TIDES OF ENFORCEMENT:
RULES AND REALITIES IN AN AMERICAN NURSING HOME

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ABSTRACT

Recent ethnographies analyzing the structure of work in nursing homes have not sufficiently explored the gap between official rules and actual organizational practices. In this paper, I argue that caregivers must systematically bend or break many workplace rules in order to protect their employment, avoid supervisory wrath, meet (or appear to meet) unrealistic job expectations, and to provide compassionate care not included in their job descriptions. I identify three distinct types of routine rule breaking, and I show that management's rule enforcement is selective and cyclical. Further, I show the relationship between rules and practices is complex and based upon a changing, interactive relationship between management, employees, and residents. Workers desire to perform their jobs in a manner consistent with rules and regulations they understand the necessity for, but they also find themselves in search of ways to protect morale, control their workload when the demands are greater than what is possible, and find ways to break rules in a way that would not compromise care in a manner detrimental to the immediate health needs of the residents. However, I did not find they often considered the long term effects of continuous systematic rule breaking. Results from this research indicate that workers do care about the quality of care they give, but their own most pressing needs such as maintaining employment play a significant role in determining how they carry out their work.
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CHAPTER 1

INTRODUCTION

It was 9:30am at Summer Haven Nursing Home\(^1\). As a Licensed Practical Nurse (LPN), I had only two hours to distribute medicines to 35 people. For each resident, I had to consult the Medication Administration Record (MAR) to see which medications were to be given. The medications themselves were kept locked in my medicine cart, in boxes labeled with residents’ names. Each box contained a 30-day supply of a single medication, in individually-wrapped doses, some residents had as few as two boxes while others had more than ten. In order to administer the medication, I had to pull out each pill from its box and compare the medication name, dose, route of administration, and scheduled time of administration on the pill label with the MAR. Then, I could open the pill packages and put them in a small cup, pour another cup full of water, and enter the resident’s room. The medicine cart had to be locked with a key each and every time it was not in my sight and then unlocked again to retrieve medicines for the next person.

Once I entered the room, I had to identify the resident, which was not always easy since I was new to the facility and residents did not wear name bracelets.\(^2\) In addition, the process of administering a cup of sometimes ten or more pills to an ailing, elderly person was not always a straightforward task. Some residents needed to take the pills, very slowly, one at a time, and I had to stay with them to make sure pills were swallowed rather than dropped on the floor or left in the cup. Many residents needed to have their pills crushed and mixed with applesauce for oral administration or crushed for

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\(^1\) The names of the facility and all staff, residents, and families have been changed to protect confidentiality.

\(^2\) Most of the residents had a photograph in the MAR for identification, but these photos were not always recent. So, when in doubt, I had to ask another employee who knew the residents, or at times, just assume it was the correct resident.
administration through a feeding tube, which was also a time consuming task as each pill was supposed to be given separately to ensure each individual medication was taken. Finally, I was expected to wash my hands thoroughly before and after every medication administration (Ohio Adm. Code 2004a).

Simple math illustrates that in order to give medications to 35 residents in 120 minutes, I had to complete my work in an average of 3½ minutes per resident. Although I am an experienced LPN, I found this to be impossible. Just completing the preparatory steps outside residents’ rooms often took more than 3½ minutes, and once inside a room it commonly took more than five minutes to get one resident to take his or her medicines. Even hand washing takes a minute or two to do correctly and thoroughly – it would have been easy to use up 3 minutes with each resident simply by washing my hands twice. And on this morning, to make matters worse, my work had been interrupted by phone calls from one doctor and a family member, and a resident had fallen. These three events required about fifteen minutes of my attention. The phone calls were short, but when a lady fell down, I had to assess her for apparent injuries before asking an aide to help me assist her back in to a chair. Then, I had to check all of her vital signs for inclusion on the incident report I had to fill out. Fortunately, she had no apparent injuries, or I would have spent even more time calling her family and the doctor right away, and perhaps even sending her out to the emergency room for further evaluation.

