care i.e. *rights* are likely to outweigh *risks*. However, for professional carers where their perceived duty to *care* is a more significant factor, the balance is likely to be tipped the other way, i.e. professional expectations and the likelihood of litigation are more likely to outweigh the rights and freedoms of the individual (Robinson et al 2007: 395). Such a situation was exemplified by one home manager participant who reflected that:

> '……………*the ideal scenarios* [in terms of resident choice] *don't fit very comfortably with health and safety*……..' (Care home manager – voluntary sector).

Clark (2000:83) suggests that in some respects the idea of '*care* [itself] *aims to minimise risk to the individual, their family and their society*'. This appeared to contrast with the rhetoric of the value base of rights and choice that suggests that

older adults should be allowed to choose the risks that they take and when they take them. Bland (1999:553) argues that the prime function of the care home is '*to care*', i.e. to take *responsibility* for or to *take charge* of people who are deemed unable to take care of themselves. The attitudes of staff implementing this *social care approach* to resident privacy and choice are therefore governed by the social construction of the resident as '*patient*' or '*family member*', even '*child*'. Bland (2005) also argues that ageist attitudes and policies deriving from a 'medical model' of ageing have come to characterise older adults as dependent, vulnerable and in need of protection.

Thus risks deemed a normal part of everyday adult life such as going into the kitchen to make a cup of tea, may become 'unacceptable' within the highly regulated domain of the care home, and the well drafted laws designed to protect people from *serious* harm might *inadvertently* be translated in ways that emphasise the physical aspects of care associated with the less than homely values of institutions[2]. Homely values might thus become subordinated to a preoccupation with avoiding risk (Bland 2005:288) and laws drafted with supportive intentions in mind *may* become controlling in effect (Burton 1998).

Risks and 'rules'

Whilst the regulator and the regulatory framework undoubtedly exert a significant influence on the way that care homes are managed, it is arguably the proprietor, home manager and staff who establish the culture within which the regulatory framework is applied. One of the most interesting and potentially significant findings of the author's empirical research has been insights into how home managers conceptualise *care* (which might on occasion be argued as synonymous with control measures) in terms of 'rules' that were designed to 'prevent' harm to *vulnerable* residents. On few occasions were these 'rules' supported by a collaborative, suitable and sufficient assessment of the risks designed to balance the quantum of risk in accordance with the model set out in Figure 1. Indeed one manager reflected that where risks assessments did take place, they rarely involved the resident:

> '*……..risk assessing is something you **do** to somebody, not something you do **with** somebody, and that's where it needs to change I think*'
> (Home manager – local authority).

Two examples further illustrate this view. In one voluntary sector home the home manager was concerned about preventing the risk of slips and trips caused by floors and floor coverings. This concern had effectively resulted in a 'rule' restricting rugs and bedside carpets within residents' rooms:

> '*Rugs in the room, we don't have them because there is a risk of them falling over, tripping over and touch wood we've never had a problem saying: do you mind not having that rug, because if you fall, you'll probably end up in hospital with a broken bone or something. And the families have agreed*' (Deputy home manager - voluntary sector).

[2] Moore (2002:231) suggests that: '*even those [homes] run by the most enlightened staff inevitably have aspects of what Goffman (1961) called batch living*'.

Whilst a prohibition on the possession of a bedside rug might not be regarded as a gross infringement of resident 'choice', it nonetheless illustrates the idea that it was the home manager who determined the control measures *independently* of the resident. The other example derives from another voluntary sector home, and the use of kettles. In this home the home manager had not imposed any form of prohibition or 'rule', however, 'permission' to use a kettle was only granted where the staff felt the resident was capable of operating one *safely*:

> '*A lot of them like to have a kettle in their own room, and if we think that they're not capable of using the kettle; we have to do a risk assessment, and we try to remove it, remove the kettle, but if they are still adamant that they still want the kettle left in their room, we have to point out all of the advantages and disadvantages of it all and try to come to a compromise*' (Deputy manager – voluntary sector).

These examples form part of a wider debate about how the expedient to prevent harm is done at the expense of *choice*. Indeed whilst carers might emphasise the physical domain of risk management, they arguably ignore the biographical domains of risk such as loss of self-identity (Clarke, 2000). The example control measures used here do not in themselves create the potential for real *physical* harm; however, during the fieldwork examples of risk '*control measures*' were observed that had the latent the potential to do so. Some of the case study homes were seen to adopt risk control measures that, *paradoxically*, appeared to introduce the potential for other, sometimes potentially more serious risks that home staff did not appear to recognise or appreciate.

