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Title page**The problems of a ‘dirty workplace’ in Domiciliary Care****Dr Gemma Wibberley*¹**

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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.

Highlights

► Shadowing and interviews with domiciliary care staff and stakeholders, on workspace. ►

Domiciliaries’ workplace is the client’s own home, and an under-acknowledged place. ► In the most

extreme cases the workplace may be dirty. ► ‘Dirty workplaces’ can have negative affects upon

domiciliaries. ► Unofficially increases domiciliaries’ work, devalues them and risks their wellbeing.

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Keywords

domiciliary care, dirty workplace, dirty work, domiciliaries, carework

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 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. The 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, 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).

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, p, 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, p,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 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 highlight that the Canadian government does not provide services for the place of care. Sims-Gould et al. (2011) reveal that crises in a client's life may result in their home becoming an unsafe space for care or work. In contrast, England and Dyck (2011) describe relatives adapting the home and their routine to enable domiciliary care provision and the 'good working conditions' these spaces offer.

Another difference in domiciliaries workplace is that relatives may also be present in the client's residence, and are often their informal carer (Milligan, 2009; England and Dyck, 2011). Furthermore, there is often a lack of clear boundaries between the care provided by domiciliaries and relatives (Cooper, 2004; Milligan, 2009; England and Dyck, 2011).

Working in a client's home also creates opportunities for household members to request extra tasks, particularly domestic chores (Gordolan and Lalani, 2009; Rubery and Urwin, 2011). Dyck et al.'s (2005) study reveals that clients with limited resources often have to 'rely' on domiciliaries to perform unscheduled and illicit household chores.

For domiciliaries, the clients' home is their workplace, but it diverges greatly from the stereotypical workplace (Twigg, 1999; Gershon et al., 2008). It is often problematic to undertake care work in a domestic space, rather than a designated care space, because the layout and equipment are typically inappropriate (Dyck et al., 2005; McKeever et al., 2006; Henriksen, 2009).

Working in unsuitable conditions can also be hazardous for domiciliaries, and much of the international literature on the space of domiciliary care is concerned with risky workplaces (Denton et al., 2002 [Canada]; Cooper, 2004; Dyck et al., 2005 [Canada]; McKeever et al., 2006 [Canada]; Taylor & Donnelly, 2006 [Ireland]; Smith, 2007 [USA]; Zaroni et al., 2007 [USA]; Gershon et al., 2008 [USA]; Henriksen et al., 2009 [USA]; Sims-Gould et al., 2011 [Canada]). A safe workplace is a basic employment right that domiciliaries often do not have (McKeever et al., 2006; Gordolan and Lalani, 2009). Indeed, Rubery and Urwin (2011) argue that domiciliaries' protection is considered too expensive for Social Services funding.

Interestingly these studies on 'risk' appear reluctant to describe client's residences as 'dirty workplaces'. Denton et al. (2002,p,12) use the phrase 'poor physical conditions in clients' homes' to describe places with infestations and bathrooms that domiciliaries would not use. Dyck et al. (2005,p,179) note that there may be 'clutter' and a 'lack of overall cleanliness'. In Gershon et al.'s (2008,p,5) study they use the term 'unsanitary conditions', and give a clinical explanation of the risks of dirty bathrooms, kitchens and cleaning

materials. Henriksen et al. (2009,p,232) describes ‘unsanitary conditions, foul odours’ and ‘vermin’ as part of the ‘home environmental factors.’

Furthermore, the literature on ‘dirty work’ in domiciliary care only hints at dirty workplaces. Twigg (2000) mentions the smell of bodily fluids and incontinent clients, but her focus is on the dirty work rather than the workplaces. Quotations from domiciliaries in Stacey’s (2005) study do reveal how dirt from the clients can infiltrate the workplace, such as the leakage of bodily fluids onto sofas. Later Stacey (2011) does briefly describe the potential for a client’s home to be “unsanitary and even threatening” (p,49), but in neither of these publications is this discussed further. Clients’ bowel accidents require cleaning up by domiciliaries in England and Dyck’s (2011) paper, yet there is no indication that these accidents can lead to a dirty workplace.

