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HOW FINANCIAL CUTBACKS AFFECT THE QUALITY OF JOBS AND CARE FOR THE ELDERLY

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(Accepted Version Industrial Labor Relations Review, January 2016)

Based on case studies in 12 nursing homes in the UK, the authors investigate how financial cutbacks affect the quality of jobs and care quality. Similar reductions in labor costs were found to have eroded the quality of jobs, but with two differential outcomes – in seven homes care quality was maintained and in five homes it deteriorated. The authors map the culture of care in these homes to job quality, to identify how and why these matter for care quality. Dimensions of job quality to suffer were those most directly related to the ability of workers to provide care – reductions in staffing, longer working hours and work intensification. In homes with a person-centered care culture, enough job quality remained for staff to create workarounds to maintain care quality. By contrast in homes where quality fell, financial pressures were more severe, management had adopted custodial-centered care culture and little job quality remained. In these homes staff were prevented from developing workarounds and a tipping point was reached – leading to a spillover from the poor quality of jobs to impoverished care.

Worries about the quality of residential elder care are a global concern (OCED 2013). As the numbers of residents in nursing homes¹ has expanded dramatically in recent decades - and will double in the next 40 years (European Commission 2008) - a key challenge is the provision of affordable, high quality residential care. The financial crisis of 2008 led to greater concerns about the quality of care because of declines in public funding.

Research on the nursing home industry has focused on two dominant themes: The poor quality of care that many residents receive and the poor quality of jobs of care workers. These are often viewed as distinct problems and investigated separately by scholars (Eaton 2000). Considered separately, job and care quality can gloss over a more complex picture of how they relate particularly at times of declines in public funding. We use data collected in the wake of the financial crisis from 12 UK nursing homes in 2009-2012 to investigate whether job and care quality are linked in a systematic way. We analyze how on-going and accelerated cost pressures differentially affect the quality of jobs and care in nursing homes with different cultures of care: ‘person-centered’ and ‘custodial-centered’. We investigate the types of cost saving measures introduced and the impact on the job quality of care workers. We show that reductions in labor costs were common across all of the homes in the study - including pay, benefits, and staffing levels - as well as changes in shift patterns and staffing mix. Yet the effect on care quality varied across homes. In seeking to account for this variation, we examined how and under what circumstances the culture of care provided the necessary support for care workers’ to protect residents from adverse effects of cost cutting and under what circumstances they did not – leading to a ‘spillover’ from the poor quality of jobs to impoverished care. For each outcome - maintained care quality and spillover into poor care - we first examined the changes in job quality at each nursing home, mapping ownership type to culture of care and the changes introduced into care workers’ jobs. Second we examined patterns in the ways in which deterioration in the quality of the job affected workers ability to provide good care. We contribute to the literature by showing the relationship between the quality of jobs and the quality of care and demonstrating that the two cannot be understood separately, as much of the prior literature has done.

Connecting Job Quality and Care Quality

¹ In keeping with international terminology, in this paper we use the term ‘nursing home’ when referring to long-term residential care of the elderly, instead of the term ‘care home’ more commonly used in the UK.

There is an increasing attention to the concept of job quality in the literature because on the one hand, there is strong evidence to show a ‘good job’ is better for health, life expectancy and life chances than a ‘bad job’ (e.g. Coats and Lehki 2008) and on the other, significant shifts in how work is organized continue to raise concerns for employment and the erosion of job quality (Osterman 2013). The effect of the financial crisis in 2008, for instance, has increased competition between organizations and the need to address budget deficits leading management to demand more of people at work, as they look to their staff to do more with less (e.g. Overell, Mills, Rovers, Lekhi et al 2010).

Job quality is defined as a ‘set of features that help to meet jobholders’ needs from work’ (Green, Mostafa, Parent-Thirion, Vermeylen et al. 2013:754). It encapsulates material and intrinsic benefits for workers (Iskander and Lowe 2013) - compensation, the degree of work intensification, the employment contract, task diversity and the level of autonomy (Findlay, Kalleberg and Warhust 2013; Holman 2013; Osterman 2013). Care work jobs are typically portrayed as ‘bad jobs’ with poor quality, as they are characterized by low-wages, low benefits, involve hard physical work and low levels of autonomy (Appelbaum, Bernhardt and Murnane 2003; Lloyd, Mason and Mayhew 2008). However, job quality across nursing homes varies widely. Some homes offer far better compensation, benefits, training and opportunities for advancement than others (Hunter 2000). As labor is the largest cost component in services such as nursing homes, it is a major target for cuts at times of on-going and accelerated cost pressures. Cuts in labor costs leads to lower job quality including lower pay and conditions and lower resources, discretion and opportunities at work. The focus of most of the literature is on workers which is important but does not link job quality to organizational outcomes such as the quality of care.

Research into care quality tends to look at care in isolation of job quality. There is an increasing emphasis on examining the influence of nursing home culture on care quality outcomes. Two alternative approaches to conceptualize care culture are found in the literature: person-centered and custodial-centered. Person centered care is guided by the individual needs and preferences of residents (Avgar, Givan and Liu 2011) which assumes residents will be active participants in shaping how their care is managed. In custodial-centered care the focus is on providing a safe physical environment and meeting the immediate physical needs of residents. Custodial-centered care assumes residents not to be capable of determining how their care is managed. Instead residents tend to be viewed as

passive recipients of routine assistance (Culley and Courtney 1993). Nursing homes providing custodial-centered care are more likely to be viewed as in need of a culture change in favor of person-centered care philosophy and practices (Zimmerman, Shier, and Saliba 2014).

Person-centered care (PCC) typically includes enough flexibility in the system of care to meet the complex, changing, and distinct individual needs of residents (see, for example, Institute of Medicine 2001; Edvardsson, Winblad, and Sandman 2008; Banaszak-Holl. Castle, Lin, and Spreitzer 2013). Such care quality is difficult to define but the concept of person-centered care typically includes the following characteristics: it is tailored to meet individual needs; takes place in suitable premises with equipment which is clean and in working order; provides persons with enough food and drink; affords persons dignity and respect, gains person's consent before treatment is given; ensures person safety and protects persons from abuse; and supports the discretion for persons to complain about their care (Care Quality Commission 2014a). Nursing homes adopting person-centered care are identified as more likely to provide residents with opportunities to exercise choice and control over their care (Eaton 2000). What is missing in studies of care quality is how job quality constrains or supports the ability of staff to provide person-centered care (Zimmerman et al. 2014).

