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Chapter 14

Bedroom abuse: the hidden work in a nursing home

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In Western society the bedroom has been constructed as a place of privacy. It has a unique symbolism for the individual in terms of personal choice. Even if other parts of the domestic home are open to public view the bedroom usually is not. (See Willcocks et al., 1987: 4-6; Goffman, 1959: 124.) Yet in forms of institutionalized care this is problematic, as these rooms are also workplaces for staff. The way that homes are organized leaves those with the least training to undertake the physical care work. This work is often bedroom-based work. It is physically hard and dirty. Also it is hidden.

The physical work behind the scenes is not seen, yet it is essential if the patient is to be presentable to others. In Goffman's (1959: 126) terms the preparatory work of the bedroom is backstage 'technical work' and is often undertaken by low-status workers whose product is then presented by higher-status workers. In the case of the nursing home the patient that the auxiliary washes, dresses and organizes is placed in the lounge where nursing staff then present the sanitized patient to visitors. [...]

This paper argues that in many homes the bedroom world is ordered and arranged by the nursing auxiliary [...] the aim of their work being the creation of the acceptable patient for public view. In this world mistreatment and punishing behaviours become acceptable, mistreatment being part of the daily grind of getting through the work - of organizing people in conveyor-belt fashion to time and chore constraints. Punishment, apart from being a more deliberate and personal form of cruelty, involved getting back at the job and taking it out on the objects of care. Both also appeared to create a subdued patient who was then easier to order. Lastly, I discuss how mistreatment and being hard towards patients had become part of the auxiliaries' subculture and had been elevated beyond simple necessity to being an essential attribute of the good worker. [...]

The home and bedrooms

Cedar Court was one such home, sited on the outskirts of a major town in the south west of England (the name has been changed to preserve anonymity). On arrival I was immediately

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struck by the isolation from the general community by a large garden surrounded by trees and a long gravel drive. The exterior of the building was modern and anonymous, unlike a domestic home. [...] Heavy glass swing doors at the front of the building gave the appearance of a hospital entrance. Inside, the home was carpeted from bedrooms to lounge with a 'seconds flawed' carpet and the walls and ceilings were all painted magnolia. To the visitor the buzzers, smells of disinfectant, uniforms, trolleys and wheelchairs gave an impression of hospitalization and a medical order. Yet, although trained staff dominated public areas, the majority of staff were untrained auxiliary workers who worked mainly in the more private area of the home. [...]

The bedroom job

The bedroom was the main site of work for the auxiliaries and most of the patients' time in the home was spent there. Morning work was virtually all bedroom work and was officially begun by the auxiliaries entering patients' rooms on the tea round. This was a point of the day at which cups of tea were served and bottoms were washed. It was customary to present the patients to the new shift intact, clean and quiet in their rooms for 8 a.m. Presenting well-ordered bodies seemed to symbolize the job properly done. The next shift spent all the morning in the bedrooms, washing and dressing patients. The workers spent most of the morning getting patients ready, then taking them down to the lounge. By lunchtime they were all down, but straight after lunch it was time to put them back to bed for a nap and later get them up again.

In the evenings work again revolved around the bedrooms as staff got patients ready for bed. By the time the night shift came on, all patients were in bed. In this way the auxiliaries' work could be said to revolve around the bedroom. And it was in this private world that they were able to decide the rules and had total hidden control.

The aim and nature of the work

The aim of work in the bedrooms was generally the creation of patients who could be presented into the lounge area: 'the lounge standard patient'. Those who were 'displayed' in the lounge were those who fitted the home's construction of the ordered patient – the physically and mentally ordered patients, dressed tidily, unsmelly and clean. The patients with whom the auxiliary worked in the bedroom was, by comparison, highly disorderly. Some states only existed in the bedroom areas: violent outbursts, confusion outbursts involving noise; shouting, spitting and other anti-social behaviour, such as continual rapping on tables or banging sticks on floors, and also very persistent and distressing crying and sobbing. Acute sickness was also visible only in the bedroom; but in these cases the trained staff took charge. All patient who exhibited these behaviours in the lounge were immediately physically confined to the bedrooms by the auxiliaries.

Depersonalization: part of the job

Mistreatment appeared a fair socialization – ignoring the presence of the patient – to save time central to time-saving. Emotional Patients who demanded too actively labelled as 'whiners' resistance was employed to justify the mistreatment.

