

## The Rules in Institutional Care: An Ethnographic Style Study Introduction

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### Abstract

**Background:** The purpose of this paper is to report on one area of findings that came from a larger doctoral study looking at what life was like for older people in receipt of long-term care in a hospital environment that was due for closure.

**Method:** Over the period of a year, the study's researcher regularly frequented a long-term care ward as a 'visitor'. Over time, she witnessed many day to day events experienced by frail older patients and recorded these as their stories in field notes as well as in her own related reflective notes. All data were transcribed and thematically analyzed.

**Results:** The researcher saw evidence of institutionalized rituals on the ward and underpinning these were one or other of four forms of thematically identified 'rules': procedural rules, hospital rules, unspoken rules and spontaneous rules. The imposition of these rules had a negative effect upon patients who were powerless in opposing them. In contrast for staff under stress, the 'rules' seemed to justify poor practice and served to excessively empower them over their patients. It was also clear that when staff displayed stress, emotional care for patients was poorer and the rules were exercised more frequently.

**Conclusions:** As the ward manager neither challenged poor practice nor prompted change towards person centered care, in the absence of management leadership, staff were left to their own devices as to their ways of working. Given staff shortages and the pressures that this placed upon workload resulted in an inappropriate economy of scale in terms of care-giving. This caused the older people to hold a inner sense of injustice and distress, that they felt unable articulate or to counter.

**Keywords:** Older; Health; Nursing; Pain; Bed-blocking

### Introduction

A part of a doctoral study, this paper focuses upon what life was like in long-term care for frail older people waiting to be discharged from a hospital setting to a nursing home [1]. Towards the end of the study, the long stay hospital was due to close, making the staff very anxious. All of the patients in this study had been transferred to a 'long stay' hospital from an acute hospital, where they had originally been admitted following an acute illness or injury. The status of such patients is formally known in the UK as 'delayed discharge', also referred to as 'bed-blocking' [2]. These patients, usually frail older people, are no longer in need of a hospital bed but are not fit enough to go back home and are waiting to be placed in an available community-based care home facility [3].

Long stay wards within the National Health Service (NHS) in the UK have been mostly discontinued, with a few facilities awaiting closure in Scotland, the research project's UK country of origin. However, the tenets of this work apply to any institution in which frail older people are cared for and include those who have had to leave their own homes for long-term care. Given that times have moved on since Goffman's seminal work on asylums [4], and that a person-centered approach is now purported to be implemented as best practice, the findings from the study show that institutional rules and

task-orientated work still pervade in some areas. The effect staff stress had on these practices is implicit in the experiences reported by the participants in this study.

### Person Centered Care

Person centered care, initially introduced as a concept in psychotherapy [5] started to appear in health care literature in the late 1960s [6]. The tenets of person-centered care put the client at the heart of care. The holistic needs of the individual, at the time and the place and in the situation they are in, have services shaped around them. The concept has been well defined and documented in the literature, although the implementation of such care is not always seen in practice. Individualized or person-centered care of older people is high on the health agenda in the Western world and is at the heart of good practice statements and policy documents. The United Nations (UN) Principles for older persons (1999) set out a clear directive for governments to ensure that older peoples' care addresses independence, participation, self-care, dignity and self-fulfillment [7]. In the UK, opportunity age proposed a strategy for the UK's ageing population, which highlighted the need for dignity, respect and well-being as key quality indicators for older people's services [8]. The European Older People's Platform proposed in addition, that older people's opinions need to be heard and their collective voice should

direct policy decisions [9]. Several authors provide further related reading [10-14].

Addressing the health and spiritual needs of frail older people in care is paramount to providing opportunities for the promotion of resilience within the individual, as this vulnerable client group struggles with issues of compromised autonomy [15]. Furthermore, the same author recommends that research should be seen through the eyes of the older people concerned and concentrate on the interactions between care givers and patients, where the relationship becomes the guiding principle for good practice [15].

There is a wealth of literature on improving quality of care and adopting a person- centered approach to the care of older people living in care homes but this lies beyond the scope of this paper. However, an excellent UK example can be seen in the National Care Homes Research and Development Forum (NCHR&D) which was established in 2003 and which published *My Home Life* (NCHR&D, 2006), a document which contains current best practice and research in the care home sector [16].