The remainder of this paper will develop and explore the idea that a 'rule' based culture can precipitate *the potential* for unintended harm, where the presence of hazards and subsequent risks exist in an apparent *dormant* or *metastable* state.

Part 3

Systems, emergence and metastability

Care homes represent complex systems comprising a large number of parts. These include the residents and their relatives, the management function, care, domestic and maintenance staff. Even the home's written documentation (Penchas, 2004), the building, furniture and equipment that make up the home can be considered as part of the 'system' (Chalmers 2002 in Johnson undated). Some homes are also part of a larger organisational system that includes regional and area management functions that form a larger 'corporate culture'.

Cox and Cox (1996:57) define systems as '*interacting sets of components forming hierarchies and networks for the purpose of fulfilling systems related objectives*'. Complex systems can be characterised in several different ways (Johnson undated), for example they may be completely 'mechanical' or 'chemical' systems. Systems also include those that can be characterised as 'socio-technical' where people interact with technology and hardware. Care homes are arguably examples of socio-technical systems where residents and staff interface with the equipment, technology and services that comprise the home. Within the home the management and organisation

of systems will be designed to fulfil numerous functions. Some of these functions will be dedicated to the care and welfare of the residents, to the maintenance of the building and equipment, whilst others will be dedicated to the support of staff and organisational management.

The interaction between these different functions can be thought of as resulting in the predictable emergence of service outcomes. Such outcomes include the degree to which the home meets the expectations of those who live and work there and compliance with the National Minimum Standards. Systems theorists call these the *functional* emergent properties that appear when all the parts of a system work together to achieve some objective.

The interrelationships and interaction between these different functions is however complex and *not always predictable*. On occasion the system might give rise to outcomes that were not, or could not, necessarily have been anticipated by looking at one particular function in isolation. System theorists call these outcomes *non-functional* emergent properties. Examples might include reliability, performance, safety, and security issues (Sommerville, 2004), i.e. a whole range of practical things that impact directly on resident and staff welfare and service delivery.

These *emergent properties* (Checkland, 1981) cannot be attributed to any specific part of the care home system. Rather, they only emerge once the system components have been integrated. The term 'emergence' is associated with the 19th century philosopher George Henry Lewes, who made the first serious attempt at investigating the concept. Lewes attempted to distinguish between *resultants* and *emergents*: in the former, the sequence of steps producing an outcome is traceable. Emergents are however not traceable (Winder 2007, Ali, Zimmer and Elstob, 1998). An event might therefore be deemed emergent if it appears to arise spontaneously and without any apparent, or predictable, connection to the elements of the system with which it is connected. This conception of *unpredictable emergence* implies that accidents or incidents *could* on occasion, be deemed as the emergent properties of a complex system, and arguably, could not therefore have been predicted. This idea is however the very antithesis of risk assessment and management methodologies. It is almost counterintuitive and too simplistic to suggest that an accident is likely to arise *spontaneously* and *unpredictably* as the result of the complexities of the home. The fieldwork did however identify examples where decision makers were apparently 'unaware' of situations where the interaction between different elements within (or outside) the home had given rise to the *potential* for an accident.

The concept of the *metastable* state

A situation that appears to give rise to the potential for an accident, yet is apparently unrecognised, might be explained by applying the theoretical idea of meta-balance or meta-stability[3]. The concept derives originally from the natural sciences where it describes transition states that are said to exist in 'delicate equilibrium'. Such a state has much in common with social systems like care homes which might also be seen as existing in a state of delicate cultural equilibrium.

[3] 'Meta' derives from the Greek meaning *beyond*, *after*, or *adjacent* to, it is a prefix indicating an abstraction or another concept. Meta-stability is therefore literally *beyond* or *adjacent* to a *stable* state.

Meta-balance is not an example of emergence, but it is part of a process that on one level appears to be an ordered system whilst on another contains 'unstable' elements. A system that is in meta-balance can thus be viewed from two different perspectives. From the global perspective of the home's proprietor, management and staff, the system seems to be *stable and ordered*. The system *appears* to deliver the outcomes that are expected, for example, an activity is completed without apparent harm to anyone. On the level of detail however, the system is *out of balance* because it contains elements that, on closer scrutiny, are potentially unsafe under particular circumstances. This idea can be illustrated with reference to one of the examples discussed later on (example 4). In this example, the residents sit down to eat and their walking frames are then removed by staff to prevent other residents from tripping over them. Residents complete their meal, their walking frames are returned and they leave the dining room. As a result of these measures no-one has had an accident.

