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Cui Bono? The Development of
the Irish *National Quality
Standards for Residential Care
Standards for Older People*

by

Ciara O'Dwyer

A Thesis submitted to the
University of Dublin, Trinity College
in fulfilment of the requirement of the
degree of Doctor of Philosophy

February 2012

DECLARATION

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SUMMARY

Purpose

Over the last fifteen years, it has become popular for governments to develop regulations through “regulatory negotiation”, i.e. with input from key stakeholders of the regulated sector in question. Proponents have argued that regulatory negotiation produces clearer rules and can also help to ensure that the rules are written in the public interest. However, others have expressed scepticism about the purported benefits of the process. Furthermore, few researchers have examined the influence of wider contextual factors on the outcomes of regulatory negotiated processes.

This thesis sets out to further develop our understanding of the regulatory negotiated process, using the case of the development of minimum standards for residential care settings for older people in Ireland. The Standards were developed by a large Working Group, established by a new, independent regulator, the Health Information and Quality Authority (HIQA) and was made up of the main stakeholders of the sector. Since July 2009, all facilities providing residential care to older people have been subject to inspection in order to ensure that they meet the regulations underpinning the Standards.

Design and Methods

Using a “governance” framework, the thesis takes the form of a qualitative case study. Three data sources were used: documentation on the process used to develop the Standards; in-depth interviews with 32 of the 37 members of the Working Group; and interviews with 12 other relevant stakeholders. Data analysis used a process-tracing approach.

Findings

Documentary analysis showed that the Standards suffer from a number of shortcomings. There are a number of ambiguities and contradictions within the document, particularly in relation to whether providers are obliged to adhere to the Standards or not. Furthermore, residential care is conceptualised within the document as a service similar to a hotel, with residents portrayed as clients or customers. However, this portrayal did not mirror the wishes and needs of older people living in residential care settings who took part in a public consultation process to inform the content of the Standards. This failure to listen to residents’ views appeared to stem from Working Group members’

deep-rooted fears about losing autonomy in their old age. Finally, a comparative analysis found significant differences between the content of the Standards and the Regulations underpinning them. These regulations were written by the Department of Health and Children, rather than by HIQA. An analysis carried out for this thesis indicates that the Department may have “diluted” the Standards for financial reasons.

Although a number of contextual factors played a role in influencing the content of the Standards and Regulations, interview and documentary data suggest that the shortcomings were created through the self-interests of Working Group members, HIQA and the Department of Health and Children and also by mismanagement of the Working Group meetings by HIQA.

Research Contribution

The findings in this thesis have cast further doubt on the relative merits of regulatory negotiation; in this case, the rules produced contained many ambiguities. The process also resulted in the wishes of older residents being sidelined. As has been shown in previous research, the promotion of the Working Group members’ own self-interests was largely responsible for these outcomes. In addition, this thesis has shown that the wider governance context may in turn have influenced the views of Working Group members. The portrayal of residents as consumers and the promotion of the interests of both the government and powerful interest groups suggest that the Working Group may have been influenced by a neo-liberal ideology. The thesis thus shows that a governance lens is useful for analysing regulatory negotiation, as it can help to contextualise why regulatory negotiation is used by governments in favour of other approaches and can also help to provide a more fundamental explanation as to why the interests of consumers tend to be sidelined.

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LIST OF ABBREVIATIONS

CQC	Care Quality Commission (England)
CSCI	Commission for Social Care Inspection (England)
DOHC	Department of Health and Children (Ireland)
EIU	Economist Intelligence Unit
EU	European Union
GAO	Government Accountability Office (United States)
HCI	Health Care Informed (Ireland)
HSE	Health Service Executive (Ireland)
HIQA	Health Information and Quality Authority (Ireland)
INHO	Irish Nursing Homes Organisation (Ireland)
IOM	Institute of Medicine (United States)
LHO	Local Health Office (Ireland)
NCA	National Consumer Agency (Ireland)
NCSC	National Care Standards Commission (Ireland)
NCAOP	National Council on Ageing and Older People (Ireland)
NCCNHR	National Citizens' Coalition for Nursing Home Reform (UK)
NESF	National Economic and Social Forum (NESF) (Ireland)
OBRA	Omnibus Budget Reconciliation Act of 1987 (United States)
OECD	Organisation for Economic Co-operation and Development
RIA	Regulatory Impact Analysis
RTE	Raidió Teilifís Éireann (Ireland)
Tasc	Think Tank for Action on Social Change (Ireland)
TD	Teachta Dála (Ireland)
UK	United Kingdom
US	United States

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To Dad, thanks for everything.

Introduction

1.1 Introduction

This thesis sets out to develop our understanding of “regulatory negotiation”, using the case of the development of minimum standards for residential care settings for older people in Ireland, *The National Quality Standards for Residential Care Settings for Older People in Ireland*, (HIQA 2009e). Regulatory negotiation refers to an innovative process used to develop regulations, whereby interested stakeholders (e.g. representatives from regulated firms, citizen groups and other affected organisations, as well as staff from the regulatory agency) negotiate the content of the rules together (Coglianese 2001a, Harter 1982). It differs from the more traditional form of rulemaking in which policy-makers alone decide on the content of the rules, with only limited and informal input from relevant stakeholders. This chapter outlines the rationale for the thesis, provides an overview of the case studied, sets out the study objectives and research design used and gives an overview of the remaining chapters of the thesis.

1.2 Rationale for the Thesis

One of the fundamental ethical principles of social research is that researchers must satisfy themselves that the research they undertake is both worthwhile and necessary (British Sociological Association 2002). This section sets out the rationale for the study, explaining its importance in contributing to the existing literature on both regulatory negotiation and residential care for older people.

1.2.1 Regulatory Negotiation and the Public Interest

Regulatory authorities have been created in such unprecedented numbers throughout OECD countries since the 1980s that commentators argue we are now living in the era of the Regulatory State (Jordana & Levi-Faur 2004, Majone 1994). Paradoxically, instances of “regulatory failure”, resulting in public scandals and crises, do not seem to have diminished public confidence in regulation as a tool of governance. Instead of using alternative policy tools, many governments have responded to the shortcomings of regulation by introducing reform, whereby new and innovative regulatory approaches are used to protect citizens (Haines 2009). However, many have suggested that regulatory reform is simply a strategy used by governments to regain the trust of the electorate, which has been declining rapidly since the 1980s (Fukuyama 1995, Jordana & Levi-Faur 2004).

One such innovative approach is the use of “regulatory negotiation”, a process that refers to participation by regulated entities and other interest groups (as well as, in certain cases, the wider public) within the rulemaking process (Coglianese 2001a). Regulatory negotiation was originally developed in the 1980s as regulators had frequently come under attack from regulated firms, who were unhappy with regulations developed by government or the regulator alone (Harter 1982). It was hoped that providing regulated firms with input into the development process would result in rules which were both clear and feasible, thus increasing levels of compliance (Harter 1982). It was also hoped that the process would benefit the intended beneficiaries of regulation (i.e. consumers) (Seidenfeld 2000). The US government endorsed the concept of regulatory negotiation, passing the Negotiated Rulemaking Act in 1990. Although regulations developed under the terms of the Act have declined in popularity (Lubbers 2008), regulatory negotiation itself (i.e. regulations written with input from relevant stakeholders) has proven a popular way of writing rules since the late 1990s. Indeed, as outlined in greater detail in Chapter Two, many countries now require input from relevant stakeholders before regulations are ratified. However, the process has been under-researched and its benefits are unclear.

Research on regulatory negotiation has focused to a considerable extent on how the process operates at a micro-level; the wider political context in which the process operates has to date not been examined. Research has also focused only on a small number of sectors, focusing predominantly on environ-

mental protection (Calcott 2008, Golden 1998, Langbein & Kerwin 2000, Wagner, Barnes & Peters 2011), with some research on regulations on safety in the workplace (Seidenfeld 2000). In addition, previous studies have rarely examined both the process and outcomes of regulatory negotiation together and have focused on the outcomes of the regulations only in a narrow way, such as examining challenges to the rules developed through regulatory negotiation (Coglianese 2001*b*), or examining which interest groups have the strongest ability to influence the content of the regulations (Furlong & Kerwin 2004, Yackee 2006).

Furthermore, as outlined in greater detail in Chapter Two, many commentators have expressed concerns about regulatory negotiation, in particular its ability to empower citizens/consumer groups within the process and thus ensure that the rules are written in the public interest. The use of regulatory negotiation within the context of residential care for older people has not been examined to date, though many countries have used a collaborative process to develop minimum standards or regulations to govern the sector. Indeed, Seidenfeld (2000) suggests that the use of regulatory negotiation within the nursing home sector (i.e. residential care settings for older people)¹ would act as a good test case for assessing the extent to which regulatory negotiation can empower the intended beneficiaries of the rules; if regulatory negotiation was shown to benefit nursing home residents, one of the most powerless groups in society, it would show that regulatory negotiation had an important advantage over traditional forms of rulemaking.

1.2.2 Improving Residential Care for Older People

The Irish Standards are an example of a growing trend within the context of care policies for older people. Many countries require residential care providers to comply with minimum standards, particularly in Anglo-American countries and in North Western Europe (Du Moulin, Haastregt & Hamers 2010). As was the case in Ireland, many countries developed minimum standards with input from relevant stakeholders from the residential care sector, including England (Department of Health UK 1999), Australia (Australian Government Department of Health and Ageing 1998), the United States (IOM 1986) and New Zealand (Equip4 2008). Yet, to date, there has been rela-

¹Although a variety of terms are used to refer to residential care settings for older people, I have chosen to use this term for convenience, as it is the term officially used in the Irish Standards.

tively little analysis carried out on either the content of these minimum standards, or of the process used to develop them. It is therefore unclear on what basis such standards are written in order to provide residents with a good quality of life. Furthermore, it is unclear which stakeholders have the greatest input into the content of these standards.

As improving the quality of care provided to older people is a key concern of researchers, carers and policy-makers (OECD 2005), this study can help to contribute to our understanding of how policy-makers and other relevant stakeholders from the residential care sector conceptualise quality for older people and how such individuals work together to write such Standards.

1.2.3 Overview

This section has argued that this case represents an opportunity to contribute to our understanding of regulatory negotiation and also to analyse how policy-makers conceptualise a model of care to improve the quality of care provided to older people. While regulatory negotiation may help to achieve greater collaboration amongst the various stakeholders of a regulated sector, it is unclear to what extent the regulations reflect the public interest. As a result, further research is needed to assess the relative merits of regulatory negotiation vis-à-vis those of more traditional rulemaking processes.

In addition, this case presents an ideal opportunity to analyse how policy-makers and other relevant stakeholders of the residential care sector understand how best to improve the quality of care provided to older people. While many countries employ minimum standards for the residential care sector, there has been little analysis of the content of such standards or of the concepts and discourses upon which they are based.

To explore these issues, the thesis uses the case of the development of minimum Standards for residential care settings for older people in Ireland (HIQA 2009e). The next section outlines the background to the development of the Standards.

1.3 Outline of the Case

1.3.1 Introduction

This section provides a descriptive overview of the background to and development of the HIQA Standards, outlining both the context in which the regulatory negotiated process was established and the chronology of events of the process.

1.3.2 Background

On 30th May 2005, a documentary, *Home Truths*, was broadcast on Ireland's main national television station, RTE 1. The programme showed "unbearable" footage (Hegarty 2005) filmed secretly by an RTE reporter within a private nursing home called Leas Cross. It showed both the physical and emotional abuse to which residents of the home were subjected and also the poor care practices of the home, including a member of the catering staff giving out medication, residents being ignored when they called for attention, being moved against their will and being left in soiled bed linen and incontinence pads. The programme led to public outrage, particularly once it emerged that inspectors had raised concerns about the home since 1998 (O'Donovan 2009). A review of the home suggested that deficiencies within the regulatory process operating at the time were partly to blame (O'Neill 2006).

1.3.3 Development of the Standards

In response to the programme, a small working group made up of civil and public servants was formed by the Minister for Health in November 2005 with the aim of developing draft standards for residential care settings (DOHC 2007b). The draft standards took into account key national and international literature, including *inter alia* the English Minimum Standards for Care Homes (Department of Health UK 2003). They were completed in January 2007 and were subsequently handed over to a new healthcare regulator, the Health Information and Quality Authority (HIQA), for further development. In order "to ensure a shared vision across all stakeholders as to what should be contained in the National Quality Standards" (HIQA 2009e, p. 6), HIQA set up its own Working Group made up of representatives of HIQA, the Department of

Health and Children (DOHC), older peoples' representatives groups, public (statutory) and private providers and those involved in the care and treatment of older people (see Appendix A for the full make up of the Working Group).

The Terms of Reference of the Working Group were to:

- review and develop the draft standards developed by the DOHC
- establish a process for targeted and public consultation
- oversee the public consultation process
- consider feedback from the public consultation process
- finalise the draft standards for publication

(HIQA 2009e)

The Working Group met on fifteen separate occasions throughout 2007. The first meeting took place on the 30th January and the last on the 20th December. As HIQA had no permanent office at the time, meetings took place in different hotels in Dublin's city centre. The Working Group published a draft set of Standards for public consultation in August 2007 (HIQA 2007). The public consultation process consisted of a series of workshops with staff working in residential care settings and focus groups with residents and their families. HIQA also placed advertisements in newspapers and wrote to relevant organisations inviting submissions. Feedback from the public consultation process informed the penultimate draft of the Standards, published in March 2008 (HIQA 2008). Following Ministerial approval (required under the terms of the 2007 Health Act, as outlined below), the final draft of the Standards (HIQA 2009e) was published in February 2009.

In total, four drafts of the Standards were published. Table 1.1 summarises the publication details of each draft and Appendix B gives a more detailed chronology of events in the development of the Standards and the regulations underpinning them.

As outlined in greater detail later, the final draft contains 32 Standards, each of which is an outcome statement that sets out what is expected in terms of the service provided to the resident (HIQA 2009e). All of the standards are accompanied by a number of criteria which are "supporting statements that set out how a service can be judged as to whether the standard is being met or not"

Table 1.1: Chronology of the Publication of the Standards

Title	Authors	Publication Date	Publication Details
Draft National Standards for Residential Care Settings for Older People	DOHC Working Group	January 2007	Handed over to HIQA for further development in January 2007.
Draft National Quality Standards for Residential Care Settings for Older People - A Consultation Document	HIQA Working Group	August 2007	Draft published by the Working Group in advance of the public consultation process.
National Quality Standards for Residential Care Settings for Older People in Ireland	HIQA Working Group	March 2008	Penultimate draft which took into account the findings from the public consultation process, but which had not yet received Ministerial approval.
National Quality Standards for Residential Care Settings for Older People in Ireland	HIQA Working Group	February 2009	Final version, approved by the Minister for Health and Children.

(HIQA 2009e, p. 8). The Standards broadly govern every aspect of how providers should maintain residents' quality of life within the care setting, from admission to discharge. Appendix C gives an example of one of the Standards and the supporting criteria.

1.3.4 Legislative Framework for the Standards

Minimum standards have no basis in legislation and it is not a legal requirement for firms to adhere to them. Thus, in order to make it mandatory for regulated firms to comply with minimum standards, they must be underpinned by legislation (Scott 2010). Indeed, it is normal for regulations to be published first, with minimum standards subsequently written to provide guidelines on how providers can comply with the regulations (Scott 2010). However, the legislative framework for the Standards was somewhat unusual, as both the primary legislation and the regulations underpinning the Standards were written after the Standards were published. This is largely because the regulatory process was in transition at the time that the *Home Truths* documentary about Leas

Cross was broadcast.

In 2001, the government indicated that they were planning to restructure the Irish healthcare system, including reforming the regulation of healthcare services, including residential care settings for older people (DOHC 2001). They suggested that a new healthcare regulator, the Health Information and Quality Authority (HIQA) would be established in due course in order to carry out this task. In January 2005, HIQA was established, though only on an interim basis, as legislation to formally establish the organisation (subsequently the 2007 Health Act) had not yet been passed. By the time the Leas Cross programme was aired, HIQA had still not been formally established - the 2007 Health Act was still being drafted and the organisation had no staff; it was therefore not in a position to take over regulating residential care settings. However, in order to reduce delays in starting the reformed regulatory regime, the internal DOHC's working group was established and commenced drafting the Standards. Legislation to formally establish HIQA and set out its functions was finally passed in May 2007 (Government of Ireland 2007), five months after HIQA's Working Group began its deliberations. The Act did not set out the regulations governing residential care settings, but gave the Minister the power to develop regulations at a later date.

In Ireland, prior to introducing regulations, government departments must carry out a regulatory impact analysis (RIA) (Department of the Taoiseach 2004). An RIA is a tool intended to assist policy-makers to understand the likely consequences for proposed regulations (Nolan 2008). As part of the RIA process for the new Standards, the Department commissioned a private sector research consultancy firm to carry out a detailed assessment of the costs of meeting the Standards by residential care homes (PA Consulting 2009). Subsequently, the final version of the Standards was approved by the Minister for Health and Children, in February 2009 (HIQA 2009e). In June 2009, the 2009 Care and Welfare Regulations (hereinafter the Regulations) were published and since July 2009, all facilities providing residential care to older people have been subject to inspection in order to ensure that they meet the required Standards and Regulations.

As the 2009 Regulations were written internally by DOHC staff, with no direct input from HIQA's Working Group, this case slightly differs from the usual regulatory negotiated process, whereby the stakeholders develop the regulations directly (Harter 1982). It is therefore important to examine the content of the Regulations, as well as those of the Standards, in order to ensure that this

case is a legitimate form of regulatory negotiation.

1.4 Study Objectives and Research Design

1.4.1 Aims and Objectives

Although the specific aims and objectives of the study are outlined in greater detail in Chapter Four, it is important to state here in general terms the study's objectives. The thesis aims to explore the impact of the regulatory negotiation on the content of the *National Quality Standards for Residential Care Settings for Older People* and the 2009 Care and Welfare Regulations in order to enhance our understanding of the regulatory negotiated process. The thesis also provides an opportunity to analyse how policy-makers and other relevant stakeholders of the residential care sector consider how best to meet the needs and improve the quality of life of older people living in residential care. The thesis uses a case study approach in order to look at the influence of contextual factors and uses qualitative methods to collect and analyse data.

1.4.2 Use of a Governance Perspective

This thesis is guided by a governance perspective. Governance refers to a shift in the organisation of political power from government to a range of other actors, including State agencies, international organisations and other non-governmental organisations (Benz & Papadopoulos 2006). Regulation is often regarded as a particularly important aspect of the transformation of governance, as it shifts power away from the central government in carrying out the functions of the State (Ayres & Braithwaite 1992). However, as discussed in greater detail in Chapter Two, many governance scholars have suggested that the rise of regulation is a way of allowing governments to highlight their responsiveness to political and social crises, while shifting blame for any future problems from the government to the regulator (Jordana & Levi-Faur 2004). The use of a governance perspective therefore allows for an analysis of how this wider context influences the use of regulatory negotiation.

1.5 Outline of the Thesis

The remainder of this thesis is structured as follows. Chapter Two reviews literature relevant to the thesis, including existing theories on the reasons for the rise of regulation as a policy tool in many countries throughout the world and also examines the rationale for the development of innovative forms of regulation that have become popular in recent years. It then moves on to examine the use of regulatory negotiation and its known benefits and shortcomings. The chapter also reviews literature on alternative approaches to improving the quality of life of older people living in residential care, including in particular, person-centred approaches to care. The chapter concludes with an overview of the use of regulation to govern the residential care sector.

Chapter Three outlines the political, social, economic and policy context of Ireland in which the Standards were written. In particular, the chapter describes the way in which regulation has risen in popularity as a tool of governance and documents the evolution of residential care policies for older people in Ireland.

Chapter Four provides a detailed account of the research design and methodology used to conduct the study. The rationale for choosing a case study design, a governance framework and a qualitative methodology are outlined, followed by the approach used to collect and analyse data. The chapter also outlines the limitations of the research design and methodology chosen and discusses how ethical issues were managed.

Chapters Five, Six and Seven present the findings of the thesis. Each chapter is organised around one of the three themes that were developed based on a review of the literature on regulatory negotiation. Thus, Chapter Five focuses on the way in which the process contributed to ambiguities apparent in the Standards. The chapter first outlines the findings of a detailed analysis of the Standards and subsequently uses interview and documentary data to show how the process used to develop the Standards explained some ambiguities in the document. Chapter Six considers the way in which the regulatory negotiated process resulted in two competing models of person-centred care within the Standards, a psycho-social model and a consumer-driven model. The chapter also discusses how the the voices of older people were taken into account within later drafts of the Standards. Chapter Seven discusses in greater detail the key differences between the Standards and the Regulations and the factors that contributed to these differences.

The implications of these findings are discussed in Chapter Eight. The contributions of the study towards our understanding of regulatory negotiation, particularly within the residential care sector, are outlined. The chapter also makes some recommendations for future research.

Literature Review

2.1 Introduction

This chapter synthesises and reviews literature relevant to the thesis. The chapter argues that, over the last three decades, many countries have adopted new modes of governance in which non-government actors have come to play a significant role in the development and implementation of government policy. This phenomenon has led to a move towards the privatisation of traditionally public services, including residential care for older people and an increased reliance on the ethos and principles of the private sector to operate public services. Governments have also come to rely on regulation as a tool of governance in order to oversee and monitor the quality of both public and private services. The chapter argues that it is in this wider context that the use of regulatory negotiation should be viewed.

Section 2.2 starts by reviewing the literature on regulatory negotiation and outlines the rationale for its increased use. Section 2.3 reviews the literature on various approaches for improving the quality of residential care for older people. Section 2.4 summarises the literature on the use of regulation in residential care and in particular highlights both the limited research that has been carried out on the development of regulations within the residential care sector and, more specifically, the use of regulatory negotiation to develop regulations within the sector. The chapter concludes by summarising the gaps in our knowledge about the use of regulatory negotiation both generally and within the residential care sector.

2.2 Regulation and Governance

2.2.1 Introduction

As noted in Chapter One, the use of regulation has grown in popularity over the last few decades, particularly in Western countries. This has been attributed to a change in the organisation of political power and policy-making (Benz & Papadopoulos 2006), which has been described as a shift from government to governance. This section discusses the literature on the rise of regulation in the context of this change from government to governance.

2.2.2 From Government to Governance

Over the last few decades, the term “governance” has grown from virtual obscurity to take an important place in the social sciences, partly displacing the concept of “government” (Daly 2003). Though “governance” remains a blurred and somewhat elusive term, bearing a range of different meanings and interpretations (Clarke 2009), it broadly refers to new processes and methods of governing and to changing conditions of the ordered rule (Rhodes 1996). In particular, governance refers to what observers have suggested is the major change in the organisation of political power that has occurred since the 1970s, whereby actors outside of central government now play a significant role in the development and implementation of public policy (Rhodes 1997). This change coincided with the rise of neo-liberalism, a political and economic ideology which believes in the power of the market to deliver public services and subsequently reduce the role of government (Steger & Roy 2010). Indeed, governance has been regarded as the scholarship of how neo-liberalism has transformed government, the public sector and society, particularly since the 1990s (Jordana & Levi-Faur 2004, Newman 2001).

Some scholars question the veracity of the theory of governance, arguing that policy-making involving non-state actors is a well-established tradition and is not a new phenomenon that has changed policy-making structures in the way governance scholars suggest (Pierre & Peters 2000). However, the interest in new forms of governance emerged when it became clear that traditionally “statist” countries were breaking with tradition. In particular, countries that adopted the principles of “New Public Management” were seen to have altered the policy-making and implementation process (Pierre & Peters 2000).

Most associated with Reagan in the United States and Thatcher in the United Kingdom, later spreading to Australia, New Zealand, Canada and subsequently throughout Europe, New Public Management emerged in the late 1980s following a global recession, aiming to operationalise the principles of neo-liberalism, namely, adopting the values of the private sector to rationalise and improve the public sector, placing an emphasis on privatisation, deregulation and efficiency (O'Flynn 2007, Steger & Roy 2010). The New Public Management approach also meant that greater reliance was placed on contracting out public services to the private sector, leading to the increased involvement of the private sector in creating and implementing government policies. This in turn has led to concerns that there has been a dispersal of power within and beyond the state (Newman 2005). Thus, while the objective of New Public Management was to roll back the State, the size of the State often increased as new state agencies were created to oversee the private sector agencies who provided services to the public (Jordana & Levi-Faur 2004).

Some scholars have argued that New Public Management went into decline in the 1990s precisely because it failed to meet its key objectives of increasing efficiency in the public sector and downsizing the State (Noordhoek & Saner 2005, OECD 2003, O'Flynn 2007). Furthermore, the reliance by New Public Management governments on the market eroded accountability and responsibility and led to suspicions that public policy was no longer being developed in the public interest, but to facilitate the wishes of private sector agencies (O'Flynn 2007). At the same time, trust in governments had started to rapidly decline within almost all advanced industrial democracies in the 1980s and 1990s (Dalton 2005, Fukuyama 1995, Putnam 1993) and it has been suggested that this decline in trust was because the public felt that New Public Management had allowed governments to prioritise their own self-interests over those of the wider society (Dalton 2005, Jordana & Levi-Faur 2004, Majone 1994).

2.2.3 From New Public Management to Public Value

As a result of the failure of New Public Management, governments have strived to make themselves more trustworthy and accountable to the electorate (O'Flynn 2007, Pharr, Putnam & Dalton 2000). In the late 1990s, many governments began to place increasing value on the importance of developing and implementing policies that achieved the broader goal of public value, na-

mely, reflecting the social values of the general public, rather than efficiency alone (O'Flynn 2007). Thus, governments spoke more about public policy in terms of "outcomes", aiming to ensure that services met the needs of citizens (Fairclough 2000, Newman 2000). Furthermore, increased emphasis was placed on consultation with citizens and service users, with policies being developed in partnership with relevant stakeholders (Fairclough 2000, Newman 2000).

This "public value" approach to governance was described as a "Third Way". The Third Way approach represented an attempt to operate a middle ground between left-wing and right-wing policies and aimed to reinforce the benefits of a traditional social democratic concern for equality and social justice with the advantages of an economic system based on a free market ideology (Hamilton 2001). Third Way policies were adopted in the late 1990s in the United States, the United Kingdom, Australia and Canada (Alford 2002). However, the philosophy is arguably most associated with Tony Blair in the UK.

In the UK, Tony Blair led the New Labour Party to a landslide victory in the 1997 general election on the basis of New Labour's Third Way approach, which envisioned a re-imagining of the relationship between state and citizen and a new emphasis on the values of community and the role of civil society (Newman 2001). However, according to Fairclough (2000), much of the language used by New Labour in the 1997 UK general election was based on a "rhetoric of conciliation", designed to rebuild the trust of the electorate following the years of Thatcher's New Public Management approach (Fairclough 2000, p. viii). "Partnership" became a New Labour keyword, to highlight the government's intention to establish a wholly new relationship with the British people (Fairclough 2000). This emphasis on partnership represented a discourse of inclusion and collaboration which was central to Labour's attempt to forge a consensual style of politics (Newman 2001). It also highlighted the aim of empowering the vulnerable by overcoming the problem of social exclusion (Clarke 2006). Although governments had used partnerships to develop and implement policy for many years, the explicit focus on the tool was a distinctive feature of New Labour's approach to governance (Newman 2001). However, many governance theorists have raised concerns about the use of partnerships, arguing that they are less a commitment to transforming decision-making processes than a way of legitimising difficult decisions made directly by the government (Newman 2005); in other words, a way of allowing the government to distance themselves from blame if problems la-

ter emerge. Furthermore, others have questioned the democratic legitimacy of governance networks, suggesting that those who claim to represent the public in such initiatives have no mandate from the electorate to do so and also may not be aware of the complexities of what the public wants and what is in their best interests (Barnes, Newman, Knops & Sullivan 2003, Bogason 2006).

According to Newman (2001), the emphasis on partnership was central to New Labour's Modernisation Agenda, a programme which aimed to reform the public policy system in the UK by focusing on the delivery of outcomes. Newman (2000) suggests that New Labour's Modernisation Agenda was an attempt to move beyond the reform programmes of New Public Management to a new set of discourses of citizen participation and user choice. The concept of choice was used as a driving mechanism within New Labour because the era of globalisation had led to a proliferation of goods and services, enabling a wide variety of wants and needs to be satisfied (Clarke 2006). New Labour thus set out to reform public services with the aim of meeting the new expectations of a public which had become accustomed to greater choice and to responsive, accessible and flexible services. Thus, within the New Labour-led government, citizens became personified as consumers and public services were encouraged to adopt many of the characteristics of the private sector. This has led many commentators to argue that, rather than being a "Third Way", New Labour actually endorsed and strengthened the neo-liberalist, market-led approach they had set out to reform (Alford 2002, Clarke 2006, Gilleard & Higgs 1998, Newman 2000, Steger & Roy 2010). Indeed, citizens were arguably even more disadvantaged under the Third Way schema; as it allowed the State to pass responsibility to the public for managing the public services they used:

By first interpreting and incorporating the consumers' voice into the state's health and welfare systems, the state can represent itself as the supporter of individual choice and consumer sovereignty, while divesting itself from as much communal and statutory responsibility as possible.

(Gilleard & Higgs 1998, p. 242)

Glendinning (2008) highlights the example of cash for care programmes (i.e. direct payments to people with disabilities to allow them to buy care directly in a way that best suits their own personal needs), which require care recipients to become the employer of a care assistant. As noted above, the Third Way model of government has spread to many other countries, including Australia, America and elsewhere in Europe. In particular, it is possible to argue that Ireland

has adopted many of the individual policy tools associated with the Third Way in the UK, including partnership, a focus on outcomes and a conceptualisation of the citizen as a consumer (MacCarthaigh & Hardiman 2010, Murphy 2010). This issue is discussed in greater detail in Chapter Three.

Poole (2000) also suggests that New Labour's Modernisation Agenda altered the approach to regulation in the UK, particularly of social and healthcare services. She argues that a concern with the performance of the public sector is much more evident in New Labour discourses than it was in the Thatcher era, with emphasis placed on state monitoring, surveillance and regulation of the National Health Service in the UK. Thus, far from a rolling back of the State, the Third Way represented an extension of its involvement and ultimately its power, despite the rhetoric of partnership and co-operation (Newman 2001). The expansion of regulation in the politics of the Third Way was merely a continuation of the reliance on oversight as a tool of governance that developed during the rise of New Public Management, as outlined below.

2.2.4 The Rise of Regulation

Since the 1980s, there has been a sharp increase in the number of regulatory agencies established across most OECD member states (OECD 1997). Regulation is used in an ever-increasing range of sectors and a greater emphasis has been placed on monitoring the quality of services. It has been suggested that the rise of regulation is connected to wider changes in the governance structures of "neo-liberal states" (Jordana & Levi-Faur 2004). Indeed, the use of regulation has increased in many European countries only at the urging of the EU, which broadly follows neo-liberal policies (Christensen & Laegreid 2007, Pollitt, van Thiel & Homburg 2007).

Proponents of New Public Management saw regulation as unnecessary red tape and so deregulation became a major electoral platform of the New Right (Jordana & Levi-Faur 2004). However, regulation actually became a key characteristic of New Public Management, as it facilitated a new division of labour which was emerging, whereby the State no longer took responsibility for the direct provision of services, but instead saw its role as to oversee private enterprises who provided services to citizens ("steering, not rowing") (Ayres & Braithwaite 1992). Thus, the rise of regulation developed from the government's need to ensure private enterprises were operating in the best interests of consumers. As New Public Management grew in popularity, a "global spread

of regulatory reforms" led to a significant rise in the number of new regulatory bodies being established (Jordana & Levi-Faur 2004). However, in the late 1980s and early 1990s, doubts began to arise about the benefits of regulation.

May (2002) cites Viscusi (1992), who noted that the regulation of occupational safety within the United States during the 1970s made relatively few improvements in improving worker safety at a large and disproportionate cost. Similarly, Davies and Mazurek (1998, cited in May 2002), evaluated pollution control within the United States during the 1970s and 1980s and found that, while substantial improvements were made in air and water quality, at least some pollution reduction programmes could have been used as an alternative to regulation. In addition, commentators began to argue that "regulatory capture" was a common problem faced by regulators. Regulatory capture refers to the ability of regulated firms to weaken regulations or limit enforcement powers (Laffont & Tirole 1991). As a result, regulations often failed to protect the "public interest". While the public interest is an elusive term, it often refers to the needs of those whom the regulations were designed to protect, most often consumers of regulated firms (Laffont & Tirole 1991, Posner 1974).

Others suggested that governments used regulation to purport to be acting in the public interest without actually changing the status quo: "When governments are short of cash or unwilling to spend it, the creation of regulatory agencies provides a low cost symbolic commitment to action" (Loughlin & Scott 1997). Braithwaite, Makkai, Braithwaite & Gibson (1993) called this process "regulatory ritualism". They argued that politicians are often induced to regulate sectors at the behest of the electorate who want to see tough action. As a result, politicians support a system that gives the appearance of being tough without bringing about major substantive change. When politicians who do want effective regulation come to power, "they are paradoxically at risk of attack from conservative ritualists when they dismantle rituals that give the appearance of toughness in favour of reforms that deliver more substance" (Braithwaite, Makkai & Braithwaite 2007, p. 220). Regulatory ritualism can occur after a regulatory failure and subsequent public scandal; politicians want to be able to invoke "a ritual of comfort that will create the appearance that checks are now in place to ensure that this cannot happen again" (Braithwaite et al. 2007, p. 220).

It is widely acknowledged that regulators need to be independent in order to be effective and that interference by government actors can compromise the regulatory process, which can undermine both the regulatory regime and the

government itself (Stern & Holder 1999). However, in practice, regulatory independence can easily be compromised. Several studies have reported problems with governments' interference with the regulatory process (Bertolotti, Cambini, Rondi & Spiegel 2011, Edwards & Waverman 2006, Gilardi 2008). Furthermore, by limiting the power and resources of regulators, governments can remain in control behind the scenes (Thatcher 2005). Not only does this show that regulation remains a problematic and limited tool of governance, but it also highlights how regulation can enhance the powers of government, while giving it the advantage of shifting the blame onto others when problems arise.

In spite of these shortcomings, the use of regulation continued to grow throughout the 1990s and 2000s. (Gilardi 2008) has indicated that the number of independent regulatory agencies increased seven-fold between 1980 and 2000. In the case of Ireland, it has been suggested that successive governments are "regulating everything" (Scott 2008). However, the shortcomings of regulation gave rise to a plethora of regulatory improvement strategies, which has been termed "The Better Regulation Movement" (Baldwin 2005). This was led by Tony Blair in the UK, who established the Better Regulation Task Force, which published a set of principles of better regulation, and was followed by similar movements in other countries and within the EU and OECD (Baldwin 2005). The Better Regulation Movement developed new and innovative models of regulation which recognised the importance of respecting the autonomy and expertise of regulated firms. It thus focused on greater collaboration between the regulator and the regulated firm itself (Baldwin 2005). Better Regulation has also resulted in changes to the way in which rules are written. Rather than a traditional approach to the development of regulations by the government, scholars began to advocate for regulations to be written with input by citizens groups and industry associations, in order to minimise the ability of governments to compromise regulators' independence and to ensure that rules were written in the public interest (Gunningham, Grabosky & Sinclair 1998, Quintyn & Taylor 2007, Smith 2009).

2.2.5 Regulatory Negotiation

As noted in Chapter One, regulatory negotiation was first proposed in the early 1980s as a way of minimising some of the problems of more traditional forms of rule-making. In particular, it was hoped that the process would result

in rules which were clearer and which regulated firms would agree to implement (thus increasing compliance rates). Later, the process was also sold as a way of allowing regulated entities and public interest group representatives to work together as compatriots in search of a mutually agreeable outcome (Harter 1982, Seidenfeld 2000). As a result, it was argued that negotiated regulation would help to limit conflict between the different stakeholder groups of regulated sectors (Seidenfeld 2000).

Few sets of regulations were developed under the terms of the 1990 Act, largely because the Act set strict criteria for the operation of negotiated processes (Lubbers 2008). Yet the Act helped to stimulate a process whereby regulations were developed in consultation with relevant stakeholders (Selmi 2005). Indeed, regulatory negotiation grew in popularity throughout the late 1990s and early 2000s, arguably stimulated by Third Way government policy objectives of partnership, consultation and Better Regulation (Baldwin 2005, Jordana & Levi-Faur 2004). Indeed, many governments now require consultation with the public and stakeholder groups before ratifying any new regulations, including Ireland (Department of the Taoiseach 2004), the UK (Better Regulation Commission 2006) and Australia (Taskforce on Reducing Regulatory Burdens on Business 2006). Third Way proponents of regulatory negotiation also began to attribute additional benefits to the process. In particular, it was suggested that regulatory negotiation could help to empower the intended beneficiaries of the process, thus providing a greater guarantee that the rules would be written in the public interest (Seidenfeld 2000).

In spite of its popularity, research on the process in general is limited and there is considerable disagreement about its proposed benefits. Only limited research describes the potential advantages of regulatory negotiation over more traditional forms of rulemaking. Freeman & Langbein (2000) found evidence to show that the financial costs of traditional rule making and negotiated rulemaking differed little, though they argued that there was also greater legitimacy and "buy-in" from participants for the latter processes. Cladart & Ashford (1992) and Selmi (2005) suggested that this approach, while not a cure-all for the shortcomings of regulation, can help parties with very different interests reach creative solutions to regulatory problems.

However, others have disputed these findings, raising concerns about the impacts of regulatory negotiation for consumers. Coglianese (2001a) found evidence which showed that negotiated rules are not of any better quality than those developed through a more traditional process, nor is there necessarily a

higher level of compliance with the regulations developed. Seidenfeld (2000) asserted that claims of collaboration usually fall short of the mark; instead of forming a consensus, participants usually attempt to create strategic advantages vis-à-vis other stakeholders. As a result, it can become difficult for rules developed through regulatory negotiation to benefit consumers of regulated firms. This is why Seidenfeld recommended that the development of rules for residential care settings for older people could act as a good test case for proving (or disproving) this theory, as already noted in Chapter One; if the regulatory negotiated process helped to empower older residents, a particularly disempowered group, it would help to show that regulatory negotiation had a significant advantage over more traditional forms of rulemaking.

Indeed, Funk (1997, 2009) has suggested that the very principle on which regulatory negotiation is based hinders rules from being written in the public interest. As the primary focus of regulatory negotiation has traditionally been to achieve consensus between the different stakeholder groups, the process effectively makes the “public” just one of the interests to be served, rather than the sole beneficiaries:

The theory of negotiated rulemaking is at war with conventional rulemaking. To the extent that negotiated rulemaking is the model for rulemaking, its theory and principles subvert the principles and theory of normal rulemaking. The incentives to make negotiated rulemaking succeed themselves undermine and subvert the principles underlying traditional administrative law by elevating the importance of consensus among the parties above the law, the facts, or the public interest.

(Funk 1997, p. 1387)

This may help to explain why a significant body of research has found that stakeholders from the regulated industry tend to dominate consultation processes and successfully alter the content of regulations in their favour (Furlong & Kerwin 2004, Golden 1998, Wagner et al. 2011, Yackee 2006). A number of studies have found that the amount of input from ordinary citizens into regulations tends to be relatively low (Coglianese 2006, Coglianese, Kilmartin & Mendelson 2009, Funk 2009, Golden 1998, Wagner et al. 2011). When citizens do take the time to comment on proposed new regulations, they often do so in informal ways and so regulators often fail to take their views into account (Cuellar 2005). Furthermore, organisations representing regulated firms tend to be better organised and also to have better links with politicians (Chari, Murphy & Hogan 2007) than public interest groups. Cuellar (2005) also found

empirical evidence to suggest that regulatory agencies who attempt to involve the public in the development of regulations may not necessarily take their views into account.

Therefore, it is possible that the popularity of regulatory negotiation may have been the fact that it broadly reflected the “Third Way” approach of working in partnership with non-State actors in an effort to highlight the trustworthiness of governments. Overall, however, research on negotiated regulation is relatively under-theorised. Most of the research on the subject tries to examine the relative strengths and weaknesses of the approach vis-a-vis more traditional forms of rulemaking. Little research has situated its use within the context of wider changes in regulatory governance in traditionally neo-liberal welfare states. Furthermore, research on the process is limited to the environmental sector and often concentrates on the interactions of the negotiating committees. There is little attempt to understand how the process impacts on the outcomes, apart from looking at the extent to which negotiated regulation can help to prevent litigation (i.e. legal challenges to the rules) (Coglianese 2001a, Selmi 2005). More importantly, there is little attempt to theorise about why regulation tends to result in regulations that can favour regulated firms, rather than the intended beneficiaries, as outlined above. A small number of researchers have examined the use of negotiated regulation in the context of theories of the public interest, though even here, problems remain, as outlined in the next section.

2.2.6 Regulatory Negotiation and the Public Interest

Much of the research carried out to date on the relationship between regulatory negotiation and the public interest has failed to critically engage with the concept of the public interest. Funk (1997) acknowledges the difficulty in determining what is meant by the public interest:

What is meant by the public interest is not always clear. I mean it to be the best interests of the nation, the people, the body politic.

(Funk 1997, p. 1383)

However, neither Funk nor other commentators outline what they understand by the term at all (Coglianese 2001b, Golden 1998, Langbein & Kerwin 2000, Wagner et al. 2011), simply using the term to refer to the interests of consu-

mers of regulated firms, without attempting to understand who constitutes the public and what their interests might be.

The limited conceptualisation of the “public interest” in the regulatory negotiation literature is not unique and is widely acknowledged as being problematic (Baldwin & Cave 1999, Feintuck 2004). The theory and practice of regulation centre on the idea that regulators aim to act in the public interest, as opposed to the interests of regulated entities (Baldwin & Cave 1999, Feintuck 2004, Gilfedder & O hOgartaigh 1998, Nolan 2008). In the case of Ireland, Murphy (2010) suggests that informal “behind the scenes” lobbying of politicians by powerful interest groups can have a stronger influence on public policy than more formal approaches because political parties in Ireland compete on an increasingly narrow issue base, and so lobby groups can retain power to show loyalty to the party most sympathetic to their needs. Although some scholars argue that regulation often does act in accordance with the public interest (Coglianese & Kagan 2007, Croley 2008), the term assumes that there is one homogenous “public” with just one interest, rather than diverse groups of citizens with different and complex interests. Furthermore, the public interest theory of regulation assumes a trustworthiness and objectivity on the part of the regulator, whereby they are capable of and willing to promote the best interests of the public. This assumption ignores a wide body of research which suggests that regulators are open to capture and may succumb to opportunities for personal profit (Baldwin & Cave 1999, Dal Bo 2006, Helm 2006, Levine & Forrence 1990). Thus, Baldwin & Cave (1999) argue that regulation often fails to deliver public interest outcomes.

In spite of these complexities, Feintuck (2004) argues that the concept of the public interest in regulation should not be written off completely, as regulation should serve to ensure that the exercise of private power is consistent with the value-set which underlies the democratic settlement (Feintuck 2004). Feintuck suggests that one possible explanation for the problems inherent in using a public interest perspective is that, in the post-Thatcher age, the public interest is often defined in economic terms, whereby the purpose of regulation is to achieve publicly desirable results which the market would fail to yield alone. For example, in a well-regulated market, individuals looking for a residential care setting would be able to select the highest quality care setting at the lowest possible price. Thus, policy-makers often argue that a market should be deregulated (i.e. opened up to competition) in order to reduce costs of the good or service to consumers:

The ideological dominance of market-driven politics is such that the preservation of the wider liberal-democratic value set stands desperately in need of protection, yet the legal system seems to struggle to develop or recognise devices which serve such values. While the legal system seems to be good at recognising individual, property-related interests, it has much more difficulty in validating and protecting “non-commodity” values. Put simply, the legal system’s ability to protect the apparent economic interests of individuals, reflecting the dominant view of us as *consumers*, will not adequately protect the broader, and often collective interests of us all as *citizens*.

(Feintuck 2004, p. 59)

However, this can serve to reinforce the assumption that the market offers solutions to all of society’s problems, facilitating the prioritisation of the interests of the private sector. Furthermore, it also has the effect of “the public” being defined as consumers, rather than as citizens. Not only does this serve to erode social democracy, it can also create challenges for individuals who now have to take responsibility for selecting a service that offers them the best value for money.

Feintuck (2004) argues that these problems can be resolved by ensuring that regulatory systems return to a citizenship-orientated perspective, as, when people are defined as citizens, their interests are conceptualised more broadly (albeit with much greater difficulty) than when they are seen as consumers. Feintuck argues that a citizenship perspective rebalances our understanding of the public interest back towards a concept of social solidarity, in which the role of community and society is to ensure the protection of human rights, and, in particular, minority interests. Seen in this light, Feintuck (2004) argues that regulation can act as a counter-balance to the excessive dominance of a market-driven approach to politics and policy-making. Feintuck (2004) further argues that regulators need to guard against the domination of the rule-making process by any one interest group (“to protect the freedom of factions to further their political interests while preventing any individual faction from undermining the freedom of others”, pg. 197).

Feintuck’s argument has received some support. Prosser (2006) and Berenson (2000) argue for regulation to be based on principles of social solidarity, whereby regulation can help to prevent or limit the socially fragmenting role of markets. Prosser (2006) ascribes to regulation a social organising function in order to ensure equal treatment between citizens on the basis of citizenship and inclusivity. Morgan (2008) also argues the ultimate goal of regulation

should be to facilitate social citizenship. This suggests that a reconceptualisation of the purpose of negotiated regulation as a way of bringing stakeholders together to define and establish rules to protect the public interest may lead to greater benefits of its use as a model.

2.2.7 The Policy Making Process

Shortcomings in the regulatory process, particularly in terms of the limited extent to which they can protect the public interest, can be better understood once it is recognised that regulation is a policy tool (Salamon 2002) which suffers from the problems that often beset the development and implementation of government policy. Indeed, many scholars have shown that policies as originally envisaged by scholars and/or civil servants are often significantly different when they are implemented in practice (Earley 1999, Hill 2005). This is partly due to the way in which “street level bureaucrats” interpret the policy. However, the design of the policy also plays a significant role in how it is implemented.

The policy-making process is extremely complex. Once a problem has been identified with reference to empirical evidence, civil servants or politicians need to think about policy options available to them, and may select a policy instrument ill-suited to the policy problem (Winter 2006). Poor implementation is also often caused by the selection of inadequate policy instruments, political posturing and manoeuvring during their development, as well as the reality of financial constraints (Bobrow 2006, Ellerman 2005, Hill 2005, Kingdon 2010). Furthermore, the facilitation and organisation of the policy-making process can often hamper the end result (Hill 2005). Policy-makers are often given a short time frame in which to develop complex policies; which can often lead to “unintended consequences”, namely, weaknesses in the policy itself (Hill 2005). In addition, Borrow suggests that, the harsh statistical reality is that the vast majority of time, our best efforts will not succeed and even when they do, repeating the same thing might not work in other circumstances or locations (Bobrow 2006). Finally, a wide range of actors often have input into important government policies; this can cause delay, distortion and ambiguity in policy documents (Loughlin 2002). Bogason (2006) has highlighted the challenges of the involvement of a “network” approach to policy-making, whereby relevant stakeholders are invited to participate in the policy-making process. In particular, it can become difficult for policy-makers to select a ba-

lanced range of stakeholders and facilitating the activities of the network can become challenging. This has led many researchers to argue that research that criticises poor or inadequate implementation of policy without attempting to highlight the contextual constraints that have led to this outcome is itself inadequate.

2.2.8 Overview

The use of new forms of governance originally developed in countries where politicians set out to implement neo-liberalism to promote the private sector. This led to the greater involvement of non-State actors and a rise in the use of regulation to oversee the development of services for the public. However, it was clear that this process was problematic; regulation is a political tool and its independence is often under threat from government. Paradoxically, governments responded to a decline in public trust by increasing the use of both partnership and regulation. In this context, it is possible to argue that the popularity of regulatory negotiation by neo-liberal governments is because it combines the benefits of regulation and partnership. While it is not clear that its benefits outweigh its shortcomings, it adds a further layer of accountability which removes government's own responsibilities to an even greater extent. Yet, to date, no research has examined the extent to which the participants of regulatory negotiated processes serve as "watchdogs" over the process. Indeed, research on regulatory negotiation is relatively under-theorised overall. Most of the research on the subject, as outlined above, tries to examine the relative strengths and weaknesses of the approach vis-à-vis more traditional forms of rulemaking. To date, research has not yet examined its use, and outcomes, in the context of wider changes in regulatory governance in traditionally neo-liberal welfare states. Furthermore, there is little attempt to theorise about why regulatory negotiation tends to lead to rules that favour regulated firms, rather than the intended beneficiaries.

2.3 Improving the Quality of Residential Care for Older People

2.3.1 Introduction

Across all OECD countries, only a relatively small proportion (5% on average) of people aged 65 and over live in residential care settings (OECD 2005). However, a significant proportion of those living in residential care have significant care needs; studies have shown that up to 80% may have dementia or another cognitive impairment (Cahill, Diaz-Ponce, Coen & Walsh 2010) and/or physical disabilities and other age-related conditions (Falconer & O'Neill 2007, Magaziner, German, Zimmerman, Hebel, Burton, Gruber-Baldini, May & Kittner 2000, OECD 2005).

Older people rarely have a preference for nursing home care; almost one-third of respondents in one study indicated that they would rather die than enter a residential care setting (Mattimore et al. 1997). This may be because older people feel that the quality of residential care is a poor substitute for the care that they can receive at home. Indeed, empirical evidence suggests that the quality of long-stay care services for older people is variable and does not always meet residents' expectations (OECD 2005). This section discusses the quality of residential care and various strategies developed to improve it since the 1960s.

2.3.2 Quality in Traditional Residential Care Settings

Residential care settings for older people have existed in many Western countries for over eight hundred years (Braithwaite 2001, Payne 2006, Timonen & Doyle 2008). Because nursing homes were originally modelled on acute care settings, both the physical layout and the way in which care was organised tended to follow the acute care format (Kane, Kane & Ladd 1998). Acute care settings, and thus nursing homes, were designed to facilitate the work practices of nurses, with features such as the presence of one, central dayroom, long, sterile corridors and shared sleeping facilities designed to allow nursing staff to monitor the well-being of residents with relative ease. These characteristics mirror those of Goffman's (1961) "total institutions".

In his seminal work *Asylums*, Goffman (1961) posited his theory of "total ins-

tutions", which claimed that facilities such as mental hospitals, prisons and concentration camps shared many characteristics. He suggested that many of the features of such institutions serve the ritual function of ensuring that both staff and patients/inmates know their function and social role, to the extent that both groups become institutionalised and patients/inmates became disempowered. Goffman suggested that:

Total institutions disrupt or defile precisely those actions that in civil society have the role of attesting to the actor and those in his presence that he has some command over his world - that he is a person with "adult" self-determination, autonomy and freedom of action.