In general, it is argued that there is insufficient knowledge about domiciliaries’ workplaces (Twigg, 1999; McKeever et al., 2006; Gershon et al., 2008; Henriksen et al., 2009; Milligan, 2009), and that improved understanding of domiciliaries’ perspective is essential (Taylor & Donnelly, 2006).

Equally there is a lack of policy focus on the ‘home’ in domiciliary care, and in particular maintaining the ‘space’ of care is not adequately considered by policymakers around the world (Dyck et al., 2005; McKeever et al., 2006, Lilly, 2008), and therefore resources are not allocated to this activity. Many English policies such as *Domiciliary Care, National Minimum Standards, Care Standards Act 2000*, and the *Induction Standards 2005* are understandably client centric, for instance focusing on client safety. The lack of attention to workers’ health is concerning, and arguably contributes to unsuitable workplaces, which has international implications.

In summary, it can be argued that the undervaluation of domiciliary care has resulted in insufficient attention being paid to the locations in which domiciliaries’ labour, and in

particular, to the potential for ‘dirty workplaces’. The aim of this paper is to offer a UK perspective on the issue that goes beyond prevailing occupational health themes, and encourages further attention in connection with the concept of the ‘dirty workplace.’

3. Method

The research for this study included interviews and shadowing with seventy-four people in total from across the domiciliary care sector in England. Within the sample, there were forty-seven interviewees comprising domiciliaries, domiciliary care managers and stakeholders in the sector. All nineteen domiciliaries were female, of various ages, and were split by employer: ten local authority, eight private sector and one directly employed by clients. Of the fourteen managers, four were male, two worked for local authority organisations and the other twelve for private companies. The fourteen stakeholders included consultants on social care, people who worked for a care employer’s association, a trade union worker, and service providers to domiciliary care organisations.

These interviews then highlighted the need to see domiciliary care in action, and so a series of observations was carried out via ‘shadowing’. This entails following an individual, who comments on their day, which enables the researcher to explore the realities of the labour process, rather than descriptions of work, plus see *how* and *where* the work is undertaken (McDonald, 2005).

Shadowing was arranged with two private domiciliary care organisations. A was a large organisation with around 200 employees, in a rural location; and B was a small organisation comprising of less than 20 staff, based in a more urban setting. Eleven domiciliaries, ten office staff and five managers were shadowed as they went about their work for around 60 hours in total. All but two of these participants were a different cohort to

the interviewees. Access was granted to accompany staff as they went on visits to clients, attended meetings, and undertook training.

It was the decision of a manager within each company as to which members of staff were shadowed, and this raised gatekeeping issues; however, domiciliaries could not be overtly watched without organisational consent. It is likely that 'good' staff were offered to shadow, yet the data did not contradict that collected in interviews with domiciliaries accessed through means other than their managers. When in a client's home the domiciliary or client dictated the researcher's behaviour. Mostly within each client house extensive notes were taken, whilst actually watching care take place. Sometimes the domiciliary or the client would explain their activities, other times notes were documenting interactions. When personal care was being undertaken, sometimes it was suggested the researcher waited outside the room, but at no point was asked to stop. Notes were taken on: observed actions and interactions; sights; sounds; smells; non-verbal communications; the home; relatives and resources present, in line with shadowing principles.

Shadowing does raise concerns about disruption to workers, however, as McDonald (2005) argues, the novelty of the situation is unlikely to have continued effects. With regard to clients, they typically treated the researcher in the same manner as they did their domiciliary, positively or negatively. A comprehensive picture of domiciliary care emerged as staff were shadowed in offices, clients' homes, and their own cars and homes. Pseudonyms have been used for confidentiality. The direct quotes cited are reflective of experiences across respondents.