Scholars also link financial resources available for a nursing home to its capacity to meet resident needs and preferences (Lucas, Lowe, Robertson, Akincigil et al. 2007) and difficulties in providing appropriately trained and consistent staff, individualized services and high quality care (Castle 2002). Koren (2010) demonstrated, for example, how workforce regulation and lower than expected reimbursement of fees limited the potential of initiatives to improve the care given to residents. Scholars tend to assume that for-profit nursing homes offer a lower standard of care because their managerial objective to provide returns to investors results in a stronger incentive to minimize expenditure than in nonprofit facilities. Research tends to assume that a business model of extracting revenue from a nursing home to distribute profits to shareholders influences the organizational priorities and spending decisions away from care, sacrificing quality and resident safety in the interests of maintaining efficiency (Pear 2008). A systematic review and meta-analysis of observational studies and randomized controlled trails investigating the quality of care in for-profit versus nonprofit nursing homes found more, or higher quality staffing, in nonprofit homes (which on

average offered 0.42 more staff hours per resident each day compared to for-profit homes) (Hillmer, Wodchis, Gill, Anderson et al. 2005). However, single studies (prior to pooling the findings) showed little difference in actual care quality outcomes (measured through numbers of deficiency ratings). Poor care and quality of care deficiencies occur in nonprofit nursing homes as well. The simple association between ownership and associated business model does not provide sufficient information about the nature of the relationship between the level of resources available to a nursing home and care quality. What is missing in these studies is the connection between care outcomes and how the front-line care work is organized.

Our research brings together job quality and care quality to examine how they relate. Labor scholars have researched the link between the organization of care work and care quality (Eaton 2000; Avgar et al. 2011; Grabowski, Stevenson and Cornell 2012; Lin 2014) with systems of staff recruitment and selection and training identified as key factors in shaping how care is provided (Hunter 2000; Castle and Enberg 2007; Yallowitz and Hofland 2008; Hyer, Thomas, Branch, Harman et al. 2011; CQC 2014a). With a small number of exceptions, the relationships between job quality and care quality – and in particular the conditions under which job quality affect care provision - are less well documented. Eaton (2000) identified the mechanism that lead from a particular work process design to specific quality outcomes for residents, highlighting that management philosophies of care in operation within the home are a factor affecting care quality. Cost saving measures such as decreasing staffing levels intensify workloads and affect staff capacity to provide quality care (Currie, Farsi and Macleod 2005). Eaton (2000) recommended, what she named ‘bundled HR practices’ (e.g. job security, team working), combined with innovative person-centered cultures of care, as being a combination likely to yield the better care outcomes. She also cautioned that strong institutional forces resulting in low-wage, low-skill work systems are often directed against this combination. The bundle approach indicates the cumulative impact of overlapping factors, but does not identify which dimensions of job quality may be crucial and in which context; and whether retaining particular components of job quality may compensate for the loss of others. Through our examination of the erosion to job quality in nursing homes with person-centered and custodial-centered cultures of care - we map the relationship between care culture and job quality to identify how and why these matter for care quality.

Research Design

We undertook qualitative field research in order to develop a theoretical understanding of why care quality varied across nursing homes. We wanted to understand the mechanisms linking financial pressures from the external environment to the quality of jobs and the quality of care. From 2009-2012, we conducted fieldwork at 12 UK nursing homes providing long-term care for elderly people².

Nursing homes in the UK are registered to provide residential care, nursing care or a mix of the two. The 12 nursing homes varied according to level of care (8 residential, 4 nursing), size (from 10-65 bed facilities), region, and ownership (for-profit and non-profit care homes and chains) (Table 1)³. None of these nursing homes had union contracts and individual employee union membership was extremely low. In the UK care sector, privatization and fragmentation of employment (because of large numbers of workplaces which are geographically dispersed, employing small numbers of people who work shifts) has posed increasing problems for trade union organizing and membership over recent decades has diminished (Hardy, Eldring and Schulten 2012).

[insert table 1 about here]

The context for this study was the post-financial crisis period when the UK government made major cuts in payments to nursing homes. From 2010 £1.17 billion was cut from grants paid from Government to Local Authorities (LAs) (Department for Communities and Local Government 2011). Approximately 49 per cent of beds in nursing homes are publically funded through LAs (Laing and Buisson 2014). Consequently, the Local Authorities reduced their funding of nursing homes by 5 per cent in real terms to a rate below the cost of providing care. This had a destabilizing effect on the UK nursing home market, leading many providers to seek ways to rapidly reduce labor costs to remain viable (Laing and Buisson 2014). By 2014, 20—22 per cent of nursing homes in England had insufficient staff on duty and care quality was falling (Care Quality Commission 2014b). This can be viewed as an exogenous financial shock that all nursing homes faced, providing us with the opportunity to observe variation in organizational response.

²Ethical approval was gained from the National Research Ethics Service 09/H0306/63 Cambridgeshire 3 Research Ethics Committee; Social Care Research Ethics Committee 11/IEC08/0011 and Scotland A Research Ethics Committee 11/AL/0325)

³ All names of homes and people are pseudonyms.

Our field research included repeated site visits to each home, interviews, observation of daily activities. The visits to each home took place over four to six weeks. We completed 429 hours of observation of everyday activities, experiences and practices during day and night shifts, on weekdays and at weekends. We conducted a total of 175 interviews: 110 with managers, registered nurses and care assistants, 38 with residents and 27 with relatives (Table 1). The interviews typically lasted between 30-60 minutes. Those with managers, registered nurses and care assistants asked about the nursing home's approach to the provision of care, employees' ability to carry out their work, and issues concerning the quality of care. Interviews with residents and relatives explored their experiences in the home and the quality of care. Secondary data, such as reports of annual resident surveys and copies of the national regulator's annual inspection reports of care quality, were also analyzed. Our case studies focused on establishing an understanding of the relationship between the organizational culture of care, job quality and care quality.