(Goffman 1961, p. 43)

Lidz, Fischer & Arnold (1992) used Goffman's work to show how the characteristics of total institutions are also applicable to residential care settings for older people, as outlined in Table 2.1.

Many of the features of total institutions can be seen in descriptions of residential care settings written in the 1960s and '70s. Townsend (1964) documented the poor conditions he observed in English and Welsh nursing homes during the 1950s, including older people being physically attached to their chairs, the tendency of staff not to disclose the deaths of fellow residents and impersonal living spaces with an institutional feel. This led him to conclude that "the conditions of the nursing homes do not adequately meet the physical, psychological and social needs of the elderly people living in them, and that alternative services and living arrangements should quickly take their place" (Townsend 1964, p. 222). Similarly, Gubrium (1997) highlighted the lack of mental stimulation provided to residents of a large, American care home in the 1970s, and also the lack of consultation with residents about their care. Since this period, there has been a sustained effort to improve the quality of residential care settings for older people.

2.3.3 Defining Quality

Improving the quality of a residential care setting requires an understanding of what broadly constitutes high quality for the sector. Indeed, "quality" is an elusive and subjective concept in the context of residential care for older people; what may be considered a high quality facility for one individual may be considered inadequate by another person's standards (Brod, Stewart, Sands

Table 2.1: The Characteristics of Total Institutions

1. Entry rituals including stripping of an individual's private identity and processing an individual's life.
2. Locational dedifferentiation: all aspects of life are conducted in the same place.
3. Dedifferentiation of authority: single, unspecialised authority, hierarchy.
4. Each phase of the patient's daily activity is carried on in the immediate company of a large group of others.
5. Daily activities are tightly scheduled by staff with little individual variation.
6. Violations of privacy are common.
7. There is a small group of staff members whose primary role is to ensure enforcement of the rules.
8. Several restrictions on patient contact with the outside world.
9. Line staff function to control patient communication to higher staff.
10. Patients and staff view each other through narrow, hostile stereotypes.
11. Patients are excluded from making plans about themselves.
12. Rituals are characterised by patient deference toward staff develop in total institutions.
13. Patients must request staff permission for routine activities and tools.
14. Discrediting reports about patients are commonly spread through staff ranks.
15. All activities are brought together into a single, rational plan designed to fulfil official aims of the institution.

Source: Lidz et al. 1992

& Walton 1999). Thus, determining (and setting standards for) the quality of residential care can be problematic. Determining whether a residential care setting is of a high quality also depends on what aspects of the home are being judged, as well as on who is making the final judgement. Researchers have often made a distinction between "quality of care" and "quality of life" in order to better measure how well a particular home meets the needs of re-

sidents. Campbell, Roland & Buetow (2000) suggest that quality of care can be understood as whether individuals can access the health structures and processes of care which they need and whether the care they receive is effective. While quality of care remains inherently a subjective concept, many objective measurement scales have been developed to evaluate care settings in terms of the quality of care they provide. Quality of care therefore often uses measures such as the rate of accidents or falls in a care setting; outbreaks of infection; psychotropic drug use; incidents of pressure sores; and nutritional intake (Zimmerman 2003).

Quality of life, on the other hand, presents many challenges to researchers, as there is little agreement on how best to define the term and how best it can be measured. Broadly speaking, quality of life is a broader concept than quality of care, consisting of a multidimensional appraisal of a variety of important domains of life, such as residents' sense of safety, physical comfort, enjoyment, meaningful activity, relationships and dignity - areas that are not parts of narrower concepts of clinical outcomes or quality of care alone (Kane et al. 2003). Higgs, Hyde, Wiggins & Blane (2003) have argued that there is also a need to consider issues more broadly related to the satisfaction of human needs, rather than just health, including the extent to which individuals have control, autonomy, pleasure and self-realisation, factors found to be important to older people living in residential care (Timonen & O'Dwyer 2009). However, this debate is arguably becoming redundant as policy-makers, researchers and practitioners have recognised the need to ensure that care settings provide residents with a good quality of life as well as high quality care (Degenholtz, Kane, Kane, Bershady & Kling 2006, Guse & Masesar 1999). There is also more emphasis being placed on the need to take into account the views of older people themselves within quality improvement policies and programmes and to implement a model of care that focuses on catering for each resident's individual needs. As a result, "person-centred care" has become widely acknowledged since the 1980s and '90s as being the best way of improving the quality of residential care for older people.

2.3.4 Person-Centred Care

The 'traditional' model of nursing home care described earlier largely reflects a 'medical' model of care that was dominant and widely accepted in services for people with disabilities up until the 1960s and '70s (Oliver 1996). Within

the medical model, people with a disability or chronic illness were viewed as problematic and were expected to give way to medical intervention in order to help them adjust to their personal tragedy and to accept socialisation into the role of a 'disabled person' (Barnes, Mercer & Shakespeare 1999).

In 1975, the Union of the Physically Impaired Against Segregation was established in the UK (UPIAS 1976). This organisation is regarded as the starting point of the Disability Movement, a campaign to raise awareness of the denial of citizenship that people with disabilities experienced. It provided people with disabilities with a theoretical tool to assist them in the struggle for better services as well as full economic social and political inclusion in society (Oliver 1990). Supporters of the social model argued that people with disabilities are the product of environmental and social structures which serve to reduce their participation in society (Oliver 1990). Disability is therefore seen by advocates of the social model as a socially constructed entity created by a range of historical and cultural factors.

The Disability Movement also influenced the care of older people with disabilities, particularly for older people with dementia. Advocates for older people living in residential care began to argue that the poor quality of care, and the medical model of care that dominated residential care settings, led to a denial of the human rights of older people (Epp 2003). In the 1970s and '80s, care practitioners began developing a new, more holistic model of care to replace this model with one which aimed to meet the subjectively-defined needs of residents (Epp 2003). Out of such work grew the "person-centred model" of care.

The term "person-centred" was first used within the field of dementia in 1988 by Tom Kitwood, in his attempt to describe a model of care that aimed to nurture the intrinsic "personhood" of each individual care recipient (Kitwood 1997). Kitwood (1997) referred to personhood as "a standing or status that is bestowed upon one human being by others in the context of relationships and social being. It implies recognition, respect and trust" [p. 8]. Kitwood's approach suggested that what was important in the treatment of dementia was not only to understand the disease process itself, but also how the person was treated by others - empathetic care would help individuals with dementia to retain their personhood and sense of self.

Kitwood's "psycho-social" model of person-centred care was influenced by the practice of client-centred psychotherapy, psychoanalytic and humanist models of therapy and care. According to Kitwood, people with dementia

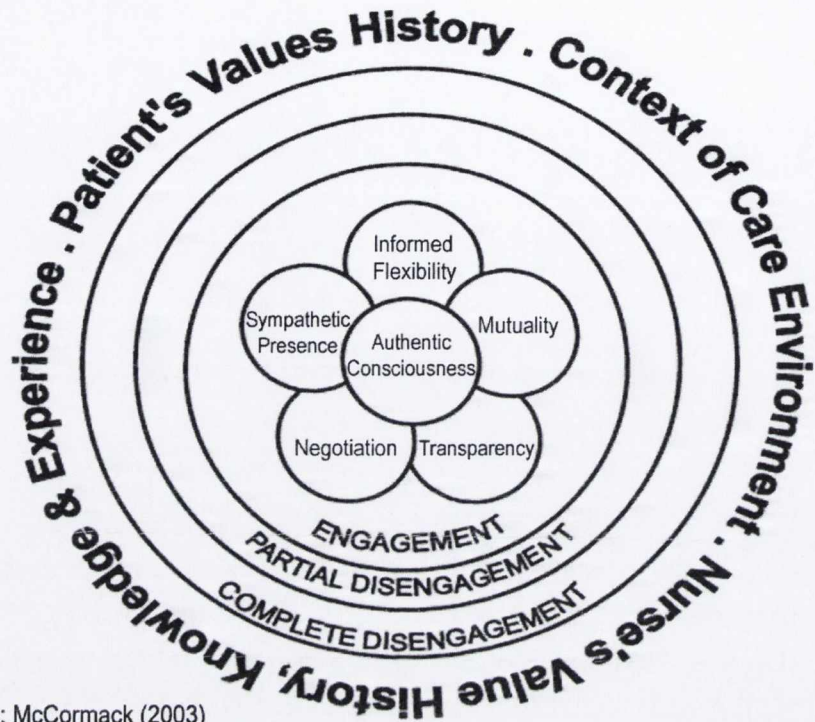
have six psychological needs: love; attachment; comfort; identity; occupation; and inclusion (Kitwood 1997). In order to meet these needs, a psycho-social person-centred model of care is required, containing four elements, each of which have equal weight:

1. Valuing people with dementia and those who care for them;
2. Treating people as individuals;
3. Looking at the world from the perspective of the person with dementia;
4. A positive social environment in which the person living with dementia can experience relative wellbeing.

While Kitwood's conceptualisation of a person-centred model of care was developed specifically for people with dementia, his work has been further developed for older people with care needs but without dementia (Davies, Laker & Ellis 1997, McCormack 2003, Nolan, Davis, Brown, Keady & Nolan 2004, Wilkinson, Meyer & Cotter 2009). Expanding on Kitwood's work, McCormack (2003) emphasised the need for carers to be able to particularise the person that the care-recipient is, the relationship that exists between them and the patient, and the understandings and expectations implicit in the relationship (McCormack 2003). This can be achieved through an understanding of the care recipient's "authentic values", namely, the decisions that care recipients make that expresses all that one believes important about oneself and the world (McCormack 2003). Thus, being person-centred emphasises getting closer to the older person and offering personal support and practical expertise, while enabling the patient to follow the path of their own choosing and in their own way (McCormack 2003). According to McCormack (2003), person-centredness is achieved through consideration of the patient's values, the carer's values, the adoption of "imperfect duties" (including being compassionate, concerned, benevolent and respectful) and trying to ensure that the care environment enhances the facilitation of person-centred practice, including not just the physical environment, but also systems of decision-making, organisational systems, staff relations and the potential of the organisation to tolerate innovate practices and risk taking (see Figure 2.1).

As the term "person-centred care" has taken on a variety of different meanings (Lepledge et al. 2007), it has become inherently difficult to imple-

Figure 2.1: A conceptual framework of person-centredness as authentic consciousness



Source: McCormack (2003)

ment (Edvardsson & Innes 2010, Koren 2010). However, findings from numerous studies indicate that a person-centred approach not only helps to provide residents with good quality care and a good quality of life (Chou, Boldy & Lee 2002, Eales, Keating & Damsma 2001, Guse & Masesar 1999), but it can also reduce the occurrence of feelings of 'learned helplessness' among residents, as they have greater control over their own lives (Tu, Wang & Yeh 2006). Person-centred care can also reduce challenging behaviour among residents with severe dementia (Fossey et al. 2006). This in turn can help to reduce the risk of elder abuse within residential care settings, as it both empowers residents and staff (Hawes & Phillips 2007, Lindblom, Brandt, Hough & Meadows 2007, Post, Page, Conner, Prokhorov, Fang & Biroscak 2010, Schiamberg, Barboza, Oehmke, Zhang, Griffore, Weatherill von Heydrich & Post 2011). The benefits of this approach have stimulated innovative practices which have helped to make many elements of residential care more person-centred, thus enhancing residents' well-being, as outlined below.

2.3.5 Person-Centred Strategies to Improve the Quality of Residential Care Settings

2.3.5.1 Improving the Physical Environment

As noted earlier, Kane et al. (1998) have argued that the typical physical layout of residential care settings was adapted from acute hospital facilities as it facilitated staff needs and was also a model that could easily be replicated. However, research has shown that physical environments which do not take the needs of residents into account can inhibit functioning and social well-being by inhibiting privacy and friendship (Parker et al. 2004).

According to Marshall (1998), good design includes the following features:

- Small size
- Familiar, domestic, homely in style
- Plenty of scope for ordinary activities (unit kitchens, washing lines, garden sheds)
- Unobtrusive concern for safety
- Different rooms for different functions
- Age-appropriate furniture and fittings
- Safe outside space
- Single rooms big enough for lots of personal belongings
- Good signage and multiple cues
- Use of objects, rather than colour, for orientation
- Enhancement of visual access
- Controlled stimuli, especially noise

Privacy is also an important element of the physical layout of a care setting (Bland 1999). Research has shown that older people enjoy having their own bedrooms (Calkins & Cassella 2007), as well as personal space and choice in which to engage in daytime activities (Barnes 2006). The presence of notable architectural features, such as visual access to the main destinations, can facilitate residents' ability to negotiate through the physical environment (known

as 'wayfinding'), particularly residents with cognitive impairments, who can otherwise become easily disoriented (Cahill 2002, Netten 1989, Passini, Pigot, Rainville & Tetreault 2000). Sensory environments, such as snoezelens (sensory rooms) and well-designed gardens also help to ensure that residents with dementia are stimulated in a meaningful way (Barnes 2006). Overall, older residents are more likely to perceive that their quality of life is high when they live in a facility that is homely and cosy (Barnes 2006).

However, problems remain with the physical environment of residential care settings, as the design must still take into account mandatory building regulations, which often fail to consider "the interaction effects of tangible physical features and multiple disabilities on a range of desired outcomes" (Cutler et al., 2006, p. 43). Cutler et al. (2006) make reference to regulations for fire safety, which usually require heavy doors that are difficult for residents to open, but often do not require an automatic door opener, which would enhance safety and resident functioning, as well as reducing their level of dependence on staff. This suggests that there may be room for improvement with regard to the physical layout of residential care settings.

2.3.5.2 Governance, Management and Staffing

There is a growing recognition that a care setting's ethos is dictated by the owner/manager and so managers who are focused on meeting the needs of residents are more likely to encourage a person-centred ethos (Barry, Brannon & Mor 2005, Braithwaite, Braithwaite, Gibson & Makkai 1994). Research carried out by Eaton (2000) suggests that homes with a higher quality grading are those with a high staff to resident ratio and a more horizontal managerial structure, in which information is freely shared between staff and nurse aides working in teams or pairs to assist one another in the emotional or physical aspects of their work. Staff wages tend to be higher and work is less task-oriented, with staff encouraged to spend time simply chatting to residents. Eaton (2000) found that this model of management resulted in fewer quality deficiencies and higher resident satisfaction ratings. Qualitative research carried out in Ireland has also shown that residents tend to report a higher level of satisfaction with their care when staff have more autonomy and greater opportunities for interaction with residents (Murphy, O'Shea, Cooney, Shiel & Hodgins 2006).

Further research has since confirmed the benefits of a care setting with a less

formalised managerial structure and which aims to empower staff. Barry et al. (2005) found that providing nurse assistants with more autonomy resulted in better resident outcomes (lower incidence of pressure ulcers and higher social engagement scores). Yeatts & Cready (2007) found evidence that self-managed nurse aide teams led to improved resident care and choices. Furthermore, high staff to resident ratios appear to have an impact on some measures of quality of care, including mortality rates amongst residents (Aiken et al. 2010).

However, Braithwaite et al. (2007) suggest that regulations which are too prescriptive can hinder this person-centred approach to management, as they can inhibit managers and staff from acting in residents' best interests. They give an example of an American facility, in which a male and female resident (staying in two separate bedrooms) share the same bathroom. Although neither resident is capable of using the bathroom, the facility is in breach of the regulation which states that male and female residents cannot share the same toilet and so one of the residents must move bedrooms, in spite of the distress this would cause. As a result, managerial autonomy is an important factor in facilitating residents' choices and improving their quality of life.

2.3.5.3 Investing Financially in Residential Care

Residential care is costly to operate - staffing, insurance and medical overheads are high for providers, as is the cost of meeting statutory regulations (Stewart, Grabowski & Lakdawalla 2009). However, research suggests that increased investment in residential care settings can improve the quality of life of older residents. Higher staffing ratios and an increase in public aid helps to improve the quality of the residential care setting and quality of life for residents (Grabowski 2001, Harrington, Kovner, Mezey, Kayser-Jones, Burger, Mohler, Burke & Zimmerman 2000). The converse is also true; research suggests that providing a high quality of care can reduce costs for providers. Paradoxically, by having a mentality that is focused more on improving quality than on retaining profit, the home may well become more financially viable. Research findings suggest that improving quality reduces costs and can thus increase profits (Braithwaite et al. 2007, Weech-Maldonado, Neff & Mor 2003). Increasing state funding for residential care settings also improves the quality of care provided (Grabowski 2001). Overall, higher quality reduces defects, staff turnover and increases productivity (Braithwaite et al. 2007). This suggests that greater financial investment in care settings will both help to improve the quality of life of older people and also increase profitability.

2.3.5.4 Rights and Empowerment

Kane & Kane (2001) suggest that, compared with younger people with disabilities, older people have difficulties accessing the type of residential care they want due to nursing home routines that prioritise efficiency and accountability over individual preferences. In addition, because older people tend to see themselves as old or sick, rather than 'disabled', they can be cut off from the supports often provided to younger people with disabilities (Kane & Kane 2001). However, if residents cannot express their preferences, their ability to receive person-centred care is limited, as the implementation of a person-centred approach relies on an understanding of residents' values and preferences (McCormack 2003).

Both advocacy initiatives (where a paid advocate or volunteer works with a resident to resolve a problem) and residents' councils (a group of residents who meet on a regular basis to discuss issues affecting their care, with a view to presenting any issues or problems to the facility's management team) have become increasingly common as a method of trying to empower residents and give them more of an input into decisions affecting their lives. Yet often, the number of practical changes brought about are limited due to the presence of cultural and structural barriers, such as internal politics and bureaucratic management systems (Forbat & Atkinson 2005, Hunter & Tyne 2001). Of the few independent evaluations of residents' councils, findings suggest that they tend to be effective in accomplishing some but not all of their objectives and many institutional factors, such as staff working practices, act as barriers to their success (Meyer 1991, O'Dwyer & Timonen 2010, Wilson & Kirby 2005).

In spite of the lack of empirical evidence which indicates that advocacy and related activities help to empower older people and promote their right to choice, many steps have been taken to empower service-users and encourage them to participate in decision-making processes at both a strategic and a practical level. For example, citizen advocacy services are available in some parts of the UK to provide volunteers to provide support and act on behalf of individuals unable to represent their own interests. In addition, all nursing homes in the United States receiving Medicare or Medicaid funding are obliged to facilitate the establishment of a residents' council. However, it is important to note that the traditional, hierarchical structure which continues to predominate within residential care settings continues to disempower older residents, who often have little privacy and are reliant on staff for routine acti-

vities (Tuckett 2007). Thus, there remains a significant need to empower older residents to improve their quality of life.

2.3.5.5 Culture Change

Over the last number of years, a model of residential care for older people has developed which can be described as a culmination of the research on how to develop and implement a person-centred model of care. In 1987, a new organisation, the Pioneer Network, was established in the United States, with the aim of transforming the culture of residential care settings for older people to facilitate a more person-centred environment (Doty, Koren & Sturla 2008). This approach aimed to create an environment within the residential care setting in which older residents thrive by encouraging residents and staff to regard the setting as a type of community. The Network encourages the presence of plants and animals, children interact with residents (Doty et al. 2008). The approach has generated similar models, such as the Eden Alternative and the Wellspring and Green House models. These models generally involve re-designing the facility, emphasising small neighbourhood communities, and changing staffing patterns to promote continuity of care (Wiener 2003). Within this approach, nurse aides and residents are together responsible for managing residents health and social care needs, while nurses and doctors act as consultants within the setting. The care setting is developed as a home, with much of the everyday activity taking place in the kitchen. There is no nurse's station. While one longitudinal quasi-experimental evaluation reported statistically significant differences in self-reported dimensions of quality of life in the experiment group compared with two comparison groups (Kane et al. 2007), no large scale study on the effectiveness of this approach has been carried out. However, Miller, Miller, Jung, Sterns, Clark & Mor (2010) argue that our understanding of the Culture Change movement is only emerging and homes within the United States are only now beginning to move towards the model. They cite a 2007 survey of residential care settings which found that a quarter of all residential care settings were influenced by the culture change movement, though only 5% of facilities stated that they had transformed their settings completely towards the new model (Doty et al. 2008). This suggests that there may be some barriers in implementing a person-centred approach within residential care settings, as discussed below.

2.3.6 Barriers to the Implementation of a Person-Centred Model of Care

While there is a significant body of evidence to show that older people respond positively to a person-centred model of care, a number of factors can hinder its implementation. Some of the most prevalent factors are outlined below.

2.3.6.1 Regulation

As illustrated in Section 2.3.5 above, regulations, particularly prescriptive regulations, can act as a barrier to the implementation of a person-centred model of care because they can often fail to take into account the needs of older people and can inhibit staff and managers from developing a model of care that offers individualised, holistic care. Often, prescriptive regulation reflects policy-makers' mistrust in the ability of providers to provide appropriate care to residents (Braithwaite et al. 2007). Furthermore, regulation focuses on punishing care homes which do not meet required standards (Wiener 2003) and can often reduce interaction between staff and residents as a result of the need to fill in mandatory paperwork (Stevenson & Gifford 2009). Similarly, Colon-Emeric et al. (2010) have found that regulations with a punitive nature are likely to inhibit an approach to care that focuses on meeting the needs of residents.

2.3.6.2 Financial Costs

As noted above, residential care is costly to operate. However, public spending on long term care for older people, particularly residential care, is relatively low in many countries; even in countries with relatively comprehensive coverage, spending on long-term care is currently only 10 to 20 per cent of total spending on health and long-term care together (OECD 2005). Many older people have to resort to private care providers (Rodrigues & Schmidt 2010). In many OECD countries, consumers of residential care often have to pay a significant contribution to the cost of residential care and some countries require those who own their own homes to use their equity in those homes to finance their care (OECD 2005). This means that residential care can be costly for consumers (Wiener 2010).

While demand for residential care is increasing in line with population ageing,

the high cost of entering residential care can act as a disincentive for many older people and so private residential care settings are required to ensure that their prices are competitive. Reducing costs can be possible by keeping staff ratios low (Aiken et al. 2010), adhering to the principle of economies of scale and by developing larger facilities (Hoess, Bachler, Ostermann & Staudinger 2011). Indeed, a study in Ireland has shown that private care settings tend to keep their fees low by employing fewer staff (McEnery 2007). However, these factors can have a negative impact on the quality of life of older people. Lower staff to resident ratios can increase resident mortality (Aiken et al. 2010). In addition, as outlined above, older people tend to prefer living in smaller, more homely facilities. However, high costs have had the effect of forcing smaller homes to close, meaning that the average residential care setting has increased in size in line with the principle of economies of scale (Castle 2005, Darton 2004, Netten, Darton & Williams 2003).

Another significant barrier is the importance of profit-making within private residential care settings, which can drive down the quality of care and lead to concerns about cost instead of quality (Braithwaite et al. 2007). Although higher quality care can often be cheaper in the long run, a person-centred approach requires a significant initial investment to increase staffing ratios, re-train staff and offer residents more privacy. Many home owners are reluctant or unable to fund this initial investment and remain unconvinced of the long-term benefits of this approach (Miller et al. 2010). Furthermore, policy-makers in several countries already have concerns about the escalating costs of residential care for older people and are thus more likely to limit state investment in long term care for older people as the population ages, rather than support providers to improve the quality of care or become more person-centred in their approach (Netten, Williams & Darton 2005, OECD 2005, Weech-Maldonado et al. 2003, Wiener 2010).

2.3.6.3 Resistance to Change

Although many residential care settings strive to offer more personalised care (Miller et al. 2010), staff have been trained in, and are thus more used to following, an acute hospital style of care (Wiener 2010). As staff traditionally have a greater level of control over the operation and management of the care setting, they can find it difficult to facilitate residents to have a greater input into decision-making. In this way, resistance to change at the micro-level is a significant barrier to the implementation of a person-centred model of care

(Robinson & Rosher 2006, Wiener 2010).

2.3.6.4 Acceptance of Ageing

The attitude of inevitability and passivity that can develop amongst older people living in residential care (Kane & Kane 2001) may act as a barrier to a person-centred approach. Although strong efforts were made in the 1980s and 1990s to ensure that younger adults with disabilities in the United States were able to receive long term care services in the most "normal" settings possible, the options for older people have been more restricted (Kane & Kane 2001). Thus, while younger people with disabilities have steadily achieved gains in the amount of autonomy they have over their care, older people, in contrast, seem reconciled to task-based care in nursing homes as an inevitable consequence of dependency.

This acceptance of a lower standard of care by older people is suggestive of the "structured dependency of the elderly" theory (Estes 1979, Townsend 1981, Walker 1980). According to Townsend (1981), changing labour market patterns up until the 1970s meant that older people often ended up with limited financial means, rendering them dependent on family for support. Thus, those without a family network were more likely to be admitted to residential care settings. In addition, older people who were labelled as 'confused' or 'wandering', 'forgetful', 'a danger to themselves', 'dirty', 'undernourished', 'restless' and 'aimless' were urged to move into a hospital or care setting. Within such settings, work practices, and a lack of specialised care, served to ameliorate the level of dependency of older residents. Thus, residential care settings serve the purpose of controlling "inmates", encouraging them to accept a position of dependency and limited autonomy, by capitalising on residents' fears of being moved to a unit for the mentally infirm and the almost total authority of the matron (Townsend 1981). Thompson (1998) suggests that ageist attitudes within society contributed to the construction of old age as a time with little or no future dimension, thus altering older people's selfhood and encouraging them not to 'be a nuisance'. The traditional model of residential care, which continues to predominate in many residential care settings, arguably persuades older residents to become passive and simply accept whatever standard of care they are given (Timonen & O'Dwyer 2009). This in turn can act as a barrier to the implementation of person-centred care, as older people can lose the ability to express their values and preferences, an important part of the person-centred approach (Davies et al. 1997, Timonen & O'Dwyer 2009).

2.3.6.5 Denial of Ageing and Consumer-Driven Society

However, later commentators argued that Townsend's structured dependency theory was too narrow a theory to explain the more cultural changes occurring for older people (Gilleard & Higgs 2000). Led by Laslett (2006), many theorists, including Gilleard & Higgs (1998) and Blaikie (1999) used a postmodern perspective to argue that, rather than older people being squeezed out of the labour market, increased life expectancy and better pension provision marked post-retirement as a new era for older people. Laslett described this period as the "Third Age", characterised by older people who have retired and remain in good health and so can avail of new opportunities within an increasingly consumer-driven society. According to Gilleard & Higgs (2005), post-World War Two brought with it an affluence and introduced for the first time a youth culture, and so the teenage years became, in the 1950s and '60s, a training ground for a lifetime devoted to consumption. By the 1980s, the power and celebration of youth had become ingrained, which created an aversion amongst the new middle-aged cohort of growing old. The solution, according to Gilleard & Higgs (2005) was to either deny or actively resist ageing, or better still, both. Thus, attitudes towards ageing and old age began to change, facilitated in part by a new approach to health and fitness and so those in their sixties began subverting the idea of old age by regarding it as a time for new opportunities and leisure.

Gilleard & Higgs (1998) suggested that marketing companies began to recognise that older, retired people with significant savings represented a new and lucrative market. In other words, the ability of older people to continue consuming post-retirement has enabled them to remain "middle aged" for longer. However, the opportunities of the Third Age had a hidden disadvantage, namely, a denial of the "Fourth Age", the time of the final years of life, characterised by sickness and ill-health:

...as the Third Age expands in both quantity and quality, deep old age ("the Fourth Age of decrepitude and senility") suffers from ... distancing, stigmatisation and denial. Positive ageing is in part a response to population ageing by marketers anxious to stimulate demand. As consumer culture targets the "grey market", positive ageing becomes conditional on the possession of sufficient income, cultural capital, and mental and physical health. Thus, while the phase of active adulthood expands to embrace many more seniors, stronger taboos form around those in poverty, those whose pastimes lack positive cultural resonances and those suffering from disability and diseases such as Alzheimer's.

According to Gilieard & Higgs (2010*b*), this denial, or fear of the Fourth Age has resulted in a cultural rejection of that which is old because it is old. This means old age is being seen more widely as a "terminal destination - a location stripped of the social and cultural capital that is most valued and which allows for the articulation of choice, autonomy, self-expression and pleasure" [p. 126]. In other words, societal views of ageing have resulted in a perception of "Fourth Agers" being incapable of agency. As individuals age, and begin to experience age-related diseases, it is possible that they themselves begin to personify these fears and see themselves as incapable of agency.

According to Jones & Higgs (2010), this fear of ageing has resulted in a "normalisation of diversity" and a new societal acceptance of old age as a time of new opportunities. Thus, while parts of the older population will continue to conform to an earlier idea of ageing with its attendant discourses of decline and dependency, many more now relate to a more normative account of ageing, which is organised around the idea of fitness and wellness. Jones & Higgs (2010) also develop Beck's (2007) work to highlight how, at a policy level, diversity is encouraged and celebrated. Thus, they suggest that there is a growing emphasis within policy documents and regulations on ensuring that individuals are being given greater responsibility to choose which version of old age they prefer. Yet they suggest that older people are expected "to act agentically in pursuit of making the right choices", namely, to choose to strive for a normative conceptualisation of old age. Nevertheless, this ignores the reality of old age; many individuals become subject to dependency as they age because of the onset of (unavoidable) age-related illnesses or diseases. This can make it more difficult for such individuals to retain their ability to choose and make decisions without adequate facilitation. Furthermore, as individuals age, they can often find their needs and wishes changing and their attitudes towards what contributes towards their well-being begin to change (Kane 2005, Ring, Hofer, Heuston, Harris & O'Boyle 2005).

A number of commentators have argued that our fear/denial of ageing, coupled with the emphasis on consumer rights within post-modern societies, may be responsible for an alternative conceptualisation of person-centred care. Brooker (2004) and Wilkinson et al. (2009) have described a consumer-driven model of care tailored to meet the needs of the individual, but which ignores the challenges faced by older people on communication and relationships between the carer and care recipient. They suggest that national policies on care

for older people in the UK have begun to adopt this consumer-driven approach, which places additional responsibility with the care recipient to manage their own care.

2.3.7 Overview

The quality of residential care for older people has been an issue of concern since the 1960s. While there have been many strategies developed to improve the quality of care, there is growing consensus that a psycho-social model of person-centred care is the best approach, as it aims to provide care that meets the needs and wishes of individual residents by focusing on communication and the development of a meaningful relationship between the carer and care recipient. However, a number of barriers exist which make this transition from a traditional model of care to a truly person-centred approach difficult, including most notably a fear of the Fourth Age. In turn, this creates fears amongst older people about becoming old and losing the autonomy that has become such an integral part of the consumer society in which we now live.

However, in spite of the emphasis on the person-centred approach, regulation remains the most popular tool for ensuring providers offer a reasonable quality of care. As a result, it is important to have a clear understanding of how regulation contributes towards, or hinders, a person-centred model of care. The next section examines the use of regulation within the residential care sector.

2.4 The Use of Regulation as a Quality Improvement Tool

2.4.1 Introduction

Regulation was introduced into the residential care sector in a number of OECD countries, including the United States, Australia, Canada, Hong Kong and the UK, as a result of an influx of private providers into the industry, giving rise to concerns about whether for-profit companies would place adequate emphasis on quality (Bartlett & Phillips 1995, Bartlett & Phillips 1996, Baum 1999, Braithwaite 2001, Harrington 2001, OECD 2005). In many of these countries, governments were motivated to ensure that providers met a minimum standard of care after incidences of abuse or mistreatment of ol-

der people were reported in the media (Bartlett & Phillips 1995, Kerriscn & Pollock 2001).

Research measuring the effectiveness of regulation as a method of improving the quality of residential care is limited. Some evidence has been found to suggest that there has been an improvement in the quality of care provided to residents in the United States since the regulations were first introduced, such as incontinence care and the number of residents physically restrained (Hawes & Phillips 2007). However, quality measures have been found in many cases to be unreliable and lacking in validity (Mor et al. 2003). The OECD (2005) cites evidence of regulatory reforms showing positive results, whereby the introduction of a new regulatory system initially shows high numbers of settings failing to pass accreditation when first inspected, residential care homes, are now passing in greater numbers. However, there is no evidence to suggest that the greater number of pass rates is not simply due to a weakening of the regulations and an informal lowering of the standard (Chen & Chan 2003). Indeed, there is a considerable amount of commentary about how little impact regulation has on improving the quality of residential care and how care services remain inadequate overall (Bravo, Dubois & Roy 2005, Drakeford 2006, Harrington 2001).

Koren (2010) suggests that this is because there is a discrepancy between the purpose of regulation and what individuals believe regulation can achieve:

The regulatory process was designed for a specific purpose: to hold providers accountable for at least meeting a minimum threshold of performance, backed up by an enforcement mechanism and a set of sanctions, graded as to severity. It was neither designed nor intended to foster the ethos of quality improvement, to distinguish gradations of good quality once the minimum was met, to assist homes achieve and maintain excellence, or to reward, in any way, outstanding accomplishment. Nevertheless, we are disappointed and frustrated when it does none of those things. Perhaps, dissatisfaction with the regulatory process may have more to do with a, possibly willful, misunderstanding of its intended purpose and a misguided hope that it could do it all. If nothing else, it underscores the wisdom and necessity of ensuring there are companion processes for achieving improvement.

(Koren 2010, p. 143S)

While regulation is often designed to improve the quality of residential care (Braithwaite et al. 2007), Koren's comments may serve to highlight the unrealistic expectations placed on regulation as a tool of governance.

To date, most research on the regulation of residential care has focused on the implementation of regulation. However, no research has been carried out on how regulations have been developed in various countries, nor on the relationship between the development process and the content of the rules produced. Yet, it is possible to use existing research to paint a picture of the context in which regulation in the sector has been developed, and also on the impact of different types of regulation on compliance rates and care provision. This section focuses specifically on the United States, England and Australia, reflecting the fact that significantly more research has been carried out in these three countries than elsewhere.

2.4.2 United States

In the 1950s and '60s, demand for long term care outstripped supply throughout the United States. Many states could not afford to fully enforce existing regulations, as the majority of homes would not meet the standards and would thus have to be closed (Ogden & Adams 2009). Regulations were effectively relaxed and homes were deemed to be in "substantial compliance" if they demonstrated the intent to improve through a plan of correction (Ogden & Adams 2009). However, a series of scandals about the poor quality of residential care (including fires, food poisonings and abuse) that occurred in the 1970s forced the federal government to act - a cycle that has been repeated nearly every decade since (Ogden & Adams 2009). President Nixon convened a high-profile White House Conference on Aging and ordered the creation of the Office of Nursing Home Affairs. However, little changed until 1983 when the United States Congress mandated a study of nursing home quality and regulation by the Institute of Medicine (IOM). The IOM formed a committee of 32 experts made up of academics, medics, nurses, (geriatricians and psychiatrists), nursing home providers, a legal advisor and the director of a residents' advocates group. After a 2.5-year study and a series of hearings, the committee issued its report (IOM 1986). The regulations governing the sector which are still in operation today, under the federal Omnibus Budget Reconciliation Act (OBRA) of 1987, were largely based upon the findings from the IOM's report. However, as a result of the dedication of activist organisations, nursing home residents, their families and staff had the opportunity to feed their views into the legislation (Ogden & Adams 2009). OBRA regulations on residential care can be seen as an early example of a loose type of regulatory negotiation within the sector. While no research has examined this process, it

is possible that these stakeholders were involved in order to add insights and expertise into the rules in order to protect residents.

While some regulatory changes were in place by the early 1990s, final enforcement regulations pursuant to OBRA 1987 did not become effective until 1st July, 1995 as a result of delays in the development of the written regulations. Furthermore, the US system has proven to be particularly problematic, as it is linked with performance indicators and financial support, so providers often fraudulently record data on residents in order to increase the level of state support they receive (Braithwaite et al. 2007). In addition, the level of detail in the regulations has created a problem whereby state inspectors often miss deficiencies in care homes, in some cases creating the impression that homes achieve a better quality than is actually the case (Braithwaite et al. 2007). A recent study found that about 15 percent of federal comparative surveys nationwide identified state surveys that failed to spot deficiencies at the most serious levels of noncompliance - actual harm and immediate jeopardy to residents (GAO 2008). Many commentators have questioned the extent to which OBRA '87 improved the quality of care (Koren 2010, Walshe 2001, Wiener 2003). According to Ogden & Adams (2009), there continue to be wide disparities between the 50 States in nursing home deficiency rates and both the federal government and states have been criticised for ongoing quality problems and laxity in regulatory oversight.

2.4.3 Australia

In the 1990s, the Australian government de-regulated the residential care industry, replacing it with a voluntary industry-controlled accreditation scheme (Braithwaite 2001), following objections from nursing home owners that they were losing profits. This led to the development of guidelines for residential care settings (Australian Government Department of Health and Ageing 1998), which promoted and regulated quality of care in the nursing home industry (Mitchell & Koch 1997). As with the American standards, organisations representing older people were consulted as the standards were developed. Reforms also occurred following scandals over the physical and sexual abuse of residents (Braithwaite et al. 2007). The standards were broadly praised for being resident-centred. There were a total of 31 standards, grouped into 7 broad objectives, concerned with the quality of care and quality of life of residents in nursing homes. The use of a small number of broad standards has

been praised as it implies a trust in care providers to reach the Standard in a way that meets the needs of each individual care recipient (Aged Care Standards and Accreditation Agency 2006, Department of Health UK 2006).

This scheme was replaced in 1997 by a mandatory accreditation system, following scandals in the sector (Braithwaite et al. 2007), a scheme which remains in place today. Providers must comply with just four standards, with a total of just 44 outcome statements, thus continuing the earlier trend to trust providers to use their skills to determine how best to meet each standard. The Aged Care Standards and Accreditation Agency has also been given additional powers in order to improve the level of compliance with regulations, with few repercussions for providers that do not meet the regulations. However, although recent research found that just 1.6% of homes are subject to sanctions, Ellis & Howe (2010) argue that this does not imply a weak regulatory system, but rather, is a characteristic of Australia's culture of compliance and quality improvement.

2.4.4 England

The regulatory system in England can be described as one in constant flux. Regulation has been used as a tool of governance since 1948, under the National Assistance Act (Peace 2003), which aimed to replace the "master" and "inmate" relationship which had existed between managers and residents of public institutions (former workhouses) with one resembling that between hotel manager and guest (Townsend 1964). However, this move was not successful because of limited financial assistance provided to residents to pay for their care. The system was not reformed fully until 1984, with the introduction of the Residential Care Homes Regulations, in response to the growth in private residential care settings. In turn, this system was replaced in 1990 with the National Health Service and Community Care Act, which aimed to reduce the perverse incentive towards residential care through the development of homecare (Peace 2003). As a result of the 1990 Act, local authority homes were subject to inspection in the same way as private and voluntary homes for the first time, but since they did not have to be registered in the same way, these state (or public) homes could not be compelled to meet the new standards.

The election of a New Labour government in 1997 led to further change. A White Paper was published *Modernising Social Services* (Department of Health UK 1998), which aimed to place greater emphasis on good practice. The White Paper led to the creation of the 2000 Care Standards Act. However, regulatory

reform in England during this period occurred at least partly following public outcry in the aftermath of the exposure of a case of abuse of residents (adults with intellectual difficulties) within a care setting. Residents living in Longcare Homes in Buckinghamshire were abused between 1983 and 1993 by Gordon Rowe, a trained social worker and owner of Longcare, as well as his wife and other managers, eventually resulting in a trial and Independent Enquiry. The incident was one of the driving forces behind the passing of the Care Standards Act (Pring 2005).

The Care Standards Act led to the establishment of the National Care Standards Commission (NCSC) to inspect against a set of minimum standards. The *Minimum Standards for Care Homes* were published in 2001 by the Department of Health (Department of Health UK 2001) and form the basis for the inspection process. The document contained 38 standards but 249 criteria, all of which providers were expected to meet. The same Care Standards Act also led to the development of minimum standards and regulations in Scotland (Scottish Executive 2005), Wales (Welsh Assembly 2004) and Northern Ireland (Department of Health Social Services and Public Safety 2005).

However, in 1999, in response to the White Paper and the pending regulatory reform system, the Department of Health had commissioned the Centre for Policy on Ageing (CPA) to devise a set of National Required Standards (Department of Health UK 1999). The CPA's Standards were developed by a 48-member advisory group, encompassing all the key interests in the field, bar nursing home residents directly. However, a substantial consultation process was carried out involving 989 individuals and organisations, including residents and potential residents. Several ways of consulting residents were adopted, including:

- questionnaires sent to homes (N = 55)
- questionnaires already sent out as part of a survey of proprietor views;
- 7 discussion groups in several homes (the number of residents in each group was not provided);
- interviews with individual residents (N = 30);
- review of the literature on residents' views of living in care homes.

However, the regulatory system established in 2001 with the introduction of the Minimum Standards has been subject to both controversy and modifica-

tion. According to Drakeford (2006) the regulations were weakened almost immediately:

In July 2002, under pressure from the sector which claimed that national standards were causing widespread closure of residential care homes, the Secretary of State for Health in England responded by diluting the requirements that had been contained in them. In a statement to the House of Commons, Alan Milburn announced his intention to consult on an "amended set of environmental standards for care homes" which would have the effect of taking physical standards (which would cost a significant amount to implement) outside the scope of regulation.

(Drakeford 2006, pp. 932)

Furthermore, in April 2004, as a result of the enactment of the Health and Social Care (Community Health and Standards) Act 2003, the NCSC ceased to exist and the Commission for Social Care Inspection (CSCI) took over responsibilities for regulating care services in England. The CSCI was created to bring together all aspects of inspection and regulation in social care under one umbrella regulatory body. In April 2009, the CSCI was itself replaced by the Care Quality Commission (CQC), which also took over the functions of other regulatory bodies. The new system replaced the minimum standards with a new version, with a total of 28 outcome standards and the new registration system commenced in April 2010.

Empirical research on the new (and evolving) regulatory regime in the UK is limited. A survey of care home managers carried out by Furness (2009) found that most providers valued the regulatory process, though many felt that expertise of the inspector was limited and thus hindered support from providers.

2.4.5 Overview

Trends in regulation of the residential care sector reflect wider trends in regulation - it is often introduced (or reformed) as a result of scandals and crisis and following increased reliance on for-profit firms. Regulatory reform mechanisms often include consultation with relevant stakeholders from the sector, though there is often a lack of clarity about the purpose of such consultation, or whether the feedback is subsequently reflected in the regulations.

In addition, it is clear that there are significant challenges in using regulation within the residential care sector. Its use is influenced by political and cultu-

ral contextual factors, and it also requires a mutual trust between regulators and regulated firms in order to optimise opportunities for effectiveness and compliance (though, as outlined in Section 2.2.4 above, a variety of factors can inhibit compliance). It is also possible to argue that regulation within the residential care sector is often seen as a cure all, when, like all policy tools, it has limitations.

2.5 Conclusion

This chapter has shown that the use of regulation to improve the quality of residential care mirrors a wider trend in which regulation is increasingly used to monitor and improve the quality of services. The shortcomings of regulation, both within the context of residential care for older people, and other sectors, have led to new and innovative forms of regulation, including regulatory negotiation. This tool, in principle, has several advantages for the residential care sector, as it allows representatives of residents to play a significant role in the development of the regulations, and ensure that the regulations are flexible and broad enough to meet the needs and wishes of all residents. In this way, regulatory negotiation can facilitate the development of regulations in the public interest. Furthermore, as the research outlined above suggests, quality of life is a subjective concept and so developing a model of residential care aiming to improve quality of life requires input by residents themselves.

However, empirical research on regulatory negotiation is limited and is broadly focused on the development of environmental regulations. No research has been conducted to date on the use of regulatory negotiation within the context of regulating residential care for older people, even though the process has been used to develop minimum standards for the sector in several countries. In particular, there is a limited understanding of the influence of the consultative process on the content of the regulations within the sector. Moreover, although many scholars have discussed the impact of regulatory negotiation on the public interest, the extent to which they have critically engaged with it as a tool of governance is limited.

As a result, there is a significant gap in our understanding of regulatory negotiation which only further research can close. Therefore, this study, which aims to enhance our understanding of the regulatory negotiated process within the residential care sector through an analysis of the process used to develop the

National Quality Standards for Residential Care Settings for Older People will help us to theorise not only about regulatory reform and regulatory negotiation in general, but also about policy-makers' views about quality within the residential care sector.

Background: The Political, Socio-Economic and Policy Context

3.1 Introduction

The benefit of the case study approach is that it enables an investigation of real life events (Yin 2003). As the case study approach acknowledges that contextual factors are likely to influence the outcomes of the case (Stake 2005), it is important to become familiar with the background to and context of the case in order to fully understand it.

This chapter outlines the political, social, economic and policy culture in which the Standards were written. Section 3.2 first provides a brief overview of the political culture of Ireland, including the use of regulation as a tool of government in Ireland, while Section 3.3 describes the socio-economic conditions prevailing at the time the Standards were written. Section 3.4 then outlines the evolution of care policies for older people in Ireland.

3.2 Political Context: The Rise of Consultation as a Tool of Governance

3.2.1 Introduction

Policy-making is inherently a political enterprise. Policy tools are often selected by policy-makers based on a variety of factors, including their judgement

of how scarce resources should best be allocated; the determination of priorities of the government and political party in power; and the values held by the party or individual politician (Gardner & Barraclough 2007). Examining the mechanisms of politics and governance in Ireland may help to show how the Standards development process dovetailed with the wider political and policy-making context in Ireland.

3.2.2 Clientelism in Ireland

Collins & O'Shea (2003) argue that Ireland has a "political system in which the central government is captured by provincial interests". They further suggest that the system of 'representations' and 'clinics', which enables constituents to lobby a Teachta Dála (TD, or Member of Parliament) on a particular issue of concern, frequently detracts from the work of politicians as members of national parliament. Within this clientelist system, politicians are expected to concentrate on local rather than national politics and to provide "favours" in return for votes. Although it is unclear how clientelism developed in Ireland, Collins & O'Shea (2003) note that its use has been considerable by one political party, Fianna Fáil, which has a strong "grassroots" support system. Between 1927 and 2011, Fianna Fáil was the largest political party in the country and the party was in power for 59 of the last 78 years.¹ In turn, this longevity allowed the party to strengthen its political powers outside of the national Parliament, by awarding party supporters with appointments to the boards of official State bodies (Collins & O'Shea 2003), in turn further securing the popularity of the party (O'Higgins & Morgan 2006).

While all of the major political parties in Ireland engage in clientelist practices, Fianna Fáil's success can be at least partly attributed to the symbiotic relationships it systematically forged with farmers, trade unions and business associations (Murphy 2010). Thus, "a persistent political bias toward a concertation of economic interests is apparent in Ireland" (Dellepiane & Hardiman 2011, p. 2), often to the disadvantage of more vulnerable groups in society. For example, while Ireland's income per capita ranked among the highest in the OECD by 2007, average levels of income inequality between 1992-2007 remained stubbornly high (Dellepiane & Hardiman 2011). This closely-knit relation-

¹The party's support began to decline in 2009 when it became clear that it was responsible for leading Ireland into the most severe recession the country has experienced since the Second World War. Support for the party in September stood at just 10 per cent, down from an overall high of 42 per cent in 2005.

ship between government and powerful interest groups, along with the emphasis the party places on consultation with its key stakeholders (O'Higgins & Morgan 2006), may have helped to stimulate the establishment of Ireland's Social Partnership Process, a mechanism which has helped to develop central social and economic policies for the country since the 1980s.

3.2.3 Social Partnership in Ireland

The term "social partnership" is often regarded as a collaboration between national governments, employer groups and trades unions to develop national wage agreements (O'Donnell & Thomas 2006). In Ireland, Social Partnership has a more significant meaning. Social Partnership in Ireland refers to discussions between the "social partners", (employers' groups, trades unions, farmers and community and voluntary organisations), culminating in agreements on macroeconomic, labour market, welfare and social policy issues, as well as pay deals (Hardiman 2006). In total, seven Social Partnership Agreements were drawn up between 1987 and 2006.

The process developed in the 1980s when a period of prolonged recession persuaded the (Fianna Fáil-led) government to develop a dialogue on pay and working conditions in order to bring about political and economic stability. The first Social Partnership Agreement - the *Programme for National Recovery* was a pact between the government, the trades unions and the employers' groups, and focused primarily on wage moderation in return for lower levels of income tax, policies to stimulate employment and enhanced social protections. Subsequent agreements aimed to moderate wage growth, control the public finances and improve competitiveness in work markets, and, in return, to maintain welfare standards (O'Carroll 2002). As the Irish economy developed, later agreements aimed to manage and sustain the growth, and also made agreements on more non-core labour market issues such as social inclusion, childcare, racism, and housing policy. In short, social partnership in Ireland became a key method of developing government policy in a wide range of areas for almost twenty years. The ability of the partnership to bring about long-term industrial stability was thought to have helped bring about the ensuing period of economic growth that subsequently occurred. This led to the Irish Social Partnership model being widely revered internationally (Roche 2007).

The operation of the social partnership process, particularly in later years,

was complex. The membership of the Social Partnership process was widened in its latter years to include a wide spectrum of civil society groups (the "Community and Voluntary Pillar" or CVP). By the time the last agreement, *Towards 2016*, was written, a total of twenty-six national organisations were involved. Each agreement was preceded by the publication of a discussion document prepared by the National Economic and Social Council, an advisory body composed of representatives of the social partners and senior civil servants (O'Carroll 2002). The document was then discussed by the organisations invited to participate in the social partnership process. The various organisations then negotiated and discussed specific aspects of labour and social policy in small groups, previously described as a dense web of working groups, committees and task forces which sought to involve the social partners in public policymaking (Doherty 2011). Because of this, it has been argued that the process was considered more important than the outcomes; a significant feature of the partnership process involved the avoidance and postponement of difficult or contentious decisions in favour of deliberation and attempts at problem-solving, often leading to entrenchment in a particular party's original position (Doherty 2011). Doherty (2011) also argues that the sheer scale of the partnership process created difficulties and confusion, playing only a minor role in the implementation of relevant government policy and resulting in few concrete initiatives otherwise. Furthermore, there is also evidence to suggest that, as with many network approaches to policy-making, there is a hierarchy of partners, with the trades unions and the employer groups having greater negotiating power, compared with the community and voluntary groups (Hardiman 2006, Larragy 2006). This means that many groups and interests became marginalised within the process.

