

# CENTRING CARE: EXPLAINING REGULATORY TENSIONS IN RESIDENTIAL CARE FOR OLDER PERSONS

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## **Abstract**

Residential care is a highly regulated sector. Regulations are often a product of scandal, and they reflect an understandable desire to safeguard nursing homes' vulnerable populations. However, research on Ontario nursing homes reveals significant tensions between regulations and care. Regulations, and the reporting they require, take valuable time away from care, often fail to account for the relational aspects of care, and disempower residents while empowering paperwork. This article describes and seeks to explain these tensions. We find that the current style of regulating follows the logic of neoliberal auditing. This evidences a top-down approach to accountability, which is reductive in nature and focuses on facilities, care workers, and care processes. It thus misses the structural aspects of care that set the conditions for care—funding, ownership, and staffing levels. We do not argue against regulation nor, necessarily, auditing. Rather, we recognize the importance of distinguishing levels of regulation, and make reference to research suggesting that structural regulations need to be prioritized.

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## **Introduction: The Paradox of Regulation**

Because the regulations are so Byzantine they can't afford to properly implement [them]. So homes aren't being inspected with their comprehensive inspection protocol. The level of detail is coming back to haunt them.

- Key informant discussing Ontario's residential care inspection process

Neoliberal economic theory assumes that market competition ensures quality. But the growing reliance on for-profit organizations to deliver long-term residential care, funded largely out of the public purse, has not led to

increased quality. Media stories about scandals have forced governments to intervene.<sup>1</sup> One response has been to increase the number of detailed regulations for care homes, which has increased the requirements for those care homes to record data about care. This response has contributed to an “audit explosion,” as Power terms it, involving a proliferation of rules, monitoring technologies, and the formation of new offices of oversight.<sup>2</sup> In this paper, we argue that more and more detailed regulations directed towards nursing homes and care processes cannot address the problems created by treating care as a commodity and accountability as counting.

***Regulating the Local*** Ontario has close to 800 long-term care facilities that primarily serve seniors requiring continuing care. Most facilities are large and are owned by for-profit companies, although all receive most of their funding from governments. In 2008, Ontario Ombudsperson André Marin initiated an inquiry into the Province’s oversight of the sector. This was a response to complaints about quality and an inspection system perceived to be excessively detailed and ineffective.<sup>3</sup> A majority of the verified complaints were made against for-profit facilities, and a large body of research demonstrates that for-profit companies provide lower-quality care.<sup>4</sup> Although Marin’s investigation found that the sheer number of standards “overwhelmed” inspectors and led to considerable “inconsistencies,” he did not provide clear recommendations on how to address these issues, nor did he raise the question of ownership.<sup>5</sup> At the same time, the Province of Ontario was overhauling its compliance system, with the stated aim of instituting a more person-centred approach to accountability.<sup>6</sup> While an altered inspection process was part of the plan, the new system did not adequately address the complexity of regulations. As a consequence, inspections are behind schedule, with no firm evidence that quality has improved.<sup>7</sup>

“Byzantine” regulations, as the informant quoted above calls them, are not limited to Ontario’s nursing homes. The US nursing home sector is routinely compared to the nuclear industry in terms of its sheer number of regulations.<sup>8</sup> It is not a coincidence that the majority of publicly funded residential care services in both Ontario and the United States are provided by for-profit operators. Although neoliberalism’s promarket strategies have

been associated with deregulation (particularly of the financial sector), neoliberalism is associated with increasing regulation and monitoring in the health and social care sectors. The regulations that have developed, often in response to scandals, are typically directed at the facility level. They evidence a top-down understanding of accountability that seeks to count and document care tasks in order to ensure their provision. We term this approach to accountability “neoliberal auditing.” Neoliberal auditing focuses on care processes and workers, and, as a result, policies that establish the structural conditions for care—such as ownership, staffing, and funding—are not addressed. Indeed, neoliberal policies in these areas make it harder to provide quality care. Such an approach to regulation has been understood as a form of “symbolic politics,” in the words of Tarman, seeking to appease a concerned public but failing to improve the conditions for care significantly.<sup>9</sup> However, this politics is more than symbolic because it has very real consequences for workers, their workloads, and their relations with both residents and colleagues.