A system is in a metastable state when it is not changing with time, yet is *potentially* unstable, i.e. it is the ability of a situation that is not in equilibrium to persist for some period of time. Equilibrium in this context refers to the balance of rights, risks and responsibilities that might be thought to exist within any social situation. Within a social system rights afforded to an individual are finely balanced within a regulatory regime. The arbitrary removal or restriction of rights takes the system out of balance. Returning then to example 4, the act of removing the walking frames removes the resident's right to determine exactly when they want to leave the table. They must first ask for their frame to be returned, if they choose not to wait, they are placed at an increased risk of falling because they do not have their frames for support. Thus at the level of detail the system is arguably out of balance or *metastable*. Even though the system *appears* to operate normally over quite some time – on the balance of probabilities one resident, one day, will choose to leave the table without their walking frame and will fall as a result.

The diagram, Figure 2 is adapted from Cox and Cox (1996:58 figure 3.7) and shows: '*the importance of the metastable state….which follows a departure from 'normal' operation, [which] may exist over quite a lengthy period*'. During the metastable phase the system, in this case an aspect of the day to day routines of the care home, continue to operate, at an increased level of risk before any harm becomes imminent. What is perhaps most significant about the adapted diagram shown in Figure 2, is the second box labelled '*Predisposing conditions in wider environment*' which might also be read as the '*culture*' of the home. The culture of the home arguably contributes to the likelihood that hazards will be *recognised* by those who work there.
Thus, in a 'rule' based culture, the rule transcends any concepts of rights and obfuscates any consideration that the rule itself, might, cause harm. The hazard or risk is therefore unlikely to be recognised. The metastable state may be considered the period between a hazard being created and that hazard either causing an accident, being recognised by staff or both.

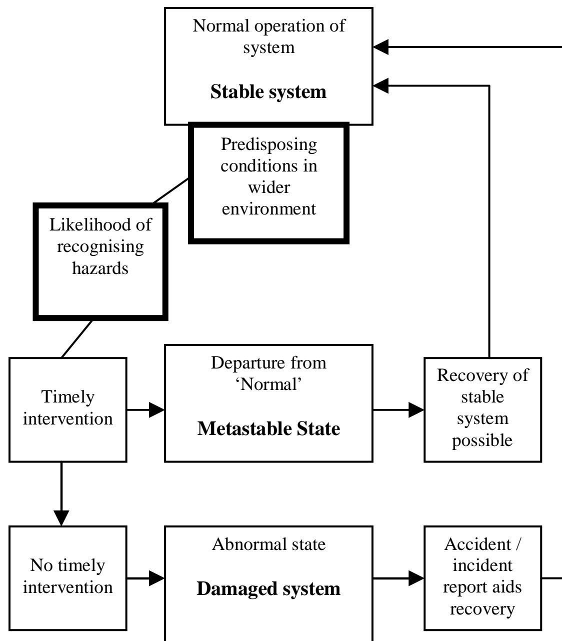

Figure 2: Metastable State Diagram
Adapted from Figure 3.7 Systemic accident sequence model in S. Cox and Cox (1996), Safety Systems and People

This section will consider 4 examples of potential 'metastable states' that were observed within the case study homes:

Example 1: **The assessment of 'high profile' risks and the ignorance of others**

This first example is about control measures for windows in order to prevent vulnerable older adults from falling out of them. Generally some providers and regulators apply a 'ritual' or 'rule' that all windows are fitted with a restrictor to prevent the window from opening more that 10cm. Indeed all but one of the case study homes had either fitted window restrictors or planned to do so. Such controls are not in themselves a regulatory requirement whereas undertaking an assessment of the risk is. However, guiding standards have effectively persuaded regulators and proprietors to adopt these control measures *irrespective* of any assessment or local choice. The choice in this case relates to the resident's ability to choose to safely open their window on a hot day. For this reason the owner and manager of the small case study home had decided not to fit window restrictors despite having been told by CSCI that the home *must* do so:

> '……..*But for instance I haven't got window restrainers on, which CSCI told me I had to have on, but I said I wasn't going to do that*' (Home manager – small private home).