Indeed, many commentators have questioned the legitimacy of the Irish social partnership model almost since it first developed, suggesting that it was undemocratic and arguably promoted the agenda of certain interest groups over others. One of the most articulate of these critics, O'Conneide (1998), suggested that the process enhanced the clientelist framework that has dogged Ireland for many years, while Hardiman (2006) argued that social partnership provided a flexible vehicle through which unions, employers and the wider voluntary sector could raise issues of particular concern to them (thus excluding minority voices). Indeed, the possibility that the success of social partnership was only due to the division of plentiful resources between the various social partners may ring true when it is considered that the process collapsed shortly after the economic recession took hold in Ireland in 2007 (McDonough

& Dundon 2010).

The extent to which the process was truly consultative also remains open to question. Hardiman (2006) has suggested that the social partners had only limited ability to set the agenda for social partnership talks; rather, the process was determined by the (Fianna Fáil) government's priorities. Doherty (2011) concurs, suggesting that "once the crisis struck, and fiscal difficulties meant the opportunities for issues to be the subject of review and compromise were circumscribed, the Government ultimately made the 'hard' decisions and took little account of the advice of partnership institutions or the social partners themselves. It was quite happy to sweep away the institutional web". This may suggest that Fianna Fáil's success may have been due to an extreme skill on the part of its key Ministers at *appearing* to consult while developing its own cautious, incremental and middle-ground policies aimed at appeasing its key voters (Weeks 2009). This may explain the growing disenchantment with politics and policy-making in Ireland, as outlined below. However, it is important to note that, in spite of its shortcomings, and its eventual decline, the social partnership process in Ireland helped to create a sense that consultation was necessary for the development of all policies, and so formal negotiations with relevant stakeholders became the norm in Ireland within many spheres.

3.2.4 Declining Trust in Irish Politics

Until the mid-1990s, when two tribunals of enquiry into possible political impropriety by senior politicians got underway, the Irish electorate had a high degree of trust in political institutions and in the democratic process in Ireland (Coakley 2005). Since then, perceptions of corruption in Ireland have increased rapidly (Transparency International 2009); trust in the Irish government by the electorate was the lowest amongst all the EU countries in 2010 (Edelman 2010). According to Transparency International (2009, p. 16), there is a perception that "personal relationships, patronage, political favours, and political donations are believed to influence political decisions and policy... The situation is compounded by a lack of transparency in political funding and lobbying".

As was the case elsewhere, Fianna Fáil responded to the growing mistrust by widening its consultation mechanisms, though critics have doubts about the extent to which this would benefit the electorate:

The Irish case arguably is a clear example of a reactive, but consensus-oriented culture, with the state drawing in non-state actors (principally,

but not only, business and unions) to enhance its own capacity and perhaps also to help legitimate “tough” policy measures (as in the early days of social partnership).

(Brown & Scott 2010, p. 16)

This points to the use of “pragmatic” policy-making, namely, decision-making in the absence of a clear policy agenda, other than to retain popularity and political power (Dellepiane & Hardiman 2011). Indeed, Fianna Fáil has a tendency to borrow or “cherry-pick” policy-making tools from other polities aimed at enhancing its reputation (MacCarthaigh & Hardiman 2010). In particular, Ireland has always borrowed policies from the UK (Collins 2004). Thus, during the 1980s and 1990s, Ireland adopted many of the principles of New Public Management (Collins 2010, MacCarthaigh & Hardiman 2010). Indeed, Irish policy-making retains features of New Public Management/Third Way policies even today, particularly in its focus on outcomes and quality improvement. However, it has been argued that Irish politicians failed to understand that New Public Management and Third Way politics were led by an overarching vision, namely to rationalise and later improve the public sector. Taylor (2005, p. 190-191) has claimed that the process of negotiated governance in Ireland has not been the outcome of a social democratic political vision...” but rather “a political project that ... contain[s] a confusing and contrasting myriad of inconsistent ideological arguments to support a particular trajectory”. This suggests that Ireland (and Fianna Fáil in particular) may have borrowed from the rhetoric of the Third Way, while retaining its own philosophy of appeasing its political partners in order to retain power.

3.2.5 Regulation as a Tool of Governance in Ireland

It is also possible to see Fianna Fail’s desire to retain power and avoid responsibility through the creation of State agencies with an oversight function. Since the early 1990s there has been a sustained pattern of the creation or reform of regulatory agencies in Ireland (Brown & Scott 2010). Indeed, Ireland has the dubious honour of being the world leader for the creation of agencies with an oversight function (Scott 2008). A recent study concluded that there were over 450 state agencies in Ireland (Tasc 2007). An official report identified 215 bodies in Ireland exercising statutory regulatory powers, either rule-making or rule enforcement (Department of the Taoiseach 2007).

Some of the accelerated growth in the creation of agencies was to ensure that Ireland was in compliance with EU requirements, which in turn was reflective of a wider trend towards the creation of regulatory authorities in neo-liberal States (Jordana & Levi-Faur 2004). However, the extent of the powers of such regulatory agencies was questioned by several commentators. For example, in 2001, an influential OECD (2001) report suggested that “consumer interests are not well represented in policy debate and deliberation in Ireland, which remains dominated by producer interests”. Furthermore, Brown & Scott (2010) argued that the picture in Ireland perhaps has historically approximated most to a “consensual” style of decision-making and policymaking:

The collaborative nature of social partnership permeated policymaking and influenced key actors in the wider regulatory governance arena for the past 30 years. This, taken together with its small size and the inevitable interconnectedness of business and political elites, may go some way towards explaining a cultural inclination towards persuasion...

(Brown & Scott 2010, p. 16)

Perhaps in recognition of these shortcomings, the government established its own “Better Regulation” programme in 2001, primarily aimed at loosening red tape and creating an environment that would stimulate the private sector, while simultaneously providing reassurance to consumer groups that the government was taking the public interest into account when developing regulations (Department of the Taoiseach 2004). Thus, one of the Irish government’s six principles of better regulation is transparency:

Transparency generates greater trust on the part of consumers. It assures and satisfies investors that there is a level playing field, and encourages new entrants to sectors. ... We will consult more widely before regulating.

(Department of the Taoiseach 2004, p. 26)

However, it has been highlighted that, in Ireland, as elsewhere, consultation in practice is often more extensive with representatives from the regulated industry than with consumer groups (Westrup 2007). Nolan (2008, p. 105) concurs with this argument, stating that “consultation with the general public serves the ends of participatory democracy, but usually the substantive discourse is with the key stakeholders” (i.e. regulated firms).

Thus, even after ten years of regulatory reform, concerns remained about regulation in Ireland. Regulatory processes are still seen as opaque, with a sometimes wide interpretation of rules set down by regulators:

Transparency is not among the traditional virtues of either public bureaucracies or business (in Ireland)... Informal networks tend to shape official regulation according to local interest, traditions and loyalties. Non-members of these networks encounter a gap between formal and informal rules and regulation.

(Collins 2010, p. 28)

This has led a number of commentators to argue that regulatory agencies continue to be set up in Ireland (like elsewhere) as a blame-shifting tactic, effectively demonstrating politicians' willingness to respond to political crises, while at the same time insulating them from further potentially unpalatable political decisions (Brown & Scott 2010, Nolan 2008, Westrup 2007). Indeed, Ireland's regulatory structures have been described as "fragmented" (Brown & Scott 2010) and "ad hoc" (OECD 2008), with a lack of accountability over who remains responsible monitoring compliance and overseeing the work of the regulator:

The case of Irish government provides a fragmented picture - partly explained by broader international trends, and partly illustrating the distinctiveness of the Irish case. Beneath this system of government lies an equally fragmented accountability framework that in many cases fails to follow the contours of the government system and which thus presents problems of coherence. The supplementing of political, financial and juridical accountability structures with a myriad of new oversight relationships has created a network of considerable density which is not easily conceptualized.

(MacCarthaigh & Scott 2009, p. 23)

However, in spite of this trend towards delegation, there is some evidence that central government, and not independent regulators, remains in charge behind the scenes. A report written by the Economist Intelligence Unit in 2009 notes that Government Ministers and their departments remain responsible for the formulation of policy and suggests that the line between the Minister's policymaking role and the role of the regulator is not always maintained (EIU 2009).

3.2.6 Policy Planning and Implementation

The confusing approach to policy making in Ireland also has negative impacts on the implementation of policy (Dellepiane & Hardiman 2011). This

can be clearly seen through the problems that developed as a result of the ill-planned reform of the health service. In 2001, a newly published national health strategy (DOHC 2001) outlined a programme of investment in and reform of healthcare services. It was the first significant reform in thirty years of the health services strategy, structure, funding and delivery (Wiley 2005). One of the main purposes of the reform programme was to improve the delivery of primary care services at local level and also to remove the influence of local politicians (councillors), who had previously sat on the boards of local health services and who fought to channel funding into their constituencies (Wren 2002). The reform programme involved significant restructuring of existing healthcare structures, replacing ten autonomous, regional health boards with one national service provider, the Health Service Executive (the HSE), in order to centralise decision-making.

However, the health service reform programme has been problematic in many ways. Firstly, there were no redundancies for administrative staff, which resulted in a top-heavy, bloated and confused system (Wren 2002). Secondly, each of the HSE's 32 Local Health Offices (LHOs) is overseen by a Local Health Manager, who has the autonomy to implement national policies in a way that best fits in with local practices. This autonomy hampered the HSE in resolving the problem of disorganisation inherent in the former system. This is further compounded by the fact that the CEO of the HSE is legally responsible for keeping the HSE within budget (Tussing & Wren 2006). As a result, while the level of political interference in decision-making has fallen, decisions are now often based on short-term financial affordability factors, rather than being driven by the needs of health service users. The establishment of the HSE was also meant to create a division of labour between the Department of Health and Children and the HSE itself, with the former taking responsibility for devising health policies and the latter for implementation. However, there was some ambiguity with regard to this division, particularly over the healthcare budget, and both deny responsibility for budgetary problems, leaving an accountability void within the health services (Wren 2002). Thus although the HSE was effectively "de-politicised", it is possible that remnants of the historical system of politicians making representations on behalf of constituents in need of services may still be impeding the development of an over-arching vision of care for older people.

3.2.7 Overview

Successive Irish governments, dominated by the leadership of the Fianna Fáil party, have long used consultation with key stakeholders and the wider public as a key mechanism for policy development. In recent years, the idea of consultation has become more formalised. There is some evidence that this has been influenced in part by the UK's "New Labour" Party, albeit in a way that lacks the ideological vision upon which policies in the UK are built. However, it has been argued by some commentators that policy-making in Ireland is primarily aimed at appeasing the key interest groups of trades unions, business associations and farmers in order to ensure the retention of power by the sitting government. Furthermore, the focus on political popularity appears to have led to a lack of vision for policy-making in Ireland, which has proven particularly problematic in the area of healthcare.

3.3 Socio-Economic Context

3.3.1 The Rise of the Celtic Tiger

In the 1980s, Ireland's labour market was one of the worst performing in Europe. The unemployment rate rose from 7 per cent in 1979 to 17 per cent in 1986. An already low labour force participation rate fell further. At the end of the decade, net emigration more than offset the rate of natural increase, leading to population decline (Walshe 2003). Yet, by the end of the twentieth century, the Republic of Ireland had transformed itself from the "poor man of Europe" to one of its leading lights, albeit much of it based on Foreign Direct Investment from multinational companies and assistance from the European Union (O'Malley & McGrath 2007). By 2007, average incomes in Ireland were amongst the highest in the world (Fahey, Russell & Whelan 2007). Over the course of the 1990s, Ireland's GDP per capita moved from about 60 per cent of the EU-15 average to about 120 percent and by 2002, Ireland's GDP was in the top five OECD countries (Nolan & Maitre 2007).

The social and cultural impact of this rapid economic growth was profoundly unique. The dream long held by the Irish people was to become prosperous, but at the same time to remain detached from materialism (Inglis 2008). Inglis (2008) suggests that this was a result of Ireland's Catholic background, which encouraged self-denial as a basis for spiritual reward. However, while

the Irish people have retained, to some extent, their devotion to the Catholic Church, this was subsequently matched “with an equal devotion to indulging themselves in the material world... The poor Irish Catholic mice seem to have had little difficulty in becoming self-consumed capitalist rats” (Inglis 2008, p. 16). The Irish government appeared to develop a similar attitude towards public spending during the boom years, “notoriously captured by Fianna Fáil Finance Minister Charlie McCreevy’s comment in the early 2000s that ““when I have it, I spend it”” (Dellepiane & Hardiman 2011).

As a result of the consumerist culture in Ireland, public spending increased significantly over the 1990s and early years of the twenty-first century. For example, total public health expenditure rose from €3.6 billion in 1997 to over €12.3 billion in 2006, an increase of more than 236%. Some of this additional funding was to be spent on refurbishing publicly-provided residential care settings for older people (DOHC 2007a). In 2005, funding of €112 million was announced to fund 860 additional residential care beds for older people and replace an additional 214 existing beds in outdated facilities with new, modern units (DOHC 2005).

3.3.2 From Boom to Bust

The prevailing economic conditions in Ireland changed dramatically over the period in which the Standards were developed (2006-2009). The bursting of the property bubble in Ireland, coupled with the global financial crisis in 2008, resulted in significant budgetary cutbacks on public services, including on healthcare. The budget allocated to health in 2010 was a five per cent reduction on the 2009 budget, the first actual cut in spending on healthcare in two decades (Burke 2010). However, spending on healthcare had in fact been levelling out since 2005, which Burke (2010) argues was already being experienced as a cut, given large increases in medical inflation and increases in demand for services over the same period. As can be seen in the next section, rising costs in the healthcare sector have impacted for many years in the area of residential care for older people.

3.4 Evolution of Care Policies and Service Provision for Older People

3.4.1 Introduction

Residential care policies for older people were not a priority for successive governments in Ireland prior to the 1950s and '60s, as there was a moral obligation on families to care for older relatives until then (Convery 2001). In 1964, the Health (Homes for Incapacitated Persons) Act (Government of Ireland 1964) was passed in Ireland. The Act made provisions for the Minister for Health to introduce regulations to govern the registration and operation of for-profit nursing homes in Ireland. This marked the first formal reference to State responsibility for the well-being of older people living in private (for profit) residential care settings (O'Shea 2003). Since 1964, successive governments have been largely pre-occupied with providing an adequate supply of residential care beds at a reasonable cost to the Exchequer, while the quality of the services has been sidelined.

3.4.2 Supply of Residential Care, 1964-2011

3.4.2.1 1964-1980s

In response to concerns about the costs, quality and under-supply of care for older people, an Inter-Departmental Committee was appointed in 1965 by the Minister for Health to examine and report on the general problem of the care of the aged and to make recommendations regarding the improvement and extension of services (O'Loughlin 1999). The ensuing report (Inter-Departmental Committee on the Care of the Aged 1968) helped to shape government policy towards older people until the late 1980s. While described as "a major catalyst for change" (Ruddle, Donoghue & Mulvihill 1997), it also encouraged the view that older people in need of care represented "an enormous problem for society", though this led to calls for improvements to services for older people, particularly in the provision of services (Pierce 2008). In particular, the report suggested that the central tenet of care policies should be to enable older people to remain living in their own homes for as long as possible, a principle which remains official government policy for older people today (DOHC 2001). Thus, the report placed an emphasis on developing domiciliary

and community-based services and suggested that the voluntary sector could play a key role in providing these services. A subsequent review, carried out in 1988, found that significant progress had been made in the implementation of the 1968 report's recommendations in the intervening 20 years, although it also pointed to many gaps in service provision, particularly in domiciliary care services, which had led to a continued bias towards residential care, particularly in the private sector (Working Party on Services for the Elderly 1988).

The rapid growth of the private residential care sector can be explained by a number of other policies formulated between the 1960s and 1980s. Both the 1964 and 1970 Health Acts provided significant incentives for private providers to enter the residential care sector. The 1964 Act did not require new private homes to be registered and the 1970 Act provided for the payment of subventions by Health Boards to residents for beds in all approved private nursing homes, suddenly making residential care an affordable option for older people. Throughout the 1970s, many private and voluntary homes sought and were granted ministerial approval and payment (NCAOP 2000). As a result, throughout the 1980s, the number of private sector beds increased dramatically, though the number of public beds declined (O'Shea & Hughes 1994).

The 1988 review of the Inter-Department's Committee policy, which was itself subsequently adopted as government policy, reiterated the earlier policy objective of facilitating older people to live at home where possible and that high quality hospital and residential care should only be used for older people who could no longer be cared for at home (Working Party on Services for the Elderly 1988). However, as O'Shea (2006) notes, the existence of a policy blueprint is no guarantee that the policy contained therein gets implemented. A comprehensive evaluation of *The Years Ahead* report found that few of the recommendations had been implemented and that little additional expenditure was made in the provision of community services in the ten years following the publication of the report (Ruddle et al. 1997).

3.4.2.2 1990s-2000s

One of the recommendations made by the Working Party that *was* implemented was the introduction of a new subvention scheme for residential care, which further increased long-stay care supply. The Health (Nursing Homes) Act 1990 (Government of Ireland 1990) legislated for the subvention of private and voluntary homes and stricter enforcement of care and welfare regulations

(O'Loughlin 1999). The subvention scheme replaced and enhanced the earlier subvention scheme introduced under the 1970 Health Act, requiring health boards to pay a contribution towards the cost of nursing home care for older people living in private nursing homes. The subvention scheme was one of two factors that resulted in the rapid expansion of the residential care sector in Ireland. The rate of subvention was significantly higher than the earlier rate and so resulted in greater demand for residential care. The availability of clients who could subsequently afford to pay for private nursing home care in turn facilitated the expansion of the private sector and so the number of beds provided by the private and voluntary sectors increased significantly. In fact, the subvention scheme created a situation whereby

any additional public expenditure during the 1990s was channelled into providing long-stay subventions for people admitted to private nursing home care. Instead of community care becoming the dominant force in the care of the elderly, the implementation of the Act absorbed the bulk of available resources for dependent people, drawing on resources that might otherwise have been used to improve the community care system.

(O'Shea 2006)

The other factor that helped to increase residential care was another financial incentive from the government, in response to overcrowding in acute hospitals. The number of acute hospital beds in Ireland dramatically reduced between the late 1980s and early 1990s, at a time of significant population growth. This led to significant bed shortages and calls for the government to respond to an escalating healthcare crisis (Tussing & Wren 2006). It emerged that one of the factors aggravating the problem was the shortage of residential care beds for older people, which meant that older people who had been admitted to acute hospitals often exceeded the average hospital stay as they waited for beds. In response, the Minister for Finance introduced tax incentives to encourage the construction of nursing and convalescent homes by the private sector in the 1998 and 1999 Budgets (O'Shea 2003). These measures effectively extended capital allowances already available for industrial buildings and hotels to nursing homes with the result that the full cost of construction of a qualifying nursing home was allowable against tax over a seven-year period. This created attractive incentives to private investors to enter the nursing home sector, thus going a long way to alleviating the under-supply of beds. However, the tax incentive scheme was seen by some commentators as an inappropriate policy response to a healthcare crisis, particularly when existing government policy

had been to create additional community-based services so as to provide older people with an opportunity to remain living in their own homes (Working Party on Services for the Elderly 1988).

By 2000, the number of beds in the private and voluntary sectors combined was one-third higher than just six years previously, in 1994 (see Table 3.1). Because of the increase in the older population during this period, the ratio of nursing home beds per 1,000 persons aged 75 and over rose little during the same period, from 111 to 117.²

Table 3.1: Trends in Bed Numbers in Long-Stay Facilities Excluding Long-Stay Beds in Psychiatric Units and Acute Care Hospitals (1991-2000)

Facility	1991 1992 1993	1994	1995	1996	2000	Change in Beds (N) 94-00	% Change 94-00
Public Long-stay	9,035	9,278	9,621	9,573	9,749	+471	+5
Private / Voluntary	7,658	9,400	9,523	9,995	12,637	+3,237	+34
Total	16,693	18,678	18,674	19,568	22,386	+3708	+20

Source: O'Shea, 2003, p. 20

In 2005, the HSE commissioned a study to assess the need for residential care for older people. Prospectus Consulting (2005) recommended the need to increase bed capacity, replace existing stock and refurbish and upgrade other units. The report, which was never made publicly available by the HSE, identified and prioritised the areas of greatest deficit and developed a programme of additional and replacement long stay residential care beds. As a result, the HSE made provisions to 'fast-track' 860 new public long-stay beds and 214 additional replacement/refurbished beds throughout the country (HSE 2008). The most up-to-date figures on long-stay care settings in Ireland indicate that there are approximately 603 long-stay care facilities for older people operating in Ireland (PA Consulting 2009). These are largely dominated by privately run facilities which provide approximately 18,057 available beds (20,997 total bed stock), compared to approximately 7,319 available beds (8,132 total bed stock) provided by publicly run HSE facilities (see Table 3.2).

These figures show that there has been a significant increase in the ratio of nursing home beds per 1,000 persons aged 75 and over, from 117 to 134 over

²Calculations based on O'Shea 2003 and population data from the Central Statistics Office (CSO)

Table 3.2: Residential Care Bed Stock and Available Beds 2009

	Public	Private and Voluntary	Total
HSE Dublin Mid-Leinster	1,991	5,789	7,780
HSE Dublin North East	1,105	3,799	4,904
HSE South	2,150	5,612	7,762
HSE West	2,886	5,797	8,683
Total Bed Stock	8,132	20,997	29,129
Est. Occupancy (%)	90%	86%	-
Est. Available Beds	7,319	18,057	25,376
Source: PA Consulting, 2009, p. 10			

the last ten years. Calculations carried out by PA Consulting (2009) suggest that demand is likely to continue to be greatest in the Dublin region, while the Western and Southern regions of Ireland will either have an over-supply or will be close to meeting demand by 2021. Reports have also suggested that the recent economic recession has led to many failed hotels, which originally opened as a result of tax incentives, re-opening as private nursing homes to retain the tax relief. As a result, Ireland may go from having an acute shortage of residential care beds for older people to potentially having an oversupply (at least in some parts of the country) within the next ten years. While this indicates the government's aim of meeting demand for residential care has been successful, it has come at the cost of limited choice for older people in need of care, as home and community services are severely limited (O'Shea 2006). Furthermore, recent changes to the financing of residential care, described below, may result in further increased demand for residential care again.

3.4.3 Costs of Care

3.4.3.1 Introduction

Total public expenditure on residential care in Ireland was significantly lower than the OECD average for many years (OECD 2005). It is perhaps unsurprising, therefore, that the cost of residential care has been the most contentious aspect of Irish care policies for older people since the 1970s. Between the 1970s and early-2000s, complex legal and political issues developed in relation to the cost and payment of residential care. A detailed description of these issues is outside the remit of this thesis. However, this section provides a brief over-

view of the most salient legislative and policy changes with regard to public expenditure on residential care for older people in order to show that the cost of providing residential care to older people, and in particular, keeping costs down, has been a significant pre-occupation of successive governments since the 1960s.

3.4.3.2 1964-1980s

The 1970 Health Act (Government of Ireland 1970) accorded free healthcare to those who could not afford to pay, broadly interpreted as medical card holders. The 1970 Health Act also allowed individuals to forgo their entitlement to service in a public setting and to avail instead of the same service in any private setting, for which they would receive a subvention towards (but not the full costs of) the fees (Office of the Ombudsman 2001). Prior to this, older people in receipt of institutional assistance had to contribute to the cost of such assistance insofar as they were able (O'Shea 2003).

In 1979, entitlement to in-patient services, including nursing home care, was extended to the entire population, which meant that all older people should have been able to avail of a subvention for private nursing homes (Office of the Ombudsman 2001). According to the Ombudsman, individuals with high incomes were those most likely to use private services. The Department saw this as an unintended consequence of the extension of entitlement to the full population and so made an informal rule that older people could no longer be given a subvention to pay for private residential care. In addition, the cost of residential care rose exponentially throughout the 1970s and 1980s and so the level of subvention in real terms fell significantly, leaving residents with significant burdens in paying for their care in private settings (O'Shea 2003, Ruddle et al. 1997). The decision not to adhere to the terms of the 1970 Act in this regard proved to be a costly mistake for the State, as outlined in further detail in the next section.

3.4.3.3 1990s-2000s

Two years after the publication of *The Years Ahead* report, the Health (Nursing Homes) Act (1990) was introduced, which was primarily aimed at reforming legislation for the costs of residential care (in order to make access to funding more equitable). The Act re-introduced subvention for older people living in

private residential care settings, which, as noted above, had been denied to residents in 1979 by the Department of Health's informal decision (Government of Ireland 1993*b*).

Latent demand for residential care and an increase in the number of newly registered nursing homes meant that expenditure on the nursing home subvention scheme increased by 422% between 1993 and 1996, compared with an increase of 8% on community care (O'Shea 2003). This led to the Department of Health and individual Health Boards introducing a number of rules and initiatives to limit public expenditure on the scheme. Firstly, although the regulations contained a provision which allowed all subvention recipients to retain some "pocket money" for their personal needs, six of the eight health boards did not comply with this provision. Secondly, the health boards also included the incomes of the applicant's children in calculating the size of the subvention the applicant would receive.

Complaints eventually prompted the Ombudsman to investigate the scheme. The report found that the actions of the health boards in retaining the pocket money and taking into account the incomes of the children of applicants were illegal. The report also highlighted the Department of Health's decision to refuse to pay subventions to older people who moved into private residential care settings between 1979 and 1993. The report suggested that the Department had deliberately (and illegally) ignored its statutory responsibilities to meet increased demand for residential care, leaving many elderly patients to fend for themselves (Office of the Ombudsman 2001). The report suggested that the actions of the Department of Health and the health boards were "fundamentally wrong" and suggested that the problems in the operation of the subvention scheme highlighted "serious issues in regard to the relationship between the Oireachtas and the Executive (i.e. Ministers acting either individually or collectively in conjunction with the civil service)" (Office of the Ombudsman 2001).

However, it was not until 2006 that the DOHC acknowledged that it had misinterpreted the 1970 Health Act for 36 years, creating significant hardship for many older people and their families. In 2004, the DOHC received advice from the Attorney General that it had been illegal to charge individuals who either held a medical card or who met means-test criteria to enter a public home for their care (Howlin, Shariff & del Rio 2006). In response, the Minister for Health and Children attempted to introduce legislation which would retrospectively legalise the actions of the Department and the various health boards but the

Supreme Court found this legislation to be repugnant to the Irish Constitution (Howlin et al. 2006). As a result, the Health (Repayment Scheme) Act 2006 was enacted, providing for those who paid the illegal charges to a refund of the money to which they were entitled. The total cost of the scheme is expected to be in the region of €1 billion (Office of the Ombudsman 2010).

Following on from this, the DOHC began the process of reforming statutory financial support for residential care for older people. In 2005, an Interdepartmental Working Group was established in order to identify the policy options for a financially sustainable system of long-term care (DOHC 2006a). Although the Working Group was tasked with looking at funding options for domiciliary care services as well as residential care, the central aim of the deliberations of the group appeared to be focused on developing a new funding scheme for residential care, based on the principle of co-payment, or cost-sharing between the State and individuals for residential care, both in private and public settings.

While the report was not published until 2008, its recommendations formed the basis for a new funding scheme announced by the Minister for Health and Children in December 2006. Known colloquially as the "Fair Deal", the scheme aimed to make nursing home care more "affordable, accessible and anxiety-free" (DOHC 2006b), was formalised under the 2009 Nursing Homes Support Scheme Act. Under the Scheme, those deemed in need of nursing home care (through a care needs assessment) would pay no more than 80% of their assessable income towards the cost of care, plus up to 5% of the value of assets of the individual (including their house) per annum, capped at 15%. It was anticipated that the scheme would commence in January 2008, but was delayed as a result of concerns over the constitutionality of asking older people with reduced mental capacity to sign up to the scheme.

The decision to structure the new financing scheme through a mixture of state funding and payments from recipients ignored alternative approaches, such as through a social insurance scheme, which had earlier been recommended (Mercer 2002). However, it is possible that the decision to share costs with older people was because of the increased costs the DOHC was facing in increasing further the supply of residential care beds (Prospectus Consulting 2005), and in repaying the illegal nursing home charges.

Concerns about the impact of the scheme on quality were raised by both private nursing homes and advocacy groups in advance of its implementation. This was largely because the scheme aimed to buy care from private homes at

the lowest possible cost from providers, a factor which may have forced private providers to cut corners in order to accept residents under the scheme. A report commissioned by Age Action Ireland found that, for private homes to provide care in keeping with good international practice, it would cost €1,101 per resident per week in an urban area and €994 in rural areas. In contrast, the average private nursing home in Ireland in 2006 charged €694.20 a week (McEnery 2007). The author of the report outlined concerns that inadequate standards and inadequate revenue funding would create funding shortages and thus lower quality in some residential care settings. Nursing Homes Ireland, a body which represents 65% of all private nursing home owners, suggested that the Fair Deal proposal was unfair and inequitable and has argued that the focus on price and not on quality will put residents at risk.

Compared with the subvention schemes, the Fair Deal is arguably a more equitable funding scheme for residential care, as it prevents the possibility of an older person (and their family) paying the full cost of private residential care, while another individual with only a slightly smaller income is entitled to State support. However, the scheme has proven somewhat problematic and contentious. Firstly, the recession in Ireland has led to severe budget cuts, which has resulted in the budget ring-fenced for the Fair Deal Scheme being reduced. As a result, in May 2011, the HSE announced that the annual budget had already been used up and so no more older people would be admitted to residential care settings. This left older people with the option of joining a waiting list or paying the full price for a bed in either a public or private home (Donnellan 2011). Furthermore, house price falls of up to 60% have meant that the calculations on which the scheme were originally based are now significantly optimistic.

In addition, a report recently published by the Ombudsman into the right to nursing home care in Ireland has argued that many older people were refused a bed in a public residential care setting between 1985 and 2005, whereupon these people had no choice but to avail of private nursing home care (Office of the Ombudsman 2010). The Ombudsman has argued that such individuals were legally entitled to a public bed and so are entitled to compensation by the State. While the report did not estimate the cost to the State such a compensation scheme would incur, it would presumably create a significant hole in the public budget. However, as outlined below, the concerns about costs appear to have led to a failure to prioritise the quality of care.

3.4.4 Quality of Care

3.4.4.1 1964-1980s

Regulations introduced in 1966 under the 1964 Health (Homes for Incapacitated Persons) Act set minimum standards for accommodation, food and care in private nursing homes (O'Shea 2003). However, care homes were not inspected against these standards, prompting the authors of the 1968 *Care of the Aged Report of the Inter-Departmental Committee on the Care of the Aged* to raise concerns about the poor conditions in residential care services at the time (Inter-Departmental Committee on the Care of the Aged 1968). However, research into the quality of residential care into the 1980s suggests that the standard overall remained low (O'Connor & Walsh 1986, O'Connor & Thompstone 1986), resulting in a call from The National Council for the Aged, an advisory body to the government, to respond to the shortcomings in the quality of residential care settings in Ireland:

[T]here is a need to alter fundamentally the Health (Homes for Incapacitated Persons) Act, 1964 which presently covers nursing homes... [I]f the Homes for Incapacitated Persons Regulations 1985 were enforced then a number of nursing homes in the voluntary and private sector would have to be closed.

(O'Connor & Walsh 1986, p. 119)

The National Council for the Aged also recommended greater oversight of private and voluntary residential care homes, including the provision for a system of registration for private and voluntary nursing homes (National Council for the Aged 1985), and advised that inspections of residential care settings should focus on how nursing homes could be assisted to provide high quality care rather than on merely implementing minimum standards (O'Connor & Thompstone 1986).

3.4.4.2 1990s-2000s

The impact of the recommendations from the *Care of the Aged* (Inter-Departmental Committee on the Care of the Aged 1968) and the *Years Ahead* (Working Party on Services for the Elderly 1988) reports led to the enactment of the 1990 Health (Nursing Homes) Act and subsequent regulations on fees, subvention and care and welfare (O'Shea, Donnison & Larragy 1991). However,

the Working Party's recommendation that an independent inspectorate of extended care facilities be established was not implemented; instead, inspection remained the responsibility of the health boards (Working Party on Services for the Elderly 1988). Furthermore, the 1990 Act provided only for inspection of private and voluntary-run homes; publicly provided homes (approximately 48% of all settings (O'Shea 2003)) were not inspected.

The Nursing Homes (Care and Welfare) Regulations, 1993, outlined the services that providers were obliged to provide for patient safety, record keeping and for the regular inspection of the homes by designated officers of the Health Board. Care homes were also obliged to ensure that a "sufficient" number of competent staff were on duty under the 1993 Care and Welfare Regulations (Government of Ireland 1993a), though no minimum staffing ratio was prescribed. As had been recommended in *The Years Ahead* report, *A Code of Practice for Nursing Homes* was published two years later (Department of Health 1995), which was intended to complement the regulations by encouraging nursing home owners to go beyond the minimum standards set out in the regulations. The *Code of Practice*, which was not legally enforceable, outlined the minimum standards expected of nursing homes. It suggests that nursing homes should have an overall aim of promoting the independence of residents; that residents should be treated with respect and their dignity preserved; and that residents should be involved in decision-making. The Code of Practice also delineated guidelines on, *inter alia*, trial stays; countering institutionalisation; restraint; medication management; complaints; and the care of the terminally ill.

Although the intention to develop regulations was praised when first introduced (The Irish Times 1990), little independent assessment (i.e. based on empirical evidence) was made of the impact of the regulations on the quality of care provided. The review of *The Years Ahead* report was one of the only assessments of any kind to be carried out on the regulations in the 1990s. It reported on findings from consultations with nursing home providers about their level of satisfaction with the new regulations, which suggested that there was a lack of uniformity across health boards in the implementation of the regulations and in conducting inspections (Ruddle et al. 1997). Nursing home residents and their families were not asked about their opinion of the regulations or of the quality of care they received. However, the authors did suggest that there was a need to ensure that public sector facilities met the standards of care.

Since 2000, more and more research has highlighted the shortcomings in the regulatory regime and has recommended that more work needs to be done

to improve the quality of service provided to nursing home residents. The National Council on Ageing and Older People NCAOP (2000) reiterated the Working Party's recommendation to establish an independent inspectorate. Another report on the provision and quality of long-stay care services in Ireland also concluded that the legislation determining the quality of care provided in long-stay care settings was inadequate and that there was very little published information available on the quality of care in either public or private long-stay care facilities (Mangan 2002). The reluctance of the government to invest money into residential care has left many settings, particularly in the public sector, under-developed. Murphy et al. (2006) suggest that the physical environment of many residential care settings in Ireland is wholly inadequate to meet the needs of residents. As many are former workhouses, they are ill-equipped to cater for the needs of older people with limited mobility and intensive care needs.

The most recently published national health strategy, *Quality and Fairness - A Health System for You* (DOHC 2001), also included goals on the development of care services for older people, including the preparation of national standards for community and long-term care of older people, the provision of additional extended care beds over the next seven years and an improvement of staffing levels in extended care units. The strategy also outlined the intention to establish a new independent Health and Information Quality Authority (HIQA), which would be given the remit of, inter alia, setting and monitoring standards of healthcare services. The report suggested that the remit of the Social Services Inspectorate, an independent statutory body responsible for the inspection of publicly provided children's residential care settings, would be extended to include residential care for older people, though it did not outline whether this would include the inspection of public as well as private and voluntary homes. The 2001 Strategy has been praised for being more person-centred than previous policies and it also highlighted the need for additional funding for care services for older people (O'Shea 2006).

Various health boards also demonstrated that they had recognised the inadequacy of the regulations by the beginning of the twenty-first century, by creating (non-mandatory) guidelines in the form of minimum standards for providers. The Eastern Regional Health Authority was the first to do so, creating a draft set of standards in January 2003 (unpublished), followed by the Mid-Western Health Board in 2004 (also unpublished). A number of voluntary accreditation schemes were also established around this time. Excellence Ireland

Quality Association, a for-profit company, established a National Quality Care Programme for Nursing Homes in 2006. The Irish Health Services Accreditation Board (IHSAB) also published standards aimed at residential care settings for older people (both public and private) as well as other residential services in late 2005 (unpublished), though this programme was never put into practice, as the organisation was subsumed into HIQA shortly afterwards. The Irish Nursing Homes Association published its own set of standards in 2006 (INHO 2006). In fact, a survey of public residential care settings in the country carried out by the HSE in 2006 showed that all settings were using at least one set of standards to help improve the quality of care to residents, many of which focused on the promotion of autonomy, improving governance, management, the physical environment and healthcare (HSE Sub-Group on Standards for Residential Care Centres 2006). Although this meant that more than twenty different sets of minimum standards were in use in different care settings around the country, the survey results showed that providers were using their own initiative to improve the quality of care provided to residents.

The media were also an importance force in highlighting potential inadequacies in the nursing home sector. Many stories of inadequate care were reported in several newspapers. For example, in August 2003, a national newspaper published an article documenting findings from the inspection reports of private nursing homes that it had obtained under the 1998 Freedom of Information Act. According to the journalists, the reports showed that “some homes have failed to wash patients regularly, heat homes adequately in winter or provide hygienic food preparation facilities” (Holland & O’Brien 2003).

However, it was arguably not until after the airing of a television documentary, *Home Truths*, on the 30th May, 2005, about the “systematic abuse” (O’Neill 2006) of residents in a private nursing home based in North Dublin, Leas Cross, that the quality of residential care suddenly became a priority for the government. The programme involved a journalist posing as a care worker who secretly filmed staff-resident interactions. As noted in Chapter One, the footage revealed abuse of residents by untrained staff, including residents being forced to take medication, being shouted at, physically threatened and intimidated and being provided with inadequate care (including bedsores being untreated and eventually rotting).

An independent review of the deaths of residents of Leas Cross, carried out by a consultant geriatrician suggested that “Leas Cross was not an isolated incident” (O’Neill 2006) and that other homes also had similar shortcomings.

He identified a number of issues which he believes are responsible for the poor quality of care provided in Irish care settings:

- Failure of management to give sufficient weight to concerns expressed by interested parties;
- Weak policy, legislation and regulation;
- Deficiencies in funding;
- The speed of growth in the private sector and capacity of the regulatory bodies to keep pace.

A second report commissioned was also critical of the poor regulatory oversight of Leas Cross. O'Donovan suggested that inspectors consistently gave the home pass ratings and did not raise any concerns within their reports about any instance of poor care being given to a resident. However, O'Donovan found that other factors had also laid the foundation for the abuse of residents in Leas Cross. Insufficient numbers of competent staff led to a serious deterioration in the standard of care in the two years before the home had closed (O'Donovan 2009). In addition, the report was critical of the HSE as an additional 73 beds were registered with the home by the Northern Area Health Board without ensuring that the home could cope with the extra demand. The report also criticised the HSE for deciding to close the home without giving adequate notice to residents and their families, creating undue stress. O'Donovan found that the HSE's actions "strongly suggest that they were anxious to close the nursing home quickly, in order to be seen to react to the Leas Cross documentary and/or because of the potential costs and risks associated with keeping Leas Cross in operation at the appropriate standard" (p. 338). This brings into question the extent to which regulatory reform alone was an appropriate response to the Leas Cross crisis, particularly given the limited funding to the sector. This issue is discussed in later chapters.

3.4.5 Overview

Providing care services to older people at a reasonable cost is a concern that all governments face. However, in spite of a comparatively low level of public expenditure on care for older people (OECD 2005), successive Irish governments have been pre-occupied with keeping costs as low as possible, even

refusing older citizens their right to free treatment. The move towards a “user-pays” principle, albeit with government support, is reflective of Ireland’s liberal “low tax-low spend” regime, which follows the wishes of the electorate who have consistently rejected more universalist expenditure systems (Payne & McCashin 2006). The pre-occupation with increasing supply while keeping costs as low as possible resulted in the quality of care being sidelined. Prior to 1993, residential care settings for older people in Ireland were not subject to inspection. Between 1993 and 2009, only private and voluntary homes were inspected; public homes were not subject to any inspection. It was only in 2009, four years after the Leas Cross programme was broadcast, that all residential care settings were subject to inspection by an independent regulator (i.e. HIQA).

3.5 Conclusion

This chapter has outlined the key contextual factors in force in Ireland when the Standards were being developed. There is evidence to suggest that policy-making in Ireland is largely reactive, or crisis-led in style. Consultation and regulation are used as tools of governance as a way of demonstrating the government’s responsiveness to public crises, yet often without having significant substantive change in practice, perhaps reflective of the trend of regulatory ritualism that has developed elsewhere (Braithwaite et al. 1993). Furthermore, although the government had expressed its willingness to invest in public services, including in healthcare, which had long been under-resourced, by the time the Standards were published and approved by the Minister for Health in 2009, public funding was being cut, leaving little room for new investment. Finally, although it was noted in Chapter Two that financial investment in residential care can not only improve quality, but also reduce costs in the long term, care policies for older people since the 1960s have focused on limiting State expenditure on residential care for older people, which led to quality being ignored. Before considering how these contextual factors influenced the development of the Standards, the next chapter presents the research design and methodology used to carry out the study.

Research Design and Methodology

4.1 Introduction

This chapter describes the approach used to carry out the study. Section 4.2 first briefly sets out the rationale for and aims and objectives of the research, then Sections 4.3 and 4.4 describe the epistemological framework and theoretical lens guiding the study. This is followed by a detailed description of the research design and qualitative approach guiding the study in Section 4.5. Section 4.6 describes the methods of data collection and Section 4.7 details the data analysis process. Section 4.8 outlines the approach to reflexivity and 4.9 discusses the issues of reliability and validity in relation to the study. Sections 4.10 and 4.11 then set out the research limitations and ethical considerations for the study respectively. Finally, Section 4.12 provides a brief synopsis of how the findings are reported in Chapters Five, Six and Seven.

4.2 Aims and Objectives

As outlined in Chapter One, the rationale for the study lies in the need to broaden our understanding of the regulatory negotiated process and to understand how policy-makers and other relevant stakeholders of the residential care sector understand how best to meet the needs of older people. Regulatory negotiation is growing in popularity in many countries as a tool of governance. Although originally made popular in the area of environmental regulation, its use has spread to other sectors, including the residential care sector, over the last number of years.

In spite of the popularity of the approach, research examining the benefits of regulatory negotiation is relatively limited. To date, no research has examined the impact of the regulatory negotiated process on the *content* of the regulations (in terms of the meaning of the language and the message conveyed). Surprisingly little research has been carried out on regulatory negotiation outside of the context of environmental regulation. In particular, no research has been carried out on the use of regulatory negotiation in the context of regulating aged care and so it is unclear whether regulatory negotiation in this sector operates in the same way as it does in other sectors. As noted in Chapter Two, it has been suggested that the development of regulations for the residential care sector may act as a good test case for assessing the extent to which regulatory negotiation can empower the intended beneficiaries of the rules to the same extent as regulated firms. As nursing home residents are amongst the most powerless, if regulatory negotiation works in that context, it would prove the pragmatic viability of the method (Seidenfeld 2000). Perhaps more importantly, as outlined in Chapter Two, regulatory negotiation as a concept is relatively under-theorised. Empirical research tends to focus on providing evidence for or against the proposed advantages of the model. Theorising on regulatory negotiation tends to focus on why regulatory negotiation is used, but there is only limited hypothesising about why the process is used and why it often results in specific outcomes.

Furthermore, while many countries employ minimum standards for the residential care sector, there has been little analysis of the content of such standards or of the concepts and discourses upon which they are based. While a wide body of literature suggests that a person-centred approach is the best model of care, there are a significant number of barriers to its implementation, and so there is a need to understand whether policy-makers thus endorse this approach and how they support its implementation through regulation.

Therefore, the aim of the thesis was to develop a theoretical understanding of the relationship between the regulatory negotiated process and its outcomes (the content of the Standards and regulations). In order to comply with this aim, the thesis' specific objectives were to explore how the regulatory negotiated process:

1. impacted upon the clarity of the Standards and the extent to which they are feasible for providers to adhere to;
2. reflected the wishes of older people living in residential care settings;

3. impacted on the inter-relationship between HIQA and the government.

Following on from this, the thesis aimed to examine the inter-relationship between the content of the two documents (i.e. the Standards and Regulations) and the process used to develop them, and further, to develop a theory for the use of regulatory negotiation within the context of residential care for older people.

4.3 Epistemological Framework: Interpretivism

Justification of our choice and particular use of methodology and methods is something that reaches into the assumptions about reality that we bring to our work.

(Crotty 1998, p. 2)

All researchers bring certain ontological and epistemological assumptions to their work (Blaikie 2007, Bryman 2001, Crotty 1998, Denzin & Lincoln 2005, Kincheloe & McLaren 2005, Robson 2002). Thus, the research strategy adopted to answer a specific research question is based on the researcher's assumptions about the nature of reality and assumptions about how that reality can be known (Blaikie 2007). Various authors have suggested that there are various epistemological "branches" or viewpoints representing alternative perspectives about how knowledge is generated. Most commonly, these branches include a positivist/essentialist approach and an interpretivist approach (Bryman 2001, Crotty 1998, Denzin & Lincoln 2005). Research carried out from a "positivist" or "essentialist" viewpoint holds that meaning, and therefore meaningful reality, exists apart from the operation of any consciousness (Crotty 1998). From this viewpoint, objective science is seen as the best way of uncovering these truths. The positivist stance predominates in the natural sciences and traditionally held a greater prestige within the social sciences (Adam & Podmenik 2005). However, the objectivist stance has been called into question by researchers operating from an interpretivist stance. Interpretivists question whether the methods of natural science can (and should) be used in studying society and social phenomena, largely because society is experienced subjectively (i.e. we give it meaning through our own actions). In this way, it is not possible to study other human actions without interpreting their meaning; thus, interpretivists argue that all social research is inherently interpretative

(Denzin & Lincoln 2005). While each epistemological approach has its limitations (and neither can be deemed the “right” way) (Denzin & Lincoln 2005), it is important to delineate which approach informs a research study in order to contextualise its findings.

This research study was informed by an interpretative approach for two reasons. Firstly, this thesis aims to build a theory about the development of Standards for residential care by analysing the hidden meanings within the language of the Standards and also to examine how the authors of the document inferred these meanings into the text. The interpretivist approach was a more suitable framework for this objective as it facilitates the researcher to analyse the meanings that people confer on their own and others actions, a stance that is rejected within the positivist tradition (Blaikie 2007, Crotty 1998). Secondly, the epistemological framework selected for research projects should be a reflection of the researcher’s own epistemological viewpoint (Crotty 1998). Thus, I used an interpretative approach as I believe that each researcher brings their own experiences and assumptions to the research. Rather than trying to mask these, it is important to reflect on them throughout the process so that we can become more aware of how they influence our own interpretation of the findings. Section 4.8 provides some important contextual information on my own experiences which influenced the study.

4.4 Governance as a Theoretical Framework

Within the interpretivist tradition, there are many alternative theoretical perspectives, including *inter alia* feminism, Marxism, social constructionism, subjectivism and critical realism (Crotty 1998, Denzin & Lincoln 2005). Although governance has not traditionally been regarded as a conceptual lens or perspective in the same way, many researchers see governance as a theoretical framework in its own right, rather than simply just a theory explaining the increased role of non-government actors in the development and implementation of government policy. Research that uses governance as an organising, or conceptual, lens means that the unit of analysis under study is no longer the government/government agencies or programmes commissioned by government, but the means by which direction and control are achieved (Heinrich, Hill & Lynn 2004). As a result, governance research often focuses on the new tools of governance in use (including regulation) (Salamon 2002) and how these tools often reflect changing styles of governing. Furthermore, research

using a governance perspective aims to explain the rationale behind changing modes of governing and also the implications on policy-making structures and implementation (Newman 2005, Stoker 1998).

A governance perspective has been used, largely in the UK, on research on care and policy-making for older people. While much research by social gerontologists highlights the benefits of consulting older people about their care, governance research adopts a more critical stance to examine why governments have become more focused on the input of older people into policy-making (Barnes 2005, Glendinning 2003, Newman, Barnes, Sullivan & Knops 2004). This approach has been useful in adding a new, critical perspective on the popularity of consultation processes with older people, arguing that these initiatives are not only designed to incorporate older people's subjective viewpoints into care policies and programmes, but are a reflection of wider trends of governance. Such research can therefore explain how such consultation processes are influenced by changing modes of governance. Other research has used a governance perspective to examine the development of policies for older people that focus more on choice and the shifting of responsibility for service use from government to individual citizens (Clarke 2006, Glendinning 2008).

Much research also uses a governance approach as a lens to explore the increased popularity of regulation as a tool of governance and to examine its implications on compliance (Christensen & Laegreid 2007, Jordana & Levi-Faur 2004, Lodge 2004, May 2002, May 2007, Scott 2004, Scott 2008). As regulatory negotiation is under-theorised, examining the Standards development process through a governance lens may help to theorise the process more generally.

In spite of the usefulness of the governance lens, little of the research on regulatory negotiation uses this approach. Furthermore, much of the literature on regulatory negotiation is derived from a more positivist viewpoint, rather than from an interpretivist slant, as it relies on research methods that strive towards objective comparison. However, this approach ignores the fact that the decision to use regulatory negotiation is often a political (pragmatic) decision and its level of success can be influenced by a variety of different variables. This suggests that a more interpretivist framework may contribute to our understanding of regulatory negotiation.

It is possible that the lack of consideration within the academic literature on why regulatory negotiation has risen in popularity meant that I came to the

governance literature relatively late within the data collection and analysis process of the thesis. For a significant amount of time, I parsed the literature on gerontology, regulation and group dynamics to find an overarching “explanation” for the findings emerging from the data. It was only when I started to read the literature on governance that I began to recognise that many of its characteristics helped to provide a useful framework for analysing the contents of the Standards and the process used to develop them. Thus, while governance is used as an organising framework for the study, it is important that readers are aware that this was a decision taken towards the end of the process, rather than used from the beginning.

The thesis also uses (to a small extent) a post-modernist perspective in order to add a more nuanced and holistic account of the findings emerging from the study. Along with governance, postmodernism is another interpretivist perspective, which broadly examines changes that have taken place in society since the 1950s that has resulted in the emergence of a consumerist culture that places significant emphasis on individualism and the construction of personal identity (Alvesson 2002). Indeed, it has been argued that postmodernism facilitated the rise of neo-liberalism and New Public Management, as both ideologies emphasise the importance of a well-functioning market as a way of facilitating individualism and choice (Gilleard & Higgs 1998). A postmodern perspective also highlights the growing emphasis placed within society (and policy) on diversity and difference and also aims to problematise and challenge established fact and “grand narratives” explaining the social world and social order (Alvesson 2002). As outlined in Chapter Two, a postmodernist stance has been used to explain the changing perspectives on ageing and older people, and in particular, the growing association of old age as a time of new opportunities, yet the onset of the Fourth Age is often feared or even denied (Gilleard & Higgs 2005). It is thus useful within the current study to use a post-modern perspective to better understand the perspective of policy-makers on the Fourth Age.