In our analysis of the tensions between nursing home regulation and the work of care, we employ a feminist political economy approach that draws attention to structure, race, and gender. We aim to take seriously the advice of a care aide who, in response to our survey, told us that while she didn’t know how to fix it all, “treating people as human beings, be they coworkers, patients, or residents, would be a good start.” Simple advice, but a challenge to follow when the dominant trend is to treat care as a commodity, workers as objects of control, and quality as something that flows naturally from market competition. Neoliberal auditing and its strategies to measure, monitor, and manage care fit well within this paradigm, but they do not fit as well with an approach that aims to do justice to the often messy, unpredictable, and relational nature of care, nor with the understanding of care as a public good.<sup>10</sup> Drawing on feminist care theory, we use our interviews, observations, and surveys with care workers in Canada to explore the tensions between neoliberal auditing and the requirements of relational care. We aim to provide at least a partial explanation of the regulatory paradox in which increasingly detailed regulation and oversight do not achieve commensurate increases in quality.

Furthermore, we seek to contribute to debates about the quality of care provided in nursing homes by drawing attention to the importance of addressing multiple levels of regulation and, in particular, addressing structural regulations, such as funding, ownership, and staffing. Structural regulations set the context for care and help determine whether care workers have the time, training, and resources to tailor care to meet their residents' complex and changing needs. By ensuring that these regulations support the conditions for relational care, we conclude that regulations can help to foster homes where residents and workers are treated with dignity and respect. We do not argue against regulating the sector, but advocate for the need to address regulations at multiple levels.

**Situating Residential Care...** We start by situating residential care. First, we situate it within approaches to care, recognizing that different approaches to care have consequences for how we regulate the residential care sector—different approaches shape the principles that drive regulation, they shape the levels of regulation that we prioritize, and they shape who is accountable to whom. We then situate residential care within multiple interacting levels of regulation, and finally within the logic of auditing and profit-seeking.

**...Within Approaches to Care** Care has long been associated with women; it is thought to be the type of labour that women can provide by virtue of being female and, as such, does not require formal training or reward.<sup>11</sup> Given that all women are assumed to have the required skills, it is possible to rely on the most marginalized women to provide care. Racialized and/or immigrant women are particularly likely to be found doing personal care work. Moreover, within liberal democracies, personal care and social support are understood to be individual responsibilities, rather than being seen as a public good and part of a collective right to care.<sup>12</sup> Neoliberalism has relied on these assumptions to intensify the privatization of care, defining such care as best met by women in families or by private enterprise. Within the public sector, neoliberal ideology has legitimated funding cuts and the auditing of care providers as a strategy to ensure, or at least give the appearance of

ensuring, that care is being provided in cost effective and efficient ways.

There is, however, a growing body of scholarship committed to making visible the centrality of care to human life.<sup>13</sup> It recognizes the ubiquity of providing and receiving care throughout life, even though its provision has historically been gendered and there are times in our lives when more care is needed. The invisibility of care is understood to be a partial product of our deep denial of human dependency and of the relegation of care to the private domain.<sup>14</sup> One consequence of this invisibility is a mainstream failure to appreciate the complexity of care, to recognize that care is a practice with its own rationality,<sup>15</sup> ethics,<sup>16</sup> and skills.<sup>17</sup> Care has a distinct “logic,” to use Mol’s term.<sup>18</sup> This logic is relational and far removed from the logic of markets and auditing. Within markets, power and access are granted by the ability to pay. Auditing, in the context of neoliberalism, tends to be more about controlling workers than supporting the relations of care. In order to improve care in a way that respects its unique characteristics, Mol advises that we must make the logic of care visible.<sup>19</sup>

**...Within the Logic of Relational Care** Applying the concept of relational care to nursing homes means at least four things. First, relationships are central to determining what good care looks like for any particular person. While auditing privileges the act of counting, “familiarity” is a style of knowing that emerges from relationships and is essential to knowing what can and should be done.<sup>20</sup> This includes not only knowledge about the kinds of social and personal care to be provided, but medical care as well. For instance, care workers who are familiar with a resident are more likely to interpret adverse clinical outcomes as preventable, rather than attributing them to age or illness—a resident might be seen as “incontinent” by those unfamiliar with her and continent “unless you make her wait too long” by those workers who know her well.<sup>21</sup>