What is interesting about the apparent 'rule' to fit restrictors is that it appeared to ignore the closely related risk posed by the integrity of the glazing itself. It could be argued that the windows in many of the older case study homes were unsafe in terms of the panes of glass that were sometimes in evidence[4]. In one of the homes for example, the CSCI inspector had noted that: '*the stained glass window at the top of the stairs has not been fitted with a restrictor*'. Whilst this 'advice' was clearly *relevant*, it ignored the equally significant hazard posed by the leaded / stained glass

[4] Some of the panes seen in the case study homes were arguably not 'safety glass'. Some were cracked or were of 'leaded glass' construction.

itself, and indeed apparently did not question the home's legal responsibility to undertake an assessment of the risks posed by this glass[5]. Thus, the application of a window restrictor would not entirely remove the risk of someone falling through the fragile pane. Whilst there might be a belief that an officially sanctioned control measure was in place, the reality was that the hazard and subsequent risk remained present in a *dormant* or *metastable* state. A resident might just as easily fall through a pane of 'flimsy' glass as through a fully open window.

This example is not intended as a critique of the *reasonableness* of protecting vulnerable people from falls by using restrictors. However, it is intended to highlight that the *ritualistic* use of control measures in the absence of a suitable and sufficient assessment of the risks, will not necessarily afford protection.

Example 2: **The control of resident safety at the potential expense of fire safety**

This example is based on empirical observation during fieldwork visits to a large private sector care home. Whilst this particular home was not 'registered' to care for older adults with dementia, there were nonetheless a number of residents who home staff identified as potentially at risk in this respect. 'Wandering' a term that has more recently been replaced with the term 'walking' (Cohen-Mansfield et al 1991, Marshall and Allen 2006, Robinson et al 2007) is common in people with dementia (Klein et al 1999, Chan et al 2003). For care home staff, the idea of *vulnerable* people 'wandering' into potentially dangerous parts of the home such as stairwells can be deemed unacceptable. This was indeed the case within the case study home where the home's handyperson had been asked to fit combination door locks to the doors giving access to such areas. It is worth noting here that this practice was also identified in other case study home as noted by a CSCI inspector in the inspection report for one of the voluntary sector homes:

> '*Access for service users to various parts of the building and the grounds is limited, as doors are kept locked with a keypad system*' (CSCI inspector).

The rationale behind such initiatives was that staff and theoretically residents, who knew the combination, could navigate around the home, whereas residents, who did not have the combination, or could not remember it, would only be able to access 'safe' areas. One of these combination locked doors, a designated fire exit, was located on the first floor adjacent to the laundry. During one fieldwork visit, the laundry assistant was asked what she thought about this arrangement, as the door represented her immediate fire escape. Without hesitation she expressed the arguably self evident concern that, 'in a panic', she might well forget the combination and may then become trapped[6].

[5] Regulation 14 of the Workplace Health Safety and Welfare Regulations 1992: Regulation 14(a): Every window (as deemed necessary by an assessment of the risk)……*shall be of safety material or be protected against breakage of the transparent or translucent material.*

[6] The issue was raised with the home's facilities manager and the combination lock was subsequently removed

Example 3: **The management of fire risk and the safety and choice of the resident**

This example discusses the use of door closers that are fitted to bedroom doors to keep them shut in order to prevent the potential spread of fire and smoke. As with window restrictors, their use can remove the choice of having the bedroom door open for ventilation. Whilst the use of these devices is not new, providers have been encouraged to fit them, arguably in response to two relatively recent events. *Firstly* the tragic fire at Rose Park care home in 2004 where 14 residents lost their lives, specifically as the result of having their room doors propped open[7]. *Secondly* the introduction of the Regulatory Reform (Fire Safety) Order 2005, which encourages the managers of all non-domestic premises to place a greater emphasis on fire prevention.

The case study home was part of a large group of care homes, and as such many of the decisions about the implementation of safety law were taken centrally. Operational policies and procedures were subsequently disseminated to the homes accompanied by guidance about their implementation, which in this case was a direction that the home's handyperson should buy and fit proprietary door closers. From the provider's perspective, it could be argued that, once the mechanical controls had been fitted, the 'risk' had been controlled. However, there was ample evidence that this had not been the case. For example, some of the residents continued to have their doors propped open at night despite the theoretical risk:

> '*I do have my bedroom door open, they prop it open at night, but they're not supposed to*' (Resident – large private sector home).