My “medicine pass” was supposed to be completed between 8 am and 10 am. Although I had begun well before 8 am, I was hopelessly behind. In order to speed things up, I began to look for shortcuts. One resident was only scheduled to receive an eye drop; another resident, only a vitamin. I skipped both of them. I also did not initial all of the medicines as I gave them. I signed out the narcotics when I took them out of their packages in a locked drawer, but with regular, non-narcotic medications, I initialed them later. When a resident wanted to talk to me about her family, I reluctantly cut the conversation short, telling her, “Listen, I would love to stay and talk, but I better get back to work.” Despite these attempts to hurry, I still finished the medicine pass 30 minutes late.
I was not the only worker at Summer Haven who had difficulty completing required tasks on time. As I soon discovered, nurses and nurse’s aides regularly deviated from official procedures because the work was impossible otherwise. I experienced this situation as frustrating and even shameful. In my nursing school, I was taught about proper nursing procedures and about how caring nurses are supposed to be. However, my classmates and I were taught very little about “the real world of nursing.” We were not told we would not have time to treat every resident as if he/she were family, and we were not told that in order to keep our employers happy, we would have to routinely risk our jobs by breaking rules in an often vain attempt to give the appearance of completed work.

Recent ethnographies analyzing the structure of work in nursing homes have not, in my view, sufficiently explored the gap between official rules and actual practices by nursing home workers, or the reasons for this gap. Several studies have acknowledged that nursing home work rules are not generally followed, indeed that they cannot be followed given the overwhelming quantity of work assigned (Foner 1994a; 1994b; Bowers and Becker 1992; Diamond 1992; Gubrium 1975), but existing research has not explored this issue in much detail. How do nursing home workers actually deal with the disjuncture between official rules and realities “on the floor”? In this paper, I argue that caregivers systematically bend or break many workplace rules in order to protect their employment, avoid supervisory wrath, meet (or appear to meet) unrealistic job expectations, and to provide compassionate care not included in their job descriptions. I identify three distinct types of rule breaking that nursing home workers engage in on a routine basis: deviation from time frames, departures from official procedures, and omission of tasks. Finally, I show that management’s rule enforcement is selective and cyclical, which creates a constant and ever-changing game in which nursing home workers must try to decipher which rules they are “allowed” to break in order to get through the day.
CHAPTER 2

RULES AND PRACTICES IN NURSING HOME BUREAUCRACIES

The genesis of the cultural disregard for all non-family caregiving began in the late 19th and early 20th centuries when the cultural view of disease and treatment shifted focus from religious and emotional support and personal connection to newly emerging scientific methods of treatment. Traditional women caregivers, once valued for their knowledge were soon only carrying out delivery of care under specific instruction and increased supervision (Abel 2000). In 1935, Old Age Assistance (OAA), the precursor to today’s Social Security provided monetary support for the elderly, but existing care facilities were unable to absorb the demand for residential care. Eventually, lack of regulation and the willing spirit of capitalism lead to development of homes for the aged opened mostly by unemployed nurses in an attempt to collect the OAA funds of the incapacitated elderly (Vladeck 1980). Guaranteed loans from the Federal Housing Administration (FHA), during the 1950’s, provided means for the proliferation of for-profit nursing homes modeled after hospitals, which were bureaucratically structured due to their size and number of employees (Vladeck 1980). Successful nursing homes require cleanliness, adequate nutrition, and a pleasant and knowledgeable staff to provide medical and custodial needs (Vladeck 1980), but it is not possible to provide these requirements without a hierarchical system of management with extensive guidelines and regulations to provide a vehicle for stability and consistent delivery of care.

A structure of rules, regulations, and hierarchy continues reign over the lives of nursing home workers and residents, and care work in nursing homes is still primarily performed by the poorer, less educated women in American society. A 1975 study by Jaber F. Gubrium addressed the rigidity and bureaucracy in nursing homes, suggesting workers actually embraced the routinization of their work days and took offense when
their developed routines were interrupted. Workers saw themselves as employees with a job to be completed and consequently, did not cope well with disruptions (Gubrium 1975). The study also mentioned top staff knew there was not enough time in the day for workers to properly complete all of their assigned work. Management or top staff had to encourage the rules be followed “by the book” and tended to operate with a “give-em-an-inch-they’ll-take-a-mile” attitude toward lower floor staff (Gubrium 1975). Management realized a certain amount of deviation from rules would not immediately compromise the quality of care. Thus, a certain amount of deviation was acceptable. Middle management, such as floor nurses, served to mediate or interpret the standards of practice for aides (Gubrium 1975). Gubrium’s study, however, did not explore precisely which rules were compromised, to what extent, or under what circumstances.