Second, relationships are a means of delivering good care and doing so safely.<sup>22</sup> Research shows that violence from residents is common, though often underreported, in some nursing homes.<sup>23</sup> Given sufficient time, however, workers can “tune in to” residents, even those with dementia, so that they understand their preferences, provide appropriate care, and mitigate

violence.<sup>24</sup> Tactics to calm, engage, or distract residents when performing intimate care work can be identified, developed, and shared, all of which goes a long way to ensure residents' well-being and to keep workers safe.<sup>25</sup> These skills constitute an expertise, though not the type of expertise that can be easily learned from textbooks. Being person specific, they require continuity and time spent with residents.

Third, as a relation, care is much more than the completion of tasks. How tasks are performed also forms part of care, as does what happens between these tasks. Toileting, dressing, and feeding can be performed in ways that enrich or alienate, dignify or humiliate both those receiving and those providing the care. Relational care thus involves individual skills and capacities—such as communication, presence, humour, and empathy—that can be supported by organizational processes, such as ensuring sufficient autonomy for workers to apply their skills.<sup>26</sup>

Finally, the relationality of care extends beyond the resident and care worker. Residents live in a nexus of relationships with sometimes competing interests that include not only their family members, but also other residents, inspectors, other care workers, volunteers, and administrators. This renders caring dynamic and unpredictable—not well suited to prescriptive rules. Rather, care requires empowering strategies that enable needs to be communicated and heard, and it requires the flexibility to balance tensions as much as possible amidst intersecting relations.<sup>27</sup> These relations extend well beyond the walls of the facility and, indeed, beyond the regulations that strive to manage the care provided within.

**... Within Levels of Regulation** In order to analyze nursing home regulations, we draw on Donabedian's multidimensional quality framework, and we distinguish between regulations that target care outcomes (such as weight maintenance and pain management), processes (such as toileting and incontinence plans), and structural conditions (such as staffing, qualifications, and equipment).<sup>28</sup> While the notion of structure in Donabedian's framework refers primarily to attributes of the setting in which care occurs, we use a feminist political economy lens to expand the concept of structure to draw attention to the policies beyond the organization that set the condi-

tions for care (for example, policies that shape ownership mixes, funding levels, educational requirements, etc.).<sup>29</sup> Indeed, we argue that much of what is possible within nursing homes is determined outside of them. Attending to “structural regulations” draws attention to the fact that care within nursing homes is structured by regulations at international, national, provincial, and municipal levels. Together, these multiple, interacting levels of regulation set the context for care. Structural regulations can influence overall trust in the system and affect matters such as whether those providing care have enough time, autonomy, and resources to do so; whether they are trained to deal with the increasingly complex needs of residents; whether homes are located near communities; and whether the physical space is adequate for both residents and staff.

At the global level, the increasing reliance on market methods to deliver public services in high-income countries, combined with an aging population, has fostered the development of a “global care industry” in which transnational corporations and private equity firms strive to play greater roles in service delivery.<sup>30</sup> These companies often have headquarters in countries far from the care homes they own, which poses challenges for regulators. Furthermore, transparency and compliance are also concerns. For example, public inquiries in the United States have revealed the lengths to which some firms have gone in order to protect profits, putting residents’ lives at risk.<sup>31</sup> Moreover, when for-profit ownership is in place, international agreements on trade and investment can make these policy choices difficult to reverse.