All interviews and shadowing notes were transcribed in full and then analysed via 'directed content analysis' (Hsieh & Shannon, 2005). Three key questions were asked of the data: 'what is domiciliaries' official work?'; 'what work actually takes place?'; and 'what

factors influence this divergence?' By coding the data in this way sub-themes were allowed to emerge, then transcripts were re-analysed to identify if issues were repeatedly raised.

Overall, it is important to note that the research focused on the perspective of domiciliaries and the managers of domiciliary care organisations, and I recognise that if I had examined the place of care from the point of view of a different group the findings are likely to have been substantially different. An older person's home as the place of care is a very controversial issue: the client, understandably, wants it to remain as their home; relatives may be disturbed by the changes to the space, due to concerns about the older person and/or their own domestic arrangements; domiciliaries require a suitable workspace; whilst the Government may perceive it as a cheaper location of care provision than institutions.

The study was also necessarily selective in that it did not incorporate other places of care such as residential homes or hospitals, as domiciliary carers only work in the community rather than institutions. Older people may move repeatedly between these various spaces, and Milligan and Wiles (2010) highlight that care is shaped by the place (or 'landscape' to use their term) in which it is performed. Undeniably the place of care is of vital importance for older people, as they are likely to reside there for substantially longer than other parties. Thus any problems, such as an unsuitable care-space, are magnified particularly if the older person does not have the resources to change their place of care (for excellent coverage of the issues older people face in their care 'landscape' see McKeever et al. 2006, Milligan 2009, Milligan and Wiles 2010). All of these issues deserve greater attention, but were not the subject of this paper. To take these multiple and diverse views would have reduced the opportunity to explore domiciliaries' workplace in depth, a currently under-researched issue.

4. More than just dirty work?

4.1. Dirty work

The evidence gathered from interviews and shadowing indicates that many of domiciliaries' tasks such as bathing clients and changing incontinence pads could be described as 'dirty work'. Domiciliaries also revealed that 'dirt' from these tasks could soil them, their clients and the workplace. It can be very challenging for domiciliaries to undertake this work, especially as they must maintain a professional attitude towards tasks that society has deemed repellent. Alex (domiciliary) describes how she had to steel herself for dirty work:

'[A client] had a colostomy bag...so literally the poo comes out of a bag, a hole in their stomach and the first time I had to change her bag I really was close to throwing up...you have to prepare yourself.'

Many of these activities are classified as 'dirty work', and can be challenging for domiciliaries. It is widely argued that because of stigma attached to the dirty work in domiciliary care, it is undervalued (Twigg, 2000; Stacey, 2005, 2011; McGregor, 2007; England and Dyck, 2011). Although surprisingly these studies have not examined how this dirt can also create a dirty workplace. This paper therefore argues that further undervaluation of domiciliary care may be linked to the potentially dirty workplaces and unrecognised work that takes place within the client's home.

4.2. Clients' homes as a workspace

Domiciliaries' workspace will now be explored so that the potential for it to be a dirty workplace can be understood. It is important to remember that this workplace is an older person's own home, rather than a residential home, hospital or other form of institution. From

the fieldwork it appeared that clients' homes vary considerably in their cleanliness, the provision of care resources, and the presence and behaviour of other household members. Monica's (domiciliary) comments were typical of respondents, as she described clients' residences as ranging from "grim [to]...middle class...well run places". In the majority of homes, the space for care was also the space used by clients, and other household members, for living, as well as by the domiciliary for working. The client's home as a workspace therefore, in agreement with earlier studies, was a contentious issue within this research. In short, there are tensions between the clients' and household members right to enjoy their place of living, the domiciliaries right to appropriate working conditions, and the clients' right to receive care.