To develop a theoretical understanding of the factors driving variation in care quality and the relationship between job and care quality we drew on Eisenhardt and Graebnor's method of 'systematic recursive cycling' (2007). We examined data from each nursing home to identify patterns in job and care quality, followed by comparative analysis across case data sets to generate theory about the conditions in which job quality affects care quality.

Findings

In our findings below, we show that all 12 nursing homes faced on-going and increasing financial pressures during the time of our study, due to real term reductions in LA fee payments, higher operating costs (rental payment, food, fuel, rise in minimum wage rates), and reductions in income due to falling occupancy rates. In response, all 12 nursing homes, introduced broadly similar cost saving measures (without involving union negotiation) including lower pay, benefits, training provision, and staffing levels and changes in individual employment contracts and the mix of skills used. The majority of changes in employee contracts were made to increase the number of working hours (e.g. changing 8-hour shift to 12-hour shift patterns and/or increasing the number of hours staff were contracted to work from fewer than 35, to 40 hours or more per week). Changes in the mix of skills used included halving the number of registered nurses (RNs) on duty during day shift

and replacing the withdrawn RN job with a senior care assistant job. Nonetheless, care quality varied. Tables 2 and 3 summarize the relationship between job quality and care quality across the full 12 case sample. We argue that cost saving measures negatively affected staff in each nursing home as their job quality deteriorated, but in seven homes, care quality was maintained and in five homes it deteriorated. These effects were consistent with two contrasting patterns. Homes that were able to maintain quality care adopted an organizational culture that was person-centered, allowing workers the support they needed to maintain quality despite erosion in the quality of their jobs. By contrast homes where care quality deteriorated adopted an organizational culture that was custodial-centered, consequently providing little support to workers to maintain quality during erosion in the quality of their jobs.

Maintaining Care Quality during Cutbacks

All the 7 homes where care quality was maintained had adopted a person-centered culture. One of these homes was for-profit and 6 were nonprofit (only required to break-even rather than to make a profit). The nonprofit homes could draw down additional funding if financial short-falls were predicted (e.g. through voluntary donations from the owning charity or additional public funds if owned by a Local Authority), but the for-profit home did not have this option. That this for-profit home was able to maintain care while increasing efficiency savings suggests that for-profit status alone is not an adequate explanation for poor care quality. In homes where care indicators (derived from regulator reports, interviews and observations) confirm care quality was maintained, the introduction of cost saving measures were found to be affecting RNs and CAs, but staff responses to the changes protected residents from the immediate effects of cutbacks. Table 2 details the 7 homes where care was maintained, the financial pressures they faced, the components of job quality affected, RN's and CA's responses to these changes and outcomes for residents' care in these homes.

[Insert Table 2. about here]

Cost saving measures affected the employment contracts of RNs and CAs through reduced levels of compensation, intensified staff workloads (as staffing levels and/or skills mix were reduced) and cheaper staff training (a shift from in-work class-room based to e-learning). In these homes, staff sought to protect residents from the effects of eroded job quality. Staff reorganized work practices and routines, for example, by swapping shifts to cover for

coworkers who were unable to work due to short term illness or who needed short time periods away from work to look after their children. They switched job roles (e.g. activities workers would switch to a CA role and a receptionist would switch to provide residents with activities). They also worked through meal breaks, continued to work after contracted hours ended (a frequent occurrence), and arranged ways to share information (e.g. outside of staff handover). Staff handover is a meeting that occurs between two shifts of nurses and care assistants where personal information about residents is transferred from staff about to end their shift to the oncoming group of staff. In these workarounds care workers absorbed the effects of erosion in job quality and protected residents from adverse effects.

These nursing homes had several things in common. Person-centered values were evident in the culture of the homes, and their business models tended to direct funds inward towards supporting the delivery of person-centered care. PCC culture asserts the human value of residents, their individuality, and their unique personality and life experiences. They place importance on the perspectives and preferences of the persons and their relationships and interactions with others (Brooker 2004; Killett, Burns, Kelly, Brooker et al. 2014). While workers in these homes experienced drops in compensation and/or increased workloads, other dimensions of job quality less related to labor costs were maintained such as the ability of staff to voice their concerns, work flexibly and have some control over how they carried out their jobs. Mayfield House is illustrative of this pattern both in terms of the erosion in job quality and staff responses.

In common with most UK nursing homes, Mayfield House faced on-going and increasing financial pressures. This for-profit chain introduced cost saving measures in 2009-2010. They reduced staffing mix (replacing one RG post with a senior care assistant role) and made changes to individual employment contracts (removing sick pay and paid meal breaks) which reduced employee pay. For instance, previously wages included payment for breaks to compensate as breaks were frequently shortened or not taken to meet demand;

They have changed a lot of things *from when I started until now, there's a* difference. They used to pay for staff break times. A lot of companies are still paying for staff breaks. So that has meant salaries went down. Lots of things here are coming down, falling away. (Robin, RN)

Cuts in staffing and higher staff turnover intensified workloads for those who remained.