The Canadian federal government is responsible for negotiating international agreements, though perhaps the most influential federal decision is the government’s failure to extend the *Canada Health Act* to include long-term care services.<sup>32</sup> This is despite the fact that the Act contains language on “extended health services” that would allow the government to do so. Such a move would bring the Act’s governing principles requiring accessible, comprehensive, universal, portable services and public administration to bear on insured nursing homes, and it would also bring federal health policy in line with the increasingly chronic and social (as opposed to acute and medical) care needs of the aging population.<sup>33</sup>

In the absence of federal regulation, there are considerable provincial differences in quality, access, affordability, ownership, and regulation.<sup>34</sup> Provincial governments play an important role in shaping care, not only through legislation regulating facilities, but also through policy choices that have direct and indirect effects on a variety of factors, such as training, ownership, and funding, and alternatives such as supportive housing. Funding levels and per diem rates set by provincial governments, for instance, determine the extent of the resources available for care, and especially whether there will be sufficient staff with enough time to provide relational care. The latter can be aided by regulations establishing minimum staffing levels, regulations that are mostly absent in Canada or have been removed despite considerable protest in British Columbia and Ontario.<sup>35</sup>

The ownership mix varies greatly across Canada and reflects a history of policy choices. In Ontario, repeated revisions of the *Nursing Home Act* resulted in the closure of small, nonprofit homes that could not afford to adapt to new standards.<sup>36</sup> The choice to allocate beds through competitive bidding—a process that is both resource intensive and market based—has also favoured big business with access to capital.<sup>37</sup> Indeed, the provinces' neoliberal funding strategies, combined with corporate chains' economies of scale, promoted the shift away from small and/or nonprofit owners.<sup>38</sup> Over time, such policy decisions have resulted in the development of large homes in Ontario, as well as the highest percentage of for-profit ownership in the country.

Structural regulation has significant consequences for the quality of care that facilities can provide. Policies favouring the for-profit sector are not in keeping with the best evidence. A growing body of research indicates that for-profit facilities provide lower quality care and lower quality working conditions than public or nonprofit facilities.<sup>39</sup> There is also evidence that companies evade regulations to protect profits.<sup>40</sup> Policy decisions also affect funding, training, and staffing, which have all been shown to have significant impacts on a variety of factors, including the quality of care provided;<sup>41</sup> the ability to follow facility-level regulations;<sup>42</sup> and the ability to do so with residents' best interests in mind rather than as a “defensive” measure to avoid citation.<sup>43</sup> Policies that target funding, training, ownership, and staffing

can have a profound impact on whether residents receive the quality of care they need and whether residents and workers are treated as human beings.

*... Within the Logic of Audits* Although structural regulations establish the context of care, the focus of discussions about regulation and the regulations themselves are typically about care workers and processes, with increasingly specific rules and documentation. Accountability here is understood as operating in one direction—workers are held accountable to ensure they do not squander public monies, rather than the state being held accountable to workers to ensure that they have the resources to provide good care. This increase of auditing, according to Power, reflects a more general transformation of the role of the state wherein the welfare state is being gradually replaced by a regulatory state.<sup>44</sup> In what he terms the “audit society,” the instruments of audit and inspection become increasingly central to the operational base of government. In the context of health and social care, they have transformed and are continuing to transform the kind of care that can be provided, and how quality problems are approached.

A key insight of the audit society thesis is that auditing is not a neutral act of verification, but might alter the very object it aims to assess. Patient classifications systems, for instance, which were designed to manage acute care but are now increasingly common in nursing homes, have constrained the practice of care.<sup>45</sup> In developing these systems, researchers timed how long it took to perform certain tasks and then used this information to develop standards. Patients entering a hospital could then be managed “efficiently” in terms of the resources they would consume. As Rankin and Campbell observe, however, this promoted a standardized, task-based approach to care and stripped it of its relational dimensions.<sup>46</sup> Such systems also devalued nurses’ professional judgment against presumably scientific classifications.

Auditing is more than a set of rules and assessment tools. It is a way of thinking about performance, and one that tends towards reductionism.<sup>47</sup> The underlying logic, according to Power, requires that “organizations establish objectives, design performance measures to reflect those objectives, monitor actual performance, and then feed the results of this monitoring

back for management attention.”<sup>48</sup> This logic helps to explain the intense pressure to implement the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessment technology in nursing homes, and it can also be seen in the way that the British Columbia Ombudsperson’s inquiry approaches quality.<sup>49</sup> The logic of auditing is clearly visible in her remarks on the problem of call bell response times. She observes that:

It is surprising that neither the ministry nor the health authorities have established standards on acceptable response times to call bells. Technology enabling the measurement of call-bell response times is available, and some facilities are already using it. Without objective data, it is difficult to determine the extent of the problem. It would be useful for health authorities to collect objective data about actual response times and use it to support the development of appropriate standards and guidelines. Once this is done, compliance with these standards can be monitored.