4.5 Research Design: Case Study Approach

4.5.1 Rationale for the Case Study Design

The case study approach possesses distinctive qualities that enable an investigation of real-life events to lend itself to an understanding of the political

phenomena associated with the policy-making process (Yin 2003). Denscombe (2007) describes the case study as an in-depth study of processes and relationships in a natural setting using multiple methods of data collection. Within a case study, the “case” is the unit of analysis, and is a specific, complex, functioning thing (Stake 2005). A case can be defined socially (e.g. an individual or a community), spatially (e.g. a building or city) or temporally (e.g. a process or period of time) (Stake 2005). For this study, the case can be defined as the process used to develop the Standards and regulations. For the purposes of the thesis, the process also includes the outcomes of the process, namely, the Standards (HIQA 2009e) and the 2009 Care and Welfare Regulations underpinning these (Government of Ireland 2009). One of the central benefits of the case study approach is that it is an extremely flexible design; as researchers come to understand more about the case and begin to develop theories about what is happening within it, they can collect additional data they had not originally anticipated needing (Stake 1995).

The case study approach is common within the governance literature (Ansell & Gash 2008, Johnstone, Ackers & Wilkinson 2009). In fact, the case study research design is particularly useful in governance research as the method is sensitive to the importance of contextual factors, which often have an impact on why and how governance changes occur (Johnstone et al. 2009).

4.5.2 Case Studies and Causality

While most academic research sets out to build or test theories, drawing causal inferences is a difficult process. While case studies can be either exploratory, descriptive or explanatory (Yin 2003), the case study design is one of a small number of approaches used for finding causal mechanisms for particular phenomena, one of the greatest challenges facing researchers in every discipline (Bennett & Elman 2006). Indeed, the case study approach has been described as one of just four different approaches to the identification of causal mechanisms, as outlined in Table 4.1.

Within the case study field, there are different approaches to determining causality. While multiple-site case studies try to infer systematically how much a specific causal factor contributes on average to an outcome within a given context, in-depth single or small n-site cases are more useful for attempting to identify how different causal mechanisms interact to produce an outcome in a particular context (Bennett & Elman 2006). In such cases, causation is es-

Table 4.1: Techniques for drawing causal inferences.

	Approach	Description	Methods
Effects of Causes	Neo-Humean	Establishes causation through constant conjunction and correlation	Large N regression
	Counter-factual	Compares similar worlds and asks whether differences between them can be attributed to a change in a particular cause	Experimental research
	Manipulation	Investigates the effects of manipulating a cause in a controlled setting	Experimental research
Causes of Effects	Process Tracing	Traces the mechanisms of a process from cause to effect	Case Study
Source: Bennett & Elman, 2006			

established by a “causes-of-effects” process, namely, uncovering traces of a hypothesised causal mechanism within the context of a historical case or cases (Bennett & Elman 2006). Case studies that rely on a small number of cases and claim to have found causal mechanisms have often been criticised for being unrepresentative (Yin 2003). However, as Bennett & Elman (2006, p. 459) argue, whether a researcher can exclude all but one of the alternative explanations for a case depends on how the accessible evidence matches up with the proposed alternative explanations, not how many independent variables are considered or how many within-case observations are made. In this way, the process-tracing approach proposed by George & Bennett (2005) may be the best approach for a “causes-of-effects” approach. It is also important that the process tracing effect, though it may provide a causal explanation for that particular case, remains difficult to generalise this explanation to other cases because contextual factors can change how events occur. Thus, while this case will aim to develop a viable explanation as to why the process influenced the content of the Standards in the way it did, it is important to be clear that this does not necessarily follow that the same explanation (outlined in Chapter Eight) will apply to other cases of the development of minimum standards for the residential care sector. Only empirical research can ascertain whether the theory proposed in Chapter Eight is applicable to these other cases.

The general method of process tracing is to generate and analyse data on the causal mechanisms, or processes, events, actions, expectations, and other in-

intervening variables, that link putative causes to observed effects (George & Bennett 2005). In other words, of the two kinds of evidence on the theoretical causal notions of causal effect and causal mechanisms, tests of covariation attempt to address the former, and process tracing assesses the latter (George & Bennett 2005). Within the general method of process tracing there are two very different approaches. The first, "process verification" involves testing whether the observed processes among variables in a case match those predicted by previously designated theories. The second, "process induction" involves the inductive observation of apparent causal mechanisms and heuristic rendering of these mechanisms as potential hypotheses for future testing (George & Bennett 2005). As the regulatory negotiated process has not been studied within the residential care sector to date, the current case will rely on a process induction approach, aiming to generate an explanatory theory that can be tested in future research studies.

4.5.3 Case Selection

Objectivity and representativeness are often cited as important principles in selecting cases for an explanatory case study, in order to rule out the possibility of selection bias (Yin 2003). As a result, Yin (2003) suggests that the selection of cases should be made on the basis of strict and unbiased sampling procedures, in order to allow for explanatory theories to be regarded as valid and reliable. Questions over the ability of research to generate "objective" knowledge notwithstanding (Blaikie 2007), according to Bennett & Elman (2006), this presupposes the use of multi-site cases relying on a "effects-of-causes" approach, which are often not applicable to studies relying on within-case analysis. They argue that selection bias can often be overstated and that there are other reasons for choosing cases on the basis of outcomes that may well outweigh the risks of that particular bias. In this way, non-probability sampling is not a requirement for the selection of a case study site. In a similar vein, Stake (1995) suggests that it is not unusual for the choice of case to be no choice at all. Stake (2005) also argues that the goal in studying such cases is to optimise our understanding of the case in order to provide insight into a particular phenomenon. In this way, it is reasonable for the case to be pre-selected, when a unique or rare opportunity occurs to study a previously under-studied case. Yin (2003) also concedes that there are occasions when a single case study is a legitimate enterprise, particularly when it offers an opportunity to study a previously un-researched, or under-researched phenomenon and to generate a hypothe-

sis that can be explored in future research (the occurrence of an extreme or unique case). As noted in Chapter Two, many countries have used a collaborative process to develop Standards for residential care settings for older people, yet the process has to date not been studied. As such, this case provided an ideal opportunity to expand our understanding of the use of regulatory negotiation within the context of regulating residential care for older people, thus enhancing our understanding of regulatory negotiation (Seidenfeld 2000) and policy-making/standard setting in the residential care sector.

4.5.4 A Qualitative Approach

Qualitative methods of data collection and analysis are often equated with an interpretative framework. Indeed, qualitative research is often seen as synonymous with an interpretative approach. This can best be seen in the work of Denzin & Lincoln (2005), who suggest that

the qualitative research community consists of groups of globally dispersed persons who are attempting to implement a critical interpretative approach that will help them (and others) make sense of the terrifying conditions that define daily life in the first decade of this new century... These scholars constitute a loosely defined international interpretative community.

(Denzin & Lincoln 2005, p. xiv)

As a result, research using a qualitative approach is often burdened with an additional, political agenda, namely, highlighting the value of the interpretative tradition (Silverman 2006).

However, Silverman (2006) suggests that this approach is erroneous, as qualitative methods are simply free-standing techniques that analyse words and images rather than numbers. Rather, what makes research critical is the adoption of a critical theoretical lens (such as governance). Silverman (2006) therefore suggests that researchers should choose a methodology based on their suitability for answering the research question. Although it is commonly assumed that qualitative studies are only good for exploratory research and for developing hypotheses, Miles & Huberman (1994) suggest that qualitative methods can be a powerful method for assessing causality. This is because qualitative analysis can identify causal mechanisms, and allows for complexities and detail. It allows for understanding of processes and can determine what

events happened in a particular order and, indeed, how one event influenced another. Furthermore, according to Bennett & Elman (2006), within-case analysis usually employs qualitative methods of data collection and analysis. They suggest that qualitative methods are particularly useful in facilitating a process-tracing approach to theory-building. Cassell & Symon (1994) also suggest that qualitative methods are particularly appropriate for answering research questions that focus on 'processes'.

4.6 Data Sources and Methods of Collection

4.6.1 Introduction

The use of multiple methods within a qualitative case study is a useful way of triangulating findings and building up a rich picture of the case and the context around it (Stake 2005). According to Denscombe (2007), there are three forms of data collection suitable for qualitative research projects, observation, interviews and documentary data. Observation of the Working Group meetings would have been useful in generating and triangulating data on how the Working Group operated, particularly in determining the strength of the relationships between the different group members, showing how decisions were made and revealing firsthand instances of camaraderie and/or tension within meetings, and ascertaining whether these factors appeared to influence the content of the Standards (Mulhall 2003, Waddington 1994). However, as the Working Group had concluded its work prior to the commencement of the thesis, it was not possible to use this form of data collection. Instead, I used both documentary and interview data to understand both the Standards and regulations and the process used to develop them.

4.6.2 Documentary Data

Atkinson & Coffey (2004) have suggested that textual communicative practices have been described as a vital way in which organisations constitute "reality" and the forms of knowledge appropriate to it. Thus, analysing textual data can often exhibit much about the cultural norms and assumptions through which specific groups operate, thus perhaps revealing the Working Group's priorities for providing older people with safe, quality care. As a result, the Standards

(HIQA 2009e) was a key documentary source of data for the thesis. This document was published on HIQA's website, publicly available for download.¹

Documentary data can also serve the added purpose of triangulating other forms of data (Hartley 1994). Thus, documentary data can be an important source for enhancing our understanding of the regulatory negotiated process (gleaned primarily through in-depth interviews, as outlined below) as well as the content of the Standards. I therefore set out to collect and analyse all documentary sources of data related to the Standards and their development.

As noted previously, a total of four drafts of the Standards were published. Different actors in the residential care sector had input into each draft. I felt it was important to analyse the content of the three earlier drafts alongside the final version, in order to be able to trace the changes made between each draft. All four of these drafts were publicly available, the first on the DOHC website, and the later two on HIQA's website and so I downloaded these in preparation for analysis. I also collected a number of press releases related to the publication of various drafts of the Standards on both the DOHC's and HIQA's websites.

I also felt it was important to consider the views of those who contributed to the public consultation process and the extent that these were taken into account by the HIQA Working Group. The final report on the public consultation process commissioned by HIQA was not publicly available, so I wrote to HIQA asking for a copy, a request which was granted. I also emailed several organisations (14 in total) I thought may have made a submission to HIQA as part of the public consultation process. I used the description of the organisations asked to participate in the public consultation process provided in the final report to identify these:

To maximise the input of all stakeholders in the development of the *National Quality Standards for Residential Care Settings for Older People*, all resident groups, residential service providers, care receiver/user/representative groups and the HSE were informed of the consultation process and invited to submit written comments on the draft standards.

(HCI 2007, p. 6)

¹As this draft was not published until close to the end of the data collection and analysis, following approval by the Minister for Health, I used the previous version (HIQA 2008), assuming that this was the final version. Once the 2009 version was published, I carried out a comparative analysis between the two documents, noting the (few) changes and updated data analysis where necessary.

Eight organisations sent me on the submissions they had originally sent to HIQA. Of the six who did not, four had not made submissions and two did not respond to my request.

In addition, I decided to examine the legislative framework for the Standards. Along with the 2009 Care and Welfare Regulation, (as noted in Chapter One), I examined the 2007 Health Act (Government of Ireland 2007), which provided a legal mandate for HIQA and also set out its functions. I also analysed documents developed and commissioned by the DOHC to facilitate the development of these 2009 Regulations. Finally, I examined guidance documents later produced as a framework for residential care providers on the legal requirements for the new regulatory process.

As noted in Chapter Two, a number of countries have developed new standards in the last number of years. As the original draft of the Irish Standards suggested that it had relied on these to develop its own standards, I felt it was important to determine which issues were reflected in the Irish Standards and which were not, and so I collected Standards from other countries in order to be able to conduct a comparative analysis.

In addition, other unpublished sources of documentary data related to the development of the Standards had been developed. However, I only became aware of their existence while I was "in the field". Stake (1995) suggests that this impromptu source of data collection is one of the benefits of the case study approach, which, as a flexible research design, allows researchers to find sources to enhance their understanding of the case even after the initial design and sources of data collection have been decided. Thus, respondents made me aware that minutes had been kept of the meetings of the Working Group which kept an attendance record and a brief account of the discussions that had taken place at each meeting. After asking HIQA staff informally for copies of these minutes, and being refused, I applied formally to HIQA for, and was granted, permission to access the minutes under the Freedom of Information Acts 1998 and 2003. As I was refused permission informally from having access to the minutes, I deliberately did not formally apply for access until after I had completed the rest of the interviews for the study in case this would lead to the development of a poor relationship with HIQA staff, key informants for the study.

In total, I analysed fourteen documentary sources for the purposes of this thesis. These were:

1. The first draft of the Standards, written by an internal Working Group established by the DOHC (DOHC 2007*b*).
2. The revised second draft of the Standards, written by the Working Group established by HIQA (HIQA 2007).
3. The third version of the Standards, amended by the Working Group to take account of the findings of the public consultation process (HIQA 2008).
4. The fourth version of the Standards, approved by the Minister for Health and Children (HIQA 2009*e*).
5. The report summarising the findings from the public consultation process commissioned by HIQA (HCI 2007).
6. Eight submissions made to HIQA as part of the public consultation process.
7. The 2007 Health Act which provided for the establishment of HIQA (Government of Ireland 2007).
8. The 2009 Care and Welfare Regulations which gave legal status to HIQA's Standards (Government of Ireland 2009).
9. Various press releases issued by HIQA and the DOHC about the Standards and commencement of the new regulatory regime (DOHC 2009*a*, DOHC 2009*b*, DOHC 2008, HIQA 2009*d*).
10. The Regulatory Impact Analysis (RIA) conducted by DOHC officials prior to the drafting of the 2009 Care and Welfare Regulations (DOHC 2009*c*).
11. The report on the assessment of the costs of HIQA's Draft Standards commissioned by the DOHC and carried out by PA Consulting (2009).
12. Guidance documents about the Standards and the new inspection process issued by HIQA to providers (HIQA 2009*a*, HIQA 2009*b*, HIQA 2009*c*).
13. Minutes of the meetings of the Working Group.
14. Standards from other countries, including Australia (Aged Care Standards and Accreditation Agency 2006), England (Department of Health

UK 2003), Northern Ireland (Department of Health Social Services and Public Safety 2005), Scotland (Scottish Executive 2005) and Wales (Welsh Assembly 2004).

Although these documents were mostly “official” sources of documents (in that they were intended for a wide, public audience and written or commissioned either by civil servants within the DOHC or by HIQA with the authority to write minimum standards) (Atkinson & Coffey 2004), they represented a variety of different types of sources (press releases, standards, legislation, commissioned reports and submissions) and so offered a variety of perspectives on the Standards and the development process. As they each served different purposes within the overall methodology, a few different methods of data analysis were used, as outlined in Section 4.7 below.

Including each of these documents in the data analysis offered several specific advantages in answering the research questions outlined in Section 4.2 above:

- Analysing the content of the Standards allowed me to better understand the values and principles underlying the document and also to examine their clarity and feasibility.
- Including the four drafts of the Standards allowed for an examination of the changes made between each of the four drafts of the Standards, thus providing an opportunity to reveal the contributions of each of the key groups (namely, the DOHC’s working group; HIQA’s Working Group; and the “general public”) towards the content of the Standards.
- Including the findings of the public consultation report provided an opportunity to assess the extent to which the views of older people (and the wider public) were taken into account in HIQA’s later draft of the Standards.
- Including the submissions allowed for an indication of how Health Care Informed interpreted the findings of the public consultation process.
- Including the legislation presented an opportunity to contextualise the role of the Standards within the wider legislative framework.
- Including the press releases, RIA, commissioned reports and the guidance documents allowed for an understanding of how HIQA and the DOHC officially interpreted the Standards and legislative framework for the regulatory regime.

- Including the minutes provided an opportunity to verify factual information about the details of the meetings, including the attendance rates of each individual; which issues were discussed at each meeting; where and when meetings took place and how decisions were made about the content of the Standards. This provided an opportunity to triangulate against verbal accounts of the meetings with Working Group members, an advantage of using multiple data collection methods within a case study framework.

4.6.3 Interview Data

The in-depth interview is one of the most widely used methods of data collection in qualitative research studies (Silverman 2006). This method offers several advantages. Interviews allow us to understand the authentic accounts of the respondent's subjective experience of a particular phenomenon (Silverman 2006). Furthermore, the use of interviews facilitates the case study approach (particularly process-tracing) to theory-building, as it allows the researcher to start identifying the factors that may have contributed to the outcomes of the process as data collection is ongoing; individual respondents may make an unexpected comment that can be explored both in that particular interview and subsequently in later interviews (Stake 1995). Thus, interviewing members of the Working Group allowed me to build up a picture of the process through the various accounts of respondents, gauge each individual's subjective experiences of the process and their views on the Standards, as well as their reasons for their particular view on the process.

However, one of the difficulties of using key informant interviews is deciding who should be included in the list of potential interviewees (Denscombe 2007). As well as the Working Group members, other relevant individuals also played an important role in the development of the Standards and regulations besides the members of HIQA's Working Group. For example, a small group of civil and public servants were involved in drafting the original version of the Irish Standards (DOHC 2007*b*) and other civil servants later developed the regulations underpinning the Standards. In addition, I interviewed staff from the private company Health Care Informed (commissioned to carry out the public consultation process on behalf of HIQA). Furthermore, it has been suggested that those selected to participate in policy-making processes ("insiders") may have different characteristics than those not selected

and than those who choose not to participate (“outsiders”) (Maloney, Jordan & McLaughlin 1994). Thus, it is possible that other relevant stakeholders not asked to participate in the Working Group may have had alternative perspectives to Working Group members’ about the process. I decided to include individuals from these groups to offer a more nuanced view of the process.

In summary, I decided to conduct interviews with:

1. Members of HIQA’s Working Group
2. Members of the original Working Group established by the DOHC
3. Officials from the DOHC responsible for drafting the 2009 Care and Welfare Regulations that gave legal effect to the Standards
4. Interviews with relevant stakeholders of the residential care sector who did not sit on HIQA’s Working Group

As the purpose of an in-depth interview is to understand the subjective experiences of respondents (Denscombe 2007), I adopted the maxim of inclusivity, on the basis that this would facilitate the examination of the Standards development process from a wide variety of perspectives. I therefore decided to try and interview all members of the Working Group. As each individual was invited to participate in the process on the basis of their individual expertise, it may have been erroneous to assume that members selected on the basis of specified sampling criteria would have been able to represent the views of others accurately (Denscombe 2007). Identifying the potential respondents from this category was straightforward, as a list at the back of the Standards gave the names and affiliated organisations of the 36 members of the Group (including HIQA staff involved in overseeing the process) (HIQA 2008).²

Similarly, I also decided to try to interview all seven of the members of the original DOHC Working Group. As two of these individuals went on to become members of HIQA’s Working Group, I decided to interview the remaining five

²As noted in Section 4.6.2 above, I only obtained the minutes of the Working Group meetings after carrying out interviews with the Working Group members listed at the back of the Standards document. This created something of a disadvantage in terms of identifying potential respondents for the study, as the minutes revealed that other individuals also attended Working Group meetings. As outlined further in the next chapter, a total of 61 individuals attended at least one meeting. In some cases, individuals attended a meeting in order to represent a colleague who was unable to attend on a specific day. However, others appeared to have joined the Working Group later in the process. In order to try to capture the views of some of these additional individuals, I contacted two individuals. For reasons of time and resource pressures, I was unable to interview all of the additional 25 individuals.

and ask the two individuals on both Working Groups about their experience of being on the original group. I also contacted the DOHC by email to request an interview with the officials who had been responsible for drafting the 2009 Care and Welfare regulations. This permission was granted and an interview was conducted with two civil servants responsible for drafting the regulations. The greatest challenge was in identifying members for the fourth category of interviewees, relevant stakeholders of the residential care sector who did not sit on HIQA's Working Group. Brugha & Varvasovszky (2000) argue that there is no one set way to carry out a stakeholder mapping exercise. I started by researching the various types of stakeholders that exist. Schmeer (2000) provides a useful list, which helped me to identify the potential groups of stakeholders of the sector:

- Providers: owners and managers of residential care settings
- Funders: government, providers.
- Legislators: the government
- Staff: professional organisations, including trades unions
- Non-governmental advocacy organisations: advocacy organisations for older people and family carers
- Users: older people living in residential care settings

All of these groups were represented on HIQA's Working Group, with the exception of the trades unions and older residents. As there is often more than one representative body, choices may have been made by HIQA about which organisations to invite to participate on the Working Group. Understanding both perspectives was important for the purposes of this thesis.

However, I decided to also exclude older residents from the process. While HIQA later invited service users to sit on the Working Group for the development of other sets of Standards (including people with disabilities for the development of standards for that sector (HIQA 2009f)), it did not include any older people living in residential care settings. Instead, as noted above, older people were consulted about their views of residential care through the public consultation process (HCI 2007). As older people were excluded from the process, it was clear that interviewing older people living in residential care would not offer any explanations about why they were excluded. As a result,

I decided not to conduct interviews with older people living in residential care directly, but simply to ascertain whether (and how) their views on improving residential care, as expressed in the public consultation process, were taken into account by the Working Group.

Using the remaining categories, I conducted a general desk-based search, using the internet, relevant literature and phone consultations to identify the relevant stakeholders from each category who did not take part in the Working Group. Secondly, I used a “snowballing” technique, asking each interviewee whether they could identify any other stakeholder who had not been part of the Working Group. This form of snowballing is commonly used within stakeholder mapping exercises (Brugha & Varvasovszky 2000). From these two strategies emerged a total of eleven non-Working Group stakeholders.

In total, I therefore had a list of 53 potential respondents for the thesis. Of these individuals, 44 agreed to be interviewed, while 9 declined to take part (see Table 4.2). Of the HIQA Working Group members, repeated attempts to contact three individuals failed, and so it was not possible to set up an interview with them. The fourth individual declined to participate on the basis of co-supervising this thesis. Of the original (DOHC) Working Group, three agreed to be interviewed, and two did not respond to repeated requests. Two of the non-relevant stakeholders declined to take part on the basis of having little knowledge of the residential care sector or of the Standards and one did not respond to repeated attempts to contact them.

Table 4.2: Potential Respondents for Interview and Response Rates

	Potential Interviewees	Decline	Number (%) Interviewed
Members of the Working Group	37	4	32 (86%)
DOHC Working Group	5	2	3 (60%)
DOHC Staff	1	0	1 (100%)
Relevant Stakeholders	11	3	8 (72.7%)
Total	54	8	44 (81%)

Before starting the interviews, I considered that the most important interviewees were likely to be HIQA and DOHC staff and providers on the Working Group. In order to make the interviews with these respondents as rich as possible, I decided that it would be best to interview these individuals last. In addition, as HIQA staff had the most involvement in the process, I also felt that it might be possible to use these interviews to triangulate the different versions

that had been given by other interviewees. This approach is consistent with the process-tracing approach (George & Bennett 2005). I therefore decided to interview respondents according to their role within the residential care sector. Thus, respondents were grouped and invited to take part in an interview in the following order, starting with what I considered to be the least important group, and finishing with the more salient stakeholders:

1. Therapists/professionals other than nurses
2. Advisors/experts on ageing
3. HSE staff with a policy-making function
4. Representatives of advocacy groups for older people and family carers
5. Directors of Nursing of Public Residential Care Settings
6. Providers of private residential care settings
7. HIQA Staff
8. DOHC officials

Each respondent was initially contacted by letter (see Appendix D), in which the aim of the thesis was outlined, along with a request for interview and the purpose and likely topics to be discussed in the interview. If respondents did not reply, this email was then followed up with a phone call approximately one week later, where additional information on the thesis and purpose of the interview was given. An appointment was then made to meet each respondent. Before the interview started, respondents were given an information sheet and asked to sign a consent form (see Appendices E and F).

I developed separate interview guides for each category of respondent (see Appendix G). The interviews with members of the HIQA Working Group focused largely on respondents' views of the Standards (including the extent to which it mirrored their own wishes); their views on the Working Group; their description of how the Working Group functioned; and their views on care policies for older people in Ireland. The interviews with members of the original Working Group focused on asking respondents to describe the process of the Working Group's operation, including how decisions were made; their opinions on the different versions of the Standards; why the group was established; and how the draft Standards were passed over to HIQA. The purpose

of the interviews with DOHC officials was to obtain information about the process used to develop the regulations, and in particular, the extent to which the Standards were referenced in writing the regulations. The interview also aimed to obtain information about the relationship between HIQA and the DOHC, both officially and informally. The topics covered in the interviews with other relevant stakeholders were similar to those covered for Working Group members, though respondents in this category were also asked about their views on the Standards and any knowledge they had of the Working Group's operations, rather than how the Group operated per se.

Each interview followed a semi-structured format; interviewees were given leeway in how to interpret and answer each question and also to veer away from the questions asked (Bryman 2001). This style was adopted for two reasons, firstly, in order to ensure that respondents felt relaxed and comfortable with sharing their views and experiences, and secondly, in order to allow each individual's subjective experiences and views to come through the interview process (Darlington & Scott 2002). Interviews lasted on average 45-50 minutes, but ranged from 30 minutes to 90 minutes; 39 were conducted in a quiet and private room in the respondent's place of work, three took place in a private, quiet office in Trinity College Dublin and two were conducted over the telephone as respondents did not have time to meet in person. Forty-three of the 44 interviews were audio-recorded; permission was refused by one respondent and so the interview was not recorded. Instead, hand written notes were taken and typed up electronically later.

All of the interviews were transcribed verbatim on the day of, or in the days immediately following, the interview in order to allow each interview to inform the rest of the interviews; hone the interview guide and start the data analysis process, described in Section 4.7 below. In addition, a Contact Summary Sheet was filled in as the interview was being transcribed (see Appendix H). A Contact Summary Sheet is recommended by Miles & Huberman (1994) to summarise the main points from the interview and how the interview illuminated new perspectives on the central themes and objectives of the research by asking standard questions for each interview. Miles & Huberman (1994) suggest that the questions should be decided by the researcher according to the research questions, but that the forms should be kept simple and short. The contact summary sheet helped commence the initial data analysis of the interviews, an overview of which is presented below.

Of the 44 individuals interviewed for the study, 32 were members of the Wor-

king Group, and twelve were not. As can be seen from Table 4.3, just over two-thirds of all respondents were female. Almost three-quarters of all respondents worked in the public sector (see Table 4.4) and just one-quarter worked on the “front-line”, working directly within a residential care setting, usually at managerial level (see Table 4.5). Most of the other respondents worked in devising or critiquing national health care policy (including respondents from the DOHC and policy advisors from the HSE), or else had a limited frontline capacity (including therapists whose client base included older people living in residential care settings).

Table 4.3: Respondents' Gender

	Male	Female	Total
Member of the Working Group	10	22	32
Non-Member	4	8	12
Total	14	30	44

Table 4.4: Breakdown of Sample by Sector

	Public	Private	Voluntary	Trade Union	Total
Member of the Working Group	23	4	5	-	32
Non-Member	6	2	2	2	12
Total	29	6	7	2	44

Table 4.5: Work Function of Interviewees

	Frontline	Limited Frontline	Policy-Maker	Total
Member of the Working Group	8	6	18	32
Non-Member	3	1	8	12
Total	11	7	26	44

4.7 Data Analysis

4.7.1 Analytical Framework

Data analysis developed in two stages. The first level of analysis aimed to examine the content of the Standards and separately to understand the development process. The second level of analysis aimed to analyse the inter-relationship between the two and developing a conceptual model from the findings. To facilitate the analysis process, I used the software programme NVivo 9 (QSR International Pty Ltd). Qualitative analysis software programmes are useful for research studies with large amounts of data to be analysed, and are used to enable the complex organisation and retrieval of data (Pope, Ziebland & Mays 2000). However, software programmes are used to assist, rather than perform, analysis. As qualitative analysis requires researchers to make connections between codes, it is not possible to rely on the software to carry out such inductive, analytical work independently; rather, it is incumbent on the researcher to instruct the software package how to make such connections (Miles & Huberman 1994). Within the programme, I set up a project file for the analysis of both the documentary data and the interview data, as outlined further below. In order to keep the analysis of the Standards separate from the analysis of the process itself, I developed two “tree” nodes, one for the analysis of the Standards and Regulations and one for the analysis of the process used to develop them. During later stages of analysis, the data were combined in order to examine the linkages between the content of the document and the process used to develop them. Appendix I provides more detailed information about the data analysis process, including about the use of NVivo 9 to assist the coding process for the study.

4.7.2 First Level Analysis

The first level of analysis aimed to develop an understanding of the content of the Standards and the process used to develop them, as described below.

4.7.2.1 Identifying the Outcomes: Content of the Standards

The first step I took in analysing the data was to analyse the content of the Standards document with the aim of constructing a picture of the concepts and

assumptions underlying it. I did this by conducting a discourse analysis of the document itself and subsequently by tracing the evolution of the creation and development of the Standards. As outlined in Section 4.2 above, I was interested first of all in exploring the clarity of the language of the Standards, the extent to which the views of older people taken on board within the process and the inter-relationship between HIQA and the government.

Discourse Analysis

I relied on a discourse analysis approach in order to link the language used within the Standards and regulations with the social context in which it was written (Fairclough 2000). Discourse refers to a form of verbal (or textual) interaction between individuals (or groups) to communicate ideas, beliefs, or to express emotion (Van Dijk 1997). Furthermore, discourse is the foundation for a pattern of interaction that reflects social and political contexts and which also constructs and is constructed by these contexts (Fairclough 2000). Discourse analysis thus aims to examine how the language used in particular situations influences beliefs and vice versa. The theory of discourse analysis operates on the basis that the words we choose are never neutral; rather, they are shaped by our own social, political and historical experiences. Thus, by using this approach, I hoped to identify some of the attitudes and beliefs of the authors who wrote it, and also to explore the prevailing social system in which it was written (Van Dijk 1997). Discourse analysis is particularly useful in analysing policy documents, for example, Fairclough (2000) analyses the rhetoric used by the Labour Party in the UK as it came to power. Discourse analysis is also used frequently to analyse health and care policy documents (Hodgins & Greve 2004, Iannantuono & Eyles 1997). Discourse analysis has been linked to many theoretical perspectives, including social constructionism, postmodernism, poststructuralism, linguistics, feminism and cultural theory (Van Dijk 1997). However, discourse analysis, as with all analytic techniques, need not be used in conjunction with its original theoretical underpinnings, but simply as the most appropriate method, in conjunction with a different theoretical approach (Bernard & Ryan 2010, Silverman 2006).

The discourse analysis of the Standards aimed to highlight the underlying meaning behind the language used within the Standards. I also used some of the techniques of a thematic analysis in order to assist with the discourse analysis. This analysis focused on identifying the trends, patterns and anomalies apparent within the Standards, in order to develop codes and themes that

could later be linked to theories that could help to explain the way in which the Standards were written. As noted above, I was particularly interested in looking at both the clarity of the language in the document and the extent to which the views of older people were taken on board within the process. While there is no set methodological approach to carry out a discourse analysis, Huckin (1997) sets out a useful approach, which I followed to analyse the final version of the Standards.³ This involved four readings of the text as a whole, and then more detailed readings of individual sections and sentences:

1. Read the text in an uncritical manner to become familiar with the document.
2. Read the text again in a critical manner, considering how it could have been written differently, considering the text as an example of its genre, how the author(s) communicate with their intended audience, and comparing it to other similar texts.
3. Consider the perspective of the document (i.e. what point of view is presented): what photographs, embellishments and diagrams are used to catch the reader's attention? what issues are not mentioned? what ideas are taken for granted? how is the author of the document represented?
4. Detailed analysis: Who is depicted as powerful? Who is depicted as powerless? Are there are examples of persuasive rhetoric aimed at manipulating the reader? What metaphors or visions are set out within the document?

This guide was supplemented by additional, open-ended guiding questions of specific relevance to the Standards document itself:

1. What issues relevant to the operation of a residential care setting are addressed?
2. How are these issues addressed (eg what language is used?)
3. What issues relevant to the operation of a residential care setting are not addressed within the document?
4. Who is the document aimed at?

³At the time I was starting the analysis process, the 2008 version was the then final draft. However, there are very differences between this version and the 2009 version which was granted Ministerial approval. I later took these changes into account.

and also by using some of the techniques suggested by Ryan & Bernard (2003), including examining contradictions, repetitions, transitions, missing data, similarities and differences in how different issues are dealt with within the document and theory-related material within the document. As the thesis aimed to develop a theoretical explanation for the case under study, I connected the codes with references to the existing literature, where possible (Mills, Durepos & Wiebe 2010). The focus on the clarity of the language in the Standards led to the development of a key theme, Ambiguity within the Standards, while the focus on the extent to which the views of older people were taken into account led to another key theme, the Model of Person-Centred Care within the Standards, as outlined in Appendix I.

Evolution of the Standards

I used a comparative content analysis to trace the evolution of the Standards and the regulations. In doing so, I was particularly interested in verifying that the Standards were broadly similar to the regulations, and so the process could accurately be described as an example of regulatory negotiation. Content analysis is often used to count various aspects of the content of written text as a way of showing trends and differences (Krippendorf 2004). The results are then used to make inferences about the messages within the texts, the writers, the audience, and even the culture and time of which these are a part.

While content analyses usually involve the development of a coding framework (Krippendorf 2004), the process in the context of this study involved simply looking at the extent to which the Standards were incorporated into the regulations. As a result, no coding framework was required. Rather than using NVivo to guide this process, I used Microsoft Excel in order to be able to visually compare the various drafts of the documents within a tabular format and to be able to categorise and count the changes. This enabled me to create a record of the key changes made within each draft and which group had made them.

As noted above, different versions of the Standards were published. The purpose of this comparative analysis was therefore to reveal the contributions of each of the key groups who contributed to the content of the Standards, namely, the DOHC, HIQA and the "general public". I began by comparing the changes made between the original DOHC draft of the Standards (DOHC 2007b) and HIQA's Draft Standards (HIQA 2007), then comparing the differences between this version and the version following the public consul-

tation process (HIQA 2008), and lastly, the final version published following approval by the Minister for Health (HIQA 2009e). I then compared the original and final versions. I also analysed the findings from HIQA's public consultation process (HCI 2007) and the eight submissions to determine whether the later version of the Standards had been altered to take into account any of the issues which the earlier version had not adequately addressed.

I also compared the Standards with key legislative documents, in order to understand the contribution of the Standards to the regulatory process. I further compared both the final and original versions of the Irish Standards with the various sets of Standards from other countries. In addition, I analysed the findings from HIQA's public consultation process (HCI 2007) in relation to the Standards in order to determine whether the later version of the Standards had been altered to take into account any of the issues which the earlier version had not adequately addressed.

Other documentary sources (e.g. press releases, the 2007 Health Act, the RIA, the report on the assessment of the costs of the Standards and guidance documents issued by HIQA) were used to inform the Standards and regulations and to triangulate statements made in interviews where necessary. These documents were not analysed in a thematic way, but were simply used to obtain relevant information to develop a more nuanced view of the process (George & Bennett 2005, Stake 1995, Yin 2003).

Another important theme emerged from the comparative analysis of the Standards and the legislation, the Ownership over the Regulatory Process. This theme, together with the Ambiguity within the Standards and the Conceptualisation of the Public Interest themes, represented the three central "outcomes" of the process explored within this thesis. As outlined in Appendix I, in order to keep all of the analysis together, I created codes within NVivo about the comparison between the Standards and the regulations.

4.7.2.2 Analysing the Process

The process-tracing method requires researchers to piece together the "story" of the process being studied (George & Bennett 2005). Mills et al. (2010) suggest that process tracing requires researchers to reconstruct an explicit chronology of the sequence of events that comprises the process under study. They suggest that this often takes the form of a chronological narrative ("storytelling to uncover a causal mechanism").

Following this guidance, I used the interviews with Working Group members, as well as interviews with other relevant stakeholders, to create a narrative account of the process used to develop the Standards. I also relied on the minutes of the Working Group meetings to enhance (and triangulate) the interview data. Thus, I divided the findings from the various sources of data into three phases: 1. events prior to the establishment of HIQA's Working Group, 2. an overview of HIQA's Working Group and 3. events that transpired following the completion of the Working Group's operations.

To analyse these data, I relied on a thematic approach. Bernard & Ryan (2010) describe a theme as a dynamic affirmation that controls behaviour or stimulates activity. In other words, themes are expressions of cultural systems that can help to show the underlying norms and assumptions responsible for an individual's attitudes and beliefs. Themes can be extracted from interview transcripts by looking at recurring trends, unusual (out of context) statements, missing or oblique references and contradictions.

In order to help with the coding process, I began by using the interview questions to guide the analysis of the interview data, focusing first on the similarities and differences between respondents accounts of the Working Group's operations; the sources of conflict within the Group; respondents' attitudes towards the process, HIQA and the Standards; their aspirations for the Standards and the new regulatory process; how they represented the views of the members of their professional organisation/group on the Working Group; and why some individuals were selected to join the Working Group and others were not; and how not being invited to attend impacted on the attitudes of non-members towards the Standards. Other themes began to emerge following analysis of the various data sources. These themes examined respondents' attitudes towards residential care, towards older people and their views of what constitutes person-centred care; respondents' views on responsibility in adhering to the Standards; reasons for the sources of conflict within meetings; and the inter-relationship between HIQA and the DOHC. A full list of the themes is provided in Appendix I. I also developed memos (reflective notes linking the findings with relevant literature or wider theoretical perspectives) to help with the analysis process, in which I was able to link particular codes with relevant literature and ideas for further analysis. The use of NVivo also allowed me to ascertain whether the themes developed were broadly representative of all respondents, and to break down themes into subcategories where there were different points of view.

I used the minutes of the Working Group meetings to glean more information about the details of the meetings, including the attendance rates of each individual; where and when meetings took place; how decisions were made about the content of the Standards; and the views of different individuals about the Standards and specific changes. As I obtained the minutes of the meetings only towards the end of the data collection process, I analysed them largely after the interview data had been analysed. This meant that it was possible to use the minutes to corroborate and highlight differences with the findings from the interviews.

4.7.3 Second Level Analysis

The first level of data analysis aimed to explore both the Standards and the process used to develop them separately. The second level of analysis aimed to examine the process and the outcomes together and to develop a theoretical explanation for the findings. This step aims to develop an understanding of how the process created the causal chain, leading eventually to the outcomes. As noted above, three key findings emerged from the discourse analysis of the Standards, Ambiguity within the Standards; the Conceptualisation of Person-Centred Care; and the Ownership over the Regulatory Process. The second level analysis aimed to identify the contribution of each of the three phases of the process contributed to these outcomes. Appendix I contains the models developed for each of the three outcome themes.

Mills et al. (2010) suggest that it is important to consider the impact of larger social forces by examining the fine grain of the process. The second stage of analysis therefore also sought to connect the findings with existing literature by developing a theoretical model for the findings, presented in Chapter Eight. Miles and Huberman's (1994) Causal Networks provided a framework for this, as they aim to connect particular instances to more general principles. According to Miles & Huberman (1994), causal networks provide a visual representation of the variables in an investigation (shown in boxes) and the relationships among them (shown by arrows). Appendix I also shows the causal network developed for the study, and also describes the steps taken to try to confirm the causal network as recommended by George & Bennett (2005) and Miles & Huberman (1994).

4.8 Reflexivity

Qualitative research is an interpretative process; the researcher makes meaning from the data they collect and the data are filtered through the researcher's perspective (Robson 2002). As every researcher brings their own learned beliefs and biases to the research, it is therefore important that researchers endeavour to identify any biases or assumptions they bring to their research. Such self-critical reflections can help to increase the validity and reliability of the research by enhancing the credibility of the researcher (Darlington & Scott 2002). While this is not a fool-proof process (researchers may be unaware of all of their biases), adopting a reflexive stance throughout the research can challenge researchers to understand, and account for, their own biases (Robson 2002). Many commentators suggest that this reflexive process should begin in advance of the study. However, as documented below, I only began to become more reflexive once data collection had already begun. Thus, in order to help the reader understand the central assumptions and biases that I brought to this study, it is important to briefly outline them here.

Between 1999 and 2004, I worked part-time in St. Michael's House to support myself while studying for my Bachelor's and Master's Degrees. St Michael's House is a Dublin-based voluntary organisation that provides services for over 1,500 children and adults with intellectual disabilities. As well as providing day-care services, St Michael's House also provides residential services to approximately 360 adult service users. Usually, approximately six adults are housed together in houses within the community. From their house, residents aim to live as independently as possible, accessing their day services or places of employment and using community services in their spare time, often with the assistance of the care staff.

Throughout my time in St. Michael's House, I worked mainly as a relief care assistant within these residential services. While the work was often challenging, I enjoyed it, particularly getting to know the residents of each house and making decisions as a group about what we would do while I was on duty, watching a DVD, going to the pub, or for a walk, etc. Having never worked in any other care-based organisation, I assumed that all residential care services followed a similar structure.

However, when I started working as a Research Fellow in the Social Policy and Ageing Research Centre (SPARC) in Trinity, I visited a residential care setting for older people for a prolonged period for the first time. I realised that the

model of care provided was inherently different to that of St. Michael's House; I felt that the residents were not given enough choice and that their views were often sidelined. I could not understand why they did not follow the model of care used in St. Michael's House. While its residents were much younger than those in "nursing homes", they generally seemed to be happier and more fulfilled. I learned that the explanation commonly provided for the use of a "traditional" model of care was that residential care services in Ireland were under-funded and the government was reluctant to provide higher levels of staff. Indeed, many residents singled out staff shortages as a cause for concern. Therefore, when I started my PhD, I decided to set out to use the development of the Standards to examine how important stakeholders within the sector determined the model of care that should be provided to older people and whether money was a factor in whether any new model would be implemented. However, as I began to collect and analyse data, and reflect on my existing views of residential care, I realised that there were other factors that appeared to have determined the model of care set out within the Standards, both in terms of how members conceptualised residential care and old age, and also in terms of the wider political context. I began to realise that I had not adequately reflected on my own assumptions prior to starting the study, and felt that it was important to do so more formally.

Thus, I began to document my initial perceptions about interviews I had conducted, including why I agreed with some individuals points of view and not others, within memos in NVivo. In addition, my commitment to reflexivity meant that I created an "audit trail" of the analytical processes (Lincoln & Guba 1985), in order to ensure that the conclusions from the study were based on the data, rather than on my own assumptions and beliefs. Following this, I began again to parse the interview data and see additional trends emerge, which I was able to subsequently see reflected in the wider academic literature. As a result, it was only after a conscious effort to reflect on my own assumptions and biases that the data began to emerge more freely.

4.9 Reliability and Validity

Researchers agree that it is important to ensure that the quality of the research they conduct meets expected standards. There are four criteria that have traditionally been used to evaluate the quality of research studies, particularly

those using quantitative methods: internal validity; external validity; reliability; and objectivity, as outlined in Table 4.6 below. Overall, these criteria focus on robust random sampling methods to avoid problems of bias and allow for generalisability of results as well as statistical tests to examine issues of reliability and internal validity. However, a number of qualitative researchers reject these measures, as they are premised on a “realist” interpretation of research as they assume that there is a valid and reliable reality external to our perception of it (Lincoln & Guba 1985, Marshall & Rossman 1989, Robson 2002). Furthermore, many qualitative studies often cannot be replicated in the same way as quantitative studies, or the findings as easily generalised to a wider population, particularly as the sample has been chosen for specific reasons (Silverman 2006). As a result, many qualitative researchers rely on an alternative set of measures proposed by Lincoln & Guba (1985), outlined in Table 4.6).

Table 4.6: Criteria for Judging the Quality of Research

Traditional Criteria for Judging Research	Alternative Criteria for Judging Research
Internal Validity Measures whether a researcher has correctly identified the true causes of the outcomes of the study.	Credibility Establishing that the results of qualitative research are credible or believable from the perspective of the participant in the research.
External Validity Assesses whether it is possible that the findings of the study are generalisable to other contexts.	Transferability The degree to which the results of qualitative research can be generalised or transferred to other contexts or settings.
Reliability A study can be said to be reliable if we would obtain the same results if we could observe the same phenomenon twice.	Dependability Dependability emphasises the need for the researcher to account for the ever-changing context within which research occurs. The research is responsible for describing the changes that occur in the setting and how these changes affected the way the research approached the study.
Objectivity Objectivity considers whether the research findings are free from the bias of the researcher.	Confirmability Refers to the degree to which the results could be confirmed or corroborated by others.
Source: Lincoln and Guba, 1985	

Not all commentators agree with this approach for qualitative research. For example, Morse et al. (2002) suggest that it is perhaps more appropriate to use “mainstream” terminology for ensuring rigour in order to ensure qualitative research is not marginalised while Seale (1999) suggests that the alter-

native methods may not be robust enough to ensure the quality of qualitative research. Yet there has been little consensus about how the quality of qualitative research can and should be evaluated, other than a general agreement that researchers should aim to outline their methods as clearly as possible and thus provide readers of the research with an opportunity to make informed decisions about the quality of the findings therein (Silverman 2006). However, the guidance offered by Miles & Huberman (1994) may provide an additional framework for researchers to reflect on the strengths and weaknesses of their research. Miles and Huberman's (1994) guidelines are particularly useful as they attempt to marry the tension between the traditional (quantitative) measures and the alternative Lincoln & Guba (1985) criteria for assessing the quality of research findings. Appendix J outlines the extent to which this study met Miles and Huberman's (1994) guidelines and highlights the steps taken to ensure that the study was of a high quality. These include the use of triangulation, multiple methods and clarity about the research question and concepts used.

4.10 Limitations

As with all research, this study suffered from some methodological limitations. As highlighted above, one of the possible options for data collection within qualitative research is through observation. Observational data may have enhanced the study by adding another perspective, providing an insight into the atmosphere of meetings, the relationships between individual members, the level of formality and any changes that occurred throughout the process. However, as the work of the Working Group had been completed before I started data collection, it was not possible to add this third type of data to the interview and documentary data collected. Furthermore, as the minutes of the meetings were only obtained as fieldwork was coming to an end, it was not possible to interview all individuals who attended Working Group meetings without being official members. However, a small number of these individuals were interviewed, and no new findings emerged from these interviews, perhaps indicating that saturation point (Robson 2002) had already been reached. Indeed, it should be noted that stakeholder identification processes, such as that which was carried out for this thesis, are not exhaustive processes. Thus, it is possible that there may be other stakeholders of the residential care sector who were not considered for this thesis (nor, indeed for the Standards Wor-

king Group itself), and some important opinions may thus be absent from the study.

It should also be stated that this was a single case study. Although some argue that this means that the research may suffer from the problem of generalisability (Yin 2003), it is clear from the methods outlined above that the process tracing approach taken means that the theoretical explanation of the Standards development process can now be tested within other settings, both in the development of standards for residential care settings for older people in other countries, and also even in standards-setting in other sectors. However, it is important to highlight that there may be more than one hypothesised causal mechanism consistent with any given set of process tracing evidence (George & Bennett 2005). When this problem of indeterminacy arises, there is no absolute standard for excluding alternative hypotheses that may be spurious. Therefore, the theoretical explanation set out in this thesis may need to be refined, or may even be refuted by future research. However, these limitations must be regarded in light of the contribution that this thesis makes to the academic literature: it is the first study to critically explore the development of minimum Standards and regulations for the residential care sector for older people using a regulatory negotiated process. Thus, the theory outlined in Chapter Eight can be further tested in future research in the same and in other sectors.

4.11 Ethical Issues

The study was carried out in accordance with the ethical principles of the British Sociological Association (2002). Throughout the process, I strived to maintain the integrity of sociological inquiry (and social policy) as a discipline by safeguarding the interests of those involved in and affected by my work and to report my findings truthfully and accurately; and also to accept responsibility towards the research participants by obtaining their informed consent and by maintaining confidentiality in relation to the data they provided.

None of the study participants could be classified as vulnerable; all were professionals working in the area of ageing or policy-making/analysis, either in providing residential care or in supporting older people and their carers, and were all used to being consulted for research studies and in connection with their work. However, it was still important to ensure that the interviews were conducted in accordance with the ethical principles of informed consent, vo-

luntary participation and confidentiality. Thus, before each interview commenced, each respondent was given an information sheet and consent form (as noted above); was given information about the purpose of the study; and was informed that their participation was voluntary and that they were free to withdraw at any stage.

The greater challenge was in protecting the confidentiality of each respondent, particularly for the Working Group members. As the membership of the Working Group was publicly available, it was possible that any reference to an individual respondent's profession or sector could make them easily identifiable by those working in the sector. As a result, the following steps were taken during the write-up process in order to protect the anonymity of respondents:

- Where direct quotes taken from interview transcripts were cited, I decided that they would not be accompanied by personal characteristics (eg gender, age). While this is a common approach to presenting qualitative data, I felt that presenting the quote without additional information would protect the anonymity of the respondent.
- I removed any references that might identify the respondent within a passage to be quoted directly prior to insertion into the text.
- The guiding principle for the data collection, analysis and write-up stages was "if in doubt, leave it out" to ensure that the anonymity of respondents was protected.

In addition, as each interview was audio-recorded, data were generated from which the respondent could possibly be identified. In order to protect the confidentiality of all respondents, recordings were kept in a secure location and were not accessed by anyone other than myself. Recordings will be destroyed upon full acceptance of the thesis (though anonymised transcripts will be retained for future research). Ethical approval for the study was granted by the Research Ethics Committee of the School of Social Work and Social Policy, Trinity College Dublin on the 26th January 2009.

4.12 Reporting the Findings

The findings chapters reflect the second level analysis for the study, showing the inter-relationship between the contents of the Standards (and regulations)

and the process used to develop them. Each of the three findings chapters is centred around one of the three key themes which emerged from the analysis of the Standards and aims to examine how both the Working Group and other factors led to these findings. Chapter Five examines the clarity in the Standards. The chapter suggests that a number of ambiguities and contradictions can be found in the document. Chapter Six examines the development of two competing models of person-centred care within the document and Chapter Seven examines the tension about the ownership of the regulatory process. Each chapter also aims to document how the process contributed to these findings. Chapter Eight then presents the explanatory theory developed to account for these findings.

Findings I: Ambiguity in the Standards

5.1 Introduction

As outlined in Chapter Two, proponents of regulatory negotiation have claimed that the process can result in rules which are clearer, though others have disputed this. Therefore, one of the secondary aims of the thesis was to explore the clarity of the language within the Standards. Indeed, ambiguity began to emerge as one of the central themes from the beginning of the analysis process. When first reading the Standards, I was unsure of their legal status. Although I had been aware from press releases issued by the DOHC that the intention was for the Standards to be enforced in all nursing homes (DOHC 2007c), I was not able to find confirmation of this in the Standards, or from respondents interviewed for the study. Indeed, I found that the language regarding the intended purpose of the Standards was vague, and I also found further ambiguity in relation to a number of other issues. As data collection and analysis developed, I became more aware of the significance of this ambiguity; as regulation is an inherently political and problematic tool of governance, any lack of clarity could serve to weaken the process by providing opportunities for residential care providers to avoid having to comply with the Standards (Braithwaite et al. 2007). I also began to recognise the ways in which HIQA's Working Group had contributed to these Standards and what this reveals about the regulatory negotiated process.