Increases to staff turnover in 2010 (possibly in response to contractual changes to paid breaks and sick pay) reduced the pool of care workers available to work shifts. Consequently, staff worked longer shifts, and more shifts at short notice, or without notice;

The work is hard. I am knackered. Sometimes, I go home, I have a shower, I'm in bed, and that's my day. I get up again at 6 a.m. come back to work, go home, have a shower, go to bed. I do four shifts a week, 44 hours a week. But last week I did six days on the trot. Somebody was messing about with the rotations again, didn't tell me what they'd done, and just left it to me to do them. Six days on the trot. I was not amused. I've been known to go home from here at 8 o'clock, one of the night shift haven't turned in and they've rang me at 9 o'clock to come in and do a night shift as well. I didn't do it, did I hell. I said "No way". (Jane, CA)

Regardless of the direct effects that changes to pay and the intensification of workloads had for staff, the prospect of letting the changes to job quality 'overlap into care' was unacceptable;

But thankfully, in this setting it doesn't affect our care towards our residents, you know. Because the minute it starts doing that you might as well walk out of your job because it isn't their fault that "management" shall we say, think it's alright to treat their staff in this way and not respect or recognize what you're doing. But the minute you start letting anything bother you, overlap into how you care, forget it, walk out the door, turn around and leave it because it's not their fault. (Maureen, CA)

The high value staff place on shielding residents from the impacts of cost saving is evident in the actions taken to protect residents from the effects of job quality erosion. Informal arrangements were made to swap shifts with coworkers enabling staff to use their day off to recover from illness – a practice one CA identified as a person-centered way of treating each other;

We treat each other in a PCC way too. Someone is allowed to have set days off because they look after their grandkids on a Monday and Tuesday. We swap round shifts because someone's kid is in a football match and your kid wants you there to watch them. If you are ill at the beginning of the week, someone will

swap their shifts with you to later in the week, if it doesn't upset the unit. (Angela, CA)

As a result of these arrangements, on-duty staffing levels were unaffected (as absences were prevented) and staff did not lose any pay. An informal system to manage unexpected domestic emergencies enabled staff to leave the nursing home for short period of time to attend to the needs of their children. Immediate temporary back fill to care was provided by office based staff (receptionist, nursing home manager, house-keeping) switching job roles. The response ensured the numbers of staff available to provide direct care to residents was unaffected, while also allowing in-job flexibility for staff to manage home-work demands.

Although the removal of pay for meal breaks affected pay levels, staff continued to work through formal break times to ensure residents' needs were met as Jo a care assistant points out; *'they stopped paying us for breaks, we don't get paid for lunch yet we work through our breaks all the time'*. Informal arrangements were also made for staff to stop working and leave the nursing home for short periods of respite;

I formally have half an hour break. It's up to me when I want to do it. But like today, I've had only 10 minutes because it's so busy. There's always something. But then I might need to take a breather away from care. I'll just turn round and say "oh I need to go out". And that's a good thing as well, if any one of us feels that feeling of being overwhelmed, we'll just say "oh can you just step in a minute, I just need a few minutes." Everybody says "yeah, go on, get out". (Julie, CA)

Although changes to employment contracts and staffing levels directly affected pay and intensified workloads, staff were able to retain some control over how they care for residents. Staff continued to be paid to come into work 15 minutes early for staff handover. Moreover, the particular approach used by management in structuring the handover, enabled CAs to participate in discussions about the care needs of residents and their care planning;

Staff come in for 15 minutes before shift for a handover, and this is paid time. We go through every single resident, and there are 5, 6, 7 members of staff at the handover, all throwing ideas around on how to do things for each of the residents... A resident on pain relieving medication was very unsettled, walking around a lot, which in turn seemed to be contributing to more pain. The doctor

had advised that the pain relieving medication could cause physical agitation, so I took this to the handover and the team discussed it, deciding to reduce the medication to see if this would reduce the unsettled behavior. (Mayfield Manager)

Listening to others, informing, discussing and taking action were common practices undertaken throughout the home. An independent inspection of the services at this home in 2010 rated the quality of care as 'Excellent' on a rating scale that went from 'Poor to Excellent;

'...Staff and residents/relatives would be confident that their concerns would be listened to and acted upon. Staff know their responsibilities in passing on any concerns which affect the safety and vulnerability of people. It was evident that the manager takes positive action to improve the quality of life of people who live at the home, often as a result of listening to what people who use the service have to say'. (Extract from National Regulator's Inspection Report, 2010).

In addition, family members remarked on the highly individualized and tailored care residents received in the home;

One thing that I like, and I've been involved with on two occasions is using the hoist. So that's involved four care assistants and on both occasions they were informing Arthur all the time what they were doing and how it would feel, and constantly reassuring him that he was safe. Instead of just saying "right that's it, you're on" which is very important...Just the ambience and the sense of care, and the friendship, and you never get a sense from anybody at all that they're only doing a job. I mean Patrick, he's a senior cleaner. He knows all the residents by name, he talks to them, knows their interests. He doesn't have to do that he could just come in and do that cleaning job. He doesn't, and none of the staff do.

(Pauline, resident's wife)

I think the care is excellent. They're kept clean, they're changed regularly, they are very well fed. They give them a good quality of life as best as possible. My husband loves a bath and they bath him regularly because they said he enjoys it so much. I don't think he could get any better to be honest. (Michele, resident's wife)

Notwithstanding the effects of cutbacks on employment contracts, compensation and workload, staff were creative in their search for workarounds and they utilized remaining job quality to protect residents and helped stabilize service provision during a difficult period.

The pattern of staff using their creativity to overcome bad job quality and prevent spillover to residents care was evident in all 7 nursing homes. Staff in each of these nursing homes collaborated to absorb the effects of job erosion and limited spillover into care through the use of various strategies. For example, to ensure that feeding and nutrition needs were met during periods of reduced staffing, CAs at Iris House arranged for residents not to go to the designated dining room because it was deemed as potentially unsafe to take them. Instead they gave residents an individually prepared tray of foods in their private room or in one of the lounge areas, a practice staff referred to as 'residents' lap tea'. At Sunflower Place, cutbacks had reduced the availability of food at the hospital where the unit was located, leading to a limited choice and concerns about one resident who was not eating enough food. In response, staff persuaded the doctor overseeing the unit to write a medical note to the catering manager requiring that the resident be provided with food he liked, in this case, sausages. In another instance, CAs at Poppy Fields were no longer allowed to attend staff handover. They realized that their knowledge about the individual needs of residents was not reaching decision-makers. In response they employed a strategy of huddling together to share information and to discuss which parts of the workload each would do. At Lily Park, when staffing levels were unexpectedly low, CAs worked through official meal breaks and switched job roles. People contracted to provide residents with activities switched into the care assistant role. In these homes, enough job quality was retained to enable staff to arrange workarounds and protect residents. In contrast to the patterns found in these homes, in other nursing homes, the effects of cutbacks spilled over into care.