Timothy Diamond’s (1992) ethnography detailed his experiences working as a nursing assistant in three separate Chicago nursing homes for three to four months each during 1982 and 1983. He found that the official rules and job descriptions failed to capture most of the important work nursing assistants perform, suggesting tasks categorized as “help as needed” in fact were the most time-consuming and mentally arduous tasks performed (Diamond 1992). Diamond emphasized that management cared only about completion of official tasks, not about compassion. He noted that management’s core interest was maintaining efficiency in the facility, whether work actually was completed properly or not. It, therefore, was extremely important that workers appeared to complete all work in the prescribed manners. Management tended to rule over workers with an iron fist, threatening job loss or ridicule if workers did not keep up with the pace dictated by the task load (Diamond 1992).

As a result, he found care work contained much that was invisible to management. In the nursing homes Diamond was employed, workers spent much of their time completing tasks not listed in the job descriptions such as waiting for slow, elderly residents to cooperate, cleaning up after confused residents, and spending time with emotionally distraught residents. The time demands these tasks placed on workers were not considered by profit driven managers, but these were the tasks which took up most of
the day. Diamond thus emphasized the gap between official and unofficial tasks, but did not explore the rule-breaking that resulted from this situation in depth (Diamond 1992).

A different ethnography argued that official rules limited the ability of workers to respond flexibly to resident needs, and that this limited autonomy fostered impersonal treatment of residents (Foner 1994a). Foner also noted that nurses did not attempt to help aides learn how to deal with the psychological and emotional needs of residents. Residents were, instead, reduced to numbers, diagnoses, and charts (Diamond 1992; Foner 1994b). This created an environment where workers gave compassionate care “on stolen time” due to fear of getting caught spending too much time with a resident. The study also revealed that the aides observed in the nursing home observed were able, despite frustration and exhaustion, to develop satisfying relationships with long term residents while also developing an ability to complete their jobs to the satisfaction of management.

Foner (1994a) succinctly noted that care plans were not strictly followed, and paperwork was not done on time. The study also briefly mentioned that workers sometimes used extreme rule following as a rebellious or resistance tactic in an attempt to show management that the demands placed on them were unrealistic. However, she observed that only aides very secure in their positions risked incurring wrath of their supervisors in this manner. Most aides were deferential and accepting of the legitimate authority, despite unexpressed anger regarding the situation (Foner 1994b). Again, this study briefly acknowledged that rules were broken in nursing homes but did not explore the breaking of rules in detail (Foner 1994b).

In contrast to the Foner thesis, a 1992 study by Bowers and Becker found that the efforts of nursing home aides “were clearly focused on getting the work done well enough to stay out of trouble (Bowers and Becker 1992).” Their study found little to no references by aides to the quality of care they were providing or the supervision they were under (Bowers and Becker 1992). The study suggested that workers in nursing homes who remained employed past the first several weeks, when approximately 90% resign, developed their own organizational routine, cut corners, and broke immediately invisible rules in order to give the appearance that work was complete. The remaining
employees fell into two categories. The first was those who were "unable to distinguish between visible and invisible infractions" or those who were not able to successfully hide their infractions. The second group did not find this necessary method of working acceptable behavior (Bowers and Becker 1992) and terminated employment themselves. Despite finding that workers routinely broke rules, the study did not extensively investigate the nature of rule breaking or the effects it had on quality of care.

My argument in this paper is that previous nursing home authors, including Gubrium (1975), Diamond (1992), Foner (1994a; 1994b), and Bowers and Becker (1992), have not delved deeply enough into the complexity of the relationship between rules and practices in the nursing home setting. Contrary to Bowers and Becker (1992), I argue the relationship is much more complicated than employees merely breaking rules that are invisible and following those that are visible. Instead, I suggest there are three types of rule breaking, including those regarding time frames, procedures, and task omission. Next, I will describe how management enforces rules selectively and cyclically.