Similar regulatory “fixes” are offered for each problem that the Ombudsperson identifies. Each problem therefore receives its own targeted regulation and, taken individually, the proposed regulations make sense. It is reasonable to have a call bell monitoring system just as it is sensible to have an incontinence plan. However, if we consider the whole—and particularly the understaffed working conditions that the Ombudsperson also describes—then such reductionist solutions are likely to cause harm. In the context of insufficient staffing, such monitoring is likely to pull resources away from other types of care, particularly the relational care that, while so important to residents, is difficult to measure and monitor. Moreover, framing the problem as “workers taking too long” rather than “there are not enough staff [members]” is likely to affect workers’ morale and their autonomy. Finally, when the entire section of the Ombudsperson’s report addressing quality of care (pages 273 to 282) is devoted to minimum standards, monitoring, and little else, it raises questions about our capacity to imagine alternative approaches to improving care.

Given the proclivity to solve problems by targeting workers and care processes rather than improving the relational context of care, it is not hard to imagine that care workers might experience the audit explosion as being less than helpful. Indeed, Power suggests that auditing has developed without

sufficient evidence of its effectiveness or consideration of its dysfunctional effects.<sup>50</sup> It therefore is imperative, he argues, that we study the effects of auditing on those being audited. We take up this challenge in the next sections, examining auditing from the perspective of those responsible for providing care. In doing so, we hope that this study may add their voices, voices that are all too often absent, to the regulation debate.

**Data Collection** The data we draw on come from two sets of studies focusing on the conditions of work and care within residential care facilities for older persons.

The first study took place between 2005 and 2007. It involved the distribution of a questionnaire to a wide range of workers in 81 facilities across Manitoba, Ontario, and Nova Scotia (n=948). The questionnaire comprised 54 closed and 10 open-ended questions in which workers could elaborate on their experiences. The survey was analyzed statistically and the qualitative data were analyzed thematically by the authors, independently and then collectively.<sup>51</sup> This involved a process of identifying data that were relevant to existing themes in the literature, and identifying new themes by looking for patterns, attending to emphasis, emotions, and unique or surprising remarks.<sup>52</sup> We presented our preliminary analysis back to the workers through a series of nine focus groups (three in each province) with the aim of validating and elaborating our findings.

The second study is an ongoing study of residential care using the technique of rapid ethnography, which incorporates documentary analysis, on-site observation, and interviews to produce a holistic understanding within a short time frame.<sup>53</sup> Sites were selected for the project through a process of key informant interviews conducted between 2011 and 2012. In this paper, we draw on the data from one rapid ethnography conducted at a large, unionized, nonprofit facility in Ontario in 2013. Data collection included 45 interviews with key informants—managers, directors of care, registered nurses (RNs), registered practical nurses (RPNs), and personal support workers (PSWs). Additionally, 13 researchers observed work and care processes within the facility over the course of four days and nights. Interviews and field observations were guided by questions developed

through initial literature reviews and previous studies; they included questions on accountability, auditing, and regulations. The field notes and interview transcripts were analyzed thematically by both authors, independently and later collectively. This study, like the previous study, was part of a larger international comparative project, though we focus on the Canadian data in this paper.

**Care Workers' Experiences with Auditing** In our discussions about regulation, interview subjects repeatedly expressed a sense of frustration with the increasing level of detail, prescription, and documentation, which, far from enabling care, was experienced as making their jobs harder. Our analysis of the data sheds some light on this paradox and reveals important tensions between auditing and the needs of relational caring. While we recognize that there was a diversity of experiences—workers drew our attention to many contradictions as well as instances of having to bend or work around regulations to provide good care—in what follows, we present the most commonly noted tensions; notably that auditing took time away from care, contributed to routinization and alienation, and decoupled care from residents.