Falling Care Quality during Cutbacks

The deterioration in job quality erosion spilled over into poorer care in 5 nursing homes that we studied (3 for-profit and 2 non-profit). These homes experienced greater exposure to the effects of national budget cuts in local government (that is, a fall in real income), and they operated without the benefit of additional income streams. Although similar components of job quality were affected in these 5 homes, staff did not maintain the prior level of care;

rather they made adjustments that undermined the quality of care with detrimental effects for residents. For example, care practices shifted towards meeting only the physical needs of residents, becoming increasingly custodial-centered or omitting care altogether. In each case, care workers responded to poor working conditions and staffing levels by cutting back on care. Table 3 details the 5 nursing homes where care quality fell, the financial pressures they faced, the components of job quality affected, RN's and CA's responses to these changes and outcomes on care for residents in these homes.

[Insert Table 3. about here]

The homes where care quality fell had several things in common. A culture of custodial-centered care was evident in these homes; management prioritized financial cut backs over individualized care. A lack of spend on maintenance and other facilities was visible; broken equipment (wheel chairs and hoists), windows and doors that either would not open or shut, and frayed and dirty carpeting. At these homes staff tended to approach care work as a series of pre-designed tasks to be completed. We argue the combination of job quality erosion, a custodial-centered culture of care, and lack of spend on essential maintenance and up-keep impeded the ability of staff to provide quality care. In these homes where financial cutbacks had severely eroded job quality, care workers were less able to voice their concerns or to arrange ways of working around the cutbacks. Instead cutbacks spilled over into poor care as staff reduced how much time they spent with each resident and the amount of care they provided. Hazel Tree Court is illustrative of this pattern both in terms of the erosion in job quality, how staff responded to these changes and effects on residents.

Hazel Tree Court faced prolonged and intense financial pressures following freezing to funding from the Local Authority and the introduction of rental costs. The home had been sold to a private equity fund in 2004, after which the assets of the company were sold and re-leased back. An equity fund has a mandate requiring the portfolio manager to invest the shareholders' cash in ownership of businesses, such as common stocks of publicly traded companies and routinely will do sale-lease back (Appelbaum and Batt 2014). In 2007 Hazel Tree Court was required to also pay property rent from the nursing home's income. By 2009 the company reported spending the profits from sale-lease back deals on expanding the business (rather than being ploughed back into the nursing homes) and that the companies owning the premises were increasing rental costs to levels nursing homes were finding

financially unsustainable. At the time of the research in 2010, the freeze in the level of income from the Local Authority further intensified the financial pressures facing Hazel Tree Court and management introduced cutbacks to catering, maintenance and staffing budgets. The numbers of staff available per residents fell from a ratio of 8:30 (2 RN, 6 CA) in 2008, to a one of 4:30 (1 RN and 3 CA) in 2010. Researchers' observations confirmed that staffing levels frequently fell below the official ratio of the home to 3:30 (1 RN and 2 CA), consequently, staff regularly 'worked short staffed',

We've worked short staffed, on many occasions. We've got through it but it's been very hard. When it's been snowing and staff can't get into work, I've stayed overnight to help and then done a day shift on top. Well we've got to because there's nobody to work. I could have just gone if I wanted but I didn't. When the home has been short I can do 5, 6, 7 twelve-hour shifts at a time. (Janice, CA)

Further cutbacks froze pay, and managers faced pressure not to exceed their staffing budget by using agency workers to cover shortages;

This year we got the notice that nobody was getting a pay rise. Yesterday we had to have an agency care assistant *because I've got two people off sick. The company never directly say no to get an agency worker in. But then you get shouted at, you are asked why you are over your budget by this much? Why have you had to have this and what are you doing about it? (Hazel Tree Court Manager)*

The severity of cutbacks to staffing levels and skills mix (2 RGNs replaced with 2 senior CAs) affected the way in which RNs and CAs carried out their jobs. As a consequence of halving the number of RNs, the RN role intensified to include the responsibilities and duties nominally undertaken by 2 RNs, with detrimental consequences for the supervision of care workers and the safety of residents:

Before with the other company there would be one nurse who would do the *medication and the doctor's appointments; and the other nurse would work with the CAs. They would look after the CAs and oversee what they are doing. During that time there was fewer mistakes with the drugs. Now the nurses make mistakes with the drugs. We wear a red apron that says do not disturb. But people do. (Andrew, RN)*

RNs attempted to manage the effects of the cutbacks, particularly the reductions in available time to supervise care assistants, by organizing the staff rotations to make sure there were experienced care workers on each shift. However, this was not always possible, leaving ‘a weak team’ who could not care properly for residents;

As a trained nurse I supervise the CAs, I want a skill mix on a shift but it is not always possible to plan for this in the staff rotation. *Sometimes, I've got a weak team and I have to keep an eye on them and check their care. If there is a weak team you've got to be alert. I wouldn't say abused, but I would say it is easy for them to miss out on care.* (Rachael, RN)

In common with all the nursing homes, measures were introduced to withdraw paid time for meal breaks, even though staff did not take any formal breaks;

The other company that owned the home had to pay us for our break times and for handover report time. This company took that away. I have a contract from the old company on-going here. *They don't pay me the handover time but they have kept my pay for breaks. I can't take my breaks anyway. I sit and eat here in the office, while I work.* (Andrew, RN)

While RNs had an option to eat food at their desk if they were unable to take a meal break, CAs' breaks were structured throughout the 12 hour shift and could be taken as two 15 minute or one 30 minute break period. If they got to have a break, getting to the staff room, preparing food, eating and drinking and returning to the floor where they worked within the designated 15 minutes was difficult to achieve;

Sometimes you don't get a break at all and that is the truth. Even if you do take a break, you're back up on your feet within minutes. You're allowed half an hour during the 12 hour shift. Or you can take up to 15 minutes in the morning and 15 minutes in the afternoon. By the time you've got to the staff room and you've rushed your food down, you're rushing back on the floor and running about. This is why I always have a drink up here. We are not supposed to but I do because it's very hard work and it's hot in the home, you need to drink all the time. But they said you're not supposed to sit with the residents and have a drink. I don't see there's any harm in that because it also helps the residents to drink fluids too if you're sat with them talking to them. (Claire, CA)

The cutbacks to staffing levels, skills mix in combinations with custodial-centered care approaches such as structuring when care staff take their formal break and disallows informal breaks, limited the potential for staff to develop workarounds. Rather front-line care was organized to meet management rather than residents' needs and preferences. In this context, a custodial-centered care culture focusing on meeting only basic physical needs inhibited the workers' autonomy to decide (with residents) how individual care might be provided.