### Consideration of the Study's Design

In setting the scene for the study, it is necessary to describe the theoretical underpinning for the chosen methodology. The study was designed as an ethnography in order to give a broad view of what was taking place within a culture and the sub-culture within it, and how these impacted on the older people involved. Ethnography is reflexive and draws from the emic (insider) and etic (outsider) points of view [17]. However, a purist approach was not possible, as the concept of 'culture' has methodological problems [18,19]. This has been described as particularly problematic in welfare systems, no less because these are neither sufficiently comprehensive nor co-ordinated for generalisation to be a valid pursuit [20].

Conducting a single interview with each patient on the ward was rejected at an early stage as this would only provide superficial evidence as a snapshot in time. Furthermore, the interviewee's perceptions might differ if recorded at a different time, regardless of whether change has occurred or not [21]. The alternative adopted for the study required the researcher to enter into the culture of the ward and get to know the patients as individuals. In this way time spent in the field reveals explanations for what is being witnessed because during this period, routine and mundane incidents emerge as worthy of consideration as special occurrences [22]. In such ethnographic style approaches it is important to remember the role of 'self' within the process [23], and the researcher accordingly made reflective notes at the end of each visit.

The underpinning philosophy of symbolic interactionism was acknowledged. This philosophy has been defined in terms of human behaviour being based upon meanings which people attribute to and bring to situations [24]. Such behaviour is not 'caused' in any mechanical way, but is continually constructed and reconstructed on the basis of people's interpretations of the situations they are in. Early work by Goffman [4,25,26] used the dramaturgical or social interactionist paradigm to examine the 'drama' of service encounter, which discloses the views of the actors, participants and audiences within the cultural context of the environment. This philosophical underpinning points the reader to how the reality of the world being researched is to be viewed and it addresses the interactions of the researcher, the participants and the study. It is only by using a

dramaturgical view of service encounters that the quality of services, as perceived by the users, can be discovered [27].

### Methodology

The researcher went as a visitor to a non-acute ward over a twelve months period. In the first six months she visited 31 times, with each visit lasting for approximately two hours. She wanted to become a familiar face and get to know the patients. In the last six months she made 6 visits, on average once a month. These visits served as a follow up with the final visit also having the purpose of saying 'goodbye and thank-you' to the patients and the staff of the ward. The research role as 'a visitor' was employed and an observer-participant stance was taken. The researcher at this point did not know what she was looking for and such a method provides a challenge for researchers to produce a logical account of a complex situation [28].

On entering the field, the researcher performed what has been referred to as 'unmotivated looking', which involves setting out the actions and initial occurrences of natural events, with no specific goal in mind at the time [29].

### The Ward Environment and the Participating Patients

The ward was a non-acute 20 bedded female unit. Fourteen frail older women had been on the ward for over a year and 6 women had been there for three months or less: all were awaiting a bed in a nursing home. All patients who were able sat in the large dayroom during the day. The chairs were arranged around the wall and over time, the patients had developed the habit of having their own particular places to sit. There was a nurse call buzzer on the wall. It did work but it was never seen to be used. There was a small television in one corner of the room, which was on all the time irrespective of whether patients were watching it or not. The volume was quite loud and many patients complained that the noise irritated them.

Activities took place every day from nine o'clock to twelve o'clock in a smaller room, except on Wednesdays, which was 'hairdressing day'. The dining area had the dual function as the place where patients' meals were served but it also was used for staff breaks and by patients if they wanted privacy with their visitors. However, in the latter usage, this was not easy to negotiate if staff were using the dining area.

The ward did not take students, which meant no active training and it had all the hallmarks of a long-stay institution, with set routines, including set times for meals, baths, basic care and activities. The researcher spoke with and observed staff, patients, relatives and visitors during the field study.