***Taking Time Away from Care*** One of the most consistently noted concerns was that the amount of documentation and reporting required by current regulatory practices—“where everything you do has got to be written down” (RN)—took valuable time away from care and added to workers' already heavy workloads. Nurses described being buried under an “avalanche of paperwork.” Evidencing the impact of the audit explosion, one director of care observed that her job was “becoming much more focused on the paperwork side of things: the documentation, the reports that are demanded of us, the reporting of everything to everybody.” Another RN described her experience of the “exponential” growth in regulations as follows: “I chose Nursing almost 32 yrs ago when RN's were in abundance and nursing was actual hands on direct care. Now I am buried in paperwork, compliance + MOH [Ministry of Health] regulations. The real enjoyment has disappeared from this noble profession.”

Not all paperwork is problematic, but most RNs (92 percent) agreed that too much of their time was spent on paperwork that they felt was “meaningless.” One manager offered the following example:

With the new long-term care Act...there's this issue of having to respond to something within 10 days *in writing* and quite honestly I haven't always done that...So I got my fingers slapped in the inspection process because I didn't have the documentation to support the activity that I'd done...It was basically a paper exercise. 'You didn't respond in writing.' I said 'Yeah, but I did it. Did he not tell you...?' 'Oh yeah, he told me that you did it...but you didn't respond in writing.' You know, so that's the kind of nonsense I find that there is.

Both nurses and managers expressed concern that the amount of paperwork was keeping them off the floor. In the words of one manager, “We're not actually paying attention to the residents and their families or being actually more engaged, you know, on the units and that. Like some days I never get out of this office.” This is not without consequence. Studies show that more RN time spent on direct care is associated with improved quality indicators, such as reduced hospitalizations, infections, and weight loss.<sup>54</sup>

Respondents also cautioned that the training of RPNs was focused increasingly on reporting, which meant that they were not prepared for bedside care. In fact, we were told that some new nurses preferred reporting to the messy realities of resident care, raising concerns for the future of the sector. Managers also raised similar concerns, noting that there was a tremendous level of executive fatigue. “I think from a stress management perspective, the willingness to continue in the positions is going to be a challenge moving forward. I think it's one of those quiet things. The system won't know it until it hits it. You say every day, 'why am I doing this?'”

***Contributing to Alienation*** Respondents also raised concerns about the focus of regulations and the way in which they emphasized a medical and therapeutic agenda instead of focusing on quality of living and dying. Such concerns have been noted more generally in the care of older persons.<sup>55</sup> This approach is written into assessment technologies that inform care planning,

such as the RAI-MDS. As Kontos and colleagues have observed, the RAI-MDS focuses on clinical indicators, behaviour, risk, and medical diagnosis, but neglects important biographical knowledge that enables care workers to personalize residents' care.<sup>56</sup> Similar concerns were raised by those we interviewed, who observed that what was being counted was not always what mattered to residents.

Dining was often used to illustrate the tensions between auditing and relational care, perhaps because of the loss of rich opportunities to foster belonging, pleasure, and connection. As one RN observed, there "is no consideration given for the residents' enjoyment of their meal, all they care about is the order in which food is served and that it is done properly." Clearly, what serving food "properly" means is contested. An RPN described the tension between auditing and relational care this way: "It's not the food or personal care they appreciate most, it is the time you spend with them—even if it is a simple hug or a listening ear. Most days there is inadequate time to do so, as we are constantly focused on Ministry needs and policies."

Despite the rhetoric of personalization, regulations were perceived to drive impersonal care. Getting residents ready for breakfast was a common example. As one PSW explains, "They have to be there at the table for breakfast at 8:30 every day. You know, some of them they fight with you. They don't want to get up. I don't see why at this time of their life we have to force them to get up. We should be adjustable, adapt to their schedule." The spirit of such rules may be well-meaning, intending to ensure that residents are supervised, but their implementation detracts from workers' ability to offer a home-like environment and the pleasure of sleeping in or eating in bed. Such regulation also fails to address key problems, such as insufficient staffing, that could enable more individual attention. Given inadequate time and restrictive regulation, workers commonly described the type of care they were able to provide as "assembly line" care. As one PSW wrote, "I fear that our care is in danger of becoming 'assembly line nursing' due to gov't demands and lack of gov't funding, lack of time to care properly for our residents; not just their physical needs but all aspects of emotional care too."