Enforcement, therefore, is not simply a matter of what is invisible or visible, but rather a somewhat predictable, constantly changing cycle. Additionally, employees are active agents influencing the cycle of management's enforcement. They respond to management's shifting attentions to their work, they have their own views about what is important and not important, and they break rules to avoid or provoke conflicts with other workers. Furthermore, workers ignore time frames in order to provide compassionate care, they develop practices which deviate from rules in order to cope with times of stress on the job, and they habitually follow these patterns even in times when rule following is possible. Finally, temporary, or agency staff, who play an important role in the nursing home, have to break more rules than regular staff because they do not know the residents well enough to know what shortcuts they can take.
CHAPTER 3

SETTING AND RESEARCH METHODS

The facility, referred to in this paper as Summer Haven Nursing Home, was a large (approximately 300 beds), not-for-profit facility in a moderate size Midwestern city. The physical layout of each unit was same. They were all in a T shape, with rooms on both sides of the long and short halls and a central nurses’ station at the intersection of the two halls. Approximately 40% of residents had private rooms, most of who were on the three intermediate care units. There were two skilled units; one was a relatively small (31 bed) unit with all private rooms for very alert, short term residents while the other larger skilled unit had primarily two-bed rooms for more critically ill and less alert residents. Summer Haven also had a 62 bed Dementia unit with two-bed rooms.

The residents of Summer Haven varied in many personal respects, but were also very similar and typical nursing home residents. The vast majority of those not currently on a skilled floor, funded by Medicare, depended on Medicaid as their singular source of financial support and healthcare. Cognitive disorders were pervasive among the residents, affecting as many as 80% of them. These ranged from mild confusion and forgetfulness to moderate, mid-stage Alzheimer’s disease and dementia to completely incapacitating late-stage Alzheimer’s disease and dementia. The acuity of care also varied throughout the facility. Many residents, especially on the intermediate floors needed little assistance with activities of daily living (ADL’s), but many more required hands on assistance from at least one staff to eat, bathe, dress, brush teeth, go to the rest room, etc. In addition to assistance with ADL’s, a majority of residents also required various nursing procedures, including but not limited to wound dressing changes, feeding tube care, and intra-venous (IV) therapy.
The occupational structure of Summer Haven was a hierarchical system presided over by the state licensed nursing home administrator. Reporting directly to the administrator were the Directors of five departments, which have numerous subordinate front-line staff. The departments include (1) Maintenance, (2) Dietary, (3) Environmental Services (housekeeping and laundry), (4) Activities, and (5) Nursing. Other employees reporting to the administrator were the Directors of Marketing and Admissions, the licensed Social Workers, and various other business office staff. Clearly, the focus of this paper is on the Nursing Department. The Director of Nursing (D.O.N.) was a Registered Nurse (R.N.). She had two Assistant Directors of Nursing (A.D.O.N.’s) who were also R.N.’s. Next, there were Unit Managers (R.N.’s or L.P.N.’s) responsible for each unit. Floor nurses were either R.N.’s or L.P.N.’s and were the direct supervisors over the Certified Nursing Assistants (aides or C.N.A.’s), who were responsible for about 90% of all direct care given to residents. There were also other office R.N.’s in the nursing department (MDS nurses, care plan nurses, restorative nurses) who were not in the direct hierarchy from the D.O.N. down to the aides.

The data collection method used for this research consisted of participant observation and in-depth personal interviews. The participant observation phase lasted approximately 12 weeks between June and August 2003. I obtained a job as a Licensed Practical Nurse at a medical staffing agency and contracted with that company to work the entire duration of my employment in the same long term care nursing facility. Throughout the summer, I worked day, evening, and night shifts on several types of units in the nursing home including (1) the Alzheimer’s Unit, (2) skilled units\(^3\), and (3) long term intermediate care units\(^4\).

\(^3\) Skilled nursing units are those which “meet criteria for accreditation established by the sections of the Social Security Act that determine the basis for Medicaid and Medicare reimbursement for skilled nursing care, including rehabilitation and various medical and nursing procedures” (Anderson and Anderson 1994, p. 974).

\(^4\) Intermediate care units are those which provide “medial-related services to persons with a variety of physical or emotional conditions requiring institutional facilities but without the degree of care provided by a hospital or skilled nursing facility” (Anderson and Anderson 1994, p. 553).
The majority of field notes were written at the end of the shift upon returning home. Small notes and jottings were taken during the shifts and utilized later when recording more extensive field notes at the end of the work day. Observations, rules (both broken and unbroken), and conversations were the main foci of the notes. These notes were then analyzed for themes regarding rule breaking and the thoughts, feelings, and morale effects surrounding the breaking of the rules.