### Materials: Observational Field-Notes of Dialogues

In the early visits to the ward, the researcher was aware that people were possibly telling her what they thought she wanted to hear. This is reminiscent of Goffman's work on *The Presentation of Self in Everyday Life* [25]. In this, he speaks of an individual's performance as being that of either the 'front room' performance (for an audience), or 'backstage' performance (with colleagues and no audience and with the additional consideration of the unexpected audience or 'outsider'). The early visits were staged by the patients and staff as patients had no wish to complain and staff wanted to be seen to be 'doing a good job. Over time though the front room performance ceased and the researcher became part of the backstage activities—that is, no one was playing to an audience.

## Ethical Considerations

Ethical permission for the study was granted through the Local Research Ethics Committee, the Research and Development department of the health board and the University of the West of Scotland Research and Ethics Committee. Once approval from all parties was agreed, the researcher entered the field wearing a name badge, clearly stating that she was a researcher. No observations took place in private areas such as bathrooms, toilets and bedrooms. Confidentiality was assured as was the anonymity of all participants in the study. Data were transcribed using pseudonyms and data with real names were stored in a locked filing cabinet in the researcher's office and were destroyed once the analysis had been completed.

## Analysis of Data

All field notes were jotted down on the ward and typed up as soon after the visit as possible. The text was entered into NVivo computer software. The text was examined and using thematic coding [30], themes of relevance to the interactions on the ward, the environment, the staff relationships to the patients, the stories told to the researcher and the running of the institution could be identified. The patterns and processes that emerged from the context of what was happening in the ward environment that day [31] were identified.

The themes were then simplified by using a 'funnel' structure [30]. This method involves progressive focusing in which the data are developed or transformed and eventually, their scope is delimited and the internal structures are explored.

## Results

### The stressors and stresses of the working environment

The first part of the results reports on the climate on the ward as perceived by the researcher over the period of time she was 'a visitor'. Her 'insider knowledge' (made possible after several months of visiting the ward), raised her awareness of the political backdrop to the working conditions of the staff.

The stress experienced by the staff during this period was of great importance to the findings. The main cause of staff stress was that the hospital was rumoured to be due for closure. Staff knew that if this happened they would be re-deployed in other hospitals. The manager was totally demoralized in anticipation of this event, which in turn fuelled uncertainty in staff, adding to the existing stressors of staff shortages due to sickness and unfilled posts. Several of the regular staff did extra shifts and this resulted in their working long hours. Agency staff were regularly employed to cover shifts and as some agency nurses were new to the ward, they did not know the patients' likes and dislikes.

The staffing issues affected and involved the patients with the more able patient being seen to intervene in care-giving by instructing the new nurses and care assistants as to what the less able patients liked and did not like. Many patients found this tiring, yet they felt obliged to do it. The patients were also aware of which staff were working long days and were reluctant to ask for assistance, knowing that the staff member was feeling tired. They also showed a fondness for some members of staff and when one care assistant left, several of the patients felt bereft at the loss of his presence.

The patients experienced the moods of the staff. When staff were distracted they spoke to each other, rather than to the individual they were caring for at that time. This left the frail older patients feeling a burden as well as exposing them to the uncertainty and worry of the hospital closure. At such times, 'favorite' patients were apparent and some of these patients felt the need to entertain the staff with stories or witticisms in order to stay in favour. In contrast, patients who were not popular with staff were well aware of their status and although they received prescribed care, they tended to refrain from asking for any extra help, lest this should aggravate their situation.

The second part of the results looked at the themes that emerged during the day to day events on the ward. One of the major themes, which are the focus of this paper, was institutional rules presented below. The main patient players referred to in these results are Kate, Ellen, Julia, Jane and Evelyn, these names being pseudonyms to protect the patients' identities.

### The emergent rules of the institution

As shown in Table 1, it became clear over time that four types of rules could be identified from the thematic analysis. There were: the procedural rules, such as health and safety and the hospital rules such as the routine protocols used on the ward. There were the unspoken rules, which were never formally acknowledged, but known by all members of the ward—such as no one pressed the nurse call buzzer in the dayroom—if help was required a more able patient went to get help. Finally, there were the spontaneous rules, those made up by staff to save explanation of why it was not possible to respond to a patient's request—such as patients not being 'allowed' to use the ward phone.