A key issue with the location of domiciliary care is that as this is a client's own home, it limits the control that domiciliaries and their managers have over the workplace. In the research, in some organisations, domiciliaries are explicitly told that they are in the client's home as a guest, thus devaluing their status as a worker, and removing any power they may have over their worksite (Twigg, 1999). The fieldwork demonstrates that this creates difficulties for the domiciliaries and their organisations, because they are responsible for all aspects of a client's wellbeing; yet they rarely have the authority to take action:

'Because it's the family who are taking care of the kitchen...so it's interfering to go and start cleaning out somebody's fridge...that's why sometimes we say it's hard, because you're seeing all these things with out of date,...you've left a note to say that you've noticed things in the fridge with the dates have gone, but we're not allowed to clear things away.' Suzanne (domiciliary)

Working in a client's own home means that their relatives are often present, and it may also be their home too. Domiciliaries therefore have to deal with relatives in a way that other care workers may not, because of the lack of temporal or spatial boundaries between the care and domestic space. Therefore, although it is unlikely to form part of their official tasks, interactions with relatives are an inherent part of domiciliaries' work. There can be substantial tensions between domiciliaries, the client and relatives regarding appropriate care, behaviour and environment. Domiciliaries may also feel obliged to undertake domestic tasks that relatives are unwilling or unable to do, despite them not being the domiciliaries' responsibility.

Furthermore, as domiciliary care takes place in a client's own home, clients often request help with domestic tasks, such as washing-up and laundry. However, these tasks are typically no longer included in care plans. Domiciliaries therefore have to decide whether or not to undertake a task, against company policy, to support their client:

'You weren't really supposed to do stuff like [changing lightbulbs], but what you going to do when some old dear is sat there with no light and she's not going to see anybody else until the next day...can't have her sitting in the dark...so of course most people do it.' (Roxanne, domiciliary)

While shadowing, it became apparent that clients' homes can be challenging as a workplace. Working in a domestic space, rather than a purpose built care facility means that space is often restricted. This is exacerbated when 'normal' residences have medical equipment in them such as hoists, commodes and hospital beds. For instance in George's (a client) home, what appeared to have been previously the front room for the family, had been converted into his only space for sleeping, living, eating and toileting. It seemed particularly

challenging to fit all the equipment and resources needed into that space, as well as well as still meet the social needs of the family. In these domestic properties care needs appeared to have subsumed 'normal' living arrangements. This concurs with Henriksen et al's (2009) research in the USA who state that the home was not designed for care, and that care equipment was not designed for the home.

Working in a client's home also means that there is a lack of workplace facilities for domiciliaries which are taken for granted in most worksites such as a staff toilet. In some households there may also be a severe lack of basic care resources, such as running hot water as was the case in one house where Joanna (domiciliary) had to continually re-boil the kettle in order to bathe the client. This makes each task more time consuming and challenging, and again differentiating domiciliary care from purpose-built care facilities in which resources may be more standardised.

4.3. Dirty workplaces?

The aforementioned issues of contested control, the separation between responsibility and authority, multiple stakeholders, the removal of domestic tasks from domiciliaries' official workload and the potential for inappropriate resources are all important to understand in how they shape domiciliaries' workplaces. These and other issues, that will be explained later, can in the most extreme situations mean that clients' homes can be 'dirty workplaces'. This term is used here to describe spaces that have been 'physically tainted' with bodily fluids, human and household waste similarly to Ashforth and Kreiner's (1999) definition of dirty work, but accept that this 'dirt' is subjective. Nevertheless there are clear parallels between Twigg's (2000) description of domiciliaries' accounts of dirty work, and the findings here, suggesting that certain forms of 'dirt' are perceived as outside the normal

boundaries of their role. Alex (domiciliary, *original emphasis*) described an environment this study classifies as ‘dirty’:

‘There is *no other* word to describe the state of the [client’s] house than...*squalid, it needed condemning!,...the stench, ...urggghhh* it was horrid...and she was obviously *so...depressed...and her toilet wasn’t working...She had no, no nothing, no cloths!,...and I had to try and empty this very full commode in a non flushing toilet, and try and flush it with water, carry water from the bath and...it was horrid, no gloves, no nothing!.’*