This example suggests that the company's policy of using mechanical controls had not influenced staff behaviour at local level, and had therefore not controlled the identified risks. In addition, and perhaps more significantly, the control measures had introduced an additional hazard to some residents in terms of a door that could not be opened easily, or would close unpredictably:

> '*The bedroom doors, one lady has objected to the way it springs shut on her, because if she's trying to go through with her Zimmer frame, the spring on the door is stronger than she is. I could see that being a real problem because she could be half way through one of these days and if she's not standing firmly and securely; if that door springs onto her, it could knock her off her feet I think. It is such a strong and heavy spring on that door…….. For the idea of protecting all of them in the case of a fire, in fact it is making daily life a lot worse for the ones that are mobile and can get to their own room*' (Activities coordinator – large private home).

This example was indeed evidenced during the fieldwork where some residents were effectively excluded from their rooms because of the difficulties that they experienced trying to negotiate the door.

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[7] There are a number of 'on-line' news reports that suggest that lethal smoke entered residents rooms through open doors, for example: the News.Scotsman.com, Published: 01 February 2004

Example 4: **Managing risks associated with walking frames and the independence and choice of the resident**

For many older adults who need additional support to maintain balance or stability, a walking frame (Zimmer frame) represents a source of mobility and independence. The frame itself can however represent a hazard as when it is not in use it tends to get in the way of other residents. This might for example be the case in a busy dining room where seated residents will leave their frame in a convenient location ready for use after their meal. In one of the case study homes, the home manager had determined that the solution to this potential tripping hazard was that, once seated, the frame should be removed out of harms way:

> '*……now Zimmer frames are always an issue because of, in the dining room where you are sitting people down, I make an instruction that risk is to take all of those Zimmer frames out of that area when they are not in use, and store them outside the dining room; and when the resident wants to move, they will be taken through by a member of staff and given back to the resident. So, a certain resident isn't very happy about that, but you know, I sort of say: I'm sorry but that is a rule, that is non-negotiable in effect; because I see the overall factor, is the most important driving point, the overall wellbeing of people, overrides his personal independence*' (Manager – large voluntary sector home).

Whilst this particular 'rule' was likely to reduce the potential for tripping over 'carelessly' parked walking frames, it was unlikely to reduce the motivation of independent minded residents who might want to leave the dining room at a time of their choosing.

Conclusion

This paper has not set out to argue that proper risk control measures are in any way inappropriate. Indeed vulnerable older adults do need to be protected from the identifiable hazards that exist in care homes by means that afford real protection without unreasonably compromising rights or introducing additional risks.

The example scenarios discussed all have at least three common characteristics:

Firstly, they relate to 'rituals or rules' designed to control the perceived risk of harm arising from within the home; *secondly*, there was little evidence that a suitable and sufficient assessment of the risks had taken place in order to inform subsequent control measures; and *thirdly*, the measures taken appeared to give rise to the possibility of consequences that had not necessarily been predicted in the form of additional 'hidden' risks.

Within the homes there appeared to be a management dichotomy that differentiated person and premises related risk and thus techno-scientific and socio-cultural perspectives on risk. Ideally the assessment of risk should consider the *interaction* between person and premises i.e. how the person behaves *within* the premises and how the premises, which include the fabric of the building, furniture, fixtures and fittings within it, impact upon the resident. In other words risks and their assessment

must be integrated and correlated. Within the case study homes the 'premises' aspects of the home's management was perceived to be the least well integrated into the local management function. This was especially evident where strategic decisions were taken by managers who were external to the home, for example by professionals within larger provider organisations. Homes were often expected to work within a techno-scientific paradigm, comprising laws and control measures, viewed through a localised socio-cultural lens. It was therefore evident that controls employed 'ritualistically' by proprietors were not necessarily applied appropriately at local level.

An emerging finding of the empirical research was the role of the 'handyperson', who appeared to be tasked with undertaking many of the techno-scientific premises related safety tasks and checks. At the same time there was little evidence that they were involved in the actual process of local risk management, especially at the level of care planning. The 'mysterious art' of the handyperson was perhaps an area that transcended the knowledge base of many care staff and was therefore kept at arms length. A reciprocal lack of understanding could be argued for the handyperson who might not have appreciated the frailties of the residents or the socio-cultural risk management concerns of the staff. This paper therefore argues that the dichotomies of the technical and the social can give rise to the possibility of a '*metastable*' state that can be viewed from two perspectives. On the superficial level the 'control measures' can be seen to work, the risk appears to have been controlled. On the level of detail however, the control measure can be seen to have reduced choice and paradoxically to have introduced additional risks. The idea of the metastable state would thus appear to have a practical application in terms of its potential for persuading proprietors and home managers to consider their control measures from all perspectives including the impact on choice and the likelihood of any possible unintended outcomes.