Type of rule	Key features	Examples
Procedural	Formal national policies, and Guidelines	Health and safety guidelines e.g. correct moving and handling procedures Professional codes of conduct
Hospital	Formal Ward-based protocols	Protocols specific to the ward environment, e.g. patients' food storage
Unspoken	Informal	Things that patients knew not to do e.g. ask about other patients; not to press the nurse call buzzer in the dayroom
Spontaneous	Informal Made up to suit the occasion	Immobile patients having their seating preferences changed against their will 'for a change of scenery'

**Table 1:** Overview of types of rules identified from the study.

On the whole, the patients complied with all of these types of rules in order to have a quiet life. Occasionally Ellen would question such rules, especially in the early months she spent on the ward. However, once she knew she was going to a care home of her choice, she stopped fighting and put up with whatever she was told to do. Julia too fought back. Kate just reported all her perceived injustices to her relatives. Kate, Ellen, Julia, Jane and Evelyn were all aware of the unspoken rules in particular and gave me many examples of these. They included the need for patients to move from chairs they usually sat in because it was

'good for them'; patients were not to ask staff about other patients; patients could not use glass or china because it was 'dangerous'. The women all stated they knew it was best not to argue, and usually just laughed such rules off. However, when they felt low, they became upset at the injustices.

Jane and Evelyn did not verbally complain about the rules, instead, Jane would get very tearful and Evelyn initially became withdrawn. However, over the months of the study, Evelyn became angry at her powerlessness. This was expressed to the researcher, but not to the staff.

The patients did not overtly differentiate between the types of rules, as they perceived that the imposition of all rules was a means of control by staff. However, when the staff were stressed and used spontaneous rules, the researcher noted that these were more likely to result in the patient participants finding them to be unjust and with outcomes of anger and upset.

Each rule has been addressed below, using extracts from the researcher's field notes to illustrate how the rules affected the patients. The many quotes used serve to tell the stories of what the patients experienced and how they perceived the rules.

### Procedural rules

Staff broke many of the procedural rules once they had become used to the researcher's presence. These included 'toilet rounds' and the use of lifting equipment.

Toilet rounds comprised the practice of taking all patients in need of assistance to the toilet at the same time. This resulted in a degrading queue of patients in wheelchairs outside the toilet cubicles. Although the staff knew it was a forbidden practice and without the ward manager's leadership to maintain good practice, the toilet round became an unspoken rule enacted before meals and before bedtime. For these patients, having to wait for the toilet as part of a queue was observed to cause anxiety:

Julia keeps looking through to the toilet area and she says, "I hope they hurry up because I am desperate for the toilet."

(June 20th 27:10)

The equipment used to lift patients was to be used by two members of staff at all times. Again, once the staff got used to the researcher's presence they ceased to stick to this rule and used the equipment on their own. This caused some discomfort to some of the patients.

I see deterioration in Kate, she is thinner and looks tired...I asked Kate how she was keeping and she said that she has terrible pains...She thinks it is caused by the hoist that the nurses use every time they move her...but she doesn't complain because she knows the nurses have to use the hoist.

(September 30th 32:5)

A further example of a procedural rule was that of food storage. This rule affected Kate, Jane and Ellen because their relatives brought food in for them. Kate did not believe this was about health and safety, Kate's relatives brought in some potted though (a Scottish beef dish)...there was too much for her to eat but permission for it to be stored was refused: "Staff say we are not allowed to store things in the fridge, it just gets thrown out, it's the rules. I'm sure the butcher doesn't throw it out if he can't sell it."

(March 25th 9:2)

### Hospital rules

One hospital rule was that all patients had to use plastic crockery, even when they were able to handle glass and china. Patients found this uncomfortable and frequently told the researcher that they loved going out with their relatives just to have a drink in a china cup. Examples from the researcher's field-notes are given below.

Julia had said that she had asked for a drink of water a long time ago, she was very thirsty. I offered to get her one...I went to the kitchen and asked Susan (the domestic) if I could have a glass of water. She asked whom it was for and I told her. She then gave me a plastic beaker with water that she had got from a jug in the fridge. Patients' and staff crockery are different. I was surprised at the obvious care with the water compared to the lack of care in the way it was presented.

