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**Fred’s essay**

1. People consider their home their own private space which they are able to control and keep separate from any public spaces in which they live or work. However, should their circumstances change, and they find themselves in need of care, this private area may be encroached or they may have to spend time in a public space. This can be an uncomfortable experience whether care is delivered in public places such as hospitals or in residential and domestic environments. The ability to determine the differences between public and private spaces is therefore essential for those who wish to be skilled and effective carers as it affects the quality of their work in all care contexts. This essay will consider the differences between public and private spaces and how these can affect the behaviour of both carers and those receiving care in hospital, residential and private homes.
2. Private and public spaces differ greatly. The most familiar and private environment is our home. Here we are in control and can usually determine who will be allowed to enter our private ‘space’. Conversely, in public spaces patients have to face the often unsettling experience of losing both privacy and control. They are reduced to living in public and are on view for most of the time. In particular, referring to hospitals, Twigg (1997, p. 22) explains, ‘the public nature of the space relates to the access of professionals, of non-kin, non-friends and of relationships that have no private quality to them’.
3. To provide good care in a mostly public space, such as the hospital environment, factors such as safety and the efficiency of the ward should be seen as paramount; however, it is also important to safeguard patients’ needs. Staff must be able to observe the patients, and have a certain degree of control over their activities, but this has the effect of reducing patients’ privacy and dignity. For example, Peace (2005) reports the experience of Esther Hurdle, who during her three years spent in hospital, enjoyed little privacy and felt that her needs had to be fitted in with staff routines. Indeed, Gann (1998) explains that ‘somehow, when patients enter hospital, it is all too easy for them to experience a loss of autonomy and dignity’. The curtains around each bed offer some ‘token’ privacy, but in reality this is minimal as conversations can be easily overheard, and any discussions between staff, patients or visitors are effectively conducted in public.
4. In the residential care setting too, it is important that staff recognise the differences between public and private spaces. While it is vital to be able to observe the residents, primarily for reasons of safety (Peace, 2005, p. 23), it is equally important to safeguard residents’ private spaces. It is generally accepted that the public areas of these buildings are communal lounges, dining rooms and corridors, and the private areas are residents’ bedrooms and bathrooms. In some homes however, residents have to share bedrooms, which reduces the privacy level to that of the hospital ward. In homes where residents have little or no privacy, it has been observed that they create their own private spaces in public areas. For example, they will always choose the same chairs in the lounge, which are then unofficially regarded as their own. This illustrates the basic human need for some kind of private space, however small.
5. In a good residential home, the staff will acknowledge the residents’ wishes to control their private space. In a carefully designed scheme, the needs of the residents are the prime consideration, although obviously the various fire and health and safety regulations have to be met. For example, at Liberty of Earley House, the residents all have their own rooms and are able to keep many personal possessions (Peace, 2005, p. 71). This enables them to retain their sense of identity and gives them a degree of control over at least part of their lives. They are happy to allow the staff access to their ‘territory’ and are grateful for the sense of security which they get from knowing that help is always on hand if required. The residents have all had to come to terms with the fact that, for reasons such as age or infirmity, they can no longer lead fully independent lives, but can happily accept this compromise.
6. The story is very different in poorly run residential homes. At Cedar Court Nursing Home, for example, residents’ rights to privacy and dignity are totally ignored by staff and residents are treated as objects of care (Peace, 2005, p. 75). As a result, the quality of life experienced by these residents appears to be very low. It is therefore clear that, in residential homes too, when carers fail to distinguish between private and public spaces and disregard residents’ wishes and needs, the quality of care suffers.
7. It would seem that those who receive care at home should be in a stronger position to maintain their autonomy, but even here carers must be aware that their behaviour can change this situation considerably. Carers’ sensitivity to their clients’ private space and needs can therefore make an enormous difference. This is because people in need of care have less choice over who comes into their homes and what carers do once inside. Even areas such as bedrooms and bathrooms can be ‘under threat’. Though the reasons for this invasion of privacy may be fully understood and accepted, it is still difficult to lose control of the home environment. For example, when she was discharged from hospital, Esther Hurdle felt that she had limited control over her day-to-day life as her carer was more concerned with her own routines than with Esther’s needs and capabilities (Peace, 2005, p. 73). Esther felt, as suggested by Twigg (1997, p. 22), that ‘being and feeling at home means managing as you wish’ and not according to some professional ‘mode of coping’.
8. A good home carer will always respect the wishes of the client and show them that their right to privacy is valued. A person’s home is rightly regarded as the last bastion of privacy and safety. It is all too easy to feel that any remaining control over one’s own life is being taken away, if home care is not dealt with sensitively. Therefore, as Bell (1993, p. 40) advises, carers should treat the home care environment as their patients’ private space.
9. Conclusion.

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