Section 5.3 describes the ambiguities in the Standards and then outlines the factors that contributed to the ambiguities in the document. Relying on interview data, minutes from the Working Group meetings and various drafts of

the Standards, Section 5.4 then discusses the factors which appeared to contribute to the ambiguity within the Standards. However, Section 5.2 first sets out to contextualise the findings presented in the next three chapters by presenting a brief overview of the content of the Standards.

5.2 Overview of the Standards

Selmi (2005) has claimed that regulatory negotiation can help parties with very different interests to reach creative solutions to regulatory problems. Indeed, it is possible to see many creative elements within the Standards. As noted in Chapter One, *The National Quality Standards for Residential Care Settings for Older People in Ireland* (HIQA 2009e) contains 32 Standards that “set out what a quality, safe service for an older person living in a residential care setting should be” [p. 6]. The standards are divided into seven sections: Rights; Protection; Health and Social Care Needs; Quality of Life; Staffing; The Care Environment; and Governance and Management.

Each “headline” standard is accompanied by a number of criteria (9.4 on average, 304 in total), along with an extra 26 supplementary criteria for dementia-specific residential care units for older people (see Table 5.1). While the headline standards are all broad statements, the 330 criteria in the document contain significant amount of detail about every aspect of life in a residential care setting, from when a resident initially considers moving into a care home, to when they leave, either through a discharge process or following their death. The document outlines the care and services residents should expect to receive around the clock within the setting, including the assistance to be provided at mealtimes, the choice of activities residents should expect to engage in and the assessment of healthcare and medication needs. The Standards also stipulate the requirements with regard to the recruitment and monitoring of staff, the management of the setting and the physical environment.

In many ways, the resident is at the centre of each of the 32 Standards and the use of clear and simple language facilitates its reading by residents and their families. The document dedicates a significant amount of space to outlining residents’ rights. The first of the seven sections, Rights, outlines the information residents should expect to receive from the provider. It also informs providers that residents’ civil, political and religious rights and also their right to privacy and dignity must be protected. Indeed, the document can be regarded almost

Table 5.1: Standards and Criteria

Section	Standard	Criteria (N)
Rights	1. Information	6
	2. Consultation and Participation	5
	3. Consent	10
	4. Privacy and Dignity	8
	5. Civil, Political and Religious Rights	8
	6. Complaints	6
	7. Contract/Statement of Terms and Conditions	2
Protection	8. Protection	4
	9. The Resident's Finances	6
Health and Social Care Needs	10. Assessment	8
	11. The Resident's Care Plan	6
	12. Health Promotion	4
	13. Healthcare	3
	14. Medication Management	13
	15. Medication Monitoring and Review	6
Quality of Life	16. End of Life Care	13
	17. Autonomy and Independence	9
	18. Routines and Expectations	6
	19. Meals and Mealtimes	12
	20. Social Contacts	5
Staffing	21. Responding to Behaviour that is Challenging	23
	22. Recruitment	6
	23. Staffing Levels and Qualifications	9
	24. Training and Supervision	8
The Care Environment	25. Physical Environment	58
	26. Health and Safety	28
Governance and Management	27. Operational Management	7
	28. Purpose and Function	6
	29. Management Systems	8
	30. Quality Assurance and Continuous Assessment	4
	31. Financial Procedures	2
Supplementary Criteria for Dementia-Specific Residential Care Units for Older People	32. Register and Residents' Records	5
		26

Source: HIQA, 2009d

as a "Charter of Rights" of older people living in residential care. This is a new departure for older people living in residential care in Ireland, who have previously been described as a disempowered and disenfranchised group as a result of the "traditional" work practices used in such settings (Hodgins & Greve 2004, Murphy et al. 2006). The Standards therefore arguably play a significant role in altering the ageist thinking within health policies for older people in Ireland. However, as outlined in the next section, there are some significant sources of ambiguity within the document.

5.3 Ambiguity in the Irish Standards

5.3.1 Purpose and Status of the Standards

As outlined in Chapter One, minimum standards have no basis in legislation and must be underpinned by legislation in order to make it mandatory for providers to comply with them (Christensen & Laegreid 2007). However, it is unclear from reading the Standards whether or not they are mandatory requirements for providers.

The Introduction to the document states that the Standards are a minimum requirement, to which all providers must adhere in order to be registered:

The Social Services Inspectorate within the Health Information and Quality Authority will inspect providers of residential care settings for older people to ensure that these Quality Standards are being met. It will also register new providers of residential care settings for older people, once they meet these quality standards.

(HIQA 2009*e*, p. 7)

However, this message appears to be contradicted elsewhere:

For service providers, these Standards provide a road map of continuous improvement to support the continued development and provision of person-centred, accountable care.

(HIQA 2009*e*, p. 6)

This creates ambiguity about whether providers are expected to meet the Standards immediately, or at an unspecified date in the future. This ambiguity is compounded by a reference in the document to undefined regulations, which appears to suggest that only some of the Standards are mandatory:

Some of these Standards are linked to regulations. Regulations differ from Standards. [...] In the case of those Standards which are not regulatory Standards, or Standards linked to regulations, failure to comply will not in themselves lead to failure to be registered or loss of registration, but they are designed to encourage continuous improvement.

(HIQA 2009*e*, p. 8)

However, nowhere in the document is it indicated which Standards are mandatory and which are not. This arguably creates challenges for providers who want to ensure that their setting is fully compliant with the mandatory requirements.

There is also a lack of clarity about the role of the 330 criteria accompanying the 32 Standards. As noted in Chapter One, the document consists of 32 (headline) Standards, which are broad statements, and criteria which give more detail on the Standard itself (as shown in Appendix C). According to the Introduction to the Standards, “the criteria are the supporting statements that set out how a service can be judged as to whether the standard is being met or not” (pg. 8). While this is a slightly ambiguous statement, it appears to imply that providers must meet all of the criteria in order to be in full compliance with the Standard. However, supporting documentation subsequently published by HIQA appears to contradict this view by suggesting that “the criteria are not meant to be prescriptive and there may be several ways in which any standard can be met” (HIQA 2009a, p. 9). This arguably also leads to confusion for providers, who may remain unclear about whether or not they must meet the criteria.

There is a significant difference for providers between meeting the headline Standard and the Standard along with all of its supporting criteria. As noted above, the document contains 330 criteria, which contain a significant amount of detail about residential care, while the Standards are broad, general statements. Thus, for example, to meet the first Standard:

Standard 1: Each resident has access to information, in an accessible format, appropriate to his/her individual needs, to assist in decision making.

(HIQA 2009e, p. 14)

providers would simply have to demonstrate that they provide residents with accessible information about key aspects of the residential care setting and the resident’s care and show that residents have had an opportunity to have an input into that decision. However, to comply with the supporting criteria, providers must develop a residents’ guide, containing detailed information about the residential care setting and the services it provides. They must also inform residents and their families about all fees they must pay; provide a staff member to meet the resident prior to entering into the residential care setting; facilitate residents to visit the care setting prior to moving in; and make additional steps upon emergency admissions.

The ambiguity in the Standards with regard to the Standards and the criteria within the regulatory regime are contrary to empirical evidence which suggests that broader standards are more beneficial to residents because of the discretion available to providers to meet their needs (Braithwaite et al. 2007). As noted in Chapter Two, ambiguity in policy documents can be an inevitable consequence of a wide range of actors having input into the policy document (as discussed below), it has also been argued that, in some cases, ambiguity can also be deliberate (Loughlin 2002). The lack of clarity allows policy-makers to shift responsibility for shortcomings onto those responsible for implementing a particular policy. This issue is discussed further in Chapter Seven.

5.3.2 Responsibilities of Key Actors within the Regulatory Process

Scott (2000) has suggested that complex webs of accountability are becoming more common within many regulatory regimes. He argues that there may be a failure to identify who is responsible when problems arise. This reflects the suggestion made by a number of academics that governments wish to shift blame for problems onto others (Newman 2005, May 2007, Scott 2000). As outlined below, the HIQA Standards seem to mirror this trend, as there is some ambiguity with regard to the responsibilities of the different actors involved in the regulatory process.

5.3.2.1 Minister for Health and Children

Readers of the Standards are informed that HIQA reports directly to the Minister for Health and Children, emphasising the fact that the government, through the Minister, is responsible for overseeing the work of the regulator. However, other than this, there is little reference to the Minister and her Department in the Standards, perhaps highlighting the government's wish to respect the principle of political non-interference within the regulatory process (Stern & Holder 1999). However, the document does not refer to the Minister's role in writing regulations to give legal effect to the Standards, arguably clouding the responsibilities of the Minister within the regulatory process.

5.3.2.2 HIQA

The responsibilities of HIQA are spelt out clearly and without any ambiguity in the Introduction to the Standards:

The Social Services Inspectorate within the Health Information and Quality Authority will inspect providers of residential care settings for older people to ensure that these Quality Standards are being met. It will also register new providers of residential care settings for older people, once they meet these quality standards.

(HIQA 2009e, p 7)

Thus, HIQA's responsibilities are to set standards, register providers and ensure they comply with the regulations and Standards. However, towards the end of the Introduction, a section informs readers that HIQA may see itself as having an additional, discretionary responsibility:

The Health Information and Quality Authority will make every effort to reconcile its responsibility for ensuring compliance with these Standards with support for those who seek to transform residential facilities for older people into home-like environments, where the holistic needs of the resident take precedence.

(HIQA 2009e, p. 9)

This suggests that HIQA does not only see itself as having responsibility for ensuring compliance but also in supporting providers who wish to give their residents "more person-centred models of care" (p. 9). This introduces a degree of ambiguity about how HIQA will treat providers who may not comply with the Standards but yet conform to its vision of a home-like environment.

5.3.2.3 Registered Provider and Person in Charge

With two exceptions, the 32 headline Standards do not identify who is responsible for ensuring that the standard is met. Standard Seven states that residents enter into a contract with the registered provider. However, nowhere in the document is it clearly stated that the registered provider is the individual with legal responsibility for ensuring all Standards are met.

Furthermore, the “person in charge”¹ of the residential care setting is also deemed to have overall “responsibility for the provision of the service” (Standard 27), and is tasked with ensuring that the setting complies with all regulatory requirements:

The person in charge ensures that applicable legislation, regulatory requirements, best practice and relevant codes of practice are met.

(HIQA 2009e, p. 60)

However, the legal position of responsibility of the person in charge is not set out and so it is unclear whether the person in charge is accountable *alongside* the registered provider for the compliance of the care setting, or if the registered provider is still ultimately accountable for ensuring that the person in charge has not carried out their duties appropriately.

The situation is further clouded by the fact that the person in charge must be a registered nurse and so is already accountable to An Bord Altranais, the State body responsible for regulating the nursing profession in Ireland. An Bord Altranais has legal powers to inquire into the conduct of a registered nurse on the grounds of alleged professional misconduct and strike any individual off the register if deemed unfit to practise as a nurse. Thus, it is unclear from the Standards whether nurses working in residential care centres are now answerable to both An Bord Altranais and HIQA.

5.3.2.4 Staff

The position in relation to the responsibilities of individuals working in residential care settings is also ambiguous within the Standards. A number of criteria identify staff as the person accountable for implementing specified actions. Staff are tasked with (*inter alia*) adhering to procedures for the safe administration of medication, managing and retaining records for residents’ finances (where relevant), maintaining and evaluating each resident’s care plan and demonstrating respect for residents. For example:

¹The person in charge of the residential service is the person with responsibility for the day to day running of the centre. They must be either a registered general or psychiatric nurse with a minimum of three years experience in the area of geriatric nursing within the previous six years, or registered general medical practitioner, with a minimum of three years experience carrying on a nursing home (HIQA 2009b).

14.4 Staff adhere to procedures for the safe administration of medication, for the prescription, supply, receipt, self-administration by residents, recording, storage, handling, and disposal of medicines that accord with legislation and professional regulatory requirements or guidance.

(HIQA 2009e, p. 26)

Thus, even if the criteria are not mandatory, the direct references to staff indicate that the authors of the document regard staff as having specific responsibilities for ensuring that the care setting is in compliance with the Standards.

However, other criteria within the document suggest that staff are not directly responsible but should be supported to carry out their functions effectively (e.g. Standard 24: Training and Supervision: Staff receive induction and continued professional development and appropriate supervision, p. 42). The person in charge is responsible for ensuring that staff carry out their work effectively:

24.5 The person in charge ensures that minimum mandatory training requirements for all staff are met and updated on an ongoing basis.

(HIQA 2009e, p. 42)

This suggests that there is ambiguity in the Standards about the extent to which individual staff members are expected to take responsibility for their own work. It is also unclear whether staff are answerable to the person in charge or the registered provider and which actor is accountable to HIQA in the event that a staff member commits an offence. While staff nurses are already accountable to An Bord Altranais, it is unclear how other staff, including care assistants, catering and administrative staff, are to be held to account.

5.3.2.5 Residents

Even residents are implicitly prescribed certain responsibilities within the document. The message given to residents throughout the document is to be pro-active and engaged:

Every resident should expect to live as full and as independent a life as possible and to direct, together with the care provider, their own care.

(HIQA 2009e, p. 3)

Residents are also expected to play a role in selecting the care home in which they go to live and so they take on a degree of responsibility for ensuring that the home will be in a position to meet their needs:

There is a guide for residents clearly written and made available in an accessible format to each resident and each prospective resident... The person in charge ensures that the prospective resident and/or his/her family or representative is invited to visit the residential care setting before he/she makes a decision to stay.

(HIQA 2009e, p. 14)

In addition, residents are told they do not have to simply acquiesce with the commands of staff. Rather, they should take control of their own care and also have a say in how the residential care setting (their own home) is managed. For example, many of the Standards focus on input by residents into the running of the residential care setting:

Standard 2: Consultation and Participation: Each resident's rights to consultation and participation in the organisation of the residential care setting, and his/her life within it, are reflected in all policies and practices.

(HIQA 2009e, p. 15)

The document also suggests that residents have a role to play, albeit minor, in assisting HIQA with the inspection process, to ensure providers are in compliance with the Standards. The document's Conclusion informs readers that HIQA will carry out observational inspections, which will include discussions with residents, to ensure that the setting meets the Standards. While facilitating residents' rights and autonomy is an important part of a person-centred approach to care (McCormack 2003), it is possible that the additional responsibility they are expected to take on arguably alters their position within the residential care setting, from passive resident to active agent, albeit to a limited extent, within the regulatory process.

5.3.2.6 Family members and Representatives

Within the document, frequent references are made to the "family and/or representative" of the resident. The "representative" of the resident has a number of responsibilities towards the resident, particularly with regard to making decisions about their treatment and care. The representative even has

the responsibility of potentially having an input into decisions regarding the resident's care at the end of their life:

16.2 The resident's wishes and choices regarding end of life care are discussed and documented, and, in as far as possible, implemented and reviewed regularly with the resident. This includes his/her preferred religious, spiritual and cultural practices and the extent to which his/her family are involved in the decision-making process. Where the resident can no longer make decisions on such matters, due to an absence of capacity, his/her representative is consulted.

(HIQA 2009e, p. 30)

The weighty responsibility of the resident's representative arguably implies that this individual has been granted legal status to make such decisions. However, the definition of a "representative" given within the document implies no such legal standing:

Representative: a person acting on behalf of a resident, who may be a relative or friend.

(HIQA 2009e, p. 77)

Such a loose definition, unsupported by legislation, could arguably create difficulties where there is disagreement amongst individual family members with regard to specific decisions that have to be made on behalf of a resident.

5.3.2.7 Overview

It appears that the HIQA Working Group may have tried to address the problem of accountability shortfalls common within both Ireland and other neo-liberal states by attempting to make each individual accountable. However, by failing to define the boundaries of each individual's responsibilities, the problem remains that each actor can shift blame onto others. This illustrates the challenges created by the implementation of additional layers of accountability (Scott 2000). Furthermore, while the emphasis on residents' involvement in decision-making highlights the need to value their autonomy, it also arguably conjures up the suggestion that "service users and providers who are excluded can be blamed for not taking up their opportunities or for seeking to get something for nothing" (Poole 2000).

5.3.3 Risk v Safety

Within the Standards, there is a tacit acknowledgement that the provision of residential care is a risky enterprise. When a resident is admitted to the care setting, criterion 10.4 requires that “a general risk assessment is carried out” (p. 23) and criterion 26.2 requires each setting to have policies and procedures that ensure it is “a safe and healthy place of work” and that there are “working practices that minimise risks to health or welfare” (pg. 54). However, the guiding principle of the Standards appears to be to manage or minimise risks to residents, rather than restricting residents’ freedom in the interests of protecting their well-being. As long as providers can satisfy themselves that residents have the mental capacity to make autonomous decisions, the Standards require them to respect the personal choice of residents to take risks. For example:

14.10 The resident may self-administer medications, where the risks have been assessed and his/her competence to self-administer is confirmed. Any change to the initial risk assessment is recorded and arrangements for self-administering medicines are kept under review.

(HIQA 2009e, p. 27)

Furthermore, the approach taken within the Standards is to try to ensure that providers are aware of the potential risks in order to manage them. The Standards therefore require residential care settings to develop more than 30 policy documents outlining the procedures for managing risks in relation to various aspects of residential care, including on whistleblowing, abuse prevention, health and safety, fire safety, continuity of care and policies on managing challenging behaviour. Overall, the risk management approach set out in the Standards fits in with the overarching principle of “person-centred, accountable care” (pg. 6). According to McCormack & McCance (2006), a person-centred approach respects residents’ rights to take risks and prioritises the individual resident’s needs and wishes, rather than trying to simply protect them from harm. It also implies an overall trust in providers to determine how best to manage the residential care setting (Braithwaite 2002).

However, it is elsewhere expressed within the document that judging whether a person has the capacity to make such decisions can be a complex challenge and may need professional assessment:

3.8 The resident’s lack of capacity to give informed consent on one occasion is not assumed to be the case on another occasion. Where there is any

doubt as to the resident's capacity to decide on any medical treatment or intervention, his/her capacity to make the decision in question is assessed by a suitably qualified professional using evidence-based best practice.

(HIQA 2009e, p. 16)

As criterion 3.8 cited above does not specify who should carry out this assessment, it is possible that the provider could override a resident's decision to engage in risky behaviour in order to protect the setting from the potential for litigation. Indeed, some criteria give providers discretion to override residents' decisions about specific issues in order to protect them from risk. For example:

17.3 The person in charge manages the residential care setting in a manner that maximises the resident's capacity to exercise personal autonomy and choice. Where the resident's choice is restricted, the reason for this is explained and documented and appropriate support is provided. (See Standard 3: Consent)

(HIQA 2009e, p. 29)

In addition, other more prescriptive standards and criteria appear to restrict residents' choices in order to prevent them from harm:

Hot water is stored at a temperature of at least 60°C and distributed at 50°C minimum, to prevent risks from legionella. To prevent risks from scalding, preset valves of a type unaffected by changes in water pressure and which have fail safe devices are fitted locally to provide water to a maximum temperature of 43°C.

(HIQA 2009e, p. 24)

Where a resident's unanticipated behaviour places him/her or others in imminent danger, short-term, proportionate and non-dangerous physical restraint measures may be taken by staff without prior formal assessment. Precipitating factors and behaviours, and the actions taken are clearly recorded in a restraint register.

(HIQA 2009e, p. 39)

These criteria appear to contradict the guiding principle within the Standards of facilitating choice by managing risk. Another criterion arguably introduces even more confusion, as it gives providers the potential to absolve themselves from blame should an accident occur:

5.7 The resident's decision to participate in activities involving personal risk is respected, and when necessary is documented.

(HIQA 2009e, p. 24)

This is in contrast to the treatment of staff, who are told that they must not put either themselves or others at risk within the care setting. For example:

26.10 Staff use appropriate protective clothing and equipment suitable for the job to prevent risk of harm or injury to themselves or others.

(HIQA 2009e, p. 55)

As a result, while providers must demonstrate that they are capable of managing risk, they can also prevent residents from engaging in risky behaviour to prevent an accident, yet paradoxically absolve themselves of responsibility should an accident occur.

5.3.4 Summary

While the Standards document is written in accessible language overall, there are a number of ambiguities that may create confusion and difficulties for both providers and residents. Firstly, it is unclear whether providers must meet all of the Standards, or just some of them. It is also unclear who is accountable to HIQA for compliance with the Standards and how the accountability structures within the regulatory system operate. Finally, the extent to which residents are expected to take personal responsibility for engaging in risky behaviour is unclear. Although some of these issues have been subsequently clarified within later documentation issued by HIQA, it is important to analyse how they first came to be in the Standards.

5.4 Explaining the Ambiguity in the Standards

5.4.1 Introduction

Although an analysis of the interview and documentary data suggests that the operations of HIQA's Working Group were responsible for creating some of the ambiguities in the Standards, other factors also appeared to have played a role, as outlined below.

5.4.2 HIQA's Working Group

5.4.2.1 Membership of the Working Group

As outlined in Chapter One, HIQA was formally given the draft set of Standards, developed by the DOHC's internal Working Group, on the 25th January 2007 with a mandate to "further develop, consult on and finalise as the mandatory, meaningful standards against which all residential care settings, both public and private will be inspected by the Authority" (HIQA 2007, p. 4). HIQA established a Working Group made up of stakeholders from the residential care sector to carry out this directive. According to HIQA, the Working Group would ensure "a shared vision across all stakeholders as to what should be contained in the National Quality Standards" (HIQA 2009e, p. 6).

In order to create a collaborative, trusting atmosphere on the Working Group, HIQA staff deliberately did not set formal rules about the membership of the Working Group. Instead, staff used an open, inclusive process to ensure all relevant stakeholders were represented on the Working Group. HIQA staff first identified and invited relevant stakeholders to attend the first meeting of the Working Group. At the first meeting, members were asked to identify other relevant stakeholders not already present, who were subsequently invited to attend the second meeting.

Members of the Working Group were very appreciative of HIQA's decision to leave the membership open and inclusive. Many felt that this inclusive approach helped to engender an atmosphere of trust, which encouraged all the different actors to work together:

Em... my initial impression was I remember you know being struck by the range of different professions, interests, vested interests, you know around the table and I remember how expertly how I felt it was chaired. Everyone was heard and listened to.

(Member of the Working Group, private sector)

However, the lack of formal rules about membership created a number of challenges; members who could not attend a particular meeting asked a colleague to attend on their behalf and so new people were joining the Group even at the third last meeting. Furthermore, some respondents claimed that Working Group members representing the private sector asked colleagues to join the Working Group, arguably in order to try to create strategic advantages for the sector:

I know after one meeting where something just got torn apart by the private sector, I actually raised the question to say "we took a vote in there but there was people in there that shouldn't have been in the room" and what they had said was that "we came because X is going to be missing three meetings so we are going to be taking over and we want to get a sense of what's happening" and all of a sudden they became permanent members of the group and the balance of the group shifted.

(Member of the Working Group, public sector)

As a result, total of 63 people attended at least one Working Group meeting (including nine HIQA staff members). Group dynamics experts suggest that the optimal performance of a group can be achieved through setting rules about membership and attendance, in order to keep the size of the group manageable and consistent (Hackman 2002, Levi 2010).

This suggests that the very desire by HIQA to create a positive working atmosphere may have had some unintended consequences for the process, as it gave Working Group members an opportunity to influence the content of the Standards.

However, interviews with non-Working Group members cast doubt on HIQA's claims to ensure the standards represented the shared vision across all stakeholders of how to provide older people with a good quality of life (HIQA 2009e). While few were disappointed that they were not asked to join the Group, others, particularly trades unions staff, felt that they had been blocked by HIQA from joining the Working Group, raising suspicions about whether HIQA was in fact open to the views of all stakeholders:

HIQA are not union friendly, under any circumstances, HIQA are not union friendly.

Why do you say that?

Well, I think why would they not have invited us to participate in a document which they intend to roll out to the public sector nursing homes where we would have clear representation? The niceties were there... but we were not invited. People can see unions as tying people up as opposed to being open and free and they didn't want to be tied up in these. They didn't want five years later to be still trying to negotiate the standards with the union. And I can see their point of view. Would we have tied them up? Maybe we would have if we were asked. Maybe we would have. That's that.

(non-Working Group member, voluntary sector)

Indeed, comments made by HIQA indicate that, in spite of their recognition of the need to be inclusive, the decision not to invite the relevant trades unions to participate was deliberate:

The unions wanted to come but we had to stop that because what had they to do with older people? They represent the staff and the staff are already at the table. You had physios and OTs and GPs representation, you had geriatricians, psychiatric... The whole list...

(HIQA Staff member on the Working Group)

Thus, although HIQA wanted to be seen to be inclusive, the organisation may have deliberately decided to exclude certain stakeholder groups, in order to control to the operations of the Working Group and the content of the Standards. While this in itself may not have created the ambiguity in the document, it illustrates the difficulties of ensuring that regulatory negotiation leads to consensus if the views of all stakeholders are not represented. Furthermore, the large group size led to disorganisation in the Working Group, which in turn appeared to have led to some of the ambiguity within the Standards, as outlined below.

5.4.2.2 Operations of the Working Group

As noted in Chapter One, the Working Group had fifteen meetings over the course of 2007, starting in January and finishing in December, with the penultimate draft published in March 2008. However, the schedule slipped considerably, as the original intention was to complete the process, and the Standards, by June 2007. The process was considerably slowed down by the large size of the Group, which made it difficult for the Working Group to operate as a cohesive "team" in writing the Standards. Over half of the Working Group members interviewed commented on the impersonal, transient nature of the meetings, as illustrated in the following quote:

Even physically in the room, just physically you couldn't even see the people at the other end of the room.

(Member of the Working Group, public sector)

People kind of flitted in and out. I can appreciate that people are busy, em, but I suppose, it didn't help at times.

(Member of the Working Group, private sector)

Furthermore, the lack of clear rules about membership meant that, by the end of the process, the representation of the different interests was somewhat imbalanced. A breakdown of the Group suggests that a large number of members were individuals who worked in the public sector (either in policy development roles or working directly as service providers for older people, including in residential care settings) (see Table 5.2). Forty-eight of the members were from the public sector, compared with just ten from the private sector and five from the community and voluntary sector.

Table 5.2: Membership of the Working Group

Public	48
Private	10
Voluntary	5
Total	63

A further breakdown suggests that members represented a wide variety of professions and organisations related to the residential care sector. A significant number were representing staff groups such as nurses, doctors and therapists who provide services directly to older people living in residential care settings, while those whose professional role involved developing national care policies for older people and providers of private homes were also heavily-represented. However, only four people at the table represented older people's interest groups (i.e. national voluntary organisations with a membership made up of mainly community-dwelling older people) and one which represented family carers. This supports findings from other research that has highlighted the tendency of "industry" to dominate regulatory negotiated processes (Furlong & Kerwin 2004, Golden 1998, Wagner et al. 2011).

Other factors also contributed to the transient feel of the meetings. The minutes suggest that no one individual attended all fifteen meetings, resulting in a lack of consistency and familiarity of faces at the meetings. In addition, as HIQA had no permanent office at the time, meetings took place in different hotels in Dublin's city centre. Given the large size of the Group, booking rooms at short notice meant that the venue of the meetings changed, which a small number of Group members (n=2) suggested had created difficulties:

I think I was in every hotel in Dublin for that Working Group... Every time we had a meeting I had to figure out what hotel we were in.

(Member of the Working Group, public sector)

Although HIQA made efforts to create an inclusive atmosphere and sense of camaraderie, as documented by almost all of the Working Group members interviewed, this itself may also have slowed down the work:

What was really important was the facilitation of the group, "have other people got views on that", you know, "let's look at that", "let's think about that", and constantly being brought up, "well, what is the intention behind that standard", you know? "Does that meet the intention or not?" There was a lot of that.

(Member of the Working Group, public sector)

In order to meet its deadline, the Group had to start working at a much more rapid pace. Thus, in one of the later meetings, the Group amended the content of sixteen Standards (and supporting criteria), compared to an average of two or three in the initial meetings. The consequence of the increased speed meant that there was little time available to consider the content of the document as a whole and whether it was clear and unambiguous:

We had nightmares of meetings, where we would have had several, like at least once a month, full day meetings of going through the standards. It was exhausting on people. Absolutely exhausting. Where we would be fighting and arguing over the finest element of detail. To a ridiculous extent.

(Member of the Working Group, public sector)

I am a very busy person and so I would go to the meetings ... but I'd have left a lot behind me, so you know, to a... this is something that I would have felt was bad about my contribution, I was very much in the here and now, I wasn't always au fait with what we had discussed three weeks before and they'd be in different sections and I don't think that we were cross-referencing and that, and while other members of the group might well have had a better strategic vision, I would have always felt, I'm fitting this in now, and I want to give my best today but I have so much to do when I get back, you know. And there were a lot of meetings. And you know, I suppose too that there would have been a lot of homework to read and I wouldn't always have the time to read it. I just didn't. And I would have wanted to do it (laughs) but I just didn't have time.

(Member of the Working Group, public sector)

Overall, this suggests that some of the ambiguity in the document, particularly in relation to the purpose and status of the Standards, was due to the transient nature of the membership and logistics of the Working Group itself.

5.4.2.3 Dynamics of the Working Group

All members of the Working Group interviewed agreed that HIQA staff succeeded in creating a positive, respectful, inclusive atmosphere in the meetings, whereby all opinions were equally valid and, where possible, would be taken on board in drafting the Standards. However, findings from the interviews also suggested that divisions developed between Working Group members as a result of conflicting self-interests, which appeared to contribute to the contradictions inherent within the Standards. These divisions developed along both sectoral and professional lines.

Sectoral Divisions

Findings from the interviews indicated that divisions developed between Group members representing the private sector and those representing the public sector. This division arose because of contrasting views about whether or not the Standards should result in significant cost implications for providers. Public sector workers were largely of the view that cost was not an issue, the priority was the well-being of residents:

I think nearly everyone who was there wanted to contribute to ensuring that the standards were as good as they possibly could be. I honestly feel everyone was totally committed to ensuring that ... To stretch the standards, possibly even beyond the point where they thought might be realistic. For the purpose of ensuring that the bar was raised on a continuous basis. And not just arriving at a compromise. There was no compromise arrived at. The bar was just constantly raised.

(Member of the Working Group, public sector)

However, it appeared that public sector workers may have had an ulterior motive in trying to raise the Standards. As many residential care settings in the public sector are housed in former workhouses (built during the Irish Famine in the 1840s), several wanted the Standards on the physical environment to be raised so high that many public settings would have to be shut down, with newer, more modern facilities built:

Well I suppose for myself... This might sound a bit strategic, but I would be concerned with the physical environment and you know... and this would have been a concern of mine for very many years working in a hospital which has a challenged physical environment, em, you know,

I would have hoped that maybe, not just the standard of the physical environment, but the type of physical environment, small family homes, that kind of thing.

(Member of the Working Group, public sector)

Almost all private sector members were of the view that the some of the proposals made by public sector members were not only costly but unnecessary, as it would result in problems for both residents and care home owners:

You had people in the HSE who were throwing stuff into the pot that really and truly wasn't necessary, it was just "oh, we're doing it"...

(Member of the Working Group, private sector)

I mean the two areas of cost were the physical environment and staff. I mean it would be impossible to do it because if you think that you would have to tear down the whole place ... How would you do it? With the residents still in here? You would just have to close down to do it and open up again. It would be a nightmare. I tell you, there wouldn't be too many nursing homes in this area doing that, because they would say, right we'll sell off the site for a housing development.

(Member of the Working Group, private sector)

Private sector members interviewed indicated that they used a number of well-planned tactics in order to win arguments and influence the content of the Standards in their favour, including encouraging colleagues to attend meetings, asking for votes on issues where they had a clear majority, as well as some more imaginative techniques:

It would have become far too expensive for us to build a new nursing home on the regs that these lads were suggesting, [so] we went into battle quite hard. It turned into a kind of filibustering. We were talking down the clock. It got to that stage, where you just kept talking and arguing and arguing, so as at the next meeting, maybe the guy who was arguing against you wouldn't be there and you would be able to knock it on the head.

And did it work?

It did I suppose, yeah. We wore a lot of people out.... we reached consensus [on that issue] pretty quickly.

(Member of the Working Group, private sector)

In contrast, Group members from the public sector relied on less formalised strategies to win arguments, simply using their powers of persuasion to influence others:

I would have put it on the agenda for the meetings and brought it up and talked about it. In terms of going around and persuading people behind the scenes, I never did that.

(Member of the Working Group, public sector)

These findings highlight the lack of unity within the Group and also the desire to promote their own self-interests over those of residents, indicating that not all members of the Working Group were predominantly concerned with protecting the best interests of residents.

Professional Divisions

The other division that developed within the Working Group was along professional lines. Working Group members alluded in interviews to tensions that developed between members who worked directly in either a public or a private residential care setting ("frontline workers") and other members of the Working Group who had roles in developing or critiquing national policies for older people through their positions as civil servants, policy planning specialists and directors of charities for older people ("policy makers/analysts"). Tensions developed largely because of a difference in perception between the two groups about the overall standard of residential care in Ireland at that time. Frontline workers recognised that there were some shortcomings in the quality of residential care settings in Ireland, but argued that these were a consequence of inadequate funding and staffing, issues over which they had little control:

We have not got enough core staff to deliver services and so we are delivering it through agency and overtime and that's one of the standards, but I think it's grossly unfair to expect that, you know, we can properly look after vulnerable people when we're not allowed to hire people.

(Member of the Working Group, frontline worker)

However, many policy makers/analysts were of the view that the quality of residential care in Ireland was wholly inadequate and regarded the frontline workers on the Group as part of a cohort that were to blame for this:

People do worry about the standards of care in nursing homes. Certainly, you know, to go into a nursing home and find people sort of sleeping in a chair, sitting around a big room, isn't inspiring to say the least, you know?

(Member of the Working Group, policy maker/analyst)

Indeed, many policy makers/analysts believed that this poor model of care had led to the Leas Cross crisis. They thus felt that the model of care needed to change:

I think people got physically overwhelmed by what they saw on the television [on the Leas Cross programme] and yet some of the things in it are what underpinned the bad care that is there now.

(Member of the Working Group, policy maker/analyst)

Policy Makers/analysts felt that the best approach to improve the quality of care was to prioritise and promote the rights of residents within the Standards. It appeared some felt that this would help to avoid residents being abused:

I don't think the Standards could in themselves do everything. But if the rights and the dignity are respected, then there'll never be abuse.

(Member of the Working Group, policy maker/analyst)

However, many frontline workers argued that, while important, this proposal was not practical in all contexts:

If someone can't walk but they want to get up, you know they are going to fall and so they should have a safety belt on. Their answer to that was that we should have sufficient staff to stay with that person but that's not practical, it won't happen.

(Member of the Working Group, frontline worker)

Impact of the Divisions

Both factions used an identical strategy to win such debates, namely, questioning the motives, and thus undermining the reputation, of other members of the Group. As noted above, many of the policy makers/analysts implied that care home owners and managers provided poor care largely to suit their own needs, to the disadvantage of residents:

A lot of the nursing homes are just worried about the risks, so they prohibit residents' choices. It's a very litigious society, unfortunately.

(Member of the Working Group, policy maker/analyst)

For their part, frontline workers suggested that members of the Group with a policy-making function also needed to accept responsibility for the inadequate quality of care as they had failed to provide care settings with adequate resources that would have allowed them to provide residents with the best quality care:

I think that older person services were always seen as the Cinderella. Most consultants in the area don't know this place. It's out there somewhere in the outback. [In the past], nobody cared, nobody was interested.

(Member of the Working Group, frontline worker)

While many respondents suggested that these arguments inevitably introduced a degree of tension into meetings, it became clear that the strategy of undermining the reputation of other Group members helped to legitimate individuals' specific viewpoints and thus gain support from other members:

Well I was arguing with the Directors of Nursing and there was an amount of to-ing and fro-ing about that but em another person backed me up and wouldn't let them anything away with anything. I am quite... I am quite gently spoken but having someone else meant we could argue together in such a way that I think it did make the Directors of Nursing really see our point.

(Member of the Working Group, policy maker/analyst)

Indeed, the strategy proved so successful that it began to be adopted by all Working Group members. Several of the public sector workers suggested in meetings that the private sector was influenced only by money and not by the well-being of their residents, while private sector members retorted by pointing out that the public sector workers were also influenced by money, as standards set at a very high level would provide them with an opportunity to call on the government for much-needed investment into public care settings, which were often run-down and unsuitable for residents' needs (Murphy et al. 2006):

They [private sector representatives on the group] were representing providers who have older people in their beds only for money. Money is a massive pre-occupation in the private sector. Massive. They just want to fill their beds, they want to make money, they are commercial organisations, so therefore they bring a priority of filling beds and making a profit.

(Member of the Working Group, public sector)

Now, unfortunately, the HSE was ... em... somewhat delinquent in the manner that they participated in it. They were sending people like... people who might be running units. And those people saw the process as a means of getting a capital budget to spend on their facilities. That was their motivation, which wasn't the correct one.

(Member of the Working Group, private sector)

These debates and arguments created tensions and mistrust between members and left each faction determined to ensure that the content of the Standards reflected their own views. This meant that a significant amount of time was spent determining the wording of particularly contentious criteria, ultimately leaving little time to consider the totality of the Standards. This in turn led many individuals to lose interest in the process and to lose sight of the overall purpose of the Standards:

I certainly went to sleep when they were talking about how much space each resident had to have and the wiring and electricity and floor space. It was mind numbingly tedious to me ... and partly there was a process of exhaustion by the end of the year you lacked the fight anymore about things you started off very passionate about.

(Member of the Working Group, public sector)

A concern I would have now [about the Standards] is that the nursing homes now are obliged to have such an amount of paperwork on each patient that I mean the net result is that they are spending less time with the patients...

And when you were on the Working Group, would that have occurred to you?

No, it wouldn't have even dawned on us, which is terrible really. But when you are going through them Standard by standard... We had to take it in blocks so you don't see them cumulatively! [...] The meetings were quite intense. They'd go on for about two or three hours and sometimes by the end... Sometimes, what I'd find would be for the first hour people would be contributing really, really well and there would be lots of debate and negotiation and then everyone would get so tired by the end that it would be, that'll do, that'll do.

(Member of the Working Group, public sector)

Thus, mistrust between members appeared to have contributed to debate both within the detail of the Standards, and at an overall conceptual level, as already suggested earlier. The mistrust between Group members also appears to have created some of the ambiguity in relation to the responsibilities of the various actors and also the issue of risk v safety for residents. Many of the policy makers/analysts were insistent on ensuring that the responsibilities of the owner, person in charge and staff of the residential care setting be clearly delineated, so that no one could shirk their responsibilities to residents:

We felt that everybody has to be responsible for the area of work they are in... It's all about what reporting systems are in place, what policies, who is reporting to who, when are they reviewed. It's complex. You can't just point the finger at one person. Overall... Having responsibility is important. And families are asking questions as well.

(Member of the Working Group, policy maker/analyst)

Furthermore, as outlined in greater detail in the next chapter, policy makers/analysts were also anxious to increase the responsibilities and autonomy of residents, in order to provide further guarantees that providers of residential care settings would not be able to shirk their responsibilities in upholding the Standards.

These findings suggest that the membership, operations and dynamics of the Working Group together contributed towards the ambiguity in the Standards. The large size of the group, the imbalance in the membership between public and private sector members, the limited time available, the mistrust between members and the poor facilitation overall all appeared to have resulted in difficulties in ensuring that the various members worked together towards a common objective. As noted in Chapter Two, these findings are commonly found in instances of regulatory negotiation, where different stakeholders have competing vested interests (Ansell & Gash 2008, Coglianese 2001a, Seidenfeld 2000, Sorensen 2002). However, as outlined below, other factors also appeared to have contributed to the ambiguities within the document.

5.4.3 Reliance on Existing Drafts

As noted in Chapter One, public outcry developed about the poor quality of residential care settings for older people following the broadcasting of the *Home*

Truths documentary about the poor standards of care in the Leas Cross nursing home in May 2005. The next day, the Minister of State with Responsibility for Older People, Sean Power, indicated that the DOHC was “urgently” reviewing the legislation on the regulation of residential care settings in order to reform the regulatory process. However, as the government was aware that it would take some time to set up a new regulator and write the legislation setting out its aims and objectives,² it decided to establish an internal Working Group to draft a set of minimum standards in order to speed up the process. Thus, in November 2005, a small internal Working Group made up of seven civil and public servants came together to write the draft Standards.

This internal Working Group was given a relatively short time to complete its work, just six months in total, a deadline to which it adhered. However, the tight timeframe created challenges in putting together a document covering minimum standards for all aspects of residential care:

It took quite a while to work through it all... You know, it was quite challenging. We got there... but what is astonishing looking at this is just how quickly we actually did it. There’s so much detail.

(Member of the DOHC Internal Working Group)

In order to be able to meet the strict deadline set, the DOHC’s Working Group relied on existing standards from other countries to guide its own Standards:

It was a small working group and we probably met maybe 10 times over the year and we worked in between and I suppose what we started with was ... Let’s not reinvent the wheel, so we used standards from Australia, Scotland, England, Wales and Northern Ireland. So then em we drafted from those standards and then adapted them to being Irish and we looked at all the legislation and that was just our starting point, the care standards from the UK.

(Member of the DOHC Internal Working Group)

A comparative analysis revealed that there were many similarities between the original draft of the Irish Standards and versions from other countries.³ Yet,

²In fact, it took two years. The Health Act which gave legal effect to HIQA was not ratified until 2007.

³Of the 38 headline Standards in the original Irish version, 28 are mirrored in the Australian Standards, along with 33 in the Northern Irish version, 26 in the Scottish document and 31 in the Welsh draft. However, the wording of many of the criteria in the DOHC’s original version of the Irish Standards differs from those in other countries.

as outlined in Table 5.3, the DOHC Working Group relied most heavily on the English Standards (Department of Health UK 2003), which in turn influenced the HIQA Standards.

Table 5.3: Similarities between the English and Irish Standards

	English Standards	DOHC Version	Irish Standards (final version)
No. of Standards	38	38	32
No. of Standards Derived from the English Version	-	32 (84%)	17 (53%)
No. of Criteria	249	306	330
No. of Criteria Derived from the English Version	-	205 (67%)	136 (41%)

An analysis of both the English and the DOHC Standards reveals that HIQA's Working Group inherited some ambiguity by using these documents as templates.

Purpose of the Standards

Like the HIQA Standards, the English draft contains ambiguities about the overall purpose of the Standards within the regulatory framework. On the one hand, providers are told that the Standards are the "core standards... which form the basis on which the new National Care Standards Commission will determine whether such care homes meet the needs, and secure the welfare and social inclusion, of the people who live there" (Department of Health UK 2003, p. vii). On the other hand, providers are also told that:

Compliance with national minimum standards is not itself enforceable, but compliance with regulations is enforceable subject to national standards being taken into account. The Commission may conclude that a care home has been in breach of the regulations even though the home largely meets the standards.

(Department of Health UK 2003, p. viii)

However, the original intention of the Irish Standards was for providers to meet all of the Standards and criteria in order to be seen to be in compliance with the new regulatory framework:

The standards set out in this document must be met in order for a care setting to operate.

Thus, it appears that, between the publication of the DOHC draft and HIQA's final version, a decision was made to make only some of the Standards mandatory requirements, thus leaving HIQA's version to rely on the intention within the English Standards. This issue is discussed in greater detail in Chapter Seven.

Responsibility

Furthermore, both the English and DOHC versions of the standards also contain ambiguities about the responsibilities of the various actors within the regulatory process. The responsibilities of the care provider (owner) and the manager (person in charge) are not set out clearly; both are named as responsible, though to whom is unclear. In both the English and DOHC versions, staff are also named as responsible for ensuring some Standards and criteria are upheld, though to whom they are answerable is also unclear. Residents also are given certain responsibilities, including to remain active and involved and also to make a decision about which care home to live in:

Standard One OUTCOME: Prospective service users have the information they need to make an informed choice about where to live.

(Department of Health UK 2003, p. 2, DOHC 2007b, p. 13)

This also suggests that the ambiguity in the HIQA Standards in relation to the responsibilities of key actors was also partly derived from the English and DOHC Standards.

Risk Versus Safety

Some ambiguities can also be seen within the English Standards in relation to the tension between respecting residents' autonomy and protecting their safety. While there is an emphasis on person-centred care and respecting residents' rights within the document, the emphasis is predominantly on avoiding risk:

Standard 38 OUTCOME The health, safety and welfare of service users and staff are promoted and protected.

(Department of Health UK 2003, p. 18)

However, overall, the English Standards designates providers as fully responsible for protecting residents and managing risk, rather than promoting residents' autonomy. Any mention of risk within the English Standards is generally preceded with an instruction that risk should only be allowed with adequate support for residents or following assessment. For example:

8.8 Opportunities are given for appropriate exercise and physical activity; appropriate interventions are carried out for service users identified as at risk of falling.

(Department of Health UK 2003, p. 32)

Similarly, the first draft of the Irish Standards (DOHC 2007*b*) also focuses on avoiding risk. This suggests that the Working Group introduced new criteria in order to place more emphasis on providers' facilitating the rights of residents, while also transferring some responsibility to residents' for engaging in risky behaviour.

These findings suggest that the reliance on the English Standards and the original DOHC version may have contributed to some of the ambiguities in the document. It is possible to argue, therefore, that the HIQA Working Group failed to spot the inadequacies in previous drafts of the Standards and amend the documents which they used as templates.

5.4.4 The Legislative Framework

Any new government policy must take into account pre-existing and overlapping policies. A failure to do so can create contradictions within the legislation overall (Hill 2005). It is thus important to consider whether the existing legislative framework may have contributed to the ambiguity contained in the document, in particular, the lack of legislation giving legal status to HIQA (and the Standards) and the absence of any legislation on mental capacity (to determine an individual's ability to make a decision with legal consequences) (Leonard & McLaughlin 2009).

2007 Health Act

As noted earlier, HIQA's Working Group started its work in January 2007. However, HIQA itself was not formally established until May 2007 when the legislation giving legal effect to the organisation (the 2007 Health Act) was pas-

sed. The 2007 Health Act set out the various functions of the Authority, including the conditions under which HIQA could develop Standards and register designated care centres. Although minimum Standards are not legally enforceable, the Act gave the Minister the power to write regulations underpinning the Standards.

This suggests that, provided the regulations underpinned the Standards, providers must adhere to them in order to be allowed to operate a residential care setting. However, the Working Group did not have confirmation about the legal status of the Standards as it commenced its work and sent its first draft (HIQA 2007) out for public consultation. Yet by the time the final version had been published in 2009, the 2007 Health Act had been published almost two years and thus HIQA was fully clear that the Standards were mandatory for providers, notwithstanding the issue of the criteria. Thus, it is unclear why the final version of the Standards did not outline more clearly their legal status and purpose within the regulatory framework. This issue is discussed further in Chapter Seven.

Mental Capacity Legislation

The absence of capacity legislation in Ireland may also have contributed towards the confusion within the Standards about the issue of residents' rights and how to ensure their safety. Several advocacy groups in Ireland have been lobbying for many years for legislation to provide guidance to service providers in instances where people who may have reduced mental capacity have to make decisions affecting their lives and may not have the capacity to do so (Leonard & McLaughlin 2009). Such legislation is important in the context of residential care for older people, where up to 80% of residents may have some form of cognitive impairment (Cahill et al. 2010).

In response to the calls for new legislation, the Government asked the independent State body the Law Reform Commission in 2006 to provide it with guidance to draft new Capacity legislation (Law Reform Commission 2006). The guidance issued by the Commission suggested that the legislation should be based on the principle that residents should be deemed to have the capacity to make informed decisions unless there was evidence to the contrary. As noted above, this principle is also reflected in the Standards. Following the publication of the report, the Department of Justice published the 2008 Scheme of Mental Capacity Bill (Department of Justice and Law Reform 2008). Thus, it is possible that the HIQA Working Group may have worked on the assumption

that new legislation would be passed shortly which would give legal support to the focus on risk management and decision making within the Standards. However, the 2008 Bill still has not been ratified, largely due to disagreement amongst legal experts about its repercussions (Leonard & McLaughlin 2009).

Thus, the absence of legislative support from the government may have been responsible for the ambiguity in the document in relation to the issue of safety and rights and also in relation to the purpose of the Standards.

5.5 Conclusion

The findings presented in this chapter have showed that the Standards have many positive points, including a focus on the rights of residents. Nevertheless, the document suffers from a number of ambiguities. The Working Group itself contributed to the lack of clarity in the document. The facilitation of the Group by HIQA, including the informal rules about membership, also facilitated each cohort to influence the content of the Standards. In turn, the development of factions within the Group, and the modus operandi of compromise and “wins” by each faction led to some of the contradictions and ambiguity within the Standards. Thus, it is possible to argue that regulatory negotiation does not necessarily help to create clearer standards/regulations, as has been previously argued (Coglianese 2001a, Langbein & Kerwin 2000). However, it is important to see this issue as an inevitable consequence of the policy process, where policy documents are developed by a wide range of stakeholders, each with a different view of the policy problem and the necessary policy response (Bobrow 2006, Winter 2006). In this way, the development of the Standards can be seen as simply another example of the tensions and difficulties that can ensue within the policy process.

The chapter has also provided further evidence to show that the participants of regulatory negotiated processes may try to create strategic advantages vis-à-vis other stakeholders (Seidenfeld 2000). Being directly involved in drafting the Standards gave all of the various stakeholders a greater opportunity to promote their own self-interests and veto proposals which did not suit their own agenda. However, the focus of Working Group members to promote their own interests raises the question of whether the interests of older people were taken into account in developing the Standards. This issue is discussed in the next chapter.

Findings II: Vision of Person-Centred Care

6.1 Introduction

According to the Standards, the authors of the document aimed to develop a “road map... of person-centred care” for residential care settings in Ireland. As person-centred care relies on an understanding of the subjective needs and wishes of residents (McCormack 2003), it is important that the development of a person-centred model takes into account the views of older people living in residential care. Indeed, as noted in Chapter One, focus groups with residents took place as part of the public consultation process in order to ensure the Standards reflected their needs and wishes. This chapter sets out to analyse both the model of person-centred care within the Standards and also to examine the extent to which this model reflects the wishes of older residents.