(March 19th 8:2)

I (researcher) went to join an activity session in the small dayroom. It was great fun and we decided to all have a cup of tea together. However, the activity worker left the room and came back with china mugs for myself, the other activity worker and herself. The patients had plastic beakers.

(March 13th 7:4)

Ellen likes going out to the tearoom with her relatives. "They have lovely cups and saucers, not those cheap plastic things". (I think of the plastic mugs on the ward).

(April 29th 19:4)

Jane tells me her daughter has been in and took her out to a tearoom. "It's lovely there, you get a china cup and saucer."

(May 5th 21:3)

I (researcher) see the symbolism of the china cup and saucer. It is a sign that you are not a patient. You can manage a proper cup, no need for a big plastic brown mug. I do know that in a care home attention is given to crockery; not so in hospital.

(May 5th 21:4)

Another hospital rule was that patients were not to be left in the dayroom or their bedrooms (during the day) by themselves. It annoyed Kate, Ellen and Julia because contrary to this rule, staff were content to leave patients together unsupervised when it suited them. This happened quite frequently after Bella died. Bella was a 'favourite' patient who was confused and needed a member of staff with her at all times. With Bella no longer there, staff rarely stayed in the dayroom. It meant that the more able patients had to look after the less able patients and call for help should this be required. It also meant that should a patient exhibit certain behaviours that were irritating; the other patients had little control over this behaviour. Examples from the researcher's field notes read: Ellen tells me "I went to my room tonight and do you know one of them (staff) saw me in there and said what are you doing here? What do you think of that (laughs) I mean it's supposed to be my room."

(May 5th 21:8)

Kate had been to bed for the afternoon and that helped to pass the time. She said it was a long day just to sit all day as she cannot do activities. She said that once she was sitting in the dayroom alone and was told she had to be taken to the dining room for dinner. Although she said she did not want to eat, she was told she was 'not allowed' to sit on her own, even though she had been sitting there alone all

morning. I asked if she was taken through and she laughed and said "What can you do? They take me through I can't argue."

(May 5th 21:5-6)

### The unspoken rules

Examples of the unspoken rules were seen many times. The main objective for this rule was to deflect patients' from questioning staff. It highlighted the powerlessness the women had over their situations. Kate gave an example in conversation: Kate said that the staff "allowed you to wear a skirt and blouse for 2 days and Then they were changed. They pick out the clothes for me to wear." She said one day she was in "all colours" and her daughter remarked on it. She had replied "look, clothes are the least of my problems (laughs)."

(February 19th 1:7)

Ellen reported that she knew better than to ask too many questions. She said that one day she hadn't seen Kate in the dayroom and was worried about her. She went on, "They (staff) don't tell you and you don't like to ask—I think she's gone to bed, but you don't ask."

(April 7th 12:14).

Evelyn too had found it best not to ask questions. I ask Evelyn about her dressing practice. "Well they made me do it sitting down which I always find difficult. I always stand when I dress myself." I ask her if she told the person helping this fact. "There's no point" she said "it's best to just do as you're told." She laughs a little.

(April 29th 19:12)

Another unspoken rule was that patients could not expect to use the ward phone without permission. Jane and Kate were allowed to take a weekly call from a relative overseas. One day Julia was extremely anxious about her home situation. Her husband had dementia and lived alone and relied completely on her son. This day she was particularly anxious, as she knew her son was unwell and did not know if he had managed to go and see to her husband. Neither had been to visit her for over a week, which was very unusual. The researcher's notes stated:

Julia is very anxious. She said her son had phoned (the staff) to say he couldn't come in as he had flu. I asked if she could phone him direct and she said no. "The only phone they have is in the office and (staff say) you can't have patients using that."

(March 19th 8:3)

A further example of an unspoken rule was the nurse call buzzer in the dayroom. This was not to be used unless for an emergency. This rule was upheld by patients and their relatives. The researcher too observed this rule to the extent that when one of the women wanted to go to the toilet, the researcher went for help rather than press the buzzer. On May 22nd an interesting event happened. Kate gets one of her visitors to press the day room nurse call buzzer because Jeannie wants to go to the toilet. I realize that Ellen was the only one who could walk and therefore go for help—but she is not here. The visitor shows a little reluctance but presses the buzzer. I am staring as much as the other patients and relatives!