In addition, five in-depth personal interviews were conducted with nurses using snowball sampling, beginning with nurses with whom I was acquainted. The interviews took place at an agreed upon location (either the participant’s home or the interviewer’s home) and addressed issues regarding rule breaking, worker morale, staffing, and charting issues. Verbal consent to participate was given by each interviewee, and each was guaranteed confidentiality of all responses. Analysis of interviews consisted of looking for themes and answers that addressed similar issues recorded in field notes. The interviews allowed probing of questions in areas regarding rule breaking that were not feasible during participant observation due to time constraints and proximity to management and residents.

These particular methods of data collection were chosen in an effort to most effectively bring forth valid answers to the research questions. While national generalization is not possible, it is likely that results are indeed applicable to other facilities in the region, as nursing home workers change place of employment often and take the nursing home sub-culture with them from facility to facility. Participant observation in the nursing home allowed me to observe other nurses and aides in their natural work environment. Participation in the nursing home culture and observations made on other workers also served to inform my interview questions, enabling me to ask probing questions I may not have known to ask without having observed the issue during participant observation.
CHAPTER 4

THREE TYPES OF RULE BREAKING

As the opening anecdote makes clear, my observations confirm that nursing home workers simply cannot complete their work if they follow every prescribed rule in the workplace. There were too many tasks to be completed and not enough time in a shift to complete them. On Summer Haven Nursing Home’s intermediate care floor, it was the norm on day and evening shift for one nurse to have 48 residents to care for, including responsibility for passing all medications, doing seven separate dressing changes that could take ten to fifteen minutes each, applying numerous creams and preventive skin care medications, ensuring numerous safety devices (moon boots to prevent heel skin breakdown, side rails, wheel chair seat belts, bed and wheel chair alarms, sheepskin blankets between knees and ankles of residents on continual bedrest, etc.) are in place, and all charting. These were just the regular tasks; more was imposed when residents fell ill or fell down, when family members had questions, and when there were doctor phone calls to take. In addition to all of these tasks, nurses were also expected to supervise and observe the work performance of the aides on the floor.

Aides on the floor were also inundated with a vast task list. There were typically three nursing assistants scheduled on each shift to care for those 48 residents, but call offs were common, often leaving only two nursing assistants to assume near total care for 48 residents. That meant each aide had between 16 and 24 residents to take to the bathroom in one manner or another every two hours, to feed, and either dress for the day or dress for bed. These direct care tasks for 16 to 24 residents are in addition to passing trays, gathering residents for activities or meals, cleaning the dining room after meals, recording meal intake, answering call lights, and doing any extra work such as taking vital signs as requested by the nurse. In order to cope with and appear to complete the
daunting task list, workers developed a rather sophisticated set of unwritten rules to
govern work routines. This systematic rule breaking is categorized into three types:
deviations from official time frames, deviations from official procedures, and complete or
near-complete omission of tasks.
CHAPTER 5

TIME SHIFTING

Deviations from official time frames for task completion were common and perhaps also the most visible rule breaking type I observed at Summer Haven Nursing Home. These broken rules were sometimes minor, as when an aide shaved male residents at noon when this task was supposed to be completed by eleven am. I also observed more significant rules broken, such as aides taking shift baseline vital signs of residents near the end of a shift rather than at the beginning. Another common deviation from time frames I observed was potentially detrimental to the health and safety of frail, infirm residents. State laws require each resident who wears absorbent undergarments due to bladder and/or bowel incontinence to be taken to the bathroom, cleansed with soap and water, dried, and changed every two hours. In spite of this, during an eight hour shift, rather than being taken to the bathroom four times, residents were typically taken three times and sometimes as few as two. This rule breaking included deviation from procedure as well.

It was exceptionally rare to see an aide actually gather warm soapy water in a basin, wash the resident, rinse, and then dry with a towel before putting on a new absorbent undergarment after every occurrence of incontinence. Most commonly, a prepared solution of fragranced “perineal wash” was used, which facilitates cleaning and alleviates most odors. The use of these prepared washes is intended for occasional, rather than routine use because soap and water is preferable due to its better cleansing properties and ability to be completely rinsed away, leaving the skin less susceptible to developing pressure ulcers. Despite this, aides at Summer Haven often chose a quicker method of cleaning the residents. Not only did they typically have another fifteen residents to change after the first one, they also had to complete the task with residents who were

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often physically resistant and combative toward the staff. The cajoling necessary to elicit residential cooperation often took more time than performing the task itself. It was not uncommon for aides to require assistance from a second staff member to care for a resistive resident. As a result, both aides were delayed in completing their tasks, creating a situation where it was not possible for them to complete their work without cutting corners to save time.