Auditing also interfered with relationship building. This was expressed by all occupational groups, from management to personal support workers.

Relationships were harmed in multiple ways. Standards prevented management from meeting unique but important family requests. Documentation also alienated care workers from their residents, as the following extended quote illustrates:

It's a requirement, you know. So instead of sitting there for 20 minutes and having just a nice chat over tea, they've got to sit there doing the busy work of documenting all that before they leave that dining room because that's what the [Long-Term Care Homes] Act says....

So that's part of the problem I have with the Act because I'm constrained by these things to not create what would be seen as a normal living circumstance for someone because you feel like you're in a lab....

Gosh forbid I walk down the hall and give somebody a drink without checking the food and fluid binder! It creates all this dissociation from what the whole intent is, which is to give the residents what they would really enjoy having for their tea or anything else. It creates this whole disciplinary approach.

***Decoupling Care from Residents*** Although the goal of auditing, at a minimum, is to ensure that basic care is being provided to vulnerable residents, and, ideally, to enhance the personalization of care, one perverse effect of auditing is that the very act of quantifying and documenting care decouples care from residents while limiting the autonomy of workers.

As Braithwaite, Makkai, and Braithwaite astutely observe, auditing invests the government's power not in the residents they are supposed to protect, but in documents, which are ultimately controlled by administrators and owners.<sup>57</sup> As one care worker observed, "I often feel the bottom line, or how it looks on paper is more important than what actually gives residents a better quality of life." Another expressed concern this way: "All management wants is for all the paperwork to be in order, even if it's the resident who suffers in order to make that happen."

The managers we spoke with had their own concerns with auditing, noting that because funding was tied to resident acuity, there is an incentive to "game" the system. This is understandable—and perhaps even constitutes a form of care—given the lean funding environment and the fact that nursing

home funding is based on the previous year's assessment, and therefore is already outdated. Gaming is no secret, and the Ministry responds in various ways. When reporting increases in acuity, for instance, one manager noted that this "doesn't actually lead to more funding, not always, and that's part of the frustration. They scale it back. They don't believe it." The Ministry also responds with its own gaming by changing the rules:

[The Ministry] changed it because you start to learn how to work around it, right? And enter certain things and all of that so then they change it to keep people honest...So they, you know, are fully aware people are trying to game it so they're going to shift things so that you can't and, you know, we both believe that's a good thing. But it's time consuming. It takes up a lot of hours.

Lack of trust is thereby built into the system, and although there is a need for more Canadian data on the accuracy of reporting, our findings about gaming mirror those of US research. Eaton notes that nursing home aides were often requested to document care that was not provided so that "the records say what they should."<sup>58</sup> This practice was sanctioned by managers. "Higher level supervisors also acknowledge...that they had created documentation for services not performed. They described this as common in the industry, as a way to deal with reporting requirements seen as too demanding."<sup>59</sup> For instance, a study by Schnelle et al. indicates that assessment of incontinence led to the documentation of the residents' incontinence history and also the documentation of toileting assistance being provided.<sup>60</sup> However, when researchers checked with residents capable of reporting the care they received, there was no difference found between those documented as having received assistance and those that were not. Commenting on this study, Braithwaite, Makkai, and Braithwaite observe that being incontinent triggered protocols and documentation, but it did not result in more care.<sup>61</sup> They term this the "ugly face" of auditing—"documentation of incontinence history and documented evidence of responding to it as a ritual of comfort. The regulatory state gets comfort while the incontinent suffers extreme discomfort."

The observation that auditing, as currently instituted, missed fundamental barriers to good care was expressed repeatedly by people interviewed

at all levels. As one nurse noted, “We keep getting more paperwork, more computer work, heavier residents. But we don’t seem to get more help.” An administrator summed up the tension by observing that “We have the most amount of legislation and we have the least amount of staff of all the health care. It doesn’t really make any sense. We have no staff yet we have so much regulation.”

## **Conclusions**

We need leadership but we keep getting regulation instead.