(May 22nd 23:12-13)

A final example of an unspoken rule was that patients were told not to gossip. The researcher's notes read, I was talking to two members of staff about the hospital closure and one said that only Jane knew this

news. I said that I overheard some relatives talking to Kate about it...One nurse said "who told her?" I pointed out it (the news) had been in the papers. They (staff) went on to talk about where they would be transferred to but no mention is made of the implications of closure upon patients. The staffs were busy worrying only about their own futures.

(May 26th 24:4)

### The spontaneous rules

These were rules made up on the spot by staff and had no consistency. The patients knew that these rules were made up and knew that there was little they could do to argue. Two examples are given below, but there were many more examples of such rules. The spontaneous rules illustrated the power of the staff and the powerlessness of the patients. The first example was minor; the second example caused much grief to the patients concerned.

I ask Ellen why she is sitting in her dressing gown. She said she had to have dressing practice and it was ridiculous as she dresses herself every day. She thinks it is because she is moving to a care home. I ask Ellen if she had asked why she was being given dressing practice and she said "No, they're not keen on telling you anything in here." I ask why she doesn't question and she says, "Why? Why should I ask? They only tell you a load of rubbish so I just do what I'm told."

(April 29th 19:2)

The second example of a spontaneous rule occurred following Bella's death. The atmosphere on the ward was tense. The staff were rarely in the dayroom and seemed very distracted. All of the patients the researcher spoke to around this time were feeling low about something. Kate and Ellen had been separated. They had been told to sit in chairs away from each other. The staff told the researcher that they did this because the two women were criticizing the staff and the staff found this demoralizing. The researcher got the story from the staff, from Jane, Kate and from Ellen as follows.

**From the staff:** I am in the staff room. I remark to Louise (care assistant) that the seating arrangements have been changed. "Yes, we had to separate Ellen and Kate. They were always commenting on everything we did in such a negative way. Even the trained staff got annoyed with it. It's horrible you'd be doing your best and then they would be saying 'look at her sitting on her backside'. These sorts of comments were hurtful and it's been better since they've been split up." I ask her how they managed to explain this change of seating to the patients. "Well they were told that it wasn't good to sit in the same place and they should mingle with other people."

(April 29th 19:8)

**From the patients:** Jane knew the reasons why Ellen and Kate were moved. The care assistants would confide in Jane and she was definitely a favourite on the ward. However, Jane knew that it might only be a matter of time before such rules applied to her and knew better than to pass comment. The researcher's notes state, I asked Jane why she hasn't been moved. "I don't want to move, I like sitting here, and this is my chair." I say that Kate and Ellen's chairs have been moved and she says that that was done because they were always complaining about the staff. I ask Jane what she thinks about it and she says she minds her own business..."It's up to the staff, I'm not making any fuss about it but I'm not moving."

(May 1st 20:5)

The researcher asked Ellen about the move of seats. Ellen was not as depressed about it as Kate because she knew she was soon going to her care home of choice and could not wait to leave.

I comment on Ellen's change of place in the dayroom. "Well that was just ridiculous. I'm upset by it and it makes me feel terrible. Poor Mrs. White (Kate), none of the others talk to her and then they decided that we shouldn't sit together." I ask her why. "You tell me" she said, "they say it was so we would have a change of scenery. I mean what do they think we are? Do they think we are that stupid? I am upset by it but I'm at least getting out of here soon".

(May 1st 20:13)

Kate had told the researcher on April 29th that she missed Ellen. Being separated meant that they could not chat and could not share cakes brought in by their relatives.

On May 1st I saw a change in Kate. She was not able to tell me her usual long stories. I ask Kate how she is and she tells me that she had an awful fit of depression last Tuesday. She just couldn't stop crying. I ask her if the nurses knew about it and she said she didn't think so. She had been sick and afterwards the nurses didn't even get her a drink of water. Kate told me that she had news that her grandson will be back from America in three weeks. Kate wants to see him as she has little desire to live much longer...I ask her why she doesn't want to live too much longer and she says "What for? What do I do? I sit, sit, sit, I have no one to talk to and I can't see. I get taken through for my meals and back here, then back for a meal then back here and then taken to bed and back here, what sort of life is that? No, I've had enough."