Section 6.2 starts by setting out the vision of person-centred care set out within the Standards. It examines the way in which residents and residential care are portrayed within the document. Section 6.3 then considers whether this vision represents the views of older people and Section 6.4 then examines the factors that contributed to how the model of person-centred care was conceptualised.

6.2 Vision of Person-Centred Care within the Standards

6.2.1 Portrayal of Residents

Overall, the Standards portray old age and residential care in a positive light. It is stated that the Standards aim to cater for the diverse needs and wishes of all older people living in residential care settings. As outlined in Chapter Five, there is a considerable emphasis within the Standards on promoting residents' autonomy and agency. Many of the Standards focus on consultation with residents; about their care, their daily lives and how the home is run. There is significant weight placed on giving residents the opportunity to participate in activities and in care planning. Many Standards and criteria also aim to ensure that residents have adequate stimulation through the provision of activities and opportunities for socialisation:

18.2 The resident is given opportunities for participation in meaningful and purposeful activity, occupation or leisure activities, both inside and outside the residential care setting, that suit his/her needs, preferences and capacities. Particular consideration is given to residents with dementia and other cognitive impairments, residents with visual, hearing or dual sensory impairments, residents with communication difficulties and residents with physical or learning disabilities.

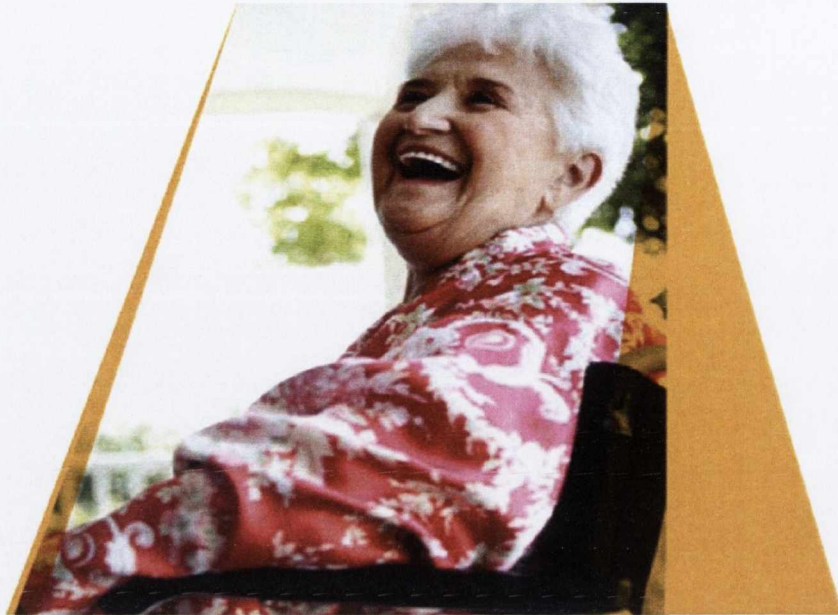
(HIQA 2009e, p. 33)

Several of the images within the document contribute to this positive portrayal of ageing, showing active, engaged, "well" older people (see Figure 6.1).

Though those living in residential care settings often have co-morbidities, or high levels of physical impairment and/or cognitive impairment (Bowman, Whistler & Ellerby 2004, Cahill et al. 2010, Falconer & O'Neill 2007, Magaziner et al. 2000), the "high level" Standards gloss over common aspects of "bodily ageing" (Gilleard & Higgs 2010c), such as the onset of frailty or age-related disease, or else couch references in vague/cryptic language ("responding to behaviour that is challenging"). Even the medical standards, including the Standard about end-of-life care, stress the need for residents' input into decision-making:

The resident's wishes and choices regarding end of life care are discussed and documented, and, in as far as possible, implemented and reviewed regularly with the resident.

Figure 6.1: Image of an “active” older woman used within the *National Quality Standards for Residential Care Settings for Older People*



(HIQA 2009e, p. 16)

Age-related diseases, such as the potential for pressure sores, the need for falls prevention, poor sleep, avoidance of physical, sexual, psychological and financial abuse are mentioned only within the criteria and in the appendices, rather than within the headline Standards. Indeed, there is almost a concerted effort to deny or minimise these more “negative” aspects of the ageing process, including the desire to prevent or minimise the use of medication for many such common problems that typically occur in later life:

15.6 Each resident on long-term medication is reviewed by his/her medical practitioner at least on a three-monthly basis, in conjunction with nursing staff and the pharmacist. Special consideration is given to the use of:

- antipsychotic medication
- sleeping tablets and other sedating medication
- anticonvulsant medication
- medication for the management of depression
- analgesic medications (pain management)
- medication for the management of constipation
- anti-platelet and anticoagulant medication (prevention of stroke)
- influenza and pneumococcal vaccines

non-steroidal anti-inflammatory drugs
different medications and their potential interactions.

(HIQA 2009e, p. 29)

The oblique references to the more negative aspects of ageing can be read as a tacit acknowledgement that at least some of those living in residential care may have difficulty making decisions unilaterally, and may need assistance and protection, hence the references to older people having access to advocates and other representatives to help them with decision-making:

2.1 Where the resident has been admitted to the residential care setting in an emergency, he/she is given time, information and, if necessary, access to an advocate, in order to decide whether or not to remain in the residential care setting on a long-term basis.

(HIQA 2009e, p. 29)

Thus, where there are images of passive, sick older people within the document, such individuals are always accompanied by staff engaged in protective gestures, such as the image of a passive, unsmiling man with crooked glasses being physically supported by an anonymous carer (see Figure 6.2).

As Murphy et al. (2006) suggest, some older Irish people with no physical disability or cognitive impairment come to live in residential care simply because there is no full time (family) caregiver available to enable them to remain living in their own home. The portrayal of residents as either active or passive can thus be seen as an attempt to reflect the wide spectrum of needs of all older people who live in residential care. However, rather than attempting to cater for the spectrum of needs of older people, the document appears to have developed a dichotomous portrayal of older people; either active, autonomous and agentic, or else frail and in need of protection. This is reminiscent of Jones and Higg's (2010) suggestion that two alternative models of old age have developed in society, one "normative" model characterised by fitness and a more "natural" or "normal" model, characterised by frailty, or dependence. However, as Jones & Higgs (2010) argue, the discourse of normative ageing that is organised around the "reflexively constituted goal of fitness" can become problematic, as older people can find themselves "caught in a spiral of perpetually unfulfilled and unattainable fitness". Furthermore, as discussed below, the focus on ageing as a time of new possibilities (Gilleard & Higgs 1998) can leave older people who suffer from ill-health and disability without the support they require.

Figure 6.2: “Passive” image of older man used within the *National Quality Standards for Residential Care Settings for Older People*



6.2.2 Portrayal of Residential Care

Implicit in the Introduction to the Standards is the view that residential care is a poor substitute for care provided within the family home:

It is widely recognised that Ireland is at a crossroads in the way we, as a society, care for our older people. In times past, the extended family meant that as people grew older they remained in the family home cared for by their relatives. This is no longer the norm, with more and more people moving into residential care settings as they grow older. This raises challenges in terms of how we protect the rights of older people who live in residential care settings and ensure that they are able to lead as full lives as possible in a caring, respectful environment.

(HIQA 2009e, p. 6)

Furthermore, residential care settings are described as employing an “institutional” approach to care, rather than a person-centred model, a trend that puts Irish care settings out of synch with their counterparts in other countries:

International best practice in residential care settings for older people is moving away from institutional “hospital” type care to more intimate

home-style settings, which enable residents to live full lives that reflect, as far as possible the lives they led prior to their admission. The National Quality Standards for Residential Care Settings for Older People will not, by themselves, bring about a transformation from institutional to more person-centred models of care.

(HIQA 2009e, p. 9)

From the passage above, it can be surmised that the authors interpreted “person-centred care” as the antithesis of institutional care. The document can thus be seen as a deliberate attempt to obliterate any trace of “institutional” care from residential settings in Ireland. While a description of institutional care is not provided within the Standards, Goffman’s (1961) characteristics of total institutions can be used as a way of highlighting the eradication of institutionalism from Irish residential care settings. As outlined in Appendix K, many of the Standards aim to ensure that privacy is respected, that residents have an opportunity to have input into the operation of the residential care setting and that each resident’s individual identity is maintained.

Within the document, “person-centred care” is understood as a focus on the needs of the individual resident and on the creation of an environment in which the resident feels safe and free to express these needs:

Person centred: a term applied to the ethos adopted by facilities which seek to tailor their services to the particular needs of individual residents. It also describes an open, listening and empathetic communication approach which fosters wellbeing, rehabilitation and healing.

(HIQA 2009e, p. 76)

This understanding of person-centred care is reflected within the Standards themselves, as the document focuses on the importance of residential care settings tailoring their services to ensure that they meet the varied and diverse needs of residents, including contracting out external services where they are not available within the setting itself:

13.2 The resident is referred to healthcare services including primary care, secondary care, specialist services, allied health professionals, and has access to assistive devices to meet his/her assessed needs, irrespective of geographical location or place of residence. A record is maintained of all referrals and follow-up.

(HIQA 2009e, p. 76)

The Standards also require residential care homes to ensure that the care environment meets residents' individual and collective needs in a "homely way" (Standard 25: The Care Environment), and also aim to ensure that the quality of life of residents is maintained (Section 4: Quality of Life). In addition, much of the focus within the Standards is on how residents should be treated as individuals and should have their individual needs met. Therefore, several standards and accompanying criteria emphasise residents' need for choice with regard to *inter alia* which residential care setting to live in; whether and what type of medical care to use; which GP to attend; which activities to engage in; and how end-of-life care is provided. Each standard uses the phrase "each resident", in order to highlight the importance of the care setting recognising and facilitating the individual personality of each individual, rather than simply aiming to cater for the basic needs of all residents collectively:

Each resident benefits from policies and practices that promote his/her health, rehabilitation and wellbeing.

(HIQA 2009e, p. 25)

This approach mirrors to a large extent the approach recommended within widely cited psycho-social models of person-centred care (Kitwood 1997, McCormack 2003). According to McCormack (2003), the "psycho-social" model of person-centred care focuses on personhood as a sense of self-identity. The factors that enable person-centredness are the patient's values, the nurse's (or carer's) values and the context of the care environment, including systems of decision-making and organisation, which are also addressed within the Standards (Section 7: Governance and Management).

However, both McCormack (2003) and Kitwood (1997) also place considerable emphasis on the relationship between the care recipient and their carer. Indeed, carers need to have an understanding of the person's (i.e. the care recipient's) authentic values (McCormack 2003), in order to provide person-centred care:

Being conscious of another's beliefs and values does not tell the nurse what to do, rather it orientates the nurse to a particular way of being... The recognition of beliefs and values allows the patient and the nurse to have the kind of caring relationship that they want to have, appropriate to the context of care.

(McCormack 2003, p. 204)

Thus, person-centred care requires engagement between the nurse and the care recipient, forming a “care partnership”, where both individuals share a deep respect for one another (McCormack 2003). This care partnership allows decision-making to take place between the care recipient and their carer (with the aid of mechanisms such as reflective practice, clinical supervision and case reviews). However, within the Standards, there is relatively little mention of the relationship between the care recipient and care staff. While there is an acknowledgement of the need for training of staff to ensure that they can communicate with care recipients with communication difficulties, most references to staff simply talk about minimum qualifications and work tasks, rather than on their relationship with residents.

There is also little emphasis on community life within residential care settings. Within the Standards, residential care is not depicted as a community, where several residents live and interact together, a factor known to benefit residents (Kane, Lum, Cutler, Degenholtz & Yu 2007). Instead, any references to “community” are about the neighbourhood outside the setting, where residents are encouraged to go in order to access external services and meaningful activities, ostensibly suggesting that the residential setting alone cannot be expected to meet the intellectual and emotional needs of residents:

5.6 The resident is facilitated to access community-based facilities.

(HIQA 2009e, p. 18)

18.2 The resident is given opportunities for participation in meaningful and purposeful activity, occupation or leisure activities, both inside and outside the residential care setting [...]

(HIQA 2009e, p. 33)

In the few instances where there is acknowledgement of residents living together, the focus is on largely formalised and task-based interaction between residents and staff, rather than on social engagement between residents:

2.4 The person in charge facilitates the establishment of an in-house residents’ representative group for feedback, consultation and improvement on all matters affecting the residents. ...One nominated person acts as an advocate for people with dementia/cognitive impairment. Issues raised by the residents’ representative group are acknowledged, responded to and recorded, including the actions taken in response to issues raised.

(HIQA 2009e, p. 33)

Thus, while there is an acknowledgement of the need for frail residents to be facilitated to make decisions, there is little onus on staff, or on the care setting, to carry out this role directly, but simply to co-operate with it if and when required.

The relationship between residents and the provider is also described in impersonal terms, as that of a client-contractor. In agreeing to move into the care setting, residents enter into, and negotiate, a contract with the provider:

7.1 Each resident or his/her representative is provided with a contract, specifying the terms and conditions within one month of admission. The resident and/or his/her representative are involved in discussing the contract and it is signed by the resident and/or his/her representative and the registered provider. Where the resident or his/her representative is unable or chooses not to sign, this is recorded. The contract is provided to the resident or his/her representative.

(HIQA 2009e, p. 20)

The provider-client relationship is also emphasised in the requirement for providers to record and respond to residents' complaints and also to give to residents an accurate description of the service and its cost prior to purchasing (Criteria 1.1 and 1.3), evoking an image of residential care as a service residents buy with all of their consumer rights protected (NCA 2007). Indeed, this service-oriented model of residential care for older people has previously been described as "hotel-style accommodation", in which the residents are seen as "customers who are always right" (Bland 1999).

The portrayal of residential care as a hotel-type service is reminiscent of the New Public Management approach to care described in Chapter Two. This model, which flourished particularly under Tony Blair and New Labour, had the effect of transforming citizens into consumers of social and healthcare services:

New Labour's rule involved fiercely contested arguments about the capacity of the mechanism of choice to drive and deliver changes in public services; about what the changes created by 'choice' mechanisms might be; and about whether people identify themselves as choice-seeking consumers in relation to public services.

(Clarke 2006, p. 526)

While those advocating a psycho-social model of person-centred care (e.g. (Kitwood 1997, McCormack 2003) emphasise choice with the aim of facilitating the needs of the individual and promoting their rights, those supporting a consumerist model of person-centred care, which stems from the “New Public Management” approach, believe a free market approach will help to drive up quality through competition and greater choice for consumers (Clarke 2006). According to Wilkinson et al. (2009), consumerist models of person-centred care tend to focus on the provision of information to facilitate choice. Indeed, the Standards also place a significant amount of emphasis on the provision of information to residents, particularly to facilitate their decision-making process in selecting a care home:

1.3 The prospective resident and/or his/her family or representative are informed of all fees payable including charges for activities and services that may have additional costs.

1.4 The person in charge ensures that the prospective resident and/or his/her family or representative is invited to visit the residential care setting before he/she makes a decision to stay. Emergency admissions are avoided where possible. The opportunity to meet with other residents during a visit is facilitated.

(HIQA 2009e, p. 14)

The focus on information in the Irish Standards may have been influenced by the English Standards (Department of Health UK 2003), which also emphasise the need for information to be given to residents:

Standard One: Prospective service users have the information they need to make an informed choice about where to live.

(Department of Health UK 2003, p. 2)

The English Standards were written to facilitate the implementation of the policy document *Modernising Social Services*, (Department of Health UK 1998), a key plank in Blair’s “modernisation project” (Butler 2000), described in Chapter Two as a process of shifting the burden of responsibility away from the state onto service users, by requiring them to select the services they use (Gilleard & Higgs 1998). This intent to pass responsibility onto providers is quite explicit within the English Standards:

By requiring proprietors to ‘set out their stall’, the problem of leaving choice to chance is overcome. There can be no room for doubt either on

the part of the prospective resident, the inspector or the proprietor. In this way diversity and range of choice across the care home sector can be maintained.

(Department of Health UK 2003, p. 1)

Thus, it appears that the consumer-driven approach to person-centred care in the Irish Standards, with its focus on consumer-directed care, in which residents retain agency and the ability to make decisions about the service they use, may have been influenced by the English Standards (Department of Health UK 2003).

6.2.3 Overview

It is apparent that the Irish Standards contains elements of two competing models of person-centred care. While there are facets of the psycho-social model, as evidenced by the emphasis on meeting the needs of residents and the focus on the individuality of each resident, the focus on “wellness” and the failure to acknowledge the importance of a care partnership between residents and staff suggests that the Standards predominantly follow the consumer-driven model of person-centred care. This latter model arguably supports the “care-telisation” of residential care settings, a term developed to denote a growing phenomenon in which the characteristics of the private sector are being used to develop publicly provided care services (Scourfield 2007a). This consumer-driven model of person-centred care evident within the Irish Standards depicts residents as discerning customers of the residential care setting (Wilkinson et al. 2009). While there is widespread consensus that a psycho-social approach to person-centred care benefits residents (Kane et al. 2007, McCormack & McCance 2010, Nolan et al. 2004), research has shown that a consumerist approach to care may not be appropriate for older people living in residential care, as they can have difficulties making informed decisions and vocalising complaints (Kane & Kane 2001, Nolan 2001). Furthermore, it is unclear whether the consumer-driven model of person-centred care reflects the wishes of residents and potential residents of Irish care settings. This issue is explored in the next section.

6.3 The Public Consultation Process

Whether provided through a psycho-social or consumer-focused model, person-centred care requires a clear understanding of the needs of care recipients (Brooker 2004). While this means that standards governing residential care need to be broad and flexible enough to allow providers to meet the needs of individual residents (Braithwaite et al. 2007), it also requires an understanding of the issues most important to residents. HIQA attempted to capture residents' views within the public consultation process.

As stated in Chapter One, the Working Group completed a draft set of Standards in August 2007 which was then sent out for public consultation. The purpose of the public consultation process was to canvass the views of relevant stakeholders and the general public in order to get feedback which would then inform the final content of the Standards (HCI 2007). HIQA commissioned Health Care Informed (HCI), a private sector healthcare consultancy firm to oversee the public consultation process. Feedback was collated through focus groups with residents, workshops with staff and written contributions from the wider public. HCI (2007) was responsible for collating and analysing the feedback and determining any issues raised that the draft Standards had not adequately addressed. According to HIQA, the draft set of Standards was subsequently amended to take into account the findings from the public consultation process:

The Authority, and the working group, gave careful consideration to the comments, observations and suggestions that came out of this consultation process and these have informed this final set of National Quality Standards for Residential Care Settings for Older People.

(HIQA 2009e, p. 7)

Health Care Informed conducted a total of ten focus groups with older people living in residential care settings, relatives/carers and prospective residents. The purpose of the focus groups was to determine participants' opinions on the key issues relating to safety and quality in residential care services (HCI 2007). Focus group participants were not asked for their opinions on the content of the draft Standards. The findings of the focus groups were assessed by Health Care Informed to examine whether the Standards met all of the issues raised within the focus groups. A total of 81 residents and family members attended the ten focus groups. Health Care Informed did not document how the focus group members were selected. Thus, it is unclear whether

residents with cognitive impairments or communication problems took part in, or were represented in, the process. As Gilleard & Higgs (1998) suggest, such individuals may often have a different set of needs than more active older people, yet their impairments may act as barriers to their inclusion in such processes. As a result, the needs of “frail” older people can become sidelined.

The focus groups revealed that the key aspect that contributed to residents’ well-being valued was the quality of staff within the residential care setting. Residents suggested that communication, interpersonal skills and continuity were the key attributes that contributed to the quality of staff. The findings also emphasised the need for effective communication channels between residents and staff. Many also indicated that they valued being treated as individuals and felt that being given respect and dignity were particularly important. Some also mentioned a desire for safety and security.

Based on these findings, Health Care Informed developed a list of 79 issues deemed by residents to contribute to the quality of a residential care setting. Of these seventy nine specific issues, HCI (2007) judged that the draft Standards developed by HIQA’s Working Group (HIQA 2007) already addressed many of these issues. The twenty-six issues, approximately one-third, which were not addressed or which were only partially addressed within the draft standards, related to several aspects of residential care, including staffing issues, the physical environment and quality of life (see Table 6.1). From this list, it is clear that the draft set of Standards developed by the Working Group had not anticipated that residents and potential residents wanted to have more input into their care and the operation of the residential care setting. Furthermore, the draft Standards had not recognised the value placed by residents on having close relationships with staff and being meaningfully engaged, issues not typically valued within a more consumer-driven model of person-centred care (Brooker 2004, Wilkinson et al. 2009).

A comparison of HIQA’s draft Standards and the penultimate version suggests that HIQA and the Working Group made several changes to the document following the public consultation process. A total of three of the 32 Standards and 83 of the 302 related criteria were changed following the public consultation process, equating to 25.7% of the document. Many of the standards that were altered (14%) related to the rights of residents, emphasising the need to ensure that residents were consulted, adequately protected and had a chance to participate in the running and operation of the home, thus suggesting that the input of residents and other relevant stakeholders prompted a renewed focus

Table 6.1: Issues Raised by Residents within the Public Consultation Focus Groups which were not addressed within the Draft Standards

Rights	1. 2. 3. 4. 5.	The need for information on residents' rights, entitlements and/or allowances to be included in information to prospective residents. The possibility of a short trial period of a few days for residents. The need for approval from residents about the provision of information to relatives/carers. The need to ensure facilities have complaints procedures that acknowledge and aim to minimise residents' fear of complaining. The draft standards specify the need for the name of the registered person-in-charge to be provided but not the details of their responsibilities.
Health & Social Care Needs	6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16.	The need to provide a separate environment for residents with dementia from other residents. The need for continuous monitoring of residents, with dementia or Alzheimer's disease or otherwise. The need for electronic monitoring devices. The need for a falls assessment or specific fall prevention equipment, for example, non-slip surfaces. The need to consider how the specific requirements of residents with reduced mobility will be managed in the event of a fire. The need for the provision of education to residents on fire safety. The need for GP involvement and attendance in three-monthly review of the resident's health, personal and social care. The need to inform residents of the availability of specialist services and allied health professionals to meet their needs. The need for specifications in relation to visits to the residential care setting by a Geriatrician. The need for the removal of the remains of dead relatives to be carried out when residents are not around. The need for a private room for relatives/carers of a dying resident.
Quality of Life	17. 18.	The potential for any excursions. The need for public transport or access to any transportation services in the draft standards.
Staffing	19. 20. 21. 22.	The need to determine the initial quality of the staff, in relation to interpersonal skills and overall attitude, during recruitment. The need for staff training in communications. Determining, during recruitment, or developing, the friendly or caring nature of staff. The need for, or developing, language and culture specific skills.
Physical Environment	23. 24. 25. 26.	The need to review the percentage of single rooms. The need for specific details in relation to the cleanliness of the toilets or bathrooms. The need for gardens. The need for public transport to be near residential care settings.

on the needs of residents. However, an analysis of these changes indicates that almost half (45.5%) were merely semantic changes; in practice, the intention of the standard remained unaltered. For example, the wording of Standard 19 changed from "Each resident received a nutritious and varied diet in pleasant surroundings at times convenient to him/her" to "Each resident received a nutritious and varied diet in pleasant surroundings at times convenient to them". Other changes were made following comments made within the workshops with staff and in general submissions that some criteria were impractical. For example, criterion 4.6 in the draft Standards, "The resident receives his/her mail promptly and unopened" was altered to "The resident's privacy is respected in relation to his/her mail" in light of comments that some residents may need assistance to open their mail.

Perhaps most remarkable was the fact that most of the changes made were a reflection of comments made within the submissions and in the workshops that were carried out with staff. In particular, suggested changes made in a number of the submissions were accepted verbatim, including one from a semi-state body whose Chairperson was also on the Board of HIQA.

Yet only four of the 26 suggestions made within the focus groups with residents and family members/carers were taken on board (see Table 6.2). All four of these changes were simply semantic and thus did not alter the intent of the Standard/criterion. Furthermore, the issues outlined above considered to be of greatest importance to residents, namely, the quality of staff, and communication with staff and other individuals, were not taken on board.

Although HIQA had no obligation to take on board any suggestion made within the public consultation process, it is noteworthy that both HIQA and the Working Group chose to ignore issues considered of importance to residents, which would have arguably helped the Standards to adopt a more psycho-social model of care, were not taken into account by the Working Group. The next section discusses how the deliberations of the Working Group led to this outcome.

Table 6.2: Changes Made on the Basis of Focus Group Comments

Standard / Criterion	Draft Standards (pre- public consultation)	Final Version (post-public consultation)
Standard 6	The complaints of each resident, his/her family, friends, and/or representative, are listened to and acted upon and there is an effective appeals procedure.	The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.
Standard 19	Each resident receives a nutritious and varied diet in pleasant surroundings at times convenient to him/her.	Each resident receives a nutritious and varied diet in pleasant surroundings at times convenient to them .
Standard 25	The location and layout of the residential care setting is suitable for its stated purpose. It is accessible, safe, hygienic, spacious and well-maintained and meets residents' individual and collective needs in a comfortable and homely way.	The location, design and layout of the residential care setting are suitable for its stated purpose. It is accessible, safe, hygienic, spacious and well-maintained and meets residents' individual and collective homely way.
Criterion 3.2	The residential care setting has a policy that outlines the procedure for seeking consent from the resident prior to any treatment or intervention, or in the case of an emergency, in accordance with best practice.	The residential care setting has a policy that outlines the procedure for seeking consent from the resident prior to any treatment or care-giving or, in the case of emergency, in accordance with best practice.

6.4 The Working Group's Vision of Person-Centred Care

6.4.1 Introduction

This section explores why a consumer-driven model of person-centred care predominates within the Standards, even though it did not comply with the wishes of residents and commentators have raised doubts about whether this model benefits residents (Brooker 2004, Wilkinson et al. 2009).

6.4.2 Understandings of Person-Centred Care

An analysis of the interview data revealed a distinction between how frontline workers and policy makers/analysts on the Working Group conceptualised "person-centred" care. Many frontline workers viewed person-centred care as holistic care, which required staff to get to know each individual resident and understand their needs:

To me it's about making sure the setting is the resident's home. That the residents have a say, that they feel that it's not just ... em... all about documentation and officialdom. It is about the whole culture within the setting. I feel that ... if somebody does have to go into care, that it is important that their needs be addressed and the big thing about it is choice, you know? Their dignity. And to know the person, know the whole person,... Because I suppose in the past we would have always concentrated maybe on their disabilities as opposed to their abilities, so to see the whole person, to see their life story. Also, to try and keep it non-clinical. That would be very strong in my view. Try and have it homely.

(Member of the Working Group, frontline worker)

In contrast, many of the policy makers/analysts often had a different understanding of the term. When asked to define "person-centred care", some of the policy makers/analysts had difficulty in doing so:

Person-centred care is about care around the person - listening to the older people, what were the, from... It was taking the evidence that was out there, in relation, we had loads of consultation with older people and sometimes like that, you could dismiss what was out there as taking the good practice, which, through the co-ordination of HIQA, too, we were able to collate all of that information and take it together and say well,

what are older people saying? So, it is about listening and obtaining that feedback from older people, collating that information and I suppose where I was coming from and where (my manager) was coming from, it was for us and the other director involved, to bring that information from our organisation, to the table and say, well this is what older people are saying and that's to me what person-centred is, it's about listening to the older people... It wasn't about systems and processes, it was about people actually living and their quality of life too, so it was again, the focus was always on older people.

(Member of the Working Group, policy maker/analyst)

However, policy makers/analysts tended to equate "person-centred care" with the facilitation of the choices and rights of older people:

I am very hot on quality of life, residency rights that they should truly be residents and I think there should be residents' committees which aim to empower residents.

(Member of the Working Group, policy maker/analyst)

It was suggested in Chapter Five that the policy makers/analysts felt that promoting the rights of residents would help to improve the quality of residential care settings. Indeed, many of the policy makers/analyst regarded the quality of residential care as poor overall, speaking of older people in residential care being treated with a lack of respect and having few activities with which to occupy themselves:

You need highly trained people who understand how to deal with gerontological care and palliative care. But also you need to understand how to try to respect people as if they are living in their own homes and you are not going to get that at the lowest end of the care spectrum... in care homes.

(Member of the Working Group, policy maker/analyst)

Very often your impression of a residential home is people all sat around in a big wide corner and very hard for communication or interaction.

(Member of the Working Group, policy maker/analyst)

Many policy makers/analysts believed that Standards which required providers and staff to respect residents' wishes would result in residents being shown a greater amount of respect and ensure residents' needs were met:

It's really serious, food just being shovelled into somebody's mouth. Because these are not sheep, these are not cows going in for milking. And yet it's all people just lumped into a room together.

(Member of the Working Group, policy maker/analyst)

There have been positive developments [in the sector] recently, it's just not as positive as probably I would like if I was in a nursing home. And that's really why we wanted to put emphasis on the complaints process.

(Member of the Working Group, policy maker/analyst)

Indeed, many policy makers and analysts spoke of the prospect of either themselves or other family members living in residential care in negative terms:

A lot of people in residential care have depression and things like that.

Why is that?

Well one could postulate a number of reasons. Firstly, they are in residential care!

(Member of the Working Group, policy maker/analyst)

Well when Leas Cross broke, the concerns of the public... in your own family... I wanted the best possible standards there. Making sure that they are standards for the future... I have an uncle who was very ill at the time, he was a bachelor and I kind of looked after his care. He was in and out of hospital at the time and I wanted to make sure he would be ok.

(Member of the Working Group, policy maker/analyst)

Moving into residential care is a last resort for the resident and for the potential resident, it's very scary. Very hard, and hard for the family too.

(Member of the Working Group, policy maker/analyst)

It's just your worst nightmare to think about ending up in a nursing home if you were cognitively impaired and had no control. If they didn't have the care and you would maybe fall and then you couldn't move at all.

(Member of the Working Group, policy maker/analyst)

Really, we were preparing for our own future, for if we ever need it!

(Member of the Working Group, policy maker/analyst)

It is possible to argue that this negative view of residential care may not have been stimulated by residential care itself, but by a more general fear of the onset of disability, and the associated loss of autonomy, that can occur with the onset of the Fourth Age. Many comments made by policy makers/analysts revealed their fears of having their own autonomy restricted:

Providers should have to give residents choice over every aspect of their life. If they don't want to get up today, they shouldn't have to, wearing their own clothes, all of that, it should be very much... And that is really about dignity, respect, it's about making sure that each person has control.

(Member of the Working Group, policy maker/analyst)

Care centres are starting from a position of just warehousing people, whether that is in the private or in the public. They are starting from a position of people sitting around the walls just staring into space. The television set on too loud with very little choice. There is very little ability for the residents to say no I don't want my tea now.

(Member of the Working Group, policy maker/analyst)

Like how would you feel if you were made to have having your dinner at 12 o'clock in the day or four in the afternoon?

(Member of the Working Group, policy maker/analyst)

As a result, it appeared that many of the suggestions made by Working Group members were based on their own needs and wishes for should they ever require residential care, often related to the retention of autonomy and independence.

I think a lot of people went in with the approach... What would I like when I am 95 and am going into a nursing home. What do I want? Or what would my mother have wanted? So what I wanted was to make sure there were activities so you don't get bored.

(Member of the Working Group, policy maker/analyst)

Well I'd be saying, well I was saying to myself, if I was in a nursing home and I'm in a position now to think about it, I'm not ill, I'm not suffering from dementia, at the moment anyway, what would I be expected? What are the kinds of standards I would expect to find there? What would enhance my dignity as a human being? Or help me to maintain my dignity... and my independence? And that's the way I approached it, and the way others approached it too.

(Member of the Working Group, policy maker/analyst)

Thus, the focus on autonomy within the Standards may have been borne out of policy makers/analyst' desires to offset the prospect of a loss of autonomy in old age. This is reflective of a more general fear of the Fourth Age, which is often associated with both entry into residential care and a loss of autonomy:

The nursing home has become reflective of a totalizing infirmity pared of all other significance. It has become a new space - a new void - within society. It exists as an institution that, although less perceptible, remains every bit as terrifying as the workhouse and its infirmaries, while the universalization of this risk and the irreversibility of the process give the nursing home a significance it scarcely possessed some 25, let alone 50 years ago. It has helped create a new social imaginary, the fourth age, where choice, autonomy, self-expression, and pleasure collapse into a silent negativity.

(Gilleard & Higgs 2010*b*, p. 126)

According to Gilleard and Higgs, individuals may not even of the impact of their fears, either in terms of their own lives, or at a societal level:

These distortions in the mirror of the third age are more than the concerns of "third agers" finding themselves at the receiving end of services labeled as "geriatric medicine" or "are of the elderly"; they also act as a fundamental ontological challenge. The irreversibility of nursing home placement, the disappearance of any personal exchange in the processes of admission, and the "deprivatization of experience" that results from admission create an immense negative force upon both the third age that surrounds but remains imperceptive of it and the general attitude to old age.

(Gilleard & Higgs 2010*b*, p. 125)

It is thus possible to argue that Working Group members may not have even been aware of how their fears of the Fourth Age influenced how they approached their work, and how it shaped the Standards. Gilleard & Higgs (2010*a*) further suggest that what separates the Third and Fourth Ages is the presence, or absence, of agency. Thus, the retention of agency and self-control mean that those in danger of reaching the Fourth Age can transgress it.

As outlined above, the English Standards offered a model that focused on rights and empowerment by providing residents with information that enabled them to make informed choices about which care setting to select, an issue that was particularly appealing to many Working Group members:

Now the other thing that was very good, this is a very important standards, is the information that is to be made available to me or my family when you're going looking for a nursing home or whatever you want to call it, a residential care, em, place, that you get very good information, so that the person has a very good idea of what to expect when they go into a home, because you don't have to happen, that you find that, when you're in a home and the day you arrive there you realise that you're one of the most unhappiest people in the world now. That's awful.

(Member of the Working Group, policy maker/analyst)

As Bland (1999) suggests, the attractiveness of a hotel-style model of residential care is that it requires providers to allow residents greater control over their own lives, aspects which may have appealed to many members of the Working Group as a way of allowing them to retain agency and self-control:

I would like to see these units audited the same way that [the local] Hotel is audited. All services, I think they should stand up the same way that you would audit... I think that you should audit the bathroom in this facility in the same way that you would audit the bathroom in [hotel]. I think they should have people to greet you on the way in. If we went up to the hotel, someone would have sprung to their feet to greet us when we went in and looked after us. Why have they got institutionalised mugs? Why is there never a choice of tea?

(Member of the Working Group, policy maker/analyst)

However, while choice and autonomy are widely acknowledged as important for older people, they can become meaningless if provided in the wrong way or in the wrong context. As Gilleard & Higgs (1998) suggest, there is a danger that choice, if provided only in a consumer-driven sense, will be difficult for "Fourth Agers" to avail of. By definition, Fourth Agers are those with physical disabilities and/or cognitive impairment, and so, the need to exercise choice can inadvertently become a barrier to good care and to the promotion of individuals autonomy (Clarke 2006, Gilleard & Higgs 1998).

The frontline workers also recognised the importance of adopting a person-centred model of care which facilitated residents' autonomy and felt this would improve the quality of residential care overall. However, many questioned whether the promotion of choice as suggested by policy makers/analysts was appropriate to the cohort of older people living in residential care:

We don't have groups of people that we have a minibus that we go off to the Abbey Theatre once a week. That is not the sort of people living in nursing homes.

(Member of the Working Group, frontline worker)

However, it appeared that frontline workers agreed to accept some of the suggestions made by policy makers/analysts in order to protect their reputation and demonstrate that they were willing to provide high quality, person-centred care to residents:

Around those tables, everyone had their own interests and of course representation and representing different groups and coming at it from different angles, but I think where we were able to make the difference and I think we did make the difference and please God we did, was that we were on the ground, we knew what would work and what wouldn't work, but I would be as I say passionate about quality of life and em always striving to improve, improve, improve. You can't stay static, you know.

(Member of the Working Group, frontline worker)

Yet, the extent to which the Working Group were fully cognisant of the needs and wishes of older people living in residential care settings was unclear. Although many members represented older people and worked with residents directly, the extent to which they were consulting such individuals was unclear. This issue is discussed in the next section.

6.4.3 The Working Group and the Public Consultation Process

As noted in Chapter Five, conflict developed between members of the Working Group, particularly between public and private sector members and also between frontline staff and those with a policy-making/critiquing function. As well as contributing to the ambiguity in the Standards, this conflict also appeared to have distracted the Working Group from reflecting on the findings of the public consultation process.

Chapter Five suggested that each faction attempted to influence the content of the Standards by questioning the motives and undermining the reputation of other members of the Group. However, such accusations were often hurtful and shocking to Group members, particularly the Frontline Workers, who had committed voluntarily to joining the Group out of a sense of obligation to residents, rather than to promoting their own interests. For example, one Director of Nursing commented:

Well I suppose, a set of standards to me really would actually be realistic measures of the quality of care in nursing homes. What I hadn't expected was to have a collective group of individuals, who actually thought, with the exception of some people, that everything we did in nursing homes was wrong and every boat needed to be risen to a level. I hadn't anticipated that and that was quite tough because everybody you know felt that we were doing nothing right in our services, that all these services were not person-centred, we weren't giving people choice, we had no consideration of dignity and privacy...

(Member of the Working Group, frontline worker)

As a result, when their reputation was under threat, frontline workers began to defend themselves against such allegations by emphasising how they had the best interests of residents at heart. To further strengthen their position, frontline workers also argued that they had a greater ability to understand the needs of older residents because they worked with them directly on a daily basis. In this way, frontline workers positioned themselves as the legitimate voice of older residents on the Working Group:

I think the group that were there were coming from a very different context then maybe somebody like myself who is coming from (looks around to indicate is within a residential care setting).

(Member of the Working Group, frontline worker)

The policy makers and analysts retaliated by also positioning themselves as the legitimate voice of older people. As this "faction" included representatives from the national older people's interest groups, they were able to claim that they legitimately represented the voice of older people directly:

[On the Group] you got insights from people like myself who was I was there representing older people... And so I saw everything as a human value factor, something to advance the values of older people...

(Member of the Working Group, policy maker/analyst)

However, it was also clear from interviews with representatives from national voluntary advocacy organisations that such individuals often had limited knowledge and understanding of the residential care sector, ultimately leaving older residents significantly under-represented at the table:

I suppose not being responsible for managing residential care, ours might be a somewhat abstract view of what might be going on, so I was very keen to listen to the providers of residential care about the detail and there was a lot of detail, like about drug management, safety issues and so on and that was very interesting and informative and way out of my knowledge and expertise.

(Member of the Working Group, policy maker/analyst)

The persuasiveness of this “legitimate voice of older people” strategy led to it being adopted by both public and private sector members. Thus, after a while, almost every member of the Working Group were able to promote their own self-interests while claiming to be representing the interests of residents. For example, most respondents working in the public sector suggested that their calls for higher standards were legitimately in the best interests of older people:

I would say the vast majority had their heart in the right place but there would have been one or two who felt if you wanted to make... I mean the size of the room was so important to them because of how much it would cost them per square foot to build and all that, which are legitimate concerns, I’m not saying they’re not legitimate, but the care needs have to be there as well, so there’s that balance. And we want services to be better.

(Member of the Working Group, public sector)

For their part, private providers suggested that standards which were too high would increase costs for residents:

People are concerned about going into nursing homes and committing financially to a nursing home, if you are talking between forty and fifty thousand euros a year in Dublin and you can pay up to sixty thousand a year. That is beyond the scope of the vast, vast majority of people... It’s going to become a lot more expensive to look after people in a nursing home. Somebody is going to have to pay for it.

(Working Group member, private sector)

All factions achieved significant “wins” by adopting this strategy. However, the fact that all factions on the Working Group claimed to legitimately represent the public interest meant that the definition of residents’ interests became somewhat blurred. This in turn led HIQA to become concerned about whether decisions were being made on the basis of what was truly in the best

interests of residents. This placed HIQA in an awkward position. From the start of the process, HIQA had strived to ensure that the process was fully inclusive and that the views of all members of the Working Group were taken into account. Thus, rejecting Working Group members' suggestions would have undermined the collaborative process, which may in turn have tarnished the relationships the organisation was seeking to develop with regulated providers and other key stakeholders. However, HIQA's primary responsibility was to ensure that the Standards reflected the best interests of residents.

The public consultation process offered HIQA a solution to its dilemma. The regulator assumed that older people would opt for higher standards and so the findings from the process offered HIQA an opportunity to sidestep the conflict between Working Group members. However, the findings from the public consultation mitigated against this plan, as some of the suggestions made by older residents were unanticipated by HIQA. One important example related to the ratio of single to shared bedrooms within each residential care setting.

Many members on the Working Group representing the public sector had argued that all residents should be entitled to single bedrooms in order to protect their privacy. As there is a need for shared bedrooms for friends or couples and also for residents in need of 24 hour high intensity care, many advocated that 80% of bedrooms should be single, the ratio in the English Standards (Department of Health UK 2003). However, private providers felt that this would result in a significant loss of beds, as many beds were provided in shared rooms. They argued that this would have a significant negative impact on residents, as there would not be enough supply to meet demand. This issue was the source of much of the tension on the Working Group and was eventually overcome by lowering the ratio to 60% and imposing this rule only on settings which opened after the Standards were published. It seemed that HIQA may have hoped to increase this rate again at a later stage as it had concerns that shared rooms were not in the best interests of residents:

Yeah, well, one of the things that came up, and there was huge amount of debate around it, the number of single rooms versus the number of shared rooms. And the public sector I guess wanted more single rooms, the private sector were a little bit iffy around that in some ways. But it was differing opinions. And say we had set it at, I don't know, 60%. And it was interesting, HIQA were probably on the public sector side. You could see that they had that same fellow feeling...

(Member of the Working Group, public sector)

However, the public consultation process found that residents expressed a preference for shared rooms rather than having their own bedroom (HCI 2007). This was a surprise for members of the Group and many struggled to find an explanation for the unexpected finding:

It was interesting, the focus group people went out and said everyone they had spoken to had said that they like to have shared rooms. Now I think that's, that's a kind of eh, that will change with time. That I won't want to share a room whereas, maybe my grandfather (laughs) or my father might have wanted to share a room because they might have shared rooms as kids, as teenagers or whatever.

(Member of the Working Group, public sector)

However, as a general cohort, older adults overwhelmingly prefer private rooms over shared rooms in residential settings, even those who thought they would prefer a shared room (Calkins & Cassella 2007). Furthermore, research has found that residents who are moved from shared rooms to single rooms were completely satisfied with their private room eight months after the move, including those who initially expected not to like having a private room (Calkins & Cassella 2007).

This finding from the public consultation process meant that HIQA was again faced with a difficult choice, namely whether to respect the wishes of older people and endorse the suggestion of a lower ratio of single rooms, or to ignore older people's choices and make a decision based on what they believed would benefit their clients the most. Ultimately, HIQA opted for the latter and made a unilateral decision about the ratio of single to shared rooms within residential care settings in the belief that they would be protecting the best interests of residents by so doing:

I can remember robust discussions about things like, "sure they'll like the company of a ward". You know? "They'll be lonely". *They?* Residents might well be lonely, but then I would come back to the empty chair in the room and say well that may well be, but if we are building premises for the next thirty or forty years, would you like to be in a ward with 30 others, or 5 others even? Or would you like a room of your own? Or would you like a choice?

(HIQA Staff Member on the Working Group)

Few Working Group members had any misgivings about this decision, even those who effectively lost out as a result. Indeed, it appears that the Working

Group admired HIQA's ability to take charge of the process and make unilateral decisions as the organisation was able to demonstrate that it was doing so in the best interests of residents:

Eventually, HIQA just got fed up of the lot of us and said, right, HIQA is deciding on [the room ratios], we'll let you know what we decide. And they were right.

(Member of the Working Group, private sector)

Perhaps this praise encouraged HIQA to make more unilateral decisions. Furthermore, it appeared that HIQA had also grown mistrustful of incorporating the findings from the public consultation process into the final draft of the Standards, as many of the submissions made were representing private providers, rather than residents *per se*:

The feedback was advice. You would look very carefully at it but you are also aware that some consultation processes are just like those lobbying things, where you give people postcards, get 150 people to write in... It all came from one organisation. You can't create a document with the aim of getting everyone to agree, because then it becomes the lowest common denominator. Or the loudest ones.

(HIQA Staff member on the Working Group)

However, members of the Working Group expressed doubts that the public consultation process was an attempt to incorporate the views of residents:

On paper the public consultation process was brilliant. But I don't think that there was ever any intention that that was going to change the standards and certainly we were told when the draft was finished before we went out for the public consultation that it was very unlikely that we were going to see significant changes and this was before the public consultation happened. So, you know, to a certain extent I wonder was the public consultation a political thing? I don't think it actually changed anything as it did in the standards, if it did it was tokenism.

(Member of the Working Group, public sector)

This perhaps gives further grounds to suggest that, while HIQA wanted the process to be inclusive and based on consensus, it also had its own views about what it wanted to be in the Standards. However, the fact that the organisation still demonstrated that its own preferences for the content of the Standards

were based on the needs of residents was what helped to garner support from Working Group members.

HIQA staff admitted that they had been somewhat naive about the use of a collaborative process and changed the way they worked when they wrote minimum standards for other sectors subsequently:

Oh, it was a huge learning process. The next time we had clearer terms of reference. We ourselves first developed kind of draft standards, circulating that in advance to people, asking them to look at it, coming back. So the learning was, we needed to take control of the process, but do it in a way that people had the time and opportunity to really think about what they wanted to say. But they were very clear what their role was and service users were essential to it.

(HIQA Staff member on the Working Group)

This may suggest that the wishes of residents were not taken into account to a greater extent because of the difficulty faced by HIQA in balancing the public interest with the self-interests of other stakeholders.

6.5 Conclusion

This chapter has provided more evidence to show that the regulatory negotiated process is dominated by private interest groups who tend to promote their own interests. This has been an outcome of a significant amount of empirical research on the process to date (Furlong & Kerwin 2004, Golden 1998, Wagner et al. 2011, Yackee 2006). In order to promote their own-self interests, individual members claimed that their suggestion would protect the interests of older people. Ironically, this led to the voice of older residents being silenced within the process, as each group claimed that their own self-interests also represent the views of the public.

This ultimately casts doubt on the ability of the regulatory negotiated process to empower the intended beneficiaries of the rules to the same extent as regulated firms (Seidenfeld 2000), at least within the residential care sector. Several studies have highlighted the difficulties older people face in having their voices heard, both within residential care settings (Abbott, Fisk & Forward 2000, O'Dwyer & Timonen 2010, Scourfield 2007b) and at a policy level (Barnes 2005). However, the failure to listen to residents' views appeared

to stem not just from financial concerns, but more deep-rooted beliefs about ageing.

Within the Standards, it is possible to see a dichotomous portrayal of residents as either passive or active, a reflection of changing perceptions of old age (Jones & Higgs 2010). In addition, the document contains elements of two competing models of person-centred care, a psycho-social model and a consumer-driven model. The tension between the two models appears to have stemmed from a lack of understanding of some Working Group members about how to conceptualise “person-centred care” and how to protect the well-being of older people living in residential care. The difficulty experienced by Working Group members in conceptualising person-centred care is not new; many scholars have suggested that the term has taken on different meanings and can be difficult to implement (Brooker 2004, Epp 2003, Lepledge, Gzil, Cammelli, Lefevre, Pachoud & Ville 2007). However, it also appeared that the emphasis on this approach seemed to have stemmed in part from some members’ fears of “the Fourth Age” and residential care as a place that strips individuality and autonomy (Blaikie 1999, Gilleard & Higgs 1998) and from a consumer culture which places emphasis on health, youth and self-care (Gilleard & Higgs 1998, Jones & Higgs 2010).

The tensions created a dilemma for HIQA, which wanted to maintain positive working relationships with all of the members of the Working Group, while also ensuring that the Standards would benefit residents’ well-being. Although in this instance HIQA ultimately decided to prioritise the needs of residents over the self-interests of Working Group members, it is noteworthy that this process did not lead to a deterioration in the relationship between HIQA and the Working Group members. Indeed, by allowing the different interest groups into the decision-making process, HIQA staff were demonstrating that they had arrived at decisions in a fair and transparent manner, one of the main benefits of the regulatory negotiated process (Coglianese et al. 2009). This suggests that the independence of the regulator is an important aspect of protecting the public interest, an issue that is further explored in the next chapter.

Findings III: Ownership of the Regulatory Process

7.1 Introduction

One of the secondary aims of the thesis was to compare the Standards and the 2009 Care and Welfare Regulations in order to ensure that the operations of the Working Group could be defined as a true regulatory negotiated process. This comparison became more important because of the ambiguity with regard to whether or not it is mandatory for providers to meet the Standards or whether they simply serve as guidelines to improve the sector over time. This issue is important both in terms of its implications for the regulation of the residential care sector in Ireland and also in illustrating the involvement of relevant stakeholders' contributions to the development of the regulatory process. However, as outlined below, a comparative analysis revealed significant differences between the Standards and the Regulations. These differences raise questions about the respective roles of the Department of Health and Children and HIQA within the regulatory process. The chapter first assesses in Section 7.2 the role of the Minister for Health and her Department in endorsing HIQA's Standards. Section 7.3 then compares the Standards and the Regulations, highlighting the differences between the two documents. Section 7.4 then examines the factors that appeared to contribute to these differences.

7.2 Endorsement of the Standards

The 2007 Health Act (Government of Ireland 2007) gave HIQA the power to set standards on safety and quality that it considered appropriate in residential

care settings for older people. In this way, the legislation enshrined HIQA's autonomous decision-making powers, highlighting the commitment by the government to respect HIQA's independence. However, under the 2007 Act, the Standards cannot be published without the approval of the Minister for Health and Children.

Although HIQA launched the National Quality Standards in March 2008, this version, although agreed by HIQA and the Working Group, had not yet been formally approved by the Minister. As a result, the Department of Health and Children re-launched an approved version of the Standards almost a year later, in March 2009. Indeed, interviews suggested that there was some disquiet within the DOHC that HIQA had decided to formally launch the Standards in 2008 without them having been formally approved by the Minister, perhaps signalling some tension between HIQA and the Department about the relative functions of each organisation within the regulatory regime:

But then what they did was, which was a bit peculiar, HIQA launched them, but no-one from the Department of Health was invited to attend, so then the Minister re-launched them herself again.

(Working Group member, public sector)

A comparison of the penultimate version of the Standards published by HIQA in March 2008 and the final draft approved by the Minister for Health in February 2009 reveals very few differences between the two documents, as outlined in Table 7.1. This would appear to suggest that the Department regarded the Standards as achievable and necessary, even though, as noted in Chapters Five and Six, some of the Standards had significant cost implications for public settings.