The withdrawal of paid time for staff handover also had the effect of reducing autonomy in CAs jobs. RNs' continued to start work and remain on duty for 15 minutes before and after their shift (now unpaid). CAs were now absent from staff handovers. Instead, RNs passed essential information about the care needs of residents individually to CAs while they were working on the floor. This information was limited to 'major' items;

Handovers used to be quite brief and general but I think if there's something major like a person's not been well and you need to check on this person then its told to you. But the staffing level is wrong for residents because if you can't see to them quickly it can cause incontinence. Sometimes you can't get back to them because you have to deal with somebody else and other staff are dealing with somebody too. Dealing with that it's horrible. The residents need to be looked after properly. You are having to turn residents every two hours but when you're turning them they also need changing, you can't just turn them and get away with it, they need more of your time. (Janice, CA)

Communicating residents' care needs in this way did not sufficiently enable CAs to provide sufficient care. CAs acknowledged that residents did not receive the care they needed and in response they tried to work faster when they could. This did not work but neither did the alternative; meeting the essential needs of one resident at a time, leaving other residents in need. A double bind resulted, which CAs found distressing.

Cutbacks had eroded job quality until little flexibility remained and the effects were felt by residents and spilled over into impoverished care in the following ways: Cutbacks in the catering budget depleted the quantity, timing and availability of food,

The lunch is good and it's well cooked and plated. But then the teatime meal is at 4 o'clock in the afternoon. It's the last food you have until next morning and all

you have are sandwiches. How many sandwiches would you need to satisfy the hunger pangs when you go without food between half past four one afternoon and half past eight the next morning; its soul destroying. (Barbara, resident)

Understaffing affected interaction between staff and residents,

It's recorded that sometimes they're so understaffed they haven't time to communicate with you, that's one of the main things I have against the home they're very understaffed. My Aunt, she's paying the whole of the fee herself. So it's a lot of money every week for quite a small service. (Annette, relative).

And affected the quality of personal care,

I didn't feel right, she [the CA] didn't get me washed properly and I felt dirty, you know, its loss of dignity, love. (Lilly, resident).

Basic care routines were hurried and impoverished. A shift in the management of front-line care work towards the en masse treatment of residents (set times for meals, getting up and going to bed, toileting and entertainment) highlighted the lack of control residents had over their schedule. Staff moved residents into the dining room as soon as they were up, washed and dressed. As a result residents were seated up to 90 minutes before breakfast was served. In the evenings CAs pressed residents to get into bed at times that suited the workload of staff;

They expect you to go to bed early and stay asleep all through the night. The night shift starts at half past seven. When it gets to half past eight, the CAs they've been in to my room about ten times to ask "are you ready to go to bed? I say "no", they say "why not?" It's because I don't feel ready to go to bed. End of story. (Annie, resident)

In the case of Hazel Tree Court, the negative effect of financial cutbacks on the quality of jobs was much more severe than in other homes, allowing staff few resources or opportunities to do workarounds and little motivation as well. The company cut back to minimum statutory levels of pay (workers' weekly take home pay reduced when pay for breaks stopped), break entitlement of 30 minutes in a 12 hour period (under Working Regulations 1988, the minimum a worker is entitled to is an uninterrupted break of 20 minutes when daily working time is more than six hours), and staffing numbers reduced to

levels deemed unsafe by national regulators. Work intensified and staff had little ability to effect change and little autonomy in decision-making about how to care for residents. Rather, a view shared among staff was that poor care was unavoidable.

In addition the use of rules preventing staff from adapting care to meet residents' needs (e.g. staff were forbidden from taking a drink with residents even though to do so would encourage residents to increase their fluid intake) are illustrative of reducing worker autonomy with disempowering effects for both staff and residents. Residents had to 'fit in with' extant care routines; to sit in the dining room 90 minutes before meals were served (to reduce time taken in handling and moving residents), to go to bed when it suited staff (so staff could complete a long list of domestic tasks during the night), and not to complain if they were not washed properly or were hungry. Nursing home staff blamed the residents and relatives for expecting too much;

I was talking to three CAs as they stood together in the corridor this afternoon. They were waiting for a resident who would need their assistance. We talked about the difficult aspects of their job. One CA (who has worked here for over 8 years) said *'the hardest thing can be the relatives'. 'They come in and pick holes in what you have done for the resident, their expectations are too high'*. (Field note observation)

At one point we informed a manager about poor care practices. Rather than dealing with the problem, the resident was blamed for expecting 'hotel' care;

I went into the office to let the manager know I had arrived. She brought the subject around to the resident I had spoken to her about in confidence. When I reported the poor care to the manager yesterday she said she was going to talk to the resident involved and not in a way that would make the resident feel *uncomfortable. She said she would do one of her 'walk rounds' where she speaks to each resident and asks how they are and if there are any things she should know about. But today the manager said that "Mrs Beecham expects too much, we can't cater for the wants of every individual, we can't provide special treatment"*. The administrator joined in saying *"she can't have hotel level care"*. (Field note observation)

Complaints about poor care were translated to mean that residents had unrealistic expectations of the care they might receive;

I have made efforts to remind CAs they are here for the resident, you know, I remind them of what they are supposed to do and that they just have to do it. Some care staff I have spoken to, have gone to the manager and complained about what I have said to them. What I get back from the manager is “*ah you’re getting like them [the residents and relatives who complain]*”. (Rachel, RN).