(May 1st 20:14-15)

I asked Kate why she and Ellen were moved and she said "oh you tell me, I haven't got a clue." I asked her if she had asked the reason and she replied that "there was no point—they (staff) would do it anyway".

(May 13th 22:5).

The most damaging aspect of this spontaneous rule was that when Ellen left the ward, Kate had forgotten that the staff had separated her from Ellen and was convinced that she and Ellen had had an argument. She was sad that Ellen had gone and she missed her, but she was very upset at the thought that they had parted company with what she erroneously assumed was "bad feeling between them".

## Discussion

The four types of rules illustrate the power that staff can exert within the ward environment and upon its patients, through their evoking spontaneous and unspoken rules. The procedural and hospital rules were used by staff when such rules suited them, even if the sub-culture of the ward did not always permit adherence to them. In contrast, the unspoken and spontaneous rules were covert and tended to contravene both hospital policy and the rights of the patients.

These latter two sets of rules concur with Goffman's work on institutional living [4]. The unspoken rules and spontaneous rules empowered staff over patients and the spontaneous rules were usually meted out when the staff were stressed or upset. The patients knew these rules were unfair but there was little that they could do about them. They also knew that these rules were exercised against some patients but not others, which made all patients aware of who was in favour and who was not.

The concept of threat is woven into the lives of those in this ward across time although for the manager, the staff and the patients the nature of the threat may not have been perceived as being the same for each group. This diversity has been addressed by Case et al., who contend that such difference arises from nature of the stressor, participants' perceptions of the effectiveness of responses to the threat (response efficacy), and their beliefs about their own ability to carry out effective responses (self-efficacy). High anxiety when coupled with feelings of low self-efficacy are likely to result in the effort to control the fear raised by threat by using denial, anger, guilt, or hopelessness as emotional responses [32], a diversity of emotions evident in this study,

These frail older people, who were living in hospital and waiting for a bed in a care home, all had anxieties about their own futures. However, the main stress they experienced did not appear to be the situation they were in as delayed discharges, but was due to the everyday situation of dealing with a sometimes hostile and uncomfortable environment and the moods of the staff. There was little shared humour on the ward between staff and patients, the former being now well acknowledged as a therapeutic activity [33]. However, this was witnessed as a coping strategy within patient to patient interactions

It was clear that the staff had concerns about the uncertainty of their futures and hence, were performing in a climate of anticipatory anxiety and transition. The hospital they were now working in was under threat of closure but information about this was not forthcoming from managers, rather it was gleaned from local press reports.

The patients interviewed during the study also complained of feeling anxious with regard to their futures for similar reasons. Although the destabilizing effects of uncertainty from the impending closure produced both worry and anxiety in staff, the main difference between the patients' stress with that of staff was that the former were in a vulnerable position and had no way of escaping the tensions within the environment. They were marking time in hospital because they were not physically and/or mentally able to live independently. As such, they had a right to good quality care [34] and the staff had a duty to provide it [35].

The literature advocates person-centered care as best practice [6,10-16]. However, this study found little evidence of this approach to care. Yet in order for staff to provide such care, it was evident that they too have to feel cared about and this was not forthcoming. Jost and Rich suggest that during change staff need an inspirational and credible leader who communicates with them, listens to their story of change as it unfolds and recognizes new opportunity [36].