By formally and publicly endorsing the Standards, the Minister and her Department were signalling their respect for HIQA's autonomy and independence within the regulatory process, thus highlighting their desire for the regulatory process to be effective (Stern 1997). In a sense, this case may signal a new respect for regulatory independence than has heretofore been the case in Ireland, as outlined in Chapter Three (Brown & Scott 2010, Nolan 2008, OECD 2001).

Furthermore, as Poortinga & Pidgeon (2003) note, public trust in the regulator is an important element in determining the effectiveness of a regulatory system. The Department's endorsement of the Standards demonstrated HIQA's

competence at developing Standards and may have encouraged the public to trust in HIQA's ability to protect their interests. Indeed, at the launch of the Standards, the Minister highlighted her belief that HIQA's forthcoming inspection process would benefit older people:

An effective, robust, independent and transparent inspection regime for residential services for older people is an absolute necessity. Our older population who can no longer live in the community because of their high levels of dependency and complex care needs deserve the reassurance that the care they will be given and the environment they will live in, will meet high standards.

(DOHC 2009b)

However, while the Minister and her Department clearly demonstrated their respect for HIQA's independence under the 2007 Health Act, minimum standards usually do not have any legal status. In order to make it mandatory for regulated firms to comply with the minimum standards, it is necessary for them to be underpinned by legislation (Christensen & Laegreid 2007). As outlined earlier, the 2007 Act gave the Minister for Health the power to write regulations underpinning the Standards, thus giving the Minister another opportunity to alter the power dynamics between the HIQA and the government, as outlined below.

Table 7.1: Changes Made to the Standards following Ministerial Approval

Standard / Criterion	Draft Standards (pre- public consultation) (HIQA 2008)	Final Version (post-public consultation) (HIQA 2009e)
Standard 6	The complaints of each resident, his/her family, friends, and/or representative, are listened to and acted upon and there is an effective appeals procedure.	The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.
Standard 19	Each resident receives a nutritious and varied diet in pleasant surroundings at times convenient to him/her.	Each resident receives a nutritious and varied diet in pleasant surroundings at times convenient to them .
Standard 25	The location and layout of the residential care setting is suitable for its stated purpose. It is accessible, safe, hygienic, spacious, well-maintained and meets residents' individual and collective needs in a comfortable and homely way.	The location, design and layout of the residential care setting are suitable for its stated purpose. It is accessible, safe, hygienic, spacious and well-maintained and meets residents' individual and collective needs in a homely way.
Criterion 1.1	There is a residents' brochure clearly written and made available in an accessible format to each resident and each prospective resident.	There is a guide for residents clearly written and made available in an accessible format to each resident and each prospective resident.
Criterion 3.2	The residential care setting has a policy that outlines the procedure for seeking consent from the resident prior to any treatment or intervention, or in the case of an emergency, in accordance with best practice.	The residential care setting has a policy that outlines the procedure for seeking consent from the resident prior to any treatment or care-giving or, in the case of emergency, in accordance with best practice.
Criterion 9.1	The residential care setting has a clear policy and procedures on the management of residents' accounts and personal property.	The residential care setting has a clear policy and procedures on the management of residents' accounts and personal property in accordance with national guidelines .

7.3 Comparison of the Standards and Regulations

7.3.1 Introduction

Section 98 of the 2007 Health Act gave the Minister for Health and Children the power to make regulations for (inter alia) “the purpose of giving effect to the Act” (Section 98(2)(c)) and for ensuring proper standards in relation to designated centres (Section 101(1)). This appears to indicate that the 2009 Care and Welfare Regulations (Government of Ireland 2009) were written to give legal effect to HIQA’s Standards.

7.3.2 Comparative Analysis

A comparative analysis of the Standards (HIQA 2009e) and the 2009 Care and Welfare Regulations (Government of Ireland 2009) highlights a significant number of differences between the two documents. Just 42% of the Standards document (154 of the 32 Standards and 330 criteria) is reflected within the Regulations. Fourteen of the 32 “headline” Standards are not referenced at all within the Regulations. The supplementary criteria for Dementia-Specific Residential Care Units for Older People are not referred to at all. Table 7.2 summarises the main issues from the Standards which are not mentioned within the 2009 Regulations.

Furthermore, a total of 82 of the 338 criteria within the Regulations are not derived at all from the Standards, many of which arguably enhance the care that residents will receive within residential care settings. There are also some instances where the Regulations contradict or diverge from the Standards.

There is little difference between the Standards and Regulations on the portrayal of residents and of residential care settings; residents are still broadly treated as “consumers” and there is also little recognition of the need for care workers to be able to facilitate the needs of residents. However, overall, the Regulations are more strongly focused on measurable, objective “bed and board” issues. There is also a reduced focus on health promotion and well-being of residents, social contact and resident consent. Although there was a significant emphasis within the Standards on the need for residential care settings to have policies and procedures documented, this emphasis is even stronger wi-

Table 7.2: Standards and Criteria Absent from the 2009 Regulations

1. Policy on Emergency Admission.
2. Policy on Rehabilitation.
3. Policy on Whistleblowing.
4. Residents handle financial affairs for as long as they wish.
5. Risk and health assessment carried out on residents upon entry to the setting, and at three monthly intervals.
6. Encouragement of links with the community.
7. Facilities in place to prevent the unnecessary transfer of residents at the end of their lives to acute care.
8. Remembrance service following the death of a resident.
9. The person in charge has a minimum of two years management experience.
10. The person in charge has a post-registration qualification in nursing of the older person.
11. The person in charge has three years experience in a management capacity and a post-registration qualification in healthcare management or equivalent.
12. The number and skill mix of staff on duty is determined and provided according to a transparently applied, nationally validated, assessment tool.
13. The staffing calculations do not take into account individuals working in a supernumery capacity i.e. individuals there for educational purposes alone.
14. All nursing staff are, where possible, facilitated to undertake a relevant post-registration qualification in the nursing and care of older people.
15. All newly recruited care staff and those in post less than one year commence training to FETAC Level 5 or equivalent within two years of taking up employment.
16. Each resident has a lockable storage space.
17. Call systems with an accessible alarm facility are provided in every room normally used by residents and for every bed with due regard to the resident's safety.
18. The existing residential care setting has a separate dedicated room(s) with facilities in place for clinical examinations and therapy.
19. The existing residential care setting has separate cleaning rooms appropriate to the size of the residential care setting.
20. The existing residential care setting provides a minimum of 9.3 m usable floor space (excluding en-suite facilities) in all single rooms.
21. The person in charge ensures that the prospective resident and/or his/her family or representative is invited to visit the residential care setting before he/she makes a decision to stay.
22. The newly built residential care setting, new extension or first time registration has a minimum of 80% of residents accommodated in single rooms.
23. The daily menu is displayed in a suitable format and in an appropriate location so that the resident or his/her representative knows what is available at each mealtime.

thin the Regulations. In particular, there is a greater emphasis on procedures with regard to risk avoidance and risk management, such as when residents are missing from the residential care setting and procedures in the case of a fire or other incidents. The emphasis on the “homeliness” of the physical setting mentioned within the Standards has also been removed. In addition, much of the detail in the Physical Environment Standard has been removed, with the Regulations instead only stipulating that the physical layout should meet the needs of each resident.

Many of the costly issues which led to significant debate on the Working Group are not mentioned within the Regulations. For example, many of the training requirements for staff listed in the Standards are not referenced within the Regulations. In addition, the Regulations do not specify bedroom sizes or the ratio of single to shared rooms. Instead, they state that the maximum number of residents to be accommodated in shared rooms in the designated centre should not exceed the number for which the designated centre is registered by the Chief Inspector of HIQA.

7.3.3 Regulatory Framework

As noted in Chapter Five, Section 41(1)(c) of the 2007 Health Act clearly states that providers must comply with the Standards set by HIQA, as well as the regulations set by the Minister in order to be allowed to register and operate a residential care setting in Ireland. As such, providers must comply with the Standards as well as the additional requirements set out in the Regulations.

However, it is arguably difficult for providers to meet the requirements set out in both documents when the contradictions between the two are considered. The differences between the two documents are also confusing in light of the fact that the original intention was for the Regulations simply to give legal effect to the Standards. Minutes of the Working Group meetings suggest that a civil servant informed the Group that “the regulations will be ‘high level’, stating the expectations [of providers] in broad terms and that the detail would be contained in the Standards. This means that the Department of Health and Children appeared to have decided to alter the original intention of the Regulations subsequent to the publication of HIQA’s Standards (HIQA 2008).

Indeed, the Department seemed to have had two different ways of interpreting the purpose of the Standards, one “public” interpretation and one slightly more hidden interpretation. When the regulations were passed into law, press

releases issued by both HIQA and the Department of Health and Children implied that the purpose of the regulations was simply to make it mandatory for providers to comply with the Standards, in line with the original intention of the regulations:

These Regulations give effect to the [new National Quality Standards for Residential Care Settings for Older People in Ireland] to allow independent registration and inspections by the Chief Inspector of all nursing homes (public, private and voluntary) to commence today... Today is a significant day for older people, particularly for each and every resident in a nursing home - we have set a bar for service providers with Standards and Regulations that will drive quality care.

(DOHC 2009b)

Nursing homes will be inspected against the *National Quality Standards for Residential Care Settings for Older People in Ireland* and regulated under the Health Act 2007 to see if they are safe and whether the residents are cared for properly.

(HIQA 2009d)

However, findings from additional documentary sources and interviews with Department officials suggests that the Department interpreted the Act, and the purpose of the Regulations, somewhat differently in practice. According to guidance documents produced for providers of residential care settings, the purpose of the regulations was to set the absolute minimum, legally required standards. Thus, Standards (and criteria) not covered within the Regulations have now simply become guidance for providers.

Regulations differ from the Standards in that they are based on primary legislation and are designed to give effect to it; i.e. a regulation sets out the detail of what the legislation intends. If the provider is not in compliance with the regulations, registration may be refused or he/she may lose the registration status. In the case of those standards which are not regulatory standards, nor linked to regulations, failure to comply will not lead to refusal to be registered or loss of registration, but they are designed to encourage continuous improvement.

(HIQA 2009a)

Indeed, an examination of inspection reports on HIQA's website indicate that providers are encouraged (rather than mandated) to adhere to the standards

and criteria not outlined in the Regulations. Interviews with some of the private providers (both Working Group members and non-members) indicate that they no longer regard the Standards as playing a significant role within the inspection process:

Well the whole Standards I think would be very difficult to meet. I think we could all work towards that [in the long term]. [In the Working Group], there was a feeling that these would be your kind of workbook. That you would be working on this. There is areas in them that they will be able to enforce. But I think there has been a bit of a change, on HIQA's behalf, that it is not the Standards now, it is the regulations. And that mightn't be a bad thing to be honest with you. I think the way the regulations are more em, it's easier to ... Not to get to that Standard, but it's easier for them to regulate against those than against the Standards.

(Member of the Working Group, private sector)

So now, we have the Act and the schedules and the articles and the Standards. So, em. Most of what we are now putting our efforts into is ticking the boxes of the regulations. Now the Standards are still there and we are still doing it and all that. But if you look at the reports that are up, it is the regulations they are following, not the Standards.

(Member of the Working Group, private sector)

It appears therefore, that the Department of Health and Children may have subtly re-interpreted the purpose of the Regulations following the publication of the Standards. Although providers are still legally obliged to meet HIQA's Standards under the terms of the 2007 Health Act, it appears that they are being told that they only have to comply with the Standards. This had the effect of weakening the Standards. As noted in Chapter Two, almost the exact same process had occurred in England, following the publication of the original English minimum standards, leading Drakeford (2006) to suggest that the standards had been "diluted" by the Secretary of State for Health in England.

The subtle re-interpretation of the Standards raises a number of questions. In particular, it is unclear why the Department decided not to simply write regulations which underpinned the Standards, which had been developed and agreed by a wide range of stakeholders in the sector. Furthermore, it is unclear why neither HIQA nor any member of the Working Group raised any objection to the Department's actions, given that the Group spent a year deliberating about the content of the Standards. These issues are explored in the next section.

7.4 Explaining the Differences between the Standards and the Regulations

7.4.1 Introduction

It is clear that the decision to re-interpret the purpose of the Standards was a decision taken solely by the Department of Health and Children. However, as outlined below, a variety of factors appeared to have influenced this decision and allowed it to occur.

7.4.2 Costs of Compliance

An interview with Department of Health and Children officials denied that the Department had re-interpreted the purpose of the Act. They suggested that the purpose of the Regulations was not to endorse the Standards, but to set the minimum standard providers must meet:

I suppose the reason is that [the Regulations] set out the minimum that you would require, the absolute barest minimum required to keep people safe. So if you are breaching the Regulations, it means you are putting people in danger and there is a need for action immediately... If you are in breach of the Regulations you are shut down full stop... Whereas with the standards, it is also about driving quality forward, so it is set at a higher level than the Regulations.

(DOHC staff member, not on Working Group)

However, the terms of the 2007 Health Act do not back up this claim. Instead, the quote above hints that the re-interpretation may have been for financial reasons. This mirrors previous actions taken by the Department of Health and Children. As outlined in Chapter Three, Department and Health Board officials misinterpreted the 1970 Health Act and illegally stole money from older people who were living in public residential care settings.

As noted in Chapter One, prior to approving any new regulations, the Minister for Health and civil servants within the Department of Health and Children had to carry out a Regulatory Impact Assessment (RIA) under the terms of the 2004 White Paper *Regulating Better* (Department of the Taoiseach 2004). An RIA is the systematic weighing of alternatives and broad consultation processes to allow the desirability of regulatory decisions to be assessed and provide the discipline of visibility (OECD 1997).

As part of the RIA, the Department of Health and Children commissioned a private sector research company, PA Consulting, to estimate the costs of implementing the Standards (PA Consulting 2009). PA Consulting suggested that the cost involved in private sector residential care settings meeting the Standards was relatively low (less than €4 million in total). As noted in Chapter Five, this low cost was largely due to the fact that private sector representatives on the Working Group had fought successfully for new costly Standards on the physical environment to apply only to new residential care settings. Existing homes were only obliged to comply with existing legislation (the 1993 Care and Welfare Regulations). These regulations had already applied to private and voluntary homes, but not to public settings. As many public residential care beds are provided within former workhouses, they do not even meet these 1993 regulations. Thus, PA Consulting estimated that the cost of ensuring that all public sector residential care settings complied with the physical environment Standards would reach approximately €1.2bn, plus minor extra costs for staff training.

As noted in Chapter Three, although the Working Group wrote their Standards during Ireland's Celtic Tiger, the economic climate in Ireland had declined rapidly soon after the document was completed. As a result, there were significant concerns over the public finances and funding was being cut throughout all public health services (Burke 2010). In this context, the investment of €1.2 billion for public residential care settings may have proved challenging. However, if funding was not given, the government may have faced the prospect that its own State-run homes would not meet the Standards and may thus be forced to close down.

Notes from a meeting with a civil servant from the Department of Health and Children appeared to back up the argument that the difference between the regulations and the Standards were the financial costs associated with the Standards:

The DOHC's first draft of the Standards was more sensitive to the fact that there were financial constraints associated with higher standards. Within the Department, you are more aware that money is an issue; the Secretary General is even more aware of the money! But it is not surprising that HIQA was not as concerned with money; their job was to try and get the standards to be as high as possible and not worry about where the funding came from.

(Notes from interview with DOHC staff member, not on Working Group)

What these findings suggest is that the Department of Health and Children appeared publicly to be supportive of HIQA, while in practice failing to endorse the decisions made by the organisation. Although the Minister had the power to openly and publicly reject the Standards developed by the Working Group, she instead chose to approve the Standards, but at the same time to deliberately misinterpret the definition and purpose of regulations to give effect to the 2007 Health Act in order to avoid having to channel funding into residential care that the public purse could ill-afford. This finding is consistent with the idea that governments continue to remain in control of the regulator behind the scenes (Thatcher 2005) and is also reflective of the suggestion raised in Chapter Three that governments in Ireland are skilled at appearing to act in the best interests of others while in practice following its own cautious, incremental, middle-ground policies (Weeks 2009).

It is important to note that the Department of Health and Children had been represented on the Working Group and therefore had had an opportunity to voice any concerns about the cost implications of the Standards. Although two senior staff members of the HSE who had responsibility for the implementation of care policies for older people were asked to attend the group, both instead sent a more junior staff member on their behalf who did not have the same responsibility to consider how the Standards would be funded through the HSE's budget. Neither of these individuals saw it as their responsibility to consider the cost implications of the Standards, as illustrated by the following quote:

My manager was initially asked to sit on the Working Group but he felt that it was people on the ground that should be on it and not himself. So he asked me to go on the Group, so I was effectively representing him and the HSE. But it was difficult... On many different occasions, there was a HSE hat that I was wearing, and similarly, I was one of the public providers [on the ground]. [...] My view was that if you are in it for the money, it's not going to work. If you want to deliver on a quality service to a reasonably high standard, it costs money.

(Member of the Working Group, public sector)

Thus, none of the members of the Working Group representing the public sector had direct responsibility for allocating public funding to residential care settings. Indeed, as previously outlined, many worked directly in providing residential care, some in settings which were run down and inadequate. They thus appeared to see the Standards as an opportunity to coerce the government to provide them with additional funding.

Furthermore, as noted in Chapter Three, in spite of recent reforms of the healthcare system, there remained ambiguity about whether the DOHC or HSE retained responsibility for budgetary issues. Thus, while civil servants from the DOHC were on HIQA's Working Group, they were of the view that the HSE representatives on the Group, rather than the Department itself, were responsible for calculating the affordability of the Standards within the sector:

So would you have been given a remit from within the Department about costing the standards?

No. The HSE has that responsibility. They determine what the service priorities are and they do it through a national service plan and capital plan which has to be approved by the Minister, but the purse strings would be with the HSE. Now we knew that certain em facilities would be old, a lot of... Very old, like 150 years old or so. But the HSE has its own funding and they determine em what's the priorities.

(DOHC staff member, not on Working Group)

Thus, the dilemma faced by the Department of Health and Children was arguably one of its own making; by failing to address the issue of whether it or the HSE was accountable for funding, it may have been forced to renege on its promise to improve the quality of residential care. However, it is important to treat the argument that the Department of Health and Children altered the purpose of the regulations for economic reasons with caution, as this was denied by the Department itself.

7.4.3 Clientelism

As outlined in Chapter Three, Irish politicians have a history of making decisions that benefit private interest groups but that mitigate against the public interest. This has been described as a consequence of the clientelist system that operates in Ireland and that results in politicians giving favours to powerful private interest groups in exchange for votes in general and local elections (Collins & O'Shea 2003). It is possible that clientelism also played a role in the failure by the government to endorse the Standards.

As outlined earlier, private sector representatives on the Working Group won a lot of arguments about the content of the Standards. In particular, as noted above, they managed to ensure that existing private residential care settings were given an exemption from meeting costly new standards which new entrants to the sector would have to meet. However, private providers continued

to have a number of reservations about the impact of the Standards on their businesses, particularly for existing residential care settings:

To be honest with you, I think, going forward, the market will decide. People will decide where they want to go based on the facilities on offer. So, even if I am allowed to have double rooms under the Standards, if the home down the road has single rooms... I mean people will want single rooms, so people will go for a place where there is a single room, so I will still lose out.

(Member of the Working Group, private sector)

Private providers thus arranged to meet the Minister for Health and Children in order to outline their concerns. Interview data suggest that private providers had some success at these meetings and managed to ensure that the Regulations did not include details on staffing ratios and the physical environment:

We did see a draft late on and we did make some suggestions and to be fair the Department took some of our suggestions on board yeah.

(Member of the Working Group, private sector)

This may suggest that the government was continuing its trend of showing favouritism to the private sector (Dellepiane & Hardiman 2011, Murphy 2010), perhaps in return for political favours at a later date.

7.4.4 The Role of HIQA

From the start, HIQA had made every effort to build its reputation as a competent regulator that would listen to all of the stakeholders but that would ultimately act in the best interests of residents and would not be swayed by private interests. The fact that HIQA did not raise objections to the Department's decisions in relation to the content of the Regulations is therefore somewhat puzzling. However, it is possible that HIQA's decision not to highlight the weakening of its own Standards was to protect its own interests.

In order to be able to persuade regulated firms to comply with the regulations, regulators need to be considered competent (Braithwaite et al. 1994, Walls, Pidgeon, Weyman & Horlick-Jones 2004). As a newly established regulator, the publication of the Standards was an important development for HIQA, as it was the organisation's first output related to its regulatory function. Indeed, there is evidence that HIQA was aware of the need to build up its reputation:

Well in a sense I think the organisation has its own reputation now. It hadn't at that point.

Which is what?

Well again, I can only say what I think it is. I think people see it as an organisation that gets things done, that had pushed for change, that an environment where... There is a sense out there in a lot of health based organisations that HIQA is a dynamic organisation, that it said it was going to do this in this timeframe and it has done it. So we have delivered in the social care area as the cuts were coming down, we got people in, got them trained up, we have them around the country. We have difficulties, but... I think people see it as a dynamic organisation.

(HIQA Staff member on the Working Group)

Admitting that much of the document was simply guidance, rather than mandatory, would effectively have been an admission that HIQA had written Standards which, although laudable, were not implementable. This may have brought into question HIQA's competence at developing Standards, thus undermining its reputation. While this was denied in interviews with HIQA staff, this explanation may help to explain why HIQA stated in its July 2009 press release (HIQA 2009*d*) that the Regulations gave effect to the Standards which had received a positive media response in 2008 (Irish Examiner 2008, O'Brien 2008, Taylor 2008).

Furthermore, according to Parker (2006), regulators require the support of government in order to impose sanctions on a regulated firm in order to compel them to comply with the rules. According to Parker, big businesses that perceive regulatory enforcement as illegitimate are likely to actively lobby the government for the political emasculation of the regulator. Even where the regulator is meant to be independent, the government can cut funding or impose other "soft" sanctions on the regulator in order to show support to big businesses that it may rely on for political support. Indeed, comments made by civil servants indicate that there was at least some anxiety to ensure that, while HIQA would remain independent, it would recognise and respect the authority of the Minister for Health:

HIQA should never have published their final draft in 2008; they were not accepted by the Minister. The 2009 version is the final one. They should have waited until they got Ministerial approval.

(DOHC staff member, not on Working Group)

HIQA have their job to do but ultimately, the authority rests with the Minister in the Act.

(DOHC staff member, not on Working Group)

Thus, regulators often find that it is preferable not to challenge governments directly, so as to retain their power, albeit limited in practice.

Interviews with HIQA staff hint that they regret the Department's decision not to make the Standards mandatory:

It would have been more helpful if regulations had been available earlier. Eh the normal way to develop these things is legislation, regulations and the standards. It was the cart driving the horse when we were asked to develop the Standards first and through that process the Department were able to test the waters to see what would rise or sink as it was. And indeed, private sector groups made separate representations to the Minister following the draft standards... So these things get worked out and obviously part of the Department's role, they have to do an RIA, so they have to cost it. And cost was the big issue, and by then we didn't have any money anymore!

(HIQA Staff member on the Working Group)

It is possible to argue that, with its decision not to underpin the Standards with regulations, the Department was giving a subtle message to providers that the regulatory system was being weakened before it had even begun. This suggests that the Department was effectively undermining HIQA's independence from the start of the process. As the government is responsible for providing funds for public residential care settings, it would have been responsible for sourcing the €1.2 billion to ensure all of its settings met the Standards. As this money was unlikely to have been made available, it is possible that the Department simply interpreted the rules in order to suit its own interests.

Indeed, comments made by HIQA staff suggest that they subsequently became more aware of the challenges they face in regulating the sector, particularly public homes, in the more constrained economic climate. Because of the financial cuts within the healthcare sector in Ireland, there are concerns that public homes will still not meet even the basic physical environment requirements set out in the 2009 Care and Welfare Regulations. It appears HIQA may now be willing to bend its rules in order to avoid further confrontation with the government. HIQA is aware that this will in turn create the potential for tensions with private sector providers:

We have to be very fair. The law applies to all homes, we can't be giving ... If we go to a private home that doesn't meet the standards, it's not

fair. The HSE knows the physical stock it has and they have improved some of it. Some of it is never going to be acceptable. Their problem is to figure out how to deal with it. What we don't want to do is to go along, find they haven't thought about it and it's so appalling that we have to do something to get them thinking. What we are saying really is, think about this and have your plan and if we go along and when we go along and if your plan sounds reasonable, then we can work with it. But if there is no plan, we can't work with no plan, but we don't want to be putting a gun to people's heads.

(HIQA Staff member on the Working Group)

This may suggest that the regulatory system for residential care for older people has effectively been weakened due to the challenges facing the government. This supports research which shows that the independence of regulators can easily be compromised by governments (Bertolotti et al. 2011, Edwards & Waverman 2006, Gilardi 2008), and thus further highlights the need for oversight of the regulatory process. Thus, while the Working Group was not formally given the role of acting as a watchdog to ensure HIQA wrote the Standards in the public interest, it is possible to explore whether they had an opportunity to carry out this function.

7.4.5 The Role of the Working Group

While regulatory negotiation was initially designed with the intention of increasing compliance with rules (Harter 1982), it also has the potential to ensure rules are written in the public interest (Seidenfeld 2000). As the prospect that the regulator may be captured by the government or the regulated industry is a significant threat, having relevant stakeholders oversee the design of the regulations may help to ensure that the rules are written in the public interest. Thus, although the Working Group were not formally given an oversight function, and was not directly involved in writing the Regulations underpinning the Standards, members were arguably in a good position to query the government's decision to water down the Standards. Thus, it is noteworthy that none of the Working Group members drew attention to the discrepancies between the two documents. This is particularly the case when, as outlined in Chapter Five, many Working Group members already had a low opinion of the Department of Health. However, it is possible that HIQA's very trustworthiness was a factor in the failure by Working Group to raise objections to the Department's decision to water down the Standards.

While there had been vociferous opposition to the Department of Health and Children's exclusion of relevant stakeholders onto its Working Group to develop its draft set of Standards in 2006, HIQA indicated from the start that it was committed to inclusivity, transparency and protecting the best interests of older residents. When the issue of important stakeholders being missing was raised at the first meeting, HIQA immediately agreed to issue invitations to additional organisations to send a representative onto the Working Group. In so doing, the organisation was able to openly demonstrate that it was determined to have as consultative a process as possible. This provided reassurance to Working Group members about the organisation's ability to carry out its work in the public interest:

Once HIQA took over, I really had a lot of confidence in the process because I actually think they are probably about the most professional public body I have seen in Irish public life thus far. HIQA were inclusive, and they asked for representatives. This is really, really atypical in Irish life. So overall, I think HIQA did a very good job really.

(Member of the Working Group, private sector)

Although there was mistrust on the Working Group, this was largely reserved for other members rather than for HIQA, as outlined in Chapters Five and Six. In fact, Working Group members came to rely on HIQA's role as the "honest broker" to withstand pressure from individual members of the Group who were trying to promote their own vested interests:

I think HIQA just got fed up of the lot of us, and said, right, HIQA's board are deciding on this, we'll let you know what they decide. And they were right. And I think in future, if they are putting new standards together, they should have a very small Working Group, not 30 or 40 people, and just get on with it.

(Member of the Working Group, private sector)

Thus, HIQA's ability to demonstrate that it prioritised the needs of residents meant that no-one saw any reason to doubt the organisation when it stated that nursing homes would be inspected against the Standards as meaning anything other than the Regulations gave legal effect to the Standards. As a result, there was no disquiet amongst the Working Group members that the Standards they had spent a year developing had effectively been sidelined by the Regulations:

And then just em... Just about the Regulations underpinning the standards, I don't know if you have looked at them?

Well I suppose you need to make everything enforceable. And I think on reflection, when we looked at all the different types of standards that were out there, when it comes to implementation, they are not enforceable, because there is nothing there in the legislation. So I suppose from that end of it, there is kind of a statutory obligation now on us to kind of move and implement as well... I mean the regulations came from the standards and I think that the message has gone out...

(Member of the Working Group, public sector)

The Standards I think are much more, em, accessible to lay people and much more accessible to staff, because staff think they wouldn't understand the regulations but this puts more meat... The Regulations would just go... Say, there must be a complaints process but it would be always augmented ... by the Standards, they put more meat on it.

And then should the Standards be aiming for higher than the regulations?

No, I think they marry each other and where the Standards are more specific, the regulations are more ...

(Member of the Working Group, voluntary sector)

However, while Working Group members did not see themselves as having a role to play in overseeing HIQA and ensuring that the Standards were written in the public interest, it is possible that others did. Interviews with non-Working Group members suggested that there was a general high level of satisfaction with the Standards and the regulatory process. Even though some were unhappy not to have been invited to participate, most non members were reassured by the establishment of the Working Group, believing that the collection of different stakeholders resulted in Standards which focused on the best interests of residents:

Ok and what's your view on the approach they took. The collaboration?

Brilliant. I think the more people on board from each angle, the better. Just from developing different policies and documents, certainly if you can have representation from each and every angle, it helps. Just to overcome the different agendas, different... priorities. I think there was a focus on money and costs from the private sector. And they were listened to, but I think there were others there that meant it is now in the interests of the residents.

(non-Member of the Working Group, public sector)

It can be therefore argued that, even though the Working Group did not verify that the Regulations endorsed the Standards, as claimed by the DOHC and HIQA, others saw their involvement in the process as a way of legitimising the new regulatory process. This arguably highlights a potential flaw in the use of regulatory negotiation, as it shows the limited capacity of non-State actors to carry out a watchdog function.

7.5 Conclusion

As outlined above, the separation of powers between regulatory bodies and the government is important in order for regulation to operate effectively and to minimise the risk of regulatory capture (Stern 1997). However, many studies have highlighted the way in which the government can undermine the independence of the regulator (Bertolotti et al. 2011, Christensen & Laegreid 2007, Edwards & Waverman 2006, Gilardi 2008). Thus, the possibility that this separation of powers was not observed in relation to the development of regulations for residential care settings for older people in Ireland was arguably not unusual. However, as outlined in Chapter Two, the involvement of non-state actors was described as a way of preventing such threats to the regulator's independence (Gunningham et al. 1998, Quintyn & Taylor 2007, Smith 2009). It was thought that, if such individuals were involved, unfair decisions could not be taken without objections being raised.

This chapter has suggested that the involvement of non-State actors in the regulatory process does not necessarily help to avoid the regulator's powers being reduced. It is clear that private sector members on the Group were happy with the Department's decision and had no motive to publicise the differences between the Standards and the Regulations. Other members were not directly involved in residential care and so had no awareness of the differences between the Standards and the Regulations. This led them to rely on HIQA, who had previously proved so trustworthy. Ironically, the trust Working Group members had in HIQA led them to believe the organisation's implicit assertion in its July 2009 press release that the Regulations gave effect to all of the Standards.

By seemingly reinterpreting the 2007 Health Act and suggesting that the Standards were not mandatory, the Department of Health and Children was clearly trying to avoid a situation where many residential care homes would have

been shut down. In this way, the Department was clearly acting in the best interests of older people (Feintuck 2004). Yet, as it undermined HIQA's independence and authority, and re-interpreted the 2007 Health Act, the Department was arguably demonstrating its desire to remain in the public favour and remain in control of the regulatory process (Black 2002, Jordana & Levi-Faur 2004, Parker 2006, Thatcher 2005). In this way, it can be argued that the development of the regulatory regime governing residential care settings in Ireland is simply another example of the misuse of regulation by the government in Ireland. As noted in Chapter Three, several commentators have argued that accountability over regulation in Ireland has traditionally been fragmented and opaque (Collins 2010, EIU 2009, Nolan 2008).

Conclusion

8.1 Introduction

As outlined in Chapters One and Two, regulatory negotiation remains under-theorised as a tool of governance in spite of its popularity in recent years. This chapter aims to demonstrate how the findings presented in Chapters Five, Six and Seven can be used to develop a new theoretical perspective on the use regulatory negotiation, particularly as it relates to the residential care sector. This theory was developed using the process-tracing approach (George & Bennett 2005), enhanced by Miles and Huberman's (1994) Event Listing Matrix, described in Chapter Four.

Section 8.2 starts by summarising what this thesis contributes to our understanding of regulatory negotiation at the operational level. This is followed by a new theoretical perspective on what drives the selection and operation of regulatory negotiation more broadly in Section 8.3. Section 8.4 then discusses the wider implications of these findings, and finally, Section 8.5 outlines recommendations for future research.

8.2 Contributions of the Thesis to Our Understanding of Regulatory Negotiation

This thesis has helped to contribute to our understanding of regulatory negotiation in several ways. As outlined in Chapter Two, previous research on regulatory negotiation has proven inconclusive about its relative merits. Some argue that it results in clearer rules, helps to protect the public interest and ensures greater co-operation from regulated firms (Cladart & Ashford 1992, Free-

man & Langbein 2000, Harter 1982, Seidenfeld 2000, Selmi 2005). It has also been argued that regulatory negotiation can also be a useful method of providing an additional layer of oversight within the regulatory process, ensuring that regulators develop rules that protect the public interest (Gunningham et al. 1998, Quintyn & Taylor 2007, Smith 2009).

Others have disputed these findings, arguing that regulatory negotiation has some serious flaws which make it a tool ill-suited to the development of regulations which aim to protect the public interest. Coglianese (2001a) and Langbein & Kerwin (2000) have argued that regulatory negotiation does not in fact help to increase the clarity of the content of the regulations. Indeed, although the Standards and the 2009 Care and Welfare Regulations are a significant improvement upon the existing regulatory system governing residential care in Ireland, both documents contain a number of ambiguities, thus consolidating Coglianese's and Langbein's argument. In fact, it is possible to argue that the negotiations of the Working Group in fact *created* ambiguity in the Standards document. As outlined in Chapter Five, the original version of the Standards (DOHC 2007b) was clearer in many respects in comparison with the final version produced by HIQA's Working Group. Although this is in many ways typical of the policy making process more generally (Loughlin 2002), it is perhaps important to highlight that claims that regulatory negotiation will lead to clearer rules may be misplaced.

The findings from this thesis also cast further doubt on the potential for regulatory negotiation to provide an oversight mechanism to ensure that the rules are written fairly and transparently, as has been previously claimed (Gunningham et al. 1998, Quintyn & Taylor 2007, Smith 2009). Though the Working Group may not have been formally tasked with this function, it is still noteworthy that they failed to publicly highlight the way in which many of the Standards are no longer mandatory for providers, as seemed to have been what was originally envisaged (DOHC 2007b).

However, arguably the most significant finding from the study was that it cast further doubt on the way in which regulatory negotiation can help to empower the intended beneficiaries of the process. Although focus groups with residents were carried out in order to inform the content of the Standards, the findings were largely ignored or distorted in order to promote the self-interests of Working Group members. Therefore, the findings from this study add to the wide body of evidence which has already found that more powerful actors tend to benefit from such processes (Furlong &

Kerwin 2004, Golden 1998, Wagner et al. 2011, Yackee 2006). Yet this study is particularly important as it acted as the “test case” proposed by Seidenfeld (2000) for proving or disproving the theory that the regulatory negotiated process can help to empower marginalised groups. The findings from the thesis therefore indicate that regulatory negotiation may not be a suitable tool to further the public interest.

The thesis also provided an insight into *how* the public interest becomes sidelined within the process. Almost all members claimed to be acting in the public interest when making specific proposals about the content of the Standards. Even when different individuals or factions were making opposing suggestions, each claimed that their proposal would help to protect the best interests of residents. Nonetheless, the suggestions made by individuals were largely intended to further their own interests; the claim that they would protect the interests of older residents was often simply a way of gaining support for their arguments. As the definition of the public interest was itself distorted, and the views of older people themselves discounted, it was difficult for HIQA to determine which proposals would truly help to protect the interests of residents. While this has previously been reported within the literature on regulation in general (Croley 2008), it has not been explored within the context of regulatory negotiation.

These findings offer a significant contribution to our understanding of the regulatory negotiated process, highlighting some significant flaws in a tool which has grown in popularity. Yet as outlined below, the thesis also offers an opportunity to provide a new theoretical understanding of the regulatory negotiated process, which previous research has to date failed to do.

8.3 Regulatory Negotiation: A Theoretical Perspective

8.3.1 Introduction

Most of the literature on regulatory negotiation describes the operation of such processes solely in terms of how group dynamics contribute towards the final outcome (the regulations developed). This thesis has the potential to offer a new conceptual understanding of the regulatory negotiated process, using the case studied to demonstrate how the outcome is determined not just by group

dynamics, but also by the wider political culture.

8.3.2 Operations of the Working Group

In many ways, the development of the Standards and Regulations indicate that it operated as a typical policy-making process. As outlined in Chapter Two, the policy-making process is complex and is often wrought with problems. Policies are often developed with input from a wide range of actors, each of whom seeks to further their own interests over those of others, and use a wide variety of techniques in order to make this happen (Bobrow 2006, Bogason 2006, Ellerman 2005, Hill 2005, Kingdon 2010). Furthermore, poor facilitation, limited time available, changing directions from politicians, an almost insurmountable workload and the local policy context can lead to shortcomings in the eventual policy document developed (Bobrow 2006, Hill 2005, Kingdon 2010, Winter 2006).

8.3.2.1 Group Dynamics

As noted above, several members of the Working Group acted to a great extent out of motives which were not necessarily aligned with those of residents and often mistrusted the motives of other members of the Working Group. These motives led to the development of different factions, based on affiliations over shared interests. Each faction used a variety of techniques to try to ensure that the contents of the Standards reflected their own wishes or point of view. In order to “win” on specific issues, each faction compromised on less relevant issues, which led to a number of ambiguities and inconsistencies within the document. In addition, fears of growing old and living in residential care appeared to encourage many members of the Working Group to ensure that the Standards focused on providing residents with autonomy and choice, without considering residents’ own wishes.

8.3.2.2 Group Facilitation

The shortcomings of the Working Group were arguably compounded by inadequate facilitation of the Working Group by HIQA. As noted previously, HIQA were under pressure to complete the Standards within an unrealistic timeframe, while the organisation was still in the process of becoming esta-

blished. This led to a significant workload for Working Group members and shifting meeting times and locations. Furthermore, as noted previously, HIQA wanted to develop a reputation as a trustworthy and competent regulator in order to win support from the public, the government and regulated firms, requirements for a regulator to carry out its work effectively (Parker 2006, Walls et al. 2004). This seemed to have influenced HIQA's decision to have an informal and open process regarding the selection of members of the Working Group created difficulties in managing meetings, resulting in a lack of cohesiveness within the Group.

8.3.2.3 Local Policy Context

A number of factors related to the Irish political, economic and cultural context also appeared to have played a role in influencing the content of the Standards, which can have implications on both the policy and its implementation (Bobrow 2006). Firstly, it is possible to argue that the tradition of clientelism in Ireland, in which the government shows a positive bias towards powerful economic interests (Dellepiane & Hardiman 2011), may have led to regulations sympathetic to the needs of private residential care providers. Furthermore, as noted in Chapter Three, successive governments in Ireland have relied on processes of collaborative governance, most notably in the guise of Social Partnership, to demonstrate to the electorate that it is willing to make decisions in the interests of the electorate. Indeed, as the Social Partnership process has articulated agreements on non-core labour market issues such as social inclusion, childcare, racism, and housing policy (Roche 2007), it is possible that the Social Partnership process in Ireland may have helped to create a sense that consultation was necessary for the development of all new policies, leading in turn to the development of HIQA's Working Group. However, many commentators have suggested that the government has become adept at appearing to consult while developing its own cautious, incremental and middle-ground policies aimed at appeasing its key voters (Weeks 2009).

The economic context also played a significant role in determining both the content of the Standards and, later, the rationale for why the Government may have decided not to underpin them with legislation. As outlined in Chapter Three, care policies for older people since the 1960s in Ireland have prioritised the provision of residential care beds at the lowest possible cost to the government over the quality of the services provided to residents. It is therefore not surprising that members of the Working Group from the public sector saw

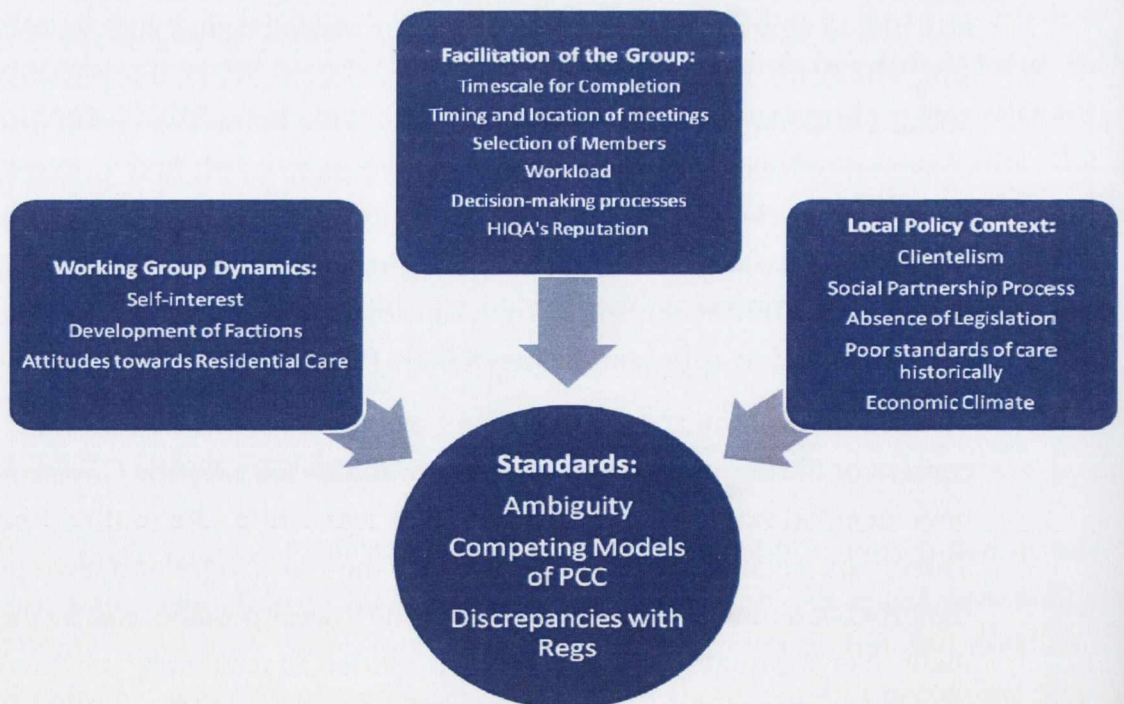
the Standards development process as a way of coercing the government to provide funding for replacing these inadequate buildings with environments which would meet the needs of both residents and staff. However, around the time the Working Group completed its deliberations, in December 2007, Ireland's property bubble burst, followed by the onset of a global economic recession. Thus, as outlined in Chapter Three, the government's finances became constrained, which may have played a role in the decision not to make all of the Standards mandatory requirements, as argued in Chapter Seven.

Finally, the legislative framework had an impact on both the Working Group and the Standards/Regulations. As outlined in Chapter Five, although the broadcasting of the Leas Cross programme arguably sped up the development of HIQA and regulatory reform of the residential care sector, the 2007 Health Act was not finalised until after the Standards had been almost completed, leaving room for confusion and misinterpretation for their role in the regulatory process.

8.3.2.4 Overview

Figure 8.1 illustrates the factors that influenced the content of the Standards, demonstrating how it mirrors the policy-making process more broadly.

Figure 8.1: The Factors that Influenced the Content of the Standards



However, as outlined below, it is possible to see how the wider political culture played a key causal role within the process.

8.3.3 Governance

Although research on regulatory negotiation has highlighted the influence of the immediate policy context on how regulatory negotiation works in practice (Funk 1997, Langbein & Kerwin 2000, Selmi 2005), it can be argued that changing governance structures played a significant role in influencing both the content of the Standards, and the process used to develop them.

8.3.3.1 Public Value and Neo-Liberalism

As outlined in Chapter Two, there has been a trend across many countries since the late 1990s to follow policies of the “Third Way”, or “public value”, aiming to be more outcome-focused. Although these policies were a reaction against the failures of the New Public Management policies that characterised the 1970s and 1980s in such countries, it has been claimed that little has changed in practice; Third Way policies remained broadly neo-liberal, emphasising the benefits of market-driven principles (Fairclough 2000, Newman 2001, Poole 2000). In fact, it has been suggested that Third Way policies put citizens at an even greater disadvantage, as the approach expected individuals to take greater responsibility for ensuring that public services met their needs (Gilleard & Higgs 1998, Newman 2001). Although political ideology is often absent from policy-making in Ireland (Taylor 2005), many of the tools of the Third Way were also adopted in this country (MacCarthaigh & Hardiman 2010), and is possible to see their influence in the content of the Standards.

Firstly, the Irish government’s initial decision to respond to the Leas Cross crisis with a strategy of regulatory reform could be interpreted as a reflection of a common Third Way strategy to use regulation as a “low cost symbolic commitment to action” (Loughlin & Scott 1997) in order to re-build the trust of the electorate. The establishment of the Working Group by HIQA also mirrored a Third Way trend to develop government policies and regulation through partnership and consultation as a way of demonstrating that the regulator was willing to subject itself to oversight and scrutiny (Jordana & Levi-Faur 2004, Newman 2001, O’Flynn 2007).

Even the possibility that the Minister for Health and her Department may

have altered the purpose of the Standards reflects the argument that, while they are willing to cede power to non-State actors in return for a more trustworthy reputation (Jordana & Levi-Faur 2004), governments can present the biggest threat to the independence of regulators, as they remain in control behind the scenes by limiting the power of regulators and limiting their resources (Thatcher 2005). This also highlights the argument made by other governance researchers that the dispersal of government power to regulators and other state agencies does not imply a weakening of the government's power; rather, it may serve to enhance the government's influence over a wider section of society (Cuellar 2005, MacCarthaigh & Scott 2009, Newman 2001).

Lastly, it is possible to see a consumer-driven model of person-centred care within the Standards, mirroring the ideology of the Third Way (Clarke 2006, Gilleard & Higgs 1998, Newman 2000). However, as noted in Chapter Six, the focus on autonomy in the Standards also seemed to have stemmed in part from Working Group members' fears of residential care. This issue requires some additional consideration.

8.3.3.2 Postmodernism and the Denial of the Fourth Age

As outlined in Chapter Two, the development of a new postmodern culture following World War Two introduced for the first time a youth culture, and so, in the 1950s and '60s, the teenage years became a training ground for a lifetime devoted to consumption (Gilleard & Higgs 2000). By the 1980s, the power and celebration of youth had become ingrained, creating an aversion amongst the new middle-aged cohort to redefine the era post-retirement as a "Third Age", a time of new opportunities, ultimately resulting in many middle aged and older people wishing to ignore, or deny the potential onset of the dependency and illness that arises with deep old age, or the Fourth Age (Gilleard & Higgs 2000).

According to Gilleard & Higgs (1998), the postmodern era also facilitated the rise of neo-liberalism; both ideologies celebrate consumerism and therefore see the market as a means to facilitate a consumer-driven identity. As a result, this celebration of consumerism began to be reflected within policy documents in health and social care; the calls for users of public services to have an input into service planning, particularly in the era of privatisation in the 1980s and 1990s, allowed the discourse of consumerism to infiltrate into public policies.

The same process also occurred within aged care policies. Indeed, as "Third Agers" began to see themselves as consumers, protected by consumer rights,

it was perhaps inevitable that policy documents began to conceptualise older people who used healthcare services as consumers. The personification of older people as consumers of services perhaps ignored the reality that those in need of such services were not the Third Agers capable of exercising their consumer rights, but Fourth Agers who, by definition, often had difficulty expressing their rights because of communication problems and other disabilities (Gilleard & Higgs 1998, Gilleard & Higgs 2000). However, the fears of reaching the Fourth Age have created something of a collective denial of ageing; the postmodern focus on agency and individuality has given rise to the belief that, by simply choosing an active lifestyle, we will not have to reach the Fourth Age and lose our autonomy (Jones & Higgs 2010). Thus, the focus on autonomy and agency within policy documents is arguably a reflection of a widespread denial of deep old age.

In this way, it can be argued that the Working Group's desire to focus on choice and autonomy was in itself an unconscious promotion of the "Third Age", a concept which developed out of postmodern culture, in turn cemented into public policies by a neo-liberal ideology. By emphasising the need for older residents to choose and thus retain their autonomy, Working Group members were turning the Fourth Age into a phenomenon that need longer be feared. As outlined below, this may be related to the fact that choice can be conceptualised in different ways.

8.3.3.3 Conceptualisation of Choice

Central to both postmodernist discourse and the neo-liberal agenda is the value both place on autonomy and choice. Postmodern culture values choice as a way of facilitating the construction of an individual identity. The market creates choices, which in turn allows individuals to differentiate themselves from one another, thus highlighting their personal tastes and values (Gilleard & Higgs 2005). Thus, within a neo-liberal framework, choice facilitates personal agency and autonomy.

However, it has been argued that the neo-liberal conceptualisation of choice differs from the citizenship approach (Clarke & Newman 2008, Meagher 2010). A citizenship perspective suggests that citizens are all automatically bestowed with civil, political and social rights, including the right to participate equally in their community/country (Bartlett & O'Connor 2006, Feintuck 2004). From this viewpoint, choice, as conceptualised within a Human Rights framework,

can be seen as almost a different concept than the market-based understanding of the same term (see Table 8.1).