Various reasons were proposed by the respondents for this dirt: including physical or mental illness of clients which prevents them from cleaning; social deprivation; the inability to contain or correctly dispose of bodily fluids and household waste; or the client’s or household members’ choice to live in this manner. McKeever et al. (2006) and Gershon et al.’s (2008) suggest that clients are potentially unable to reduce workplace hazards, whereas Taylor and Donnelly (2006) and Milligan (2009) argue that clients and relatives can be reluctant to change their home to make it more suitable as a care workplace if this contradicts their expectations of a living space. All of these factors applied in this study. In contrast Sims-Gould et al. (2011) suggest that hazardous homes are only a result of a ‘crisis’, and whilst this may be the case in some households, for others it may be a long-term problem as suggested by Elizabeth (Manager):

‘(Client) keeps his hens in his house... you’re wading through hen muck’

For the domiciliaries who have to deal with these dirty worksites, it can be very distressing, and respondents privately complained about it. Caring in a dirty workplace become even more challenging in situations like Alex's in which there are no suitable resources to clean the worksite or protect the domiciliary. Without gloves and other protective clothing and equipment, there is a high risk of domiciliaries being contaminated by the client's bodily fluids, or other dirt:

'You have to be prepared to go in to some of the most disgusting houses that you can ever imagine...and get bitten by fleas...wade through the filth...get covered in faeces.'

(Laura, domiciliary)

Typically, contemporary workplaces are portrayed as welcoming, sanitised offices as a respite from home (Reeves, 2001), yet for domiciliaries whose workplace is someone else's home they may not enjoy this 'respite'. To illustrate, one house visited with Louise and Joanna (domiciliaries) was neglected and rundown. There was a lack of wallpaper or carpet, the paint was old and cracked, and the furniture was threadbare. The front room in which the client slept, and appeared to spend all of their day in, was very messy. It was not just the sights that could make these workplaces unpleasant, but also the smells, for instance open commodes in overheated residences made the rooms smell of urine or faecal matter.

Whilst shadowing, it was noted that the houses could be hazardous to domiciliaries: overheated; under-ventilated; the presence of pets, which could create extra 'dirt'; or household members may smoke. These hazards potentially posed by clients' homes have also been noted in other, mostly international literature on 'risky workplaces' as described earlier. In these studies the focus is on 'risk' and 'hazard', rather than dirty workplaces, however, this

language seems to conceal the causes of these risks and the problems domiciliaries are experiencing instead of protecting them.

Of course many households in receipt of domiciliary care were not like this, and were warm and welcoming, but cuts in social care and welfare means that the inappropriate worksites described are not an exception to the rule. Respondents stated that Social Services no longer procure domiciliary care for clients' just requiring support for domestic chores and have allegedly squeezed it out of many care plans for clients with more severe needs, consequently if clients could not privately arrange funding or individuals to undertake this cleaning, homes could become dirty:

'cleaning should be paid for privately [but] where's the money, so what do (you) do? Do you let somebody live in absolute squalor?...Because they can't do it themselves'
(Nicola, domiciliary, original emphasis)

4.4. Dirty workplaces can lead to extra tasks for domiciliaries

Attention also needs to be drawn to the link between 'dirty workplaces' and extra tasks. In this research it appeared that as a result of domiciliary care taking place in a client's own home, various tasks can be required that are not part of domiciliaries' formal labour process. For instance, when a client's residence is dirty domiciliaries may need to clean the workplace in order to undertake their official tasks:

'You've gotta to clean in the area that you work in....So if someone chooses not to have a cleaner...you're still gonna end up cleaning for them...because there's no way you can work in a environment, cos it becomes a health risk.' (Suzanne, domiciliary, original emphasis)