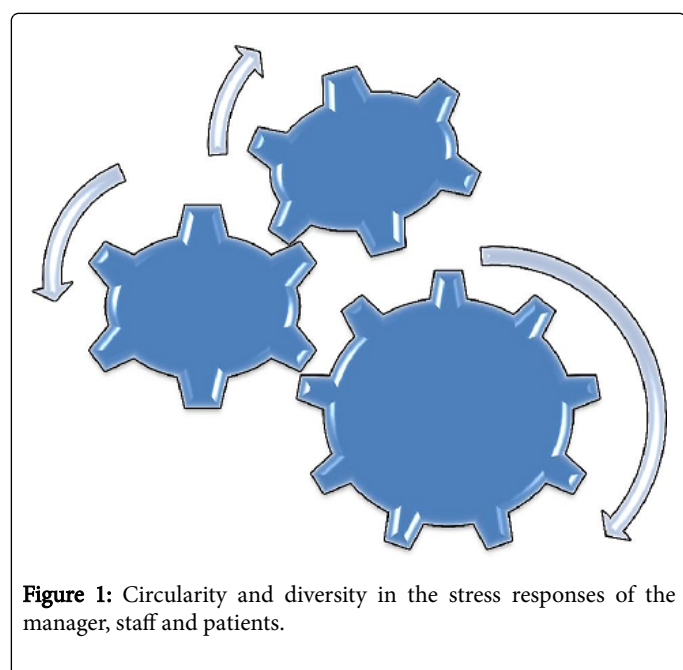
As depicted in Figure 1, the findings suggest a circularity of stress reactions in the ward environment. The ward manager became stressed by top-down knowledge of hospital closure: a threat that she did not share with staff. This diminished her active impact upon staff as a leader and possibly resulted in her becoming oblivious to or in denial of the poor care practices on the ward that contravened hospital and procedural rules.

Without meaningful leadership, staff seemed to have become stressed by the uncertainty arising from lack of information concerning the rumour of closure and in addition to other on-going work-related pressures. This could have given rise to their observed inconsistency in the imposition of hospital and procedural rules. However the imposition of unspoken and spontaneous rules could suggest a more deep-seated and possibly longer-standing failure in their duty of care that cannot be explained by the context of hospital

closure alone. For, as these latter rules empowered staff over patients it seems possible that they were used as a justifying process for the staff's shortfall in offering quality care.

Finally, patients also had concerns for their future but in the main adopted a covert survival mode in which there was an overt compliance with the rules imposed by staff. This was preferable to confrontation and avoided the risk of becoming the unpopular patient. However, that the patients adopted this survival mode indicates an outward acceptance of the staff's authoritarian power that was a source of distress.

Thus, although it seems that the stress from one group contributes to that of another and overall leads to an unhappy ward climate, the stress responses from group to group seem to have differed in the way that they were outwardly expressed.



## Conclusions

Although many standards have been written around the concept of person-centered care for older people, this approach was not apparent within the ward's environment. Instead, the staff gave the appearance of being too busy, fraught and disconnected to attend to the emotional needs of those in their care. Although the circumstances of this ward were unique, we suggest that this work could be of importance to the understanding of staff's use of institutional rules as a justification and empowering feature in their relationships with their older patients. As such it may have a similar relevance to practice in other long-stay care facilities for older people when a personalized care approach is not in operation.

Staff stress from the uncertainty of the impending hospital closure went unsupported by the ward manager who seemed to turn a blind eye to the contravening of hospital and procedural rules. The negative impact upon the frail older people of the imposition of unspoken and spontaneous rules in particular, produced a sense of injustice and distress largely suffered in silence. Although in the final stages of their lives, the small niceties of life, once enjoyed, such as tea in a china cup or enjoyable food were not made available to them. Instead, they were

observed to be suffering from boredom, sadness and injustice. Such experiences show the lack of person-centeredness for all players: staff and patients alike.

What was remarkable, given the physical frailty of the older people involved, was their concurrent humour, fortitude and respect, which they showed to each other during this transitional period.

## Recommendations

The study's findings demonstrate some outcomes from the failure to practice in a person-centered manner by adopting the use of rules to justify this, as experienced by the patients in this study. Support, training, openness and inclusion are needed at all levels in an organization particularly when major change such as hospital closure is to take place. Staff and their managers need to recognize and address their vulnerability to stress and alleviate it by removing as much uncertainty as possible from the ward environment.

The unique stressful circumstances affecting the ward's manager and staff during the course of the study offer some rationale for the staff's use of the four types of rules. However, it would be useful to conduct further research in a long stay facility that is not under the extreme threat of closure. This would further the understanding of staff's use (or not) of rules and the nature of their circumstantial and cultural relationships as a symptom of poor practice.

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