The erosion of job quality left scant resources and few opportunities for staff to shape their jobs. CAs were aware of the double bind they faced in attempting to meet needs, but were unable to effect change. The effects for residents were poor standards of care and when residents or relatives voiced their concerns, strategies to redefine the problem were deployed. By redefining complaints as a mismatch in expectations, poor care was tolerated and care standards left to decline. In effect the relation between job and care quality had reached a tipping point at which spiraling declines in care occurred.

Due to declines in job quality, depletion of resources, and the custodial-centered culture of care staff were left little opportunity to develop workarounds. Rather care practices were channeled towards the en masse, hurried treatment of residents that did nothing to improve care. Rather, than a PCC value to enshrine standards and approaches, poor care was tolerated by blaming residents for being unrealistic and staff concerns were dismissed. The organization was unconcerned about residents as individuals and staff could not protect them.

This pattern of spillover from depleted job quality into poor care was evident at all 5 nursing homes (Table 3). Although staff initially tried to absorb the effects of cutbacks they were unable to develop workarounds to protect residents. For example in Hyssop Place and Tulip Grange, staff worked unpaid hours to supplement low staffing levels. Similarly staff at Hyssop Place organized fundraising to continue activities for residents when the owners removed this service. However in all 5 homes, staff were unable to prevent falling care quality during cutbacks. In Tulip Grange, for example, care assistants and managers wrestled unsuccessfully, to turn around a decline in care quality (rated as ‘Poor’ by inspectors in 2010) by working additional shifts and unpaid overtime to cover staff vacancies and staff sickness. After three months, however, staff became highly task focused in their approach; they closed areas of the home previously used by residents and put residents in one communal sitting room where they could watch them while also writing up care records. In effect, care became

custodial. Similarly in Chives Court, staff often worked double shifts in an attempt to protect staffing levels and maintain care. However, there were high levels of fatigue among staff, en masse treatment of residents and immobile residents were isolated and unattended for long periods. Where depleted job quality spilled over into care, cutbacks had eroded the very job quality needed for care work and had fundamentally changed the purpose of their jobs towards task completion resulting in impoverished care.

Conclusion

As we demonstrate with these findings, financial cutbacks introduced in all 12 homes had led to cuts in labor costs, eroding job quality – lengthening working hours, reducing staffing, intensifying work - resulting in two differentials for care quality. In nursing homes where care quality was maintained, management had adopted a culture of person-centered care and encouraged workers to do the same. Workers embraced the PCC of care and developed workarounds to protect residents from spillover effects. In these homes enough job quality remained to enable workers to develop shift and/or job role swapping and ensure usual staff-resident ratios remained unchanged. In addition if the staffing level was to fall below the home's operational ratio, management in these homes had the resources available to buy-in additional staff from outside agencies. By forgoing rest breaks at times of demand (despite these becoming unpaid) staff ensured that they could continue to meet demands for care. Communication of resident's personal information about their care continued to be shared between staff in these homes (because attendance at staff handover was supported or because staff developed ways to share information they deemed to be important in providing care with each other).

In homes where care quality deteriorated, financial cutbacks were so severe that workers did not have the time or resources to protect residents or maintain prior levels of care. This was particularly the case in Hazel Tree Court, where cutbacks to labor costs (including resources for managers to buy in staff from outside agencies) reduced staffing levels to below the home's own operating ratio, pared back pay and condition to statutory minimum levels and increased the level of work intensification. In this home the company had also cut-back on care provision, reducing catering and maintenance budgets and staff could not buffer residents from these cutbacks. As a result of cost cutting, front-line care work was

reorganized using pre-determined schedules for meeting the hygiene, nutrition, and toileting needs of residents. A shift towards custodial care had occurred (as was the case in all of the homes where care quality fell). The dearth of resources available and low job quality combined with a culture of custodial-centered care, failed to provide staff with the features of job quality they need to help them determine how to provide care – leading to a spillover into impoverished care.

Our findings go beyond previous research that links care quality to job quality (e.g. Eaton 2000; Yallowitz and Hofland 2008; Avgar et al. 2011) to indicate that the dimensions of job quality that suffer most during times of financial cutbacks are the ones that matter most for care. Spillover effects from the erosion of job quality into poor quality care, resulted in nursing homes where workers were unable to develop workarounds. Loss in job quality can be mitigated by employees' workarounds which are possible only if nursing homes have some resources and a person-centered-culture of care that allows workers more autonomy and flexibility to determine how to provide care.

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Table 1. Case Study Details

Nursing Home	Care Provider Type	No. of Beds	Number of Interviews			Hours of Obs.	Documents & Reports 2008-11
			Residents	Relatives	Managers and staff		
Sunny Rose	Non-nursing residential	25-49	7	3	10	40	Resident Survey; Inspection
Poppy Fields	Non-nursing, residential	25-49	12	4	16	40	Resident Survey; Inspection
Sunflower Place	Nursing, Dementia	≤ 24	None	2	14	35	Standards audit
Lily Park	Non-nursing residential, Dementia	≤ 24	1	1	11	31	Resident Survey; Inspection
Crocus Row	Non-nursing residential	≤ 24	4	1		26	
Iris House	Non-nursing residential	25-49	8	1	9	45	Resident Survey; Inspection;
Hazel Tree Court	Nursing & non-nursing residential	49-69	6	3	12	48	Inspection
Tulip Grange	Non-nursing residential, Dementia	≤ 24	None	5	14	29	Inspection
Mayfield House	Nursing, Dementia	25-49	None	2	10	48	Inspection
Marjoram Place	Non-nursing residential	25-49	None	2	5	32	Inspection
Chives Court	Non-nursing, Dementia	≤ 24	None	None	3	15	Inspection
Hyssop Place	Non-nursing residential, Dementia	49-69	None	3	6	40	Inspection; Standards Audit
Total			38	27	110	429	