Therefore cleaning must be squeezed into the visit by the domiciliary, as well as performing the allocated tasks. Many respondents described how they had to be inventive in order to clean, especially if there was a lack of resources. Suzanne also explained that clients or relatives may perceive the domiciliary to be ‘interfering’ if they perform unrequested cleaning. The domiciliary therefore has to decide what to do for the best in each situation, but they can be reluctant to leave a workplace dirty, because it creates hazards:

‘If somebody is in self-neglect we would go in and clean their kitchen and clean their home...so that we’ve got a clean working environment, and this helps them to get better, but...our main function is not...cleaning’ (Laura, domiciliary)

The day-to-day health and safety of domiciliaries was another task that did not appear to be officially acknowledged. Domiciliaries did not always have the barrier equipment they require or had to spend time looking around for it. The residence itself also presents challenges and domiciliaries had to quickly become aware of the physical space that they are working in, and any potential hazards. For instance, Amy (domiciliary) banged her head, as she tried to manoeuvre in a small room. All of these activities are unrecognised, unrewarded, and place further physical, psychological and mental demands upon domiciliaries.

5. Conclusions

This research builds upon previous studies of dirty work in domiciliary care, by demonstrating how dirt can also infiltrate the space, and potentially create a dirty workplace. Working in a client’s home can lead to tensions over the use of space, resources and behaviour, and the domiciliaries have little control over their workplace. The huge variation

in clients' homes also means that they can be inappropriate as a workplace, and even hazardous. 'Dirty workplaces' pose a key risk to domiciliaries, and I would argue that research should not conceal this behind the language of health and safety, but instead it should highlight the broader impact on the domiciliary of the difficult and often distressing environments that they work in. There do not seem to be clear links between the 'dirty work' and the international 'risky workplaces' literature, but I would suggest that it is in part the 'dirt' of bodies and households that creates these risks, and therefore these fields of study should be brought together, and the topic of 'dirty workplaces' needs to be addressed both in the UK and internationally.

Working in a client's home, particularly a dirty one, creates extra unofficial work for domiciliaries in terms of workplace management, undertaking domestic tasks and managing their own health and safety. Yet, as revealed, these workers may feel they have little choice in doing so, because of the needs of the client, the demands of the job or for their own wellbeing. I believe that the unrecognised nature of these tasks creates further devaluation of the work carried out by domiciliaries. There appears to be a vicious circle in domiciliary care of undervaluation, with dirty tasks being performed in a potentially dirty workplace, invisible to and ignored by society, by workers with limited labour market power, for clients that are deemed as too costly by the Government.

This paper has been necessarily focussed on the description of 'dirty workplaces', and the problems that this can create for domiciliaries, but this is not to argue that all households in receipt of domiciliary care are 'dirty' and participants described feeling 'at home' in many of them. Nevertheless, efficiencies in public spending have far reaching consequences and can contribute to inappropriate care/workspaces. Household cleaning is now rarely funded by Social Services, and respondents argued that when clients did not have alternative resources to provide this cleaning, homes could become dirty. Instead of proposed harmful cuts to

domiciliary care there should be sufficient funding and appropriate policies to offer domiciliaries a safe workplace (Rubery and Urwin, 2011; Sims-Gould et al., 2011). Mirroring Dyck et al.'s (2005) calls for changes in Canada, domiciliary care policies in England and elsewhere must also be expanded to ensure that care is re-introduced for the client's home where necessary, rather than relying on domiciliaries to perform unrecognised work in managing dirty workplaces, for the wellbeing of both clients and staff.

This study has also highlighted key areas in need of future research, including further exploration of the problems arising if the client's home is an unsuitable carespace from the perspective of older people, and their relatives. While this paper has noted the difficulties experienced by workers, these issues may be magnified for those unable to leave at the end of a visit. It could also be valuable for studies to compare more closely the different places of care, and the challenges and benefits they offer to those who work and live in them. A client's home is just one type of carespace, and may not always be the ideal as portrayed by policy.

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