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The problems of a 'dirty workplace' in domiciliary care

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ABSTRACT

'Dirty work' is an acknowledged part of domiciliary care, with tasks such as bathing and toileting, but there is little examination into whether the workplaces may also be dirty. Domiciliaries' workplace is the client's own home, but this space has been under-researched and is often not considered essential to client's care in policy. Through shadowing and interviews with domiciliaries, managers and stakeholders this paper suggests that in the most extreme cases the workplace may be dirty. Arguably 'dirty workplaces' have a negative effect upon domiciliaries through unofficially increasing their workload, further devaluing their work and risking their wellbeing.

1. Introduction

The concept of 'dirty work' within domiciliary care is widely recognised within the literature; however, the potential for dirty *workplaces* within this occupation appears less apparent. This paper seeks to draw attention to the possibility of dirty workplaces and the problems this can cause for domiciliaries.

Domiciliary care is the provision of care for an older person in their own home. Paid careworkers, domiciliaries, travel to the residences of these older people to undertake a variety of personal and health care activities. Domiciliary care has undergone substantial changes in recent years in terms of the service provided, clients cared for, its organisation and funding arrangements, but it is still typically perceived as *just* 'home help', receiving scant attention or resources.

This undervaluation is linked to both the services and location of domiciliary care. Many of the activities that domiciliaries undertake can be described as 'dirty work', thus devalued in terms of economics and social status. Furthermore because domiciliary care takes place in a client's own home, it is hidden from society, and suffers from associations with informal care, which is notoriously under recognised (Twigg, 2000).

However, despite its invisibility, the place in which care is located is important because it shapes the nature of care (Milligan, 2009). Yet, although the client's home impacts upon domiciliary care, there has been limited research on this topic, and there have been calls internationally for more studies into domiciliaries' workplaces. Although this is a UK study, the place of domiciliary care is a subject of international interest (Dyck et al., 2005; Taylor and Donnelly, 2006; Henriksen et al., 2009).

Interestingly, despite the recognition of dirty work in domiciliary care studies, the notion of a dirty workplace is largely absent. Whilst the limited literature (even internationally) that focuses on domiciliary care workplaces typically emphasises the hazards it entails, even these studies appear reluctant to describe client's homes as 'dirty workplaces'. Thus there is a gap between the concept of dirty work and workplaces. Drawing upon interviews and shadowing data from a broader study of the labour process of domiciliaries, this article will reveal that in the most extreme cases clients' homes can be 'dirty workplaces'. This paper explores the ways in which this 'dirt' can infiltrate the workplace, and how domiciliaries manage this, and the pressures that they face to do so. It suggests that domiciliaries are often expected to perform extra unofficial and unrewarded tasks in these dirty workplaces. This article proposes that these potentially dirty workplaces and unrecognised tasks further devalue domiciliaries.

The concept of a 'dirty workplace' in domiciliary care also has important policy implications, both in England and internationally, due to its potential impact upon domiciliaries and clients (McKeever et al., 2006; Milligan, 2009). Yet currently the place of care is under-recognised in the provision of domiciliary care, and funding is rarely allocated for its cleaning (Age Concern, 2010).

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2. What is known about domiciliary care?

2.1. Overview of domiciliary care

In England domiciliary care was originally known as 'home help' and was designed for older people with low-level needs. Since the *NHS and Community Care Act* 1990 there has been a shift towards keeping older people in their own homes for as long as possible, and a corresponding reduction in residential care. Thus 'home help' was insufficient and evolved into domiciliary care. Domiciliaries' tasks now include bathing, dressing, feeding and traditional nursing activities such as changing catheters and administering medication.

Simultaneously, domiciliary care has been largely outsourced from local authority provision to the private sector (Rubery and Urwin, 2011). In the search for further efficiencies eligibility criteria has risen so that only clients with the highest level of needs are likely to be entitled to care (Passingham, 2010), and activities have been rationalised, for instance domestic help is rarely provided (Age Concern, 2010).

There has also been a purchaser–provider split; therefore although Social Services and domiciliary care services may still be part of the same local authority they operate separately, and Social Services must commission their domiciliary care colleagues to provide care. However, Social Services mostly procure care from private providers, because they receive lower rates than local authority providers (Mathew, 2004). These competitive pressures between providers are linked to domiciliaries' low pay and poor working conditions (Lilly, 2008).

Tied into the economic devaluation of domiciliaries, is the low status of the occupation (Stacey, 2011). Like other care workers, the majority of domiciliaries are women, who often have caring responsibilities themselves and are typically middle-aged and working class. Moreover, migrants and members of the black and minority ethnic communities are overrepresented (Timonen and Doyle, 2007).

