End of Life Care in English Care Homes: Governance, Care Work and The Good Death

Dana Teggi
PhD Candidate
Social & Policy Sciences
University of Bath
D.Teggi@bath.ac.uk
Governance

- Custody
- Keeping alive
- Reducing costs (to the NHS and care providers)
- Senior staff’s prediction work
- Anticipatory prescribing of EOL medication by the GP
  - Workload increase & understaffing
- Death in the care home vs in hospital
  - (1) prioritization of bodily care, (2) extension of residents’ dying, (3) construction of death as natural (intervention & non-intervention vs accidents & neglect)
- The good death is the regulations-complying death > Coroner’s + CQC
The three typical end-of-life trajectories (Teggi, 2018)
Care Work

• Carers wanted to improve residents’ lives, but the care home system (governance) was not geared towards this.

• Bed and body work
  • Emotional work
    instrumental vs non-instrumental

• ‘Being with’ residents at the end of life (EOL) countered social death.

• The *predicament of care work* in care homes was compounded at the EOL.
The Good Death

<table>
<thead>
<tr>
<th>MEDICAL</th>
<th>DOMINANT GOVERNANCE-MANDATED</th>
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<tbody>
<tr>
<td>Death is predicted and managed by senior staff, GPs and DNs: death occurs in the care home and is pain-free.</td>
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<tr>
<th>NATURAL</th>
<th>AUXILIARY STAFF-IMPLEMENTED</th>
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<tbody>
<tr>
<td>Death from illness or deterioration (causes internal to residents’ bodies) as opposed to accidents (falls, injuries, choking on food/drink) or a resident’s decision to self-dehydrate/starve (causes external to residents’ bodies). Natural death is both the product of intervention and non-intervention. Sudden natural deaths are problematic because unpredicted.</td>
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<th>SACRED</th>
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<td>Death is expected by the relatives/close companions of the dying resident.</td>
<td>Death is accompanied by the carers (and/or relatives) of the dying resident.</td>
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</table>
REFERENCES

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