Auxiliaries often ignored the third person, and saying instead 'the patient'.

At night treating patients was a ritual. But for workers this was a time to relax.

The same ritual is observed in the morning. When the light is switched on, a jug is exposing them to the air, their bottoms might need to be rolled over and flushed, the jug is washed, then the patient is ready. If two auxiliaries are in the room they deal with them. Should a patient refuse to get back to sleep. Any patient awake is dealt with. Many patients lie motionless (fieldwork notes: nights)

Personal space and presence were ignored. Auxiliaries would enter rooms without traditional greetings. Briefly they would find out whether the patient was awake, look at their bottoms, and then leave. They were doing this to save time.

The exit out of the room after the patient was ready for the next chore was done the shutting of the door [...]

These acts of mistreatment were part of the care. But other forms did exist. Patients were seen as 'having some fun with the work'. For some way with the work. For some 'race' down the corridor, and some were crying in pain would be seen. Staff copying the words of the patient to understand jokes that the workers made at them. But 'joking' appeared to reduce stress and gave them some social contact.

Depersonalization and mistreatment – part of the job

Mistreatment appeared a fairly everyday strategy to get through the work. It involved depersonalization – ignoring the individual's spatial rights, ignoring the patient's words, or even their presence – to save time. Workers' felt resistance to the individual's emotional needs was central to time-saving. Emotional work had to be repressed and physical labour prioritized. Patients who demanded too much emotional time and refused the role of 'object' were negatively labelled as 'whiners' and were avoided. The more that patients demanded, the more resistance was employed to prevent their emotional needs from being fulfilled.

Auxiliaries often ignored the presence of patients, preferring to talk about them in the third person, and saying insensitive things. [...]

At night treating patients as objects was virtually the sole form of interaction observed. But for workers this was a time-saving device, as illustrated by the rituals of rounds.

The same ritual is observed in each room entered: the auxiliaries go alone or in pairs, the toilet light is switched on, a jug is collected from the toilet, the patients' bed sheets are pulled back exposing them to the air, their night clothes are pulled up to allow the leg bag to be emptied. They might need to be rolled over to allow access. The urine is then thrown down the toilet which is flushed, the jug is washed, the sheets are pulled back over each patient and the auxiliary exists. If two auxiliaries are in the same room on the round they very often chat over the patients while they deal with them. Should a patient stir or open their eyes during this ritual they are told to go back to sleep. Any patient awake at night is considered an inconvenience to this two-hourly ritual. Many patients lie motionless with their eyes open and staring blankly as this ritual is performed. (fieldwork notes: nights)

Personal space and presence was also disregarded in the format of entrances and exits into rooms. Auxiliaries would often enter a room with little regard for the convention of traditional greetings. Brief introductions were often followed by invasive procedures to find out whether the patient was soiled, such as pulling sheets back, rolling patients over to look at their bottoms, and then giving some brief explanation of what the auxiliaries were doing.

The exit out of the room also tended to be unmarked by the usual rituals. Once a work chore was done the shutting of the door seemed to suffice as the end of the interaction. [...]

These acts of mistreatment involved the staff ignoring patients and not involving them in care. But other forms did involve the patient. Making jokes at the patient's expense was seen as 'having some fun with the patients' and workers argued that it involved patients in some way with the work. For example, patients who could not walk properly were told to 'race' down the corridor, and jokes would be made about Nigel Mansell, etc. Patients who were crying in pain would be told to buck up and smile. Mimicry was also common, with staff copying the words of confused residents. Most patients either could not hear, see or understand jokes that the workers made at their expense, while others became distressed at them. But 'joking' appeared to help auxiliaries get through the work; it broke up the stress and gave them some sort of control.

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Mistreatment involved a wide range of behaviours all of which served to create complacency in patients. Mistreatment served to give workers more control over the objects they had to process, within strict temporal constraints around the space of the home. They were partially a product of constraints on the job and also appeared to stem from ignorance about how to work with confused people and elevation within the subculture of the role of restraint and containment as part of the job.

Punishment

Auxiliary staff believed that physical abuse towards patients was unacceptable, and many gave accounts of whistle-blowing on violent colleagues in the past. However, there was no notion of mental or emotional cruelty. Telling people off, ignoring them and 'teaching them a lesson' in ways other than physical violence were seen as acceptable. When working with nursing staff the auxiliary took the role of the verbally punitive partner. It was her role also to deal with the patient who behaved badly in the lounge, to make it clear that certain behaviours were not acceptable. [...]