References

Ahmed, S. (1999), *Home and away Narratives of migration and estrangement*, Sage: International Journal of Cultural Studies, Volume 2, Issue 3, pp 329-347

Ali, S., Zimmer, R. and Elstob, C. (1998), *The Question Concerning Emergence: Implications for Artificiality*, The first international conference on computing anticipatory systems, AIP Conference Proceedings, Volume 437, pp. 138-156 (1998)

Allen, I, (1992), *Elderly People: Choice, Participation and Satisfaction*, London: Policy Studies Institute

Arculus, D. (2004), *Bridging the Gap - Participation in Social Care Regulation,* London: HMSO

Avebury, Lady (1984), *Home life: Code of Practice for Residential Care*, Centre for Policy on Ageing, Henry Ling Ltd, The Dorset Press

Avebury, Lady (1996), *A better home life: a code of good practice for residential and nursing home care*. Report of an advisory group convened by the Centre for Policy on Ageing and chaired by Kina, Lady Avebury.

Beck, U. (1994), *The Reinvention of Politics: Towards a Theory of Reflexive Modernization*, in U. Beck, A. Giddens, and S. Lash (eds.), *Reflexive Modernization*, Cambridge: Polity

Bowling, A. (1997), *Research Methods in Health: Investigating Health and Health Services*, Buckingham: OU Press

Bland, R. (1999), *Independence, privacy and risk: two contrasting approaches to residential care for older people*, Ageing and Society, **19**, 1999, 539 - 560.

Bland, R. (2005), *Senior Citizens, Good Practice and Quality of Life in Residential Care Homes*, Ph.D. thesis, Stirling University

Burton, J. (1998), *Managing Residential Care*, London: Routledge

Chalmers D. (2002), Varieties of Emergence, Technical report, Department of Philosophy, University of Arizona, USA

Chan, D. C., Kasper, J. D., Black, B. S. and Rabins, P. V. (2003), *Prevalence and correlates of behavioural and psychiatric symptoms in community-dwelling elders with dementia or mild cognitive impairment: The Memory and Medical Care study.* International Journal of Geriatric Psychiatry, 18(2), 174 – 182

Checkland, P. (1981), *Systems Thinking, Systems Practice.* John Wiley & Sons, Chichester

Clark, C. (2000), '*Risk: Constructing care and care environments in dementia*', Health Risk and Society, 2(1), 83-93

Cohen-Mansfield, J., Werner, P. and Marx, M. S. (1991), *Two studies of pacing in the nursing home*. Journal of Gerontology: Medical Sciences, 46(3), M77– M83.

Cox, S. and Tait, R. (1991), Reliability, Safety and Risk Management, Oxford: Butterworth-Heinemann

Cox, S and Cox, T. (1996), *Safety, Systems and People*, Oxford: Butterworth-Heinemann

Department of Health and Department of Social Security (1989**),** *Caring for People: Community Care in the Next Decade and Beyond*, London HMSO

Department of Health (1998), *Modernising Social Services*, London: DoH

Department of Health (2007), *Independence, Choice, and Risk: A Guide to Best Practice in Supported Decision Making*, London: DoH

Drakeford, M. (2006), *Ownership, regulation and the public interest: The case of residential care for older people*, Critical Social Policy, vol. 26(4): 932-944

Douglas, M. (1992) *Risk and Blame: Essays in Cultural Theory,* London: Routledge

Fox, L. (2002), *The Meaning of Home: A Chimerical Concept of Legal Challenge*, Journal of Law and Society, Volume 29, Number 4, December 2002

Giddens, A. (2000), *Runaway World: How Globalization is Reshaping Our Lives*, New York: Routledge

Goffman, E. (1961), *Asylums: Essays on the Social Situation of Mental Patients and other Inmates*, London: Penguin

Gomm, R. (2000), *Case Study Generalisation*, Case Study Method: Key Texts, 98-115, London: Sage

Hampton, P. (2005), *Reducing Administrative Burdens: Effective Inspection and. Enforcement.* Report by HM Treasury, March 2005

