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

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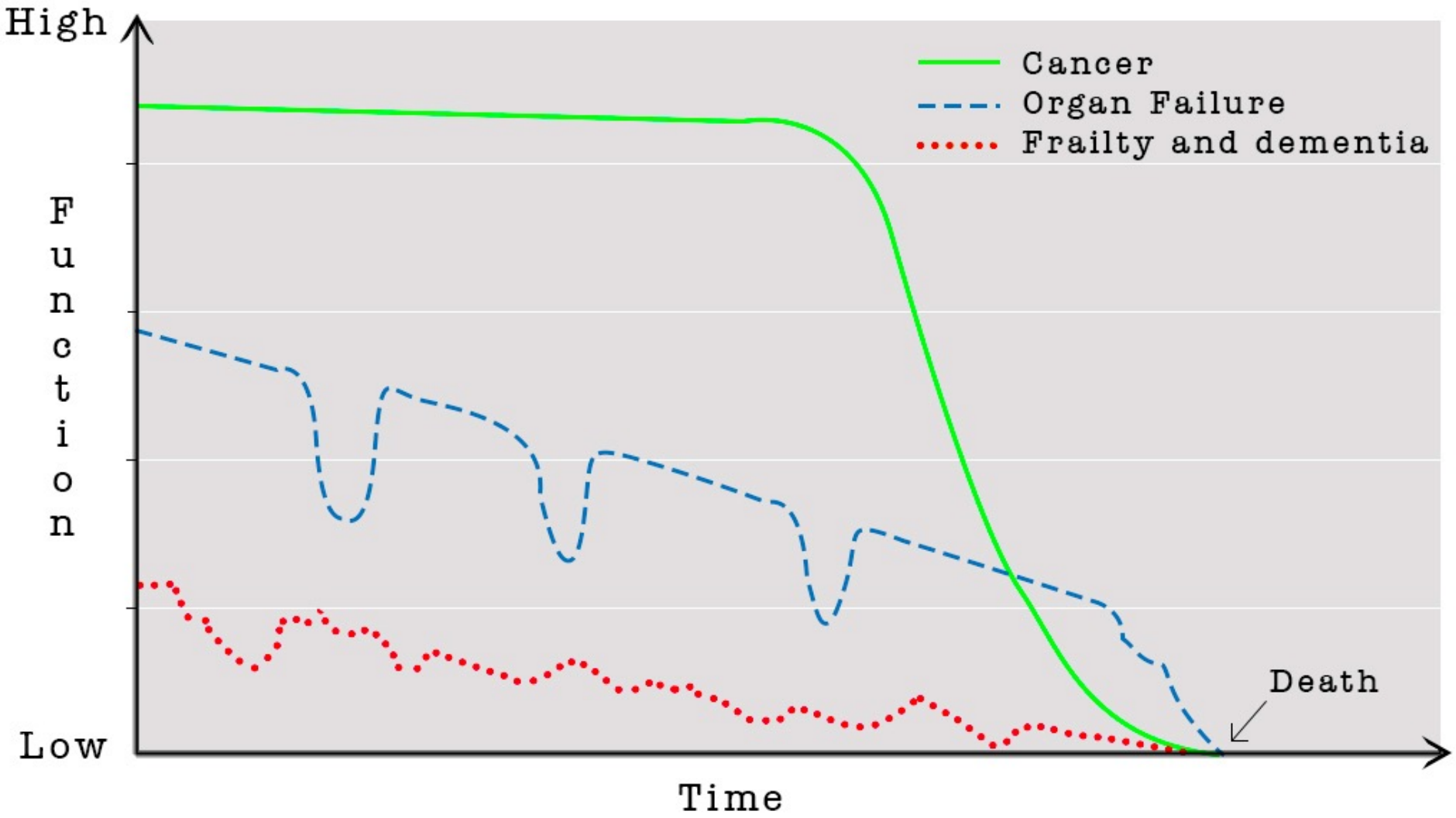
Governance

- 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

	DOMINANT GOVERNANCE-MANDATED	AUXILIARY STAFF-IMPLEMENTED
MEDICAL	Death is **predicted** and managed by senior staff, GPs and DNs: death occurs **in the care home** and is pain-free.	
NATURAL (a misnomer)	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.	
SACRED	Death is **expected** by the relatives/close companions of the dying resident.	Death is **accompanied** by the carers (and/or relatives) of the dying resident.

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