Use of call buzzers was particularly disliked and one of the ways a patient could be punished was for their buzzing to be ignored. Due to immobility of patients, ignoring buzzing induced a powerlessness they could do little about. [...] Active stratagems were used to deal with other less capable 'buzzers'. [...]

Others 'harsh' night remedies included pulling the bed out from the wall, thus leaving the patient unable to reach the buzzer. Some 'naughty', persistent buzzers had begun to confound this punishment by calling to other patients to get them to use their buzzers for them. On one occasion a patient who was talking to another in the four-bedder was put in a chair, taken downstairs to the lounge and sat in a corner on her own until she 'seemed quiet'. Communication and group resistance from patients were not tolerated.

Day punishments went on mainly in the form of telling people off, teasing them or even denying their realities. More lucid patients were punished mainly through avoidance; their buzzers would be ignored and they would be left until last. 'Confused' patients were generally treated with a much more confrontational form of punishment. For example, they were called names: 'dying duck', 'moaning Minnie' or told they were 'pathetic', 'stupid' or 'being childish'. With these patients fear tactics, such as using a threatening tone of voice or physically being noisy in the surrounding environment, ramming the metal sides of hospital beds down violently, were observed daily. Punishment and control strategies such as these seemed a way to get back at the job.

The hard culture

Auxiliary work in nursing homes is hard work: low paid, low status, dirty, physically back-breaking and tiring. However, far from complaining about the conditions of their work the nursing auxiliaries appeared to have elevated the notion of personal hardship within their subculture. Personal hardship and hard behaviour towards patients seemed central to auxiliaries' understanding of what they were supposed to do. They spoke about others, such as residential home workers, and trained staff, as too 'soft'. A strong emphasis was placed

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Violence from patients was common: swearing, biting, kicking. Patients were having personal those considered to be suffer the basis for staffroom stories watch certain chores that illustrate to observe a patient who was

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Conclusions

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References

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upon coping and getting on with the work, even avoiding the use of hoist and aids, despite the frequency of serious back problems.

Violence from patients was experienced on a daily basis. Verbal and physical violence were common: swearing, biting, kicking, hitting (with the hand, stick or frame) usually occurred when patients were having personal care chores done. The physical violence was usually exhibited by those considered to be suffering from forms of confusion. Physical abuse was seen as funny – the basis for staffroom stories and myth-making; part of the job. Auxiliaries often invited me to watch certain chores that illustrated this type of violence. For example, one auxiliary invited me to observe a patient who was always aggressive in the evenings, referring to the chore as 'fun'.

The violent behaviour of patients was discussed at the end of shifts. The auxiliaries would recount patients' aggressive acts and compare bruises with pride. In situations where a trained staff member was present and a patient exhibited violent behaviour it was the auxiliary who physically positioned herself to take the brunt of it, restraining the individual and ticking them off for their behaviour. Taking and containing aggression was being 'hard', which itself was part of the role of being an auxiliary.

Within this subculture of personal hardship and the elevation of containment and ordering aspects of the job, it is unsurprising that acts of mistreatment and punishment were pervasive and unquestioned. [...]

Conclusions

[...] In Cedar Court, bedroom work was auxiliaries' work and in some ways they had colonized the space as a workplace, with the patients having little control over these areas. The physical state of the patient was the only indicator of the job being done. Physical care was attained at Cedar Court through practices of daily mistreatment. Through these the individual could be ordered around the routine quicker, and they did appear to effect a state of compliance in most patients. Both punishment and mistreatment rapidly helped to create 'the lounge standard patient', which indicated that care was being carried out. Within this hidden bedroom world non-physical abuse was very difficult for trained staff, visitors or others to perceive. For example, it appeared that the trained staff who worked in fairly close proximity, but rarely in the bedrooms, were not aware of the existence of such abuse. The hard culture which had developed amongst auxiliaries positively sanctioned non-physical abuse as part of the work. Thus abuses could be carried out in front of other auxiliaries without being commented upon.

In Cedar Court the principal aim of the auxiliary was the ordering of the patient in the private world of the bedroom, and care was judged by the state of the patient's body. In this context non-physical mistreatment of the patient becomes routinized and difficult to detect. Research on institutional abuse needs to uncover both the hidden nature of care tasks and the meanings of such work to staff, to understand abuse more fully.

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