Holden, C. (2002), *British government policy and the concentration of ownership in long-term care provision*, Ageing & Society 22, 2002, 79-94, Cambridge university press

Holland, J. (1998), *Emergence: from chaos*, Oxford: OUP

Hood, C., Rothstein, H. and Baldwin, R. (2004), *The Government of Risk: Understanding Risk Regulation Regimes*, London: OUP

Hutter, B. (2001), Regulation and Risk: Occupational Health and Safety on the Railways, Oxford: OUP

Johnson, C. (undated), *What are Emergent Properties and How Do They Affect Engineering of Complex Systems*? Department of Computing Science, University of Glasgow [online] @ www.dcs.gla.ac.uk

Klein, D. A., Steinberg, M., Galik, E., Steele, C., Sheppard, J. M.,Warren, A. et al. (1999), *Wandering behaviour in community-residing persons with dementia*. International Journal of Geriatric Psychiatry, 14(4), 272 – 279.

Lewis, I, (2006), *Dignity in Care*, letter to Chief Executives and Directors of Social Services regarding the 'Dignity in Care' campaign, Department of Health, London: HMSO

Lupton, D. (1999), *Risk*, London: Routledge

Macrae, C. (2008), Learning from patient safety incidents: Creating participative risk regulation in healthcare, Health, Risk and Society, 10:1, 53-67

Mallett, S. (2004), *Understanding Home: a Critical Review of the Literature*. Sociological Review 52(1): 62-89

Manthorpe, J. (2007), Managing risk in social care in the United Kingdom, Health, Risk and Society, 9:3, 237-239

Maniadakis, N. and Gray, A. (2000), *The economic burden of back pain in the UK*, Pain, vol. 84, no. 1, pp. 95-103

Marris, C., Langford, I., Saunderson, T. and O'Riordan, T. (1997), *Exploring the "Psychometric Paradigm": Comparisons Between Aggregate and Individual Analyses*, Risk Analysis, vol. 17, no. 3, 1997 pp. 303-311

Marshall, M. and Allen, K. (2006) Dementia: Walking not Wandering (London: Hawker Publications).

McLaughlin, K. (2007), *Regulation and Risk in Social Work: The General Social Care Council and the Social Care Register in Context*, British Journal of Social work: 2007; 37: 1263-1277

Means, R. (1997), *Home, independence and community care: time for a wider vision*? Policy and Politics, vol. 25, no. 4, pp. 409-419

Moore, S. (2002), *Social Welfare Alive*, third edition, Cheltenham: Nelson Thornes Ltd

Morowitz, H. (2002), *The emergence of everything: how the world became complex*, Oxford: OUP

Moss, S. and Edmonds, B. (undated), *Sociology and Simulation: Statistical and Qualitative Cross-Validation*, Manchester Metropolitan University, Centre for Policy Modelling [on-line] @ http://cfpm.org [accessed March 2009]

Peace, S. and Holland, C. (2001), *Homely Residential Care: A Contradiction in Terms?* Journal of Social Policy, 30, 3, 393–410, Cambridge University Press

Peace, S. and Katz, J. (eds.), (2003), *End of Life in Care Homes: A palliative care approach*, Oxford: Oxford University Press

Penchas, S. (2004), *Complexity in Health Care Systems*, ComPlexUs journal, 2003, 1:149-156

Robinson, L., Hutchings, D., Corner, L., Finch, T., Hughes, J., Brittain, K. and Bond, J. (2007), *Balancing rights and risks: Conflicting perspectives in the management of wandering in dementia*, Health, Risk and Society, 9:4, 389-406

Sommerville, I. (2004), *Software Engineering*, 7th edition, Pearson/Addison-Wesley, 2004

Stake, R. (1995), *The art of case research,* Newbury Park, CA: Sage Publications
Tansey, J. and O'Riordan, T. (1999), *Cultural theory and risk: A review*, Health, Risk and Society, 1:1, 71-90

Taylor-Gooby, P. (2002), *Varieties of Risk*, Health, Risk and Society, Vol. 4, number 2, 2002

Von Bertalanffy, L. (1968), General systems theory: foundations, development, applications, New York: George Braziller

Winder, N. (2007), Innovation and Metastability: a Systems Model, Ecology and Society 12(2): 28. [Online] @ www.ecologyandsociety.org, accessed March 2009

Yin, R. (2002), *Case Study Research: Design and Methods*, Third Edition. Applied social research method series Volume 5 California: Sage