Table 2. Nursing Homes that Maintained Care Quality

Ownership & business model	Financial Pressures	Aspects of job quality affected	Staff responses	Care quality indicators 2010
1. Mayfield House For-profit, corporate chain	2009: Hedge Fund takes over & introduces efficiency measures. 2010: LA payments frozen.	Compensation, Staff reductions 2010: Sick pay and paid breaks removed from individual contracts. 2 RNs reduced to 1 RN per shift.	Swapping shifts with coworkers. Working through official breaks. Organizing unofficial respite breaks. Collaborating to carry out duties and responsibilities previously part of RN role.	Staff, residents & relatives describe good individualized care. No concerns raised by inspection system.
2. Sunflower Place Nonprofit, NHS	2010: Reductions to NHS long-term care services.	Compensation, staff reductions, job security 2010: notice of possible closure and job redundancies. Staff levels reduced through attrition.	Staying in post (rather than actively looking for alternative jobs). Creative use of resources e.g. persuade medic to write a medical note to ensure resident's catering preferences are met.	Staff, residents & relatives describe good individualized care. No concerns raised by service audit.
3. Poppy Fields Nonprofit, charity	2010: LA payments frozen.	Employment contracts, task diversity 2011: Employment contracts of varying hours replaced with 30 hour contracts; CAs no longer allowed to attend shift-change meetings regarding residents.	Turnover temporarily increases (5 of 25 staff leave because they cannot work 30 hours). Informally organizing to share information about residents' care.	Staff, residents & relatives describe excellent premises, facilities and equipment; high levels of cleanliness and individualized care. No concerns raised by inspection system.
4. Lily Park Nonprofit, LA	2010: LA payment frozen. Imminent change of organization as LA ceases direct provision of services.	Staff reductions, employment contracts, job security 2010: Staffing levels reduced. LA ceases direct provision of services, leading to threat of job insecurity.	Activity workers switch to providing care. Staff work harder, forgoing breaks.	Relatives describe confidence in the care, close cooperation with CAs. No concerns raised by inspection system.
5. Crocus Row Nonprofit, LA	2010: LA payment frozen.	Staff reductions 2010: Staffing levels reduced.	Forgo breaks and activity workers switch to care.	Residents describe good care and a sense of homeliness. No concerns raised by inspection system.
6. Iris House Non-profit, LA	2010: LA payment frozen.	Staff reductions 2010: 'Relief staff' on guaranteed hours replaced by agency staff. Reduces manager's discretion resulting in deployment of unknown, lesser trained agency staff. Staffing levels reduced. Work responsibilities increase to include medication administration.	Work harder, including working double shifts and off duty days to cover for staff shortages. Reorganize dining to reduce work load, refuse to administer medication without increases to training/pay.	Relatives describe staff 'going out of their way' to support residents. No concerns raised by inspection system.
7. Marjoram Place Non-profit, charity	2010: LA payment frozen. 2011: Successfully registers as dementia specialist provider	Staff reductions; Autonomy 2010 Work responsibilities increase to include care for people with dementia; Reduced worker discretion over timing of breaks	Activity worker takes on CA role to meet residents' demands for care. Staff attempt to maintain informal teams in face of reorganization.	Numerous examples of positive care, in particularly connectedness between CAs and residents; effective key worker system. No concerns raised by inspection system.

Table 3. Nursing Homes with Declines in Care Quality

Ownership, & business model	Financial Pressures	Job quality affected	Staff response	Indicators of care quality 2010
8. Hazel Tree Court For-profit, corporate chain	2004-7: A private equity fund takes over & property is sold & leased back. Rental payments & efficiency measures are introduced. 2010: LA fee is frozen.	Compensation, staff reductions, employment contract, task diversity 2007-8: Sick pay & paid breaks removed. 2 RNs replaced by senior CAs. Paid training replaced by unpaid, mandatory training. 2009: Staffing levels are reduced. 2010: Staff vacation time changed to 1 week at a time. Removal of paid time to attend staff handovers.	2008: Work harder. 2009: Provide custodial-centered care. Fall in training completion. 2010: Reset expectations for a lower standard of care.	Residents' complain of reductions in food, increases in waiting times for help. Staff do not receive important information about resident's care needs. Staff ignoring residents' calls for help. Concerns raised by inspection system for care quality, respect, dignity & safety of residents, staffing, management.
9. Sunny Rose Family owned For-profit	2009 Minimum wage raised and statutory holiday entitlement increases. 2010: LA fee is frozen.	Staff reductions, employee contracts, task diversity, autonomy 2009: Contracts changed weekly working hours to 35. Staffing levels reduced System of lean working , (calibration of minutes needed to meet physical needs of residents) reduces task diversity & autonomy.	2009: Provide custodial-centered care.	Residents in need wait for care; inspection system rated care as 'good' out of a scale from 'poor' to 'excellent' but problem raised with the length of time residents are required to wait for care.
10. Tulip Grange Corporate chain For-profit	2004-7: A private Equity fund takes over & property is sold and leased back. Rental payments & efficiency measures are introduced. 2010: LA fee is frozen.	Staff reductions, employment contracts, task diversity, autonomy 2009: Manager post unfilled 2010: Staffing levels reduced. 2010: Contracts change daily working hours from 8 to 12. 2010: Task diversity and autonomy decrease.	2010: Work harder and increase unpaid overtime. Shut a lounge used by residents. Provide custodial-centered care.	Poor hygiene (odor of urine).Overcrowding of persons into lounge. Residents become agitated & aggressive with each other. Concerns raised by inspection system for quality of care, respect, dignity and safety.
11. Chives Court LA Nonprofit	2010: LA budget reduced and scrutiny increased.	Staff reductions, task diversity, autonomy 2010: Rapid reduction in staffing levels. Freezing recruitment to deputy manager post.	2010: Provide custodial-centered care. Staff work double shifts to cover shortfall. High level of fatigue and staff miss shift change meetings regarding residents.	Immobile residents left isolated and unattended. Lack of individualized care. Concerns are raised by inspection for staffing levels, quality of care planning and safety.
12. Hyssop Place Charity Nonprofit	2009: Ownership transferred to large nonprofit 2010: LA fee is frozen.	Staff reductions, task diversity 2010: Staffing levels reduced. Provision of activities taken out of CA role.	2010: Work harder, provide custodial-centered care. Raise money to purchase transport for residents to attend activities.	Residents do not have daily activities. Slips in standards for cleanliness & hygiene noticed by residents & relatives. Concerns raised by the inspection system for health, safety and welfare.