Nurses also deviated from time frames officially governed by facility and state regulations during my time at Summer Haven. The most common nursing deviations noted surrounded medication administration times. Again, state laws require medications be administered within one hour before or after the prescribed time. In other words, a medication scheduled for 9:00am can legally be given anytime between 8:00am and 10:00am.

It was standard procedure for the 9:00am medication pass to start just after 7:30am and end closer to 11:00am than the scheduled 10:00am. While reason contends this problem could be alleviated by staggering scheduled medication administration times, the idea was ignored when I suggested it to the Director of Nursing at Summer Haven. It was difficult to impossible to get the medications out to all of the residents when there were no interruptions, but when sporadic interruptions such as family or doctor phone calls, resident falls, or dealing with an employee conflict occurred, adherence to the time schedule became significantly less likely. In fact, on a typical second shift, I began the 5:00pm med pass at 3:45pm and did not finish until almost 7:15pm. Nurses also often deviated from time frames when they decided to give a medication ordered for administration at midnight at 6pm. Several causal explanations exist for this behavior. The medication time may be changed because past experience taught that the particular resident would not wake up at midnight or would not be able to go back to sleep if awakened in the night. Additionally, when the evening nurse believed the night nurse does not pass all the medications that are ordered, she changed the time and give a midnight scheduled medicine at ten pm. She did this in order to prevent eventual health consequences for the resident not receiving the particular medication from the night
nurse. While overmedication was also a possibility, the night nurse in question told me that she counted the medication often to provide evidence for herself that the night nurse was in fact not administering the medicine.

I observed both aides and nurses carry out other rule violations regarding time frames. Aides and nurses alike had paperwork requiring completion during the shift. Often times, nurses were observed to initial or sign off medications long before (at the beginning of the shift just after report) or long after actual administration (toward the end of the shift while smoking in the breakroom) despite official rules requiring this to be completed immediately following task performance. Another variation of not signing medications at the indicated time occurred when nurses signed routine meds as they went along, but wrote pm's (as needed) and narcotic administrations on a note pad for charting later in the shift while doing the narrative charting. Treatments were also supposed to be signed as they were completed (Ohio Adm. Code 2004c), but I never saw this take place even one time while working at Summer Haven. Instead, treatments were routinely initialed all at one time, typically at the end of the shift. In addition, they were initialed whether they had been completed or not. During a state inspection, facilities are often cited for incomplete charting. So, whether treatments or medications are given or not, they must be signed as given. Finally, narrative charting in the nurse's notes were also often charted at the end of the shift when most of the physical tasks had been completed. Nurses found it easier to do all charting at once rather than to do it as tasks are completed, which was technically the rule (Ohio Adm. Code 2004c).

Aides also had paperwork to complete as part of their job. I routinely noted several aides recording the meal intake (how much each resident ate and drank at a meal) for breakfast and lunch at the end of the shift. At that point up to six hours following the meal, it was not likely their memories provided accurate numbers for each resident for up to two meals eaten during the shift. Research suggests that information from events, tasks, and activities experienced in the time since the initially memorized event cause retroactive interference in the ability to recall earlier information, and information loss increases over time as little as a few hours (Roediger 2004). Aides were also required to chart on flow sheets tracking frequency and size of bowel movements for each resident.
Again, no matter what, each block had to be filled in. If the aide did not know if a mobile continent resident had a BM, an answer was written down nevertheless. Most often, when the aides did not know if one took place, I noted they recorded that no bowel movement took place. They were not secretive about this practice. In fact, more than one aide said, “It’s better to chart you don’t know than to make it up ‘cause you don’t want to say they are going if they might not be.” This was an example of aides using their own knowledge of the medical necessity of monitoring bowel movements to guide their charting.
CHAPTER 6