Table 8.1: Frames for Conceptualising Choice

	Neo-Liberal	Human Rights
Origins	Top Down (NPM/Public Value)	Bottom-Up
Concept of the Individual	Atomistic, an agent with wants	Concrete, a person with rights
Concept of Choice	Abstract, instrumental, <i>a good in itself</i>	Substantive, a means to enact self-determination, <i>a good in itself</i>
Perspective	System-wide	Person-centred
Source: Adapted from Meagher, 2010		

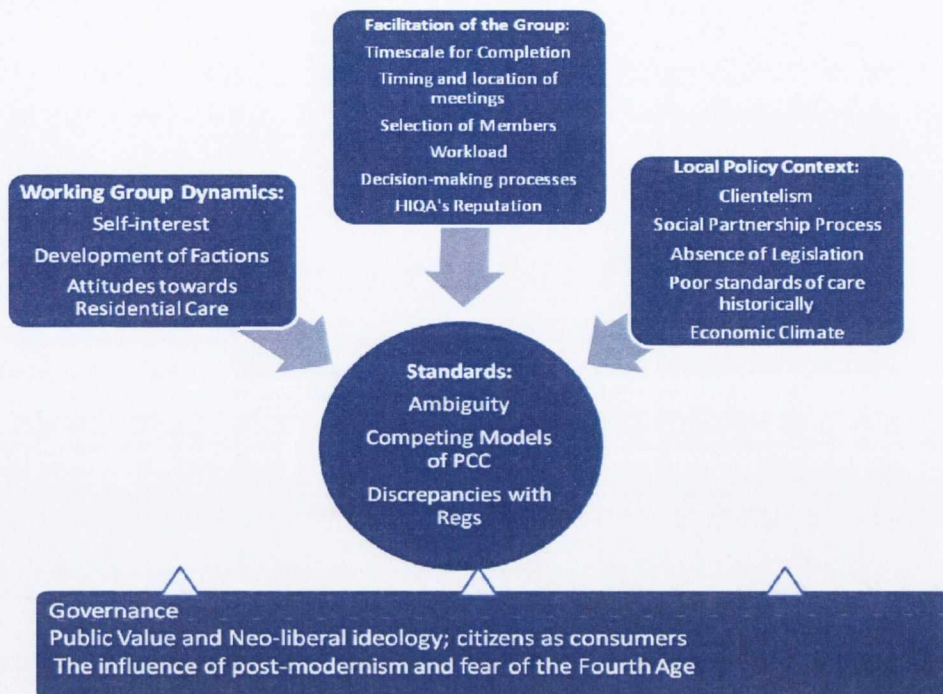
It has been argued that policy-makers have used the rhetoric of the human rights conceptualisation of choice to gain support for their market-driven policies (Meagher 2010, Newman & Vidler 2006, Newman, Glendinning & Hughes 2008). It could thus be argued that the Working Group may have focused on promoting choice and autonomy within the Standards as they believed that this would help to promote the human rights of older people living in residential care settings in Ireland, while at the same time alleviating their own fears of residential care and the Fourth Age. Arguably, the consequence is a further marginalisation and silencing of older people living in residential care in Ireland.

8.3.4 Summary

This section has shown that the development of the Standards and the Regulations for the residential care sector in Ireland could be regarded as a typical policy-making process. However, to use only this literature would be to ignore the political and cultural ideologies of neo-liberalism and postmodernism that were arguably significant driving forces for the process, as illustrated in Figure 8.2. The thesis has shown that the use of regulatory negotiation for the residential care sector has the potential to place older residents at a considerable disadvantage if developed according to Third Way principles. This suggests that there may be a need to consider further the applicability of regulatory negotiation for furthering the public interest, or at least to re-conceptualise the

public interest within the regulatory process.

Figure 8.2: The Influence of New Modes of Governance on the Standards Development Process



8.4 Implications: Re-Conceptualisation of the Public Interest

8.4.1 Implications

This thesis has highlighted the way in which the use of regulation can create a vicious circle; it is used by governments to re-build the trust of the electorate without necessarily changing the status quo (Loughlin & Scott 1997). However, as regulation then fails to protect the interests of the electorate, particularly disempowered minority groups, the trust of the electorate declines further. It is possible that the cycle may be broken by ensuring that regulation better addresses the needs of the public, particularly marginalised groups.

Feintuck (2004) argues that re-defining the public interest according to a citizenship perspective may achieve this objective, as, when people are defined as citizens, their interests are conceptualised more broadly (and with much greater difficulty) than when they are seen as consumers. Feintuck defines a citi-

zenship perspective of the public interest back as one in which the role of community and society are prioritised to ensure the creation of societal equality and the protection of human rights, particularly of marginalised groups. Seen in this light, Feintuck (2004) argues that regulation can act as a counter-balance to the excessive dominance of a market-driven approach to politics and policy-making. Feintuck (2004) further argues that regulators need to guard against the domination of the rule-making process by any one interest group (“to protect the freedom of factions to further their political interests while preventing any individual faction from undermining the freedom of others”, pg. 197).

While the use of regulatory negotiation is a product of neo-liberalism, and thus will always be limited in its ability to act in the public interest without the development of greater trust and a greater delineation of responsibility and accountability within society (Fukuyama 1995, Putnam 1993), it is possible to develop some guidelines that may ensure that regulatory negotiated processes operate in the public interest within the residential care sector. Firstly, as regulators have proven their ability to act in the public interest (Dal Bo 2006, Helm 2006), it is important that the regulator has the power of veto over the process (Lubbers 2008), and defines the public interest clearly at the start of the regulatory negotiated process, using a citizenship perspective. Thus, in defining the “public interest” within the residential care sector, it should be recognised that most older people living in residential care are those with communication problems, those with dementia and other cognitive impairments, those with physical disabilities and those who are dying. From empirical research, it is possible to recognise that the interests of such individuals are to remain comfortable, engaged, with meaningful relationships (Chou et al. 2002, Eales et al. 2001, Guse & Masesar 1999). Understanding the “public interest” in this way may help to reduce the shortcomings outlined in this thesis.

However, it is possible that there is a need to look beyond regulatory reform to limit the shortcomings of the neo-liberal agenda and instead to focus on changing the neo-liberal mentality that can lead to power imbalances and mistrust within society (O’Flynn 2007). Indeed, the Third Way ideology has arguably also fallen into decline and, just like neoliberalism, has been classed as a failure (Jordan 2010). The occurrence of the global economic recession has left the world at a turning point, in search of a new ideology to help shape public policies, in Ireland, the UK and elsewhere.

It is possible that the quality of residential care may be better protected by

removing the market-based, and profit-making, approach from the sector. For example, Chapter Two highlighted the way in which bottom-up change, through the Culture Change movement (Doty et al. 2008), has helped to develop an alternative model of residential care for older people. Although regulation has to some extent inhibited the development of this model of care (Miller et al. 2010), empirical evidence has highlighted how the movement, which is broadly based on the principles of the psycho-social model of care, has helped to improve the quality of life of residents (Kane et al. 2007). While there will inevitably be challenges involved in developing any new approach to improve the quality of residential care, particularly one that is not based on a fear of ageing (Gilleard & Higgs 2010a), it is clear from this study that even new forms of regulation within a neo-liberal framework are unlikely to truly respond to the needs of older people living in residential care.

8.5 Recommendations for Future Research

Three key findings from this case are worthy of further investigation. Firstly, I have suggested that Third Way policies were instrumental in influencing the way in which the process used to develop the Standards was structured, and also in influencing the content of the Standards and regulations. However, as this was the first case to study the use of regulatory negotiation within the residential care sector, it would be important for the study to be replicated in other countries not traditionally associated with the Third Way ideology to see if different outcomes emerge.

Secondly, commentators have suggested that the greatest shortcoming of regulatory negotiation is that it prioritises the development of consensus over the protection of the public interest (Funk 1997, 2009, Seidenfeld 2000). While this case found evidence to support this argument, it also found that many stakeholders claimed that their proposals were in the interests of older residents in order to legitimise their own self-interests. While this has previously been reported within the literature on regulation in general (Croley 2008), it has not been explored within the context of regulatory negotiation. As a result, it would be worth investigating in greater detail whether this phenomenon occurs within other regulatory negotiated processes, and the impact it has on the rules subsequently developed.

Thirdly, this study has argued that the emphasis within the Standards on pro-

moting residents' autonomy have the potential to create barriers for residents who do not have the capacity to make choices without adequate support. While the Standards no longer play an important role within the regulatory process, the document is still used by HIQA as a way of encouraging providers to (voluntarily) improve their services. It is important to understand how the vision of care set out within the Standards has been implemented by care providers in the day-to-day operations of residential care settings in Ireland, particularly on residents' well-being.

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Appendices

Working Group Membership

Table A.1: Official Membership of the Working Group

Robin	Webster	Age Action Ireland
Maurice	O'Connell	Alzheimer Society of Ireland
Kathy	Murphy	An Bord Altranais
Emma	Benton	Association of Occupational Therapists of Ireland
Brigid	Barron	Caring for Carers Ireland
Suzanne	Cahill	Dementia Services Information and Development Centre, St James Hospital
Julie	Ling	Department of Health and Children
Dave	Walsh	Department of Health and Children
Irene	O'Connor	Elder Abuse National Implementation Group
Michele	Clarke	Health Information and Quality Authority
Tracey	Cooper	Health Information and Quality Authority (Chairperson)
Ann	Ryan	Health Information and Quality Authority
Marion	Witton	Health Information and Quality Authority
Jane	Carolan	Health Service Executive, Assistant National Director for Older People
Joan	Deegan	Health Service Executive, Senior Environmental Health Officer
Margaret	Feeney	Health Service Executive, National Planning Specialist for Older People
Helen	Flint	Health Service Executive, Director of Nursing Research and Development
Mary	Flanagan	Health Service Executive, Director of Nursing
Fiona	O'Riordan	Health Service Executive, Senior Administrator
Peter	Ryan	Health Service Executive, Assistant National Director of Estates
Breda	Hayes	Health Service Executive, Director of Nursing
Daphne	Doran	Hospice Friendly Hospitals Programme
John	Brennan	Irish Association of Social Workers
Elaine	Whelan	Irish Association of Speech and Language Therapists
Michael	Boland	Irish College of General Practitioners
Michael	O'Halloran	Irish Senior Citizens' Parliament
Marian	Glynn	Irish Society of Chartered Physiotherapists
Shaun	O'Keefe	Irish Society of Physicians in Geriatric Medicine
Bob	Carroll	National Council on Ageing and Older People
Tadhg	Daly	Nursing Homes Ireland
Pat	Durcan	Nursing Homes Ireland
Michael	Eustace	Nursing Homes Ireland
Paul	Rochford	Nursing Homes Ireland
Maureen	McNulty	Nursing Homes Nursing Project
Helena	Moore	Nursing Homes Nursing Project
Aisling	Denihan	Psychiatry of Old Age Services
Ruth	Loane	Psychiatry of Old Age Services

Table A.2: Additional (Unofficial) Members of the Working Group

Andrew	Fagan	HIQA
Jennifer	Doran	HIQA
Ally	Flynn	HIQA
Zivas	Fitzgerald	HIQA
Niall	Baneham	HIQA
Barbara	Carr	HIQA
Pat	Healy	HSE, Assistant National Director of Primary, Community & Continuing Care
Laverne	McGuinness	HSE, National Director of Primary, Community & Continuing Care
Frank	Murphy	Health Service Executive
Siobhan	O'Brien	Health Service Executive
Paul	de Freine	Health Service Executive, Estates
Eleanor	Masterson	Health Service Executive, Estates
Geraldine	Fitzpatrick	Department of Health and Children
Alison	Keogh	Department of Health and Children
Henry	Colm	Irish Society of Physicians in Geriatric Medicine
Alice	Gormley	Association of Occupational Therapists in Ireland
Alison	Enright	Association of Occupational Therapists in Ireland
Rozanne	Barrow	Irish Association of Speech and Language Therapy
Aoife	O'Mahony	Irish Association of Speech and Language Therapy
Des	O'Neill	Elder Abuse Implementation Group
Patricia	Hallihan	Dementia Services Information and Development Centre, St James Hospital
Maeve	Clarke	Dementia Services Information and Development Centre, St James Hospital
Geraldine	Joy	Nursing Homes Nursing Project
Eithne	niDhomhnaill	Nursing Homes Nursing Project
Caroline	Connelly	Nursing Homes Ireland
Shiree	Gilchrist	Nursing Homes Ireland

Chronology of Events in the Development of the Standards and Regulations

26 November 2001 National Health Strategy, *Quality and Fairness* (DOHC 2001) published. It sets out the government's intention to develop an independent Health and Information Quality Authority to ensure the services provided in the health system meet nationally agreed standards.

7 January 2005 First meeting of the Board of the interim HIQA.

May 2005 iHIQA given some skeleton staff.

30 May 2005 *Home Truths* programme on the Leas Cross nursing home broadcast on Irish television.

31 May 2005 Junior Minister for Health states that the government is in the process of reforming the regulatory system for both public and private Irish nursing homes.

November 2005 DOHC internal Working Group established to write a draft set of minimum Standards for residential care settings for older people in Ireland.

January 2007 Draft Standards published (DOHC 2007*b*) handed over to iHIQA. HIQA's Working Group has its first meeting.

May 2007 2007 Health Act passed, and HIQA formally established.

August 2007 HIQA's draft Standards published (HIQA 2007) and sent for public consultation.

November 2007 Report on the findings of the public consultation published (HCI 2007).

December 2007 HIQA's Working Group completes its deliberations.

March 2008 Final draft of HIQA's Standards published (HIQA 2008).

February 2009 Final version of HIQA's Standards approved and re-launched by the Minister for Health and Children (HIQA 2009e).

July 2009 2009 Care and Welfare Regulations published and ratified by the Minister for Health and Children. Press releases issued by HIQA and the DOHC state that the regulations underpin the Standards (DOHC 2008, HIQA 2009d). All residential care settings for older people now subject to inspection under the new Regulations.

Example of one of HIQA's Standards

Standard 1: Information Each resident has access to information, in an accessible format, appropriate to his/her individual needs, to assist in decision making.

Criteria

1.1 There is a guide for residents clearly written and made available in an accessible format to each resident and each prospective resident. It includes a description of:

- the residential care setting's statement of Purpose and Function (see Standard 28: Purpose and Function)
- the services and facilities (including external facilities) provided
- the programme of activities provided, including those that are available in the local community
- the individual accommodation and communal space provided
- the name of the person in charge and the general staffing arrangements
- the number of places provided and any special needs or interests catered for
- the arrangements for inspection of the residential care setting and details of how to access the Office of the Chief Inspector and inspection reports
- local Health Service Executive contact details
- an outline of the residential care setting's complaints procedure
- arrangements for visiting
- the name of the registered provider
- contact details of organisations providing advocacy services

- 1.2 The residential care setting ensures that information is available to the resident in a format and language that suits his/her communication requirements.
- 1.3 The prospective resident and/or his/her family or representative are informed of all fees payable including charges for activities and services that may have additional costs.
- 1.4 The person in charge ensures that the prospective resident and/or his/her family or representative is invited to visit the residential care setting before he/she makes a decision to stay. Emergency admissions are avoided where possible. The opportunity to meet with other residents during a visit is facilitated.
- 1.5 The prospective resident is given the opportunity to have an appointed member of staff meet him/her in his/her own home or current accommodation, to further discuss and plan for the transition into long-term care.
- 1.6 In emergency admissions, the person in charge or delegate informs the resident as soon as possible and no later than 24 hours about key aspects of the service.

Letter of Invitation to Respondents

Name

Address

PhD Thesis on the Development of the National Quality Standards for Residential Care Settings for Older People

Dear X,

My name is Ciara O'Dwyer. I am a PhD Student in the Social Policy and Ageing Research Centre in Trinity College Dublin. I am writing to ask for your help with my thesis.

My thesis explores the processes used to develop the *National Quality Standards for Residential Care Settings for Older People*, for which you were on the Working Group. While other countries have used a collaborative approach to develop minimum care standards for care settings for older people, no country has yet documented the pros and cons of using this approach. Thus, the recent process represents an ideal opportunity for other countries to learn from the Irish situation.

I am hoping to interview all of the members of the Working Group to try to identify the various strengths and weaknesses of the collaborative approach used which will allow me to develop recommendations for the use of this approach in other countries and for other relevant policies in Ireland.

I would therefore greatly appreciate it if you would be able to meet me for about an hour to discuss your role in and your opinions on the Working Group which developed the National Quality Standards. Ethical approval for the study has been granted on the basis that your participation would be voluntary and your anonymity would be protected.

I will contact you by phone during the coming week to ascertain your response to my request. I will be available to conduct the interview at any time and location that suits you and am happy to answer any questions or concerns you may have. You can contact me by phone on 01 896 3363 or 087 6528460 or email me at cmodwyer@tcd.ie.

Best wishes

Ciara O'Dwyer

Information Sheet

The Development of the National Quality Standards for Residential Care Settings for Older People

Ciara O'Dwyer, a PhD student in The Social Policy and Ageing Research Centre, in the School of Social Work and Social Policy, Trinity College Dublin is conducting research on the development of HIQA's National Quality Standards for Residential Care Settings for Older People, published last year. While other countries have used a collaborative approach to develop minimum care standards for care settings for older people, no country has yet documented the pros and cons of using this approach. Thus, the recent process represents an ideal opportunity for other countries to learn from the Irish situation.

The study aims to document the process through which the standards were developed, and to gain the views of those directly involved in their development about the process, as well as those of other relevant individuals.

The interviews will last approximately one hour and will seek to explore:

- Your views on the final draft of the Standards
- Your views on the process through which the Standards were developed
- Details of how the Working Group operated
- Details on the public consultation process

Participation in the research is completely voluntary. Should you wish to withdraw from the interview, you may do so at any time without giving a reasons or explanation for doing so. The interviews will be transcribed and the information you give us will be kept strictly confidential. All references to names and personal details will be removed and details concerning specific locations or events can be changed. Anonymous portions of the interview may be used in any resulting publications, lectures, education, or broadcasts.

Should you have any further questions regarding the research please contact Ciara O'Dwyer (tel 01 896 3363) in the Social Policy and Ageing Research Centre, or her supervisor, Dr Virpi Timonen (tel 01 896 2950).

Consent Form

CONSENT FORM FOR PARTICIPATION IN RESEARCH

Social Policy and Ageing Research Centre
School of Social Work and Social Policy
Trinity College Dublin

- I agree to be interviewed and tape recorded by the researcher.
- I understand that the information that I have given will be treated with complete confidentiality and anonymity.
- I understand that the information I provide will be incorporated into the student's PhD thesis and other publications emanating from the research.
- I have been given a copy of the information sheet and any queries I have had have been satisfactorily answered.
- I understand that I am free to withdraw from the interview at any time, without giving a reason.
- I understand that any details recorded will be treated in complete confidence and stored in a secure place.

Interviewee's Signature

Date

Researcher's Signature

Date

If you need any further information, please contact: Ciara O' Dwyer at Social Policy and Ageing Research Centre, School of Social Work and Social Policy, Trinity College Dublin, College Green, Dublin (Tel: 01 896 3363), or Ciara's supervisor, Dr Virpi Timonen (Tel: 01 896 2950).

Interview Guides

G.1 Interview Guide for Working Group Members

Introduction

My name is Ciara from the Social Policy and Ageing Research Centre in Trinity College. As you know, I am here to talk to you about your views on the *National Quality Standards for Residential Care Settings for Older People in Ireland*. The interview should last about an hour. All the information that you give me will remain confidential. Extracts from the interview may appear in my thesis or other research papers, but under no circumstances will your name or any identifying characteristics be included. Your participation is entirely voluntary, you are free to end the interview at any time and you can refuse to answer any question.

Background

1. Can you tell me why you think the standards were developed when they were?
2. Why do you think you were selected as a member of the Working Group?
3. What are your overall views on the membership of the Working Group?
4. Can you describe in your own words the process used to develop the Standards?
5. IF NECESSARY: Can you tell me what you know about the original DOHC version?
6. What were the main aims and objectives of the Working Group in developing the Standards?
7. What were your own aims and hopes when you were starting out?

Operations of the Working Group

1. Could you summarise the way in which decisions were made by the Working Group? (PROMPT IF NECESSARY: unanimous vote? majority

vote? Chairperson made final decision?) How satisfied were you with this approach?

2. About how many meetings were you required to attend? About how many did you actually attend? Were you required to do much work between meetings?
3. The purpose of the Working Group was to ensure that all of the relevant stakeholders were involved in drawing up the Standards. To what extent do you think this aim was achieved?
4. Whose voice was most heard within the group?
5. What were the main factors taken into consideration by the Group in drawing up the final content of the Standards?
6. To what extent do you think this strategy was successful?
7. How was the public consultation process carried out?
8. Can you explain how the findings from the public consultation process were taken into account in drafting the final version of the Standards?
9. How many meetings took place between the finalising of the draft and final version of the Standards (ie to consider findings of the public consultation process)?
10. How satisfied were you with how the public consultation process was carried out?
11. What were the main challenges of working in the Group?
12. What were the main areas of controversy in drafting the standards?

Views on the Standards

1. How satisfied are you with the final content of the document?
2. Would you be happy to live in a nursing home that operated according to these Standards?
3. Thoughts on specific aspects: the physical environment; abuse prevention; residents' rights; quality of life; legal issues (eg advanced care planning, meaning of representative and person-in-charge)?
4. In thinking about the content of the final draft of the Standards, is there anything not addressed in the document that should be? IF NECESSARY: Why not?
5. What impact do you think the Standards will have on Irish nursing homes? On nursing home residents?

6. Did you enjoy the process of developing the Standards?
7. Did you learn anything? (Has it changed your perception of others on the group?)
8. If you were asked to give advice to another country /sector in developing minimum standards, what would you say?

G.2 Interview Guide for Original Working Group members

Introduction

My name is Ciara from the Social Policy and Ageing Research Centre in Trinity College. As you know, I am here to talk to you about your views on the original draft of the *National Quality Standards for Residential Care Settings for Older People in Ireland*, and in particular on how these standards were developed.

The interview should be between 45-60 minutes. All the information that you give me will remain confidential. Extracts from the interview may appear in my thesis or other research papers, but under no circumstances will your name or any identifying characteristics be included. When using direct quotes, any references made within the interview that might identify you will be removed prior to insertion into the text. Your participation is entirely voluntary, you are free to end the interview at any time and you can refuse to answer any question.

Original DOHC Standards

1. You were involved in developing the original set of Standards, produced by the Department of Health and Children in 2007. Can you tell me a bit about how those standards were developed?
2. How did the group operate?
3. Who made final decisions?
4. Was a template used (eg English minimum care standards)
5. Why do you think the group was set up when it was?
6. What definition of 'quality' was used?
7. What were the main challenges of working in the Group?
8. Can you tell me a bit about the selection of the members of the working group?
9. What is your overall view of this set of standards?

10. What were your own aims and hopes when you were starting out?

HIQA Standards

1. Do you have any knowledge of how HIQA's Working Group operated?
2. On what basis were members selected?
3. How were decisions made?
4. What was the rationale for handing over the original DOHC draft to HIQA?
5. What is your overall opinion of the final draft of the Standards (vis a vis the original version?)
6. In thinking about the content of the final draft of the Standards, is there anything not addressed in the document that should be?

G.3 Interview Guide for Department of Health and Children Staff

Introduction

My name is Ciara, I'm a PhD student from Trinity College. As you know, I am here to talk to you about the development of the regulations underpinning the *National Quality Standards for Residential Care Settings for Older People*.

The interview should last half an hour to an hour. Everything you say will remain confidential. Quotes from this interview may appear in my thesis or other research papers, but under no circumstances will your name or any identifying characteristics be included. Your participation in the interview is entirely voluntary, you are free to end the interview at any time and you can refuse to answer any question.

Background

1. Can you just start by telling me a little bit about how the different roles relating to policies and services for older people within the Department are organised?
2. What's your specific role within the Department?
3. Did you attend any of the meetings of HIQA's Working Group?
4. Did you have any communication with other DOHC staff who attended meetings in an official capacity?

Standards

1. What was the rationale for the development of the original draft of the Standards?
2. How much control did the Department have over the content of the Standards?
3. Did you have any role in selecting people for the Working Group? (Or advising HIQA on who to select?)
4. The purpose of the Working Group was to ensure that all of the relevant stakeholders were involved in drawing up the Standards. To what extent do you think this aim was achieved? (voice?)
5. What is your overall opinion of the final draft of the Standards?

Development of the Regulations

1. Can you tell me a bit about how the 2009 Care and Welfare Regulations were developed?
2. What was the timeline for their development?
3. What is the relationship between the Standards and the Regulations?
4. What impact will standards not backed up by regulations have?
5. What was the basis for selecting the content of the regulations?
6. Why were a number of Standards left out of the regulations?
7. What role did the PA Consulting Report have on the content of the regulations?

G.4 Interview Guide for Relevant Stakeholders

Introduction

My name is Ciara, I'm a PhD student from Trinity College. As you know, I am here to talk to you about your views on the new minimum standards for nursing homes that were developed recently.

The interview should last half an hour to an hour. Everything you say will remain confidential. Quotes from this interview may appear in my thesis or other research papers, but under no circumstances will your name or any identifying characteristics be included. Your participation in the interview is entirely voluntary, you are free to end the interview at any time and you can refuse to answer any question.

Background

1. Can you just start by telling me a little bit about your organisation?
2. What's your specific role within the organisation?
3. Does your organisation have any involvement in the residential care sector? (IF NECESSARY) Can you tell me a bit about this?
4. Can you tell me what you know about the HIQA Working Group and the development process in general? What are your views on it?
5. Why do you think you/your organisation were not selected as a member of the Working Group? How do you feel about not having been on the WG? Was representation of older people living in residential care enough?
6. Can you tell me about the relationship between your organisation and the government/Department of Health?
7. Has anyone from your organisation sat on similar working groups?

Operations of the Working Group

1. Can you tell me why you think the standards were developed when they were?
2. Can you tell me what you know about the development process?

Views on the Standards

1. What is your overall opinion of the final draft of the Standards?
2. How well do you think the Standards represent the views of older people?
3. The purpose of the Working Group was to ensure that all of the relevant stakeholders were involved in drawing up the Standards. To what extent do you think this aim was achieved?
4. Did your organisation make a submission to the public consultation process?
5. What are your views on the representation of older people in nursing homes in Ireland?
6. What impact do you think the Standards will have on the Irish residential care sector?

Contact Summary Sheet

Interviewee ID Number:

Length of interview:

Contact date:

Today's date:

1. What were the main issues or themes that struck you in this contact?
2. Summarise the information you got from the interviewee?
3. Summarise the information you failed to get from the interviewee?
4. Anything else that struck you as salient, interesting, illuminating or important in this contact?
5. What new or remaining target questions do you have in considering the next contact?

Data Analysis

I.1 The Use of NVivo within the Thesis

NVivo 9 is software designed to aid qualitative data analysis. NVivo does not replace the researcher in coding data, rather, it is a tool designed to assist with the analysis process. NVivo allows researchers to import interview transcripts, documentary data, audio files, pictures and videos into a “library”, from which data can be coded to look for themes and later explore relationships and trends within the data.

For this thesis, I first imported all relevant documents outlined in Section 4.6.2 into a new NVivo file. Using NVivo’s Tree Node function (which allows codes, or “nodes”, as they are called in NVivo to be catalogued in a hierarchical structure). I used the tree function in order to separate the analysis of the Standards from the analysis of the process. Within the “Standards” tree, all of the nodes were created equally at first, rather than within a hierarchy.

The next step was to import all of the interview transcripts into the NVivo file. This was done over a protracted period of time, to allow data collection and analysis to occur simultaneously. For each transcript, I created a separate “case”, an NVivo function which allows additional information to be added about each person. This allowed me to record each respondent’s profession, the sector in which they worked, whether or not they were members of the Working Group and the number of meetings each attended, where relevant. The case function allows researchers to assess whether data within each code/node vary according to the attributes of the group. The interview data were coded within a second “tree” node.

I initially coded all of the transcripts using the interview guides as an initial starting point. I then recoded each of the transcripts to identify additional codes. I also developed memos, a tool which allows the researcher to create notes about the data at any stage during the data analysis, such as references to existing literature or observations about the data. The memos can be stored according to topic, and can be linked with nodes, allowing them to be either specific to the data or more general reference points to possible explanatory theories.

I developed a total of 27 memos, as shown in Table I.1 below.

Table I.1: Memos Created During the Analysis Process

Absent Voices of Older People
Analytical Framework
Contentious Issues
Decision Making
Development V Implementation
Elder Abuse
Group Factions
Health Act 2007
HIQA
Implications of Over-regulation
Insights into the Operations of the Working Group
Leas Cross
Level of Interest in Outcomes
Memory
Money and Financial Issues
Partnership
Policy Context
Position of Voluntary Homes
Quality of Nursing Homes
Regulation
Representation
Risk V Quality of Life
Saviours v Enemies
Standards as a Turning Point
Trust and Mistrust
Vested Interests of Respondents
Views on Inspection

Later, I sorted the nodes developed hierarchically (see below) and then looked at the inter-relationship between them.

I.2 Development of Themes from the Standards

As outlined in Chapter Four, the analysis of the Standards aimed to look predominantly at the discourse underlying the Standards. Initially, I examined the document by looking at how issues relating to the improvement of the quality of life of older people were dealt with, what issues (from my examination of the literature and of Standards from other countries) were absent from the Standards, who was the key audience, or intended readership of the document, and how were residents portrayed within the Standards. This initial analysis yielded a total of 21 codes, as outlined in Table I.2 below:

From these codes, I began to recognise that there were a number of ambiguities within the Standards, and also that there appeared to be a tension between the positive aspects of ageing and residents' autonomy, and the more negative aspects of the ageing process, and residents as frail. From this, I developed two codes, Ambiguity and the Model of person centred care, into which I was able to collapse the various codes. While I initially used Excel in order to visually compare the Standards and Regulations, I subsequently developed codes within NVivo for this theme in order to keep all aspects of the data analysis together in the same place.

Table I.3 shows the development of the three themes.

Table I.2: Initial Codes from the Analysis of the Standards

Agency and Autonomy
Broad V Detailed Standards
Consultation
Complaints
Contract
Costly Standards: Physical Environment and Staffing
Decision-Making
Dignity
Financing
Frailty
Health Promotion
Homely Atmosphere
Institutionalisation
Negative Aspects of Ageing
Positive Aspects of Ageing
Protection
Relationship between Staff and Residents
Relationships between Residents
Residential Care as a Hotel
Responsibility
Rights of Residents
Risk V Choice
Risk Management
Role of the Minister
Role of HIQA
Role of the Provider
Role of Staff
Role of Residents Role of Family/Representatives
Role of the Criteria
Standards vis-a-vis the Regulations

Table I.3: Development of Themes in the Standards

Ambiguity	Purpose of the Standards	Role of The Standards Role of The Criteria
	Responsibility	Role of the DOHC Role of HIQA Role of the Provider Role of Staff Role of Residents
	Risk V Safety	Agency and Autonomy Consultation Decision-Making Frailty Protection Rights of Residents Risk Management
Person-Centred Care	Consumer Driven Model	Agency and Autonomy Contract Complaints Consultation Decision-Making Health Promotion Institutionalisation Negative Aspects of Ageing Positive Aspects of Ageing Residential Care as a Hotel Responsibility Rights of Residents
	Psycho-Social Model	Agency and Autonomy Consultation Decision-Making Dignity Frailty Homely Atmosphere Negative Aspects of Ageing Positive Aspects of Ageing Protection Relationships between Residents Relationships between Staff & Residents
Standards V Regulations	Reflected in the Regulations	Retention of written policies Abuse prevention Focus on risk management Brief outline of many Standards
	Absent from the Regulations	Whistleblowing Focus on residents' autonomy Input from residents into decision-making (Costly) Physical environment standards (Costly) Staffing qualification requirements Requirement for advocacy Links with local community Much of the Details provided in the Standards
	New in Regulations	Additional detail in records Focus on safety Risk Management Policy Communication Policy Staff awareness of regulations

I.3 Development of Themes from the Process

An initial reading of the 44 interview transcripts yielded a total of 29 codes, as outlined in Table I.4 below.

Table I.4: Codes Developed from the Initial Analysis of the Process

Attitudes towards Older People
Benefitted from Membership of the Working Group
Considerations of the Financing of the Standards
Considerations of the Implementation of the Standards
Contradictions
Decision-Making Processes
Direct Relevance of the Standards to Respondents
Factors influencing the Content of the Standards
Influence of Public Opinion on Residential Care
Memory
Motivations for the Development of the Working Group
Operations of the Working Group
Policy Context
Public Consultation Process
Regulations
Representation
Saviour V Enemy
Tensions between Public and Private Providers
Tensions between Frontline Workers and Policy Makers
Trust and Mistrust
Understandings of QOL and Person-Centred Care
Vested Interests
Views on DOHC
Views on HIQA
Views on Residential Care
Views on Successful Regulation
Views on the Process
Views on the Standards
Workload and Preparation

Following this initial analysis, I re-organised the codes to facilitate the process-tracing approach, examining the process prior to, during and after HIQA's Working Group separately. In particular, as outlined in Figure I.1, I considered various aspects of the Working Group separately, and was informed by the literature on group dynamics in order to help understand the operations of the group more clearly.

Figure I.1: Themes Derived from the Process

Pre-HIQA Working Group		HIQA Working Group					Post-Working Group
DOHC Working Group	Policy Context	Membership	Operations of the Group	Policy Context	Group Dynamics	Views and Attitudes	Benefitted from Membership
Impact of the Deadline	Role of HIQA	Impact of Group Size	Workload and Preparation	Celtic Tiger	Vested Interests	Views on Leas Cross	Relationship between HIQA and DOHC
Membership	Leas Cross	Representations of Older People	Leadership: Role of HIQA	Policy-Making Processes	Contentious Issues	Views on the Process	Implementation of the Standards
Decision-Making Processes	DOHC's Agenda Public Opinion	Membership Selection Process	Public Consultation Process	Role of the DOHC Public Opinion on Residential	Decision-Making Processes Representation	Views on Older People Views on HIQA	Policy Context: Changing Economic Climate
						Views on Person-Centred Care & QOL	
						Responsibility	
						Trust and Mistrust Influencing the Content of the Standards	
						Views on the DOHC Views on the Standards	

I.4 Inter-Relationship between the Process and the Standards

As outlined in Chapter Four, the second phase of the analysis process was to examine the inter-relationship between the Standards and the process used to develop them. In this process, I examined each of the three themes that emerged from the analysis of the content of the Standards separately, and looked at how the operations of the Working Group appeared to have resulted in these outcomes. Figures I.2, I.3 and I.4 illustrate the outcomes of this analysis.

The analysis of the inter-relationship between the process and outcomes helped me to determine the gaps in the causal “story”, particularly in highlighting the factors that influenced the operations of the Working Group and the initial decision to use regulation to react to the Leas Cross crisis. As a result, I returned to the scholarly literature in order to look for theoretical explanations to complete the process-tracing analysis. As outlined earlier, this led to the addition of aspects of the theory of governance as a wider contextual framework for the findings, as outlined in Figure I.5 below.

Figure I.2: Explaining the Ambiguity in the Standards

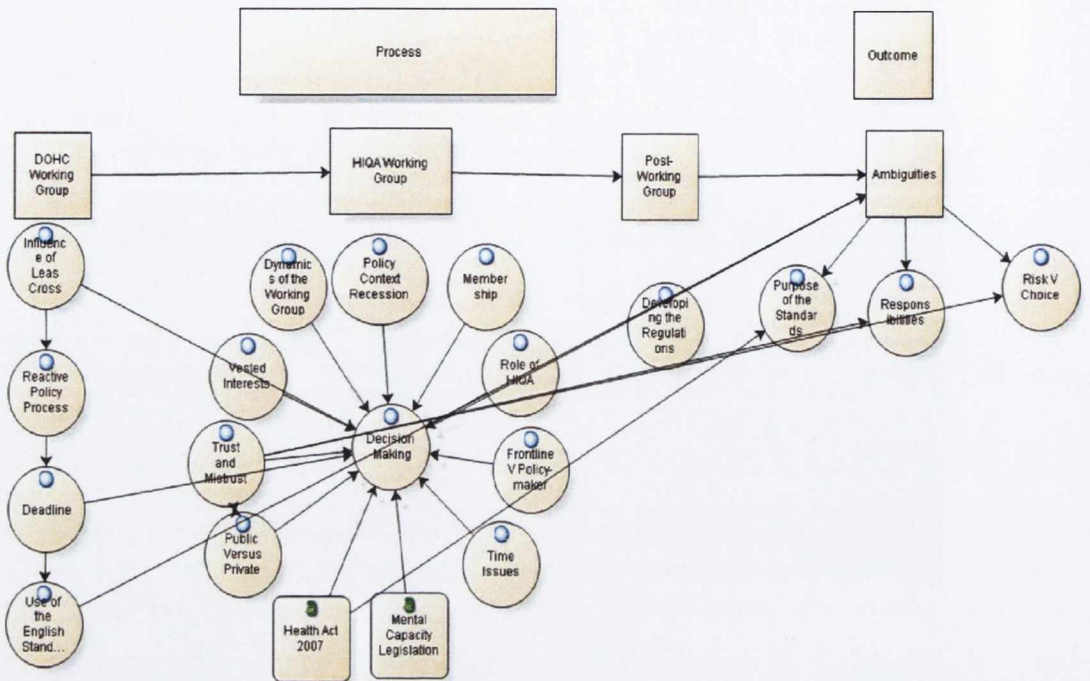


Figure I.3: Explaining the Conceptualisation of Person-Centred Care within the Standards

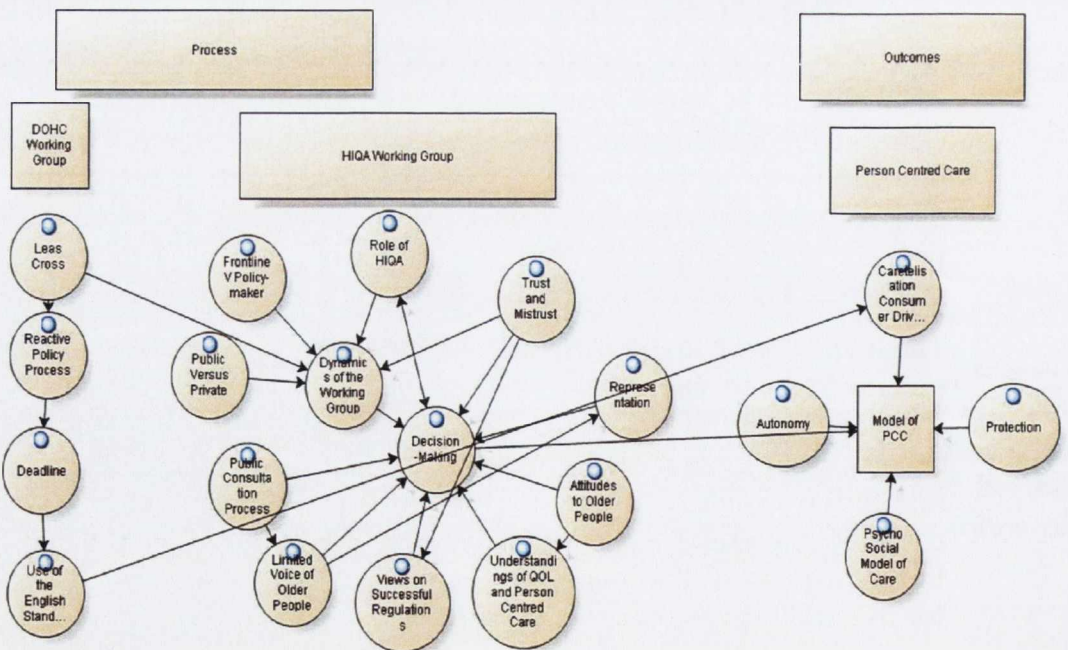


Figure I.4: Ownership over the Regulatory Process

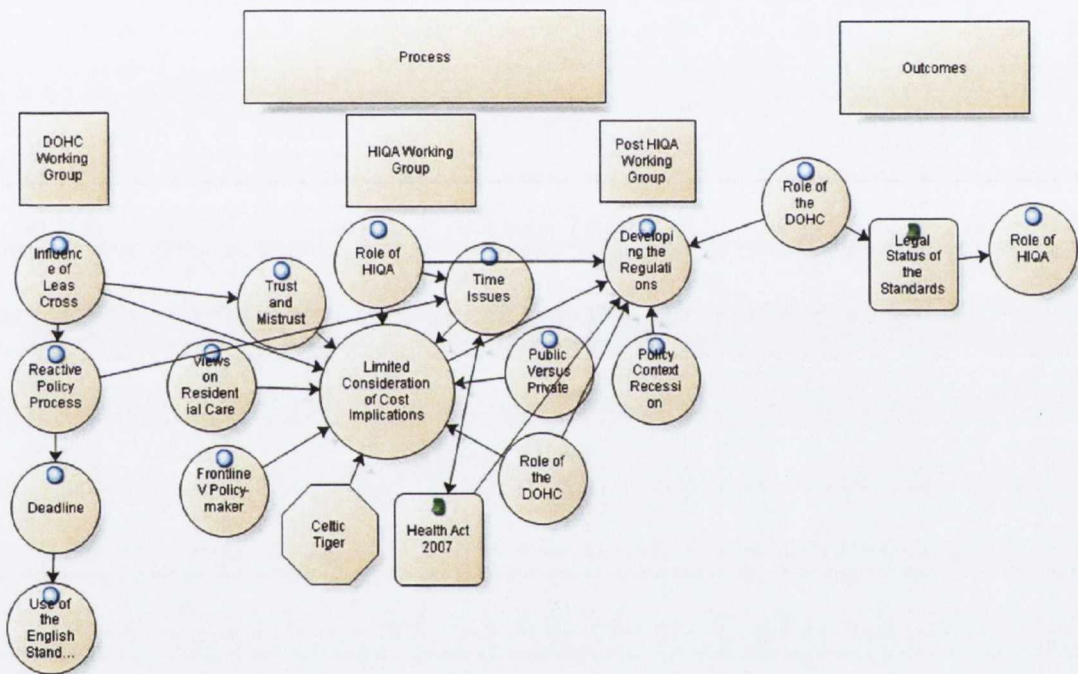
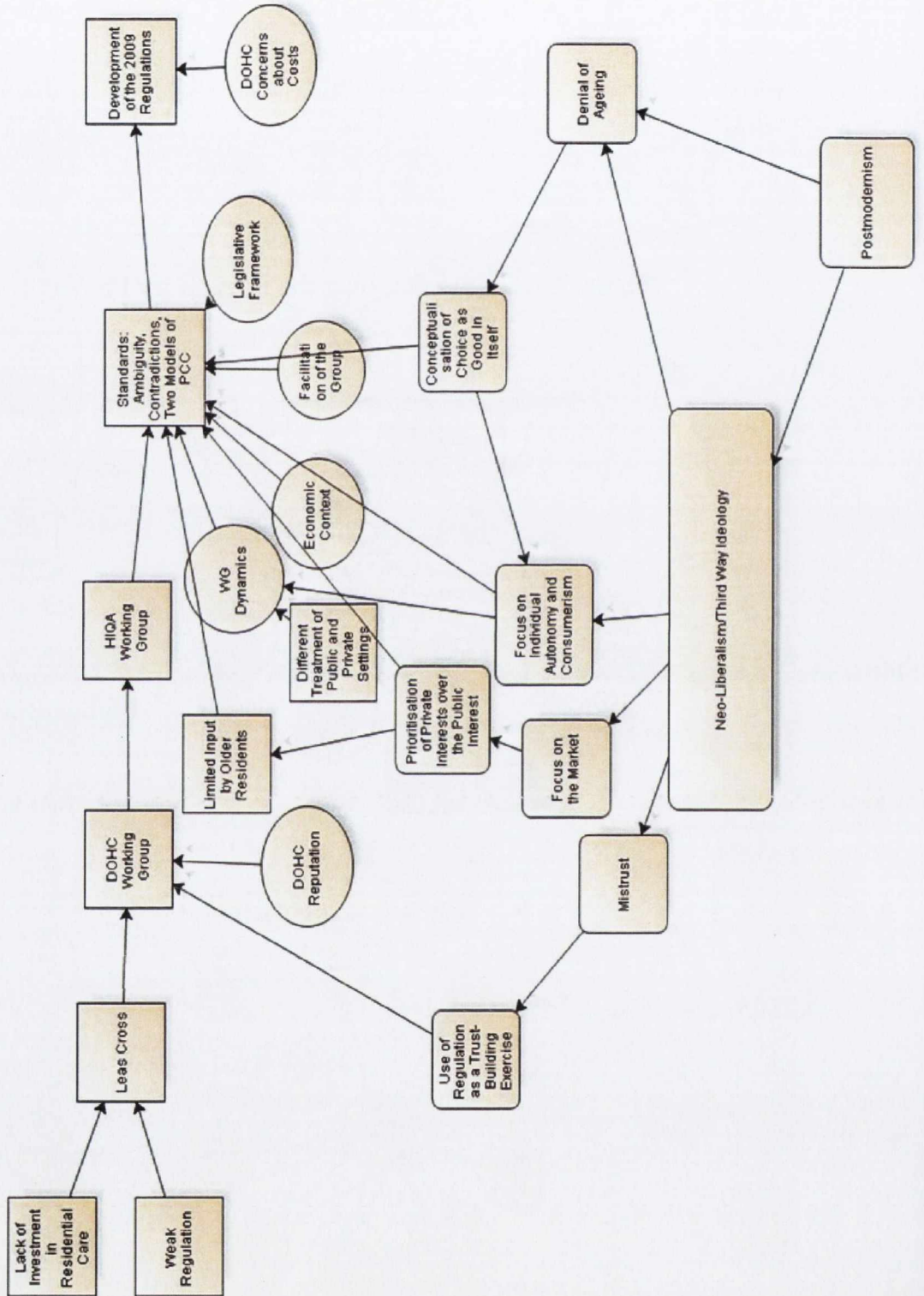


Figure I.5: Influence of Neo-Liberalism on the Process and Outcomes



1.5 Confirming the Causal Network

As outlined in Chapter Four, it is important to try to confirm the findings in a study using a process-tracing approach to develop an explanatory theory. It is however important to note that causal explanations are often flawed as they rely on researcher's personal assumptions. Regardless of how much researchers attempt to expunge their biases from their findings, what we notice and how we explain them may differ from how others would (Miles & Huberman 1994). Thus, Miles & Huberman (1994) suggest that researchers should reflect on the accurateness of the causal explanation they propose. The value placed upon theory confirmation is also recommended within the process tracing method (George & Bennett 2005).

George & Bennett (2005) suggest that confidence in an explanation proposed using a process-tracing approach can be increased if the following elements are present:

- An explanatory account that runs from beginning to end.
- An account that has no noteworthy breaks in the causal story.
- The presence of evidence to support the explanation.
- The presence of evidence inconsistent with alternative explanations.
- Alternative explanations have been considered and ruled out.

It is possible to argue that the explanatory theory outlined in this chapter runs from beginning to end, with no noteworthy breaks in the story. This can be confirmed by way of reference to the diagram presented in Figure X, which highlights how events unfolded and outlines the factors that appeared to have influenced this chain of events. It is important to state, however, that an important "factual" finding was not confirmed, namely the reason why the Department of Health and Children decided to reinterpret the purpose of the Standards and underpin only some of them with regulations. Although I have asserted that this was a deliberate decision made for financial reasons, this was denied by both the DOHC and HIQA. However, HIQA staff have suggested informally that this appears to be the most plausible explanation.

Furthermore, while alternative explanations, in the form of other "grand theories" were not considered formally in the thesis, it is important to reiterate that, throughout my time collecting and analysing data, I sought to find an explanatory theory within the literature on social gerontology, regulation, group dynamics and policy development but, none seemed a good explanatory "fit" with the data. From these bodies of literature, I gradually moved towards the literature on governance, which appeared to me a better fit for the findings emerging from my thesis and to explain the link between the Standards and the process used to develop them.

Quality Standards for Qualitative Research

J.1 Assessing the Quality of the Research

As noted in Chapter Four, Miles & Huberman (1994) provide a checklist to allow researchers to assess the quality of their research. Table J.1 overleaf outlines the extent to which this study meets these criteria.

The Standards and Institutionalism

Table K.1: Use of the Standards to exorcise the characteristics of “institutions” from Irish residential care settings for older people

Characteristics of Total Institutions	Standards
1. Entry rituals including stripping of an individual's private identity and processing an individual's life.	1: Information: Each resident has access to information, in an accessible format, appropriate to his/her individual needs, to assist in decision making. 7: Contract/Statement of Terms and Conditions: Each resident has a written contract/ statement of terms and conditions with the registered provider of the residential care setting.
2. Locational dedifferentiation: all aspects of life are conducted in the same place.	20: Social Contacts: Each resident maintains contact with his/her family, friends, representatives and the local community according to his/her wishes.
3. Dedifferentiation of authority: single, unspecialised authority, hierarchy.	2: Consultation and Participation: Each resident's rights to consultation and participation in the organisation of the residential care setting, and his/her life within it, are reflected in all policies and practices. 6: Complaints: The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure. 27: Operational Management: The residential care setting is managed by a suitably qualified and experienced nurse with authority, accountability and responsibility for the provision of the service.
4. Each phase of the patient's daily activity is carried on in the immediate company of a large group of others.	4: Privacy and Dignity: Each resident's right to privacy and dignity is respected
5. Daily activities are tightly scheduled by staff with little individual variation.	18: Routines and Expectations: Each resident has a lifestyle in the residential care setting that is consistent with his/ her previous routines, expectations and preferences, and satisfies his/ her social, cultural, language, religious, and recreational interests and needs.
6. Violations of privacy are common.	4: Privacy and Dignity: Each resident's right to privacy and dignity is respected.
7. There is a small group of staff members whose primary role is to ensure enforcement of the rules.	17: Autonomy and Independence: Each resident can exercise choice and control over his/ her life and is encouraged and enabled to maximise independence in accordance with his/ her wishes.
8. Several restrictions on patient contact with the outside world.	5: Civil, Political and Religious Rights: Each resident is facilitated to exercise his/ her civil, political and religious rights in accordance with his/ her wishes. 20: Social Contacts: Each resident maintains contact with his/ her family, friends, representatives and the local community according to his/ her wishes.
9. Line staff function to control patient communication to higher staff.	6: Complaints: The complaints of each resident, his/ her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.
10. Both patients and staff view each other through narrow, hostile stereotypes.	7: Contract/Statement of Terms and Conditions: Each resident has a written contract/ statement of terms and conditions with the registered provider of the residential care setting.
11. Patients are excluded from making plans about themselves.	23: Staffing Levels and Qualifications: There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these Standards and the needs of the residents.
	11: The Resident's Care Plan: The arrangements to meet each resident's assessed needs are set out in an individual care plan, developed and agreed with each resident, or in the case of a resident with cognitive impairment with his/ her representative. 13: Healthcare: Each resident's assessed health needs are reviewed and met on an ongoing basis in consultation with the resident.
12. Rituals are characterised by patient deference toward staff develop in total institutions.	16: End of Life Care: Each resident continues to receive care at the end of his/ her life which meets his/ her physical, emotional, social and spiritual needs and respects his/ her dignity and autonomy. 3: Consent: Each resident's consent to treatment and care is obtained in accordance with legislation and current best practice guidelines.
13. Patients must request staff permission for routine activities and tools.	6: Complaints: The complaints of each resident, his/ her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.
14. Discrediting reports about patients are commonly spread through staff ranks.	17: Autonomy and Independence: Each resident can exercise choice and control over his/ her life and is encouraged and enabled to maximise independence in accordance with his/ her wishes.
15. All activities are brought together into a single, rational plan designed to fulfil official aims of the institution.	8: Protection: Each resident is protected from all forms of abuse.
	28: Purpose and Function: There is a written statement of purpose and function that accurately describes the service that is provided in the residential care setting and the manner in which it is provided. Implementation of the statement of purpose and function is clearly demonstrated.