Domiciliaries typically work alone in clients' homes, with as little as 15 minutes in which to care for an older person, before they must drive off to the next client (Rubery and Urwin, 2011). The care that is provided is based upon the client's care plan that identifies the tasks required. However, critics argue that some necessary tasks are not acknowledged in the care plan; thus domiciliaries are performing unrecognised and unpaid work (Cooper, 2004). In effect, domiciliaries' role has been transformed, upskilled and intensified, yet this is not reflected in their reward or recognition.

2.2. The dirty work

One of the reasons for the undervaluation of domiciliary care is the 'dirty work' it entails. The term 'dirty work' refers to Hughes' (1958) and later Ashforth and Kreiner's (1999: 414) definition of work that has 'physical, social or moral taint'. In domiciliary care the work is 'physically tainted' from its association with bodies and bodily fluids, human and household waste, death and disease (Stacey, 2005, 2011). It is also 'socially tainted' through its association with a stigmatised group – older and disabled people – who are also discriminated against in terms of care; and because of the potentially 'servile relationship', to use Ashforth and Kreiner's term (1999: 415), between domiciliaries and their clients. Therefore this 'dirty work' has low social-status and financial remuneration (England and Dyck, 2011).

Twigg (2000) provides a detailed account of domiciliaries' perspectives on undertaking 'dirty work', that is "dealing with human wastes: shit, pee, vomit, sputum….managing dirt and disgust" (p. 395). She reveals the difficulties domiciliaries encounter physically and psychologically. McGregor's (2007) study of dirty work focused on migrants, who describe their role as 'British Bottom Cleaners', and who also found such work challenging. Stacey's (2005, 2011) American research acknowledges that such work is hard; nevertheless she also argues that domiciliaries derive 'dignity' from being able to do such dirty work through their skill and ability to perform these tasks, and the benefits this has for their clients. However, England and Dyck's (2011) account suggests that there is little dignity in performing 'dirty work', as it has been delegated down the care hierarchy to domiciliaries. In part, domiciliary care has not received sufficient research attention because of its links with this 'dirty work' (Twigg, 1999, 2000).

The concept of 'dirty' is arguably subjective and culturally bound (Campkin and Cox, 2007). Dirt includes materials, places and activities considered unseemly such as bodily fluids; offensive smells; diseases; cleaning; laundry; sewers; human and household waste; bathrooms; sex work; rotting food; death; refuse handling and 'other people'. Campkin and Cox (p. 4) highlight Douglas', (1966) description of dirt as "matter out of place" and the stigmatization of 'dirty things'. This classification also applies to those performing the 'dirty work', as they are devalued, which is simultaneously linked to and reinforces inequalities in gender, class, ethnicity and immigration status (Anderson, 2000; Campkin and Cox, 2007; Wolkowitz, 2007). Wolkowitz also argues that the dirty work of care is particularly stigmatized, in part because it is feminized and also due to its association with bodies. However, the typical portrayal (Barbosa, 2007; Campkin and Cox, 2007) of outsourcing dirty work to someone more disadvantaged is not as clear cut in care work. People in receipt of care services are typically unable to undertake their own dirty work due to physical or mental health problems, rather than just unwilling. Yet, rather than increasing the status of care workers by demonstrating the vital nature of their work, it disempowers those requiring care, resulting in discrimination against both those needing and performing dirty work (Wolkowitz, 2007).

2.3. Understanding domiciliaries' workplace

One of the key differences between domiciliary care and other occupations is the location of the workplace, as it is the client's home rather than a formal site of caring. Milligan (2009) explains that the client's home is seen as the best place for care from the perspective of the state and the client, whilst noting that this is based on an 'ideal' home. Even when the home is the preferred place, several studies argue that there can be tensions between domiciliaries, clients and relatives with regards to their use of the home (Twigg, 1999; Dyck et al., 2005; Milligan, 2009; England and Dyck, 2011). These authors argued that the main reason for this tension is because working in the client's home makes domiciliaries different to other care workers. Domiciliaries are often perceived as a 'guest' or even an 'intruder'; they have less power, and need the client's permission to perform tasks, and use space and resources. This power imbalance can be particularly acute for some migrant workers providing domiciliary care, who may experience mistreatment (Anderson, 2000; Gordolan and Lalani, 2009).

Part of the conflict is a result of formal care contradicting with the ideology of home as a private place, ordered by personal routines (Milligan, 2009). Milligan (2009) and Taylor and Donnelly (2006) recognise that domiciliaries need a suitable and safe workspace, but highlight that this may conflict with clients' and relatives' requirements and they therefore may challenge any changes. North American studies argue that it might not be possible for clients to create an appropriate workspace, because of a lack of resources or restrictions in their ability (Dyck et al., 2005; McKeever et al., 2006; Gershon et al., 2008). They also