PROCEDURAL DEVIATIONS

Deviations from official procedures were also commonplace as workers attempted to complete all of their work. I saw aides routinely cut corners in care including the aforementioned simplification of care during toileting (taking residents to the bathroom). In addition to this, I observed nurses cutting corners in procedures. One notable nursing procedural deviation was the routine manner in which medications were given through gastric tubes (g-tubes). While protocol demands proper placement of the tube is checked through auscultation with a stethoscope prior to administration of any medications, water, or liquid feedings, I saw one nurse routinely alter this task to save time. She did not use the stethoscope to listen for the telling ‘pop’ heard when air enters the stomach; instead, she trusted the presence of residual stomach contents aspirated in the tube to adequately assure proper placement. I found the fact that she was open about performing this deviation in front of me very revealing of the extent to which such behaviors were pervasive, acceptable, and deemed necessary in the underground culture of nursing home workers. In addition, official protocol requires medications to be given through g-tubes one at a time preceded and followed by a nominal amount of water. I never saw this take place. Even I, a nurse who did try to follow as many rules as possible, gave medications through a tube more than one at a time. Most often, I gave meds and saw other nurses give g-tube medicines more than one at a time preceded and followed by water.

Another deviation from the prescribed rules involving a resident with a g-tube took place following the initial placement of the tube in the resident’s stomach. The inserting physician had written orders for the tube to be flushed with 20cc (less than one ounce) of water every one hour around the clock for ten days. In the ten days following the tube insertion, I worked four shifts on that unit, two at night and one each during the day and
evening. On day shift and evening shift, it was not feasible to go all the way to the end of the hall to Mrs. Smith’s room to properly check placement of her tube, check for stomach residual, return the residual to the stomach, and then flush the tube with less than one ounce of water every single hour on the hour. Between passing medicines, assisting the nursing assistants, doing treatments, and charting that did not always get completed thoroughly, there was not enough time in the shift to go to that room every hour to spend five minutes to give only 20cc’s of water. Other nurses corroborated the notion that this doctor’s order was unrealistic and unnecessary as well. While I worked that floor, I tended to flush the tube every two hours with about 45cc of water. Even when very busy on the day or evening shift, I did take time to perform the task every other time it was ordered. On night shift, the decreased workload allowed time for the task to be completed every hour, but it was typically completed just as it was during the day. Another nurse and I discussed the matter, and she felt it was “just stupid to give 20cc’s every hour.” She continued to say that she would not do it every hour because “every two or three is more than enough.” Research has linked patient behaviors regarding personal illnesses to the illness representations they possess regarding illness identity, cause, consequence, and duration (Meyer, Leventhal, and Gutmann 1985). I suggest it is possible to attribute very similar behaviors in health care givers. An example was the case of nurses altering the fluid order for the new tube. This offers support to the notion that nurses make decisions regarding rule violations based upon their own beliefs of necessity of the orders.
CHAPTER 7

TASK OMISSION

The third type of rule violation I noted at Summer Haven was complete omission of certain tasks within a larger set of tasks to facilitate speed of completion. For example, I observed aides opting not to check vital signs when they were behind schedule. Instead, they made them up if the resident seemed as they normally appeared. It is important to note here as well that I did not notice anyone falsify vital signs when the resident was clearly exhibiting non-typical physical or mental symptoms. Again, I suggest these decisions were based upon the illness representations possessed by the employees regarding the severity of illness and anticipated consequence of the task omission.

Aides and nurses at Summer Haven also skipped other tasks they felt impeded their ability to complete their work on time. I noted aides skip scheduled changes of bed linens when the beds looked very clean. In addition, I noted one aide known in the facility as a good aide skip giving a resident a shower when that resident had no noticeable odor. She opted instead for the quicker but more importantly, what she deemed to be equally effective bed bath. While aides and nurses alike generally wore gloves when the potential to come in contact with bodily excretions, I noted more aides failed to wash their hands properly or skip it completely. Many nurses not only altered time frames for medications, but also chose not to give some medications at all despite the doctor’s order to give them. Medications typically skipped to save time during a medication pass were those deemed less immediately medically necessary such as vitamins, one calcium pill that is given three times per day, or Natural Tears eye drops. I even witnessed one nurse omit eye drops prescribed to treat glaucoma to save time. Often times, other nurses and aides expressed to me that prioritizing was very important during the shift. One aide clearly described the situation when she told me, “Some days,
you just have to prioritize what has to be done, what needs to be done, and what can go.” Essentially, aides and nurses alike prioritized based upon their judgment of the severity of conditions. Once more, this was the staff utilizing their representations of the situations at hand to make decisions.
CHAPTER 8