— Community partner

Residential care is a highly regulated sector. Regulations are often a product of scandals, and they reflect an understandable desire to safeguard nursing homes’ vulnerable populations. The prevailing tendency in residential care, however, is to engage in the ritualism of proposing rules that target facilities, care workers, and care processes.<sup>62</sup> This approach constrains those responsible for care, and prevents them from adapting to the unique and often unpredictable needs of residents and family members, in addition to balancing the tensions that inevitably arise when caring for groups of people in the context of finite resources. Moreover, current regulations and auditing do not adequately address one of the main barriers: insufficient time for care. Instead of protecting residents’ well-being, regulations and auditing practices consume considerable time and resources, and empower documents, not residents or workers.

We have sought to understand this tension between regulations and quality by contrasting the logic of auditing with the logic of care. Auditing derives paradigmatically from financial and scientific management in the for-profit sector. As such, it strives to rationalize care, treating quality as a data management problem, both at the resident level—through assessment technologies that presumably result in more accurate care plans—or more generally through documenting the care supposedly provided as a way to ensure accountability. Ideally, as the Canadian Institute for Health Information’s recent RAI-MDS-driven report on quality illustrates, the goal is for these data to be fed back to management in the hopes of improving

care in individual facilities through systems-level comparative analyses.<sup>63</sup> Such information may well have its uses if conditions are present to ensure its accurate production and successful implementation. But as our data show, there is reason to be doubtful.

Neoliberal auditing fails to respond to the local, communicative, embodied, and dynamic realities of caring for people and the context that sets the conditions for care. It is only by recognizing the relational qualities of care that we can hope to improve long-term care in a manner that treats both workers and residents with dignity and respect. As care workers advise, both in the original research presented here and in research that we have reviewed, providing relational care requires that workers have, at a minimum, adequate time, training, constancy, communication, presence, autonomy, flexibility, and respect. All too often these conditions are absent in nursing homes, and most often in those facilities seeking profit. Neoliberal auditing does little to foster these conditions for care. Rather, current regulatory efforts seek to address quality independently from the conditions of care because of a narrow focus on facility and care processes. Worse, regulatory efforts seek to secure quality on top of poor working conditions.

Attending to the logic of care points us in at least two important and complementary directions related to seeking to enhance accountability and quality. First and most importantly, improving quality care in nursing homes requires attending to the structural regulations that set the conditions for care. By funding and ensuring adequate staffing, as well as supporting the nonprofit and/or public delivery of services, for example, structural regulations can contribute to enhancing overall trust in the system and ensuring that workers have the time and resources to do care work well. This, however, will require us to think beyond facility-level regulations and incorporate international, federal, provincial, and municipal regulations in our efforts to ensure quality and accountability. Indeed, structural regulations that target the conditions of care ought to be thought of prior to facility-level regulations that attempt to manage care processes or outcomes. No matter how sensible facility regulations are, without the appropriate conditions to implement them, they risk being ignored, or risk redirecting efforts away from other important work.

Second, the multilevel approach to regulation that we are advocating does not deny the importance of facility-level regulation. Rather than ritualistically turning to rules, science, or technology to improve auditing, however, we agree with Braithwaite, Makkai, and Braithwaite who recommend a principled and dialogical approach to facility regulation.<sup>64</sup> They advise developing standards grounded in a few simple, broad principles. These standards should guide an inspection process relying not so much on documentation for verification, but on dialogue with residents and care workers. Such an inspection process might appear to be more subjective on the surface, but, as their research convincingly demonstrates, when confronted with too many rules and too few resources, inspectors also take shortcuts, leading to inaccuracies and inconsistencies. Multiple inspectors, shared sensibilities produced through training, and a focus on residents and care workers are means of securing reliability within this framework.

The benefits of a multilevel approach to regulation—one that understands that structural regulation is needed prior to facility regulation—can be expected to be felt across a range of caring activities, rather than simply targeting individual care tasks. However, regulating at the structural level is political. It raises challenging questions about the current distribution of resources and involves targeting powerful actors, such as international corporate chains, as opposed to comparatively disempowered workers. Such an approach to nursing home regulation also requires that we address ethical questions about the place of care in society, and the worth of the elderly and those who care for them. We should not avoid these ethical and political matters in the hope that more technical, facility-level regulation can secure quality.

## Notes

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