CYCLES OF MANAGEMENT ENFORCEMENT

The challenge workers faced in deciding which rules could and could not be broken is discriminating as management not only enforced some rules very strictly while ignoring rule breaking in other areas, but also engaged in cyclical patterns of rule enforcement. Rules enforced most strictly on a routine basis at Summer Haven were those most visible to management such as urging workers to stay busy, to complete all paperwork (focus on completion, not accuracy), and to wear proper uniforms. These were the rules that were also most easily monitored. They were visible and immediately notable by any visitors to the facility, including the state surveyors who could arrive at any time of day within a six month period surrounding the date of the previous year’s survey. At Summer Haven, management enforced the uniform policy very strictly. They placed great emphasis on having all employees in clean, proper colored scrubs and to not wear any type of scarves on the head. The headscarves were an issue as many African American nurse’s aides preferred to wear head coverings. This was an area of contention as management expected the nurses to enforce the no headscarf policy, but the collective thought among the nurses I spoke with was that they did not want to upset the already overworked and overruled aides with rules they considered petty. Aside from believing it was rather petty, the nurses also feared that annoying or angering the aides would decrease the amount or quality of work that would be completed on the shift. The nurses depended on the aides to keep the floors running smoothly. All nurses knew and tried to keep in mind that “happy aides do more and better work than unhappy aides.”

Management also strove to make sure all employees wore their nametags, just as noted by Diamond (1992, p. 175). While these rules did not directly affect patient care, they were most visible and violations that were worthy of citations if the state surveyors
observed them. It is important to note that while management indeed attempted to enforce visible rules more often than invisible rules, as Bowers and Becker (1992) argued, the selective cycles of enforcement I observed go beyond visible versus invisible rules to a plane of enforcement where enforced rules are in a constant state of flux. A visible rule, such as nametags, enforced one day was ignored the next when a more invisible rule, such as omission of proper skin care during absorbent undergarment changes, was enforced.

During my time at Summer Haven, I also observed management employ unofficial means to monitor subordinate compliance with some rules. These methods were informal and very specific to each person in management. However, behaviors and methods of deviations from rules at each level tended to travel throughout the nursing home industry as employees commonly worked in one facility after another. I noted, on more than one occasion the shift supervisor marking sheets with a yellow highlighter in an inconspicuous place so that she could come back to make sure they were changed on the scheduled day. Management and floor nurses often made a concerted effort to monitor the aides in their potentially detrimental habits of not wearing gloves for direct care or properly washing their hands. While aides said they found these rules menial, they also said they felt they were two of the best activities to skip in order to save time. I argue it was overwork and the impossibility of complete rule following that lead to a work culture of rule breaking and shortcuts that, in some cases, resulted in some very important rules being broken.

Management focused on gloves and hand washing because failure to perform these tasks is a serious infection control issue. Improper hand washing and failure to wear gloves has been reliably found responsible for the spread nosocomial infections, those spread within a facility, while proper hand washing is the single most effective method of disease prevention (Barbacane 2004). It should also be noted that nurses often did not wear gloves for procedures such as checking blood sugars, giving injections, and giving eye drops. Nurses verbalized to me that despite official policy to the contrary (Ohio Adm. Code 2004a), it was unnecessary as long as your hands did not come in contact with body fluids or excretions. They perceived a practical difference between cleaning
residents after toileting or feeding and checking blood sugars where there was a merely a potential to come into contact with blood, which is potentially more hazardous than urine or saliva. I observed that nurses and aides alike wore gloves for all procedures when family members or management were present.

Other issues that management tended to rather strictly enforce were those that state surveyors tended to focus on while performing inspections. Completed paperwork was one of these issues. It was very important to management to make certain that charting was consistently complete, thorough, legible, and in the correct color of ink. Nurses and aides were reminded by management daily that charts were legal documents requiring care and caution in what is charted. One of the required in-services for nurses while I worked at Summer Haven instructed employees on guidelines about required elements of charting, what should be avoided, and certain words and phrases that should never be used. One item the state surveyors can cite for when not properly documented is notification of the family and physician following any change in mental or physical status. It was not uncommon for nurses to forget to chart new doctor’s orders in the narrative charting or forget to notify the responsible family member. As a result, the facility had a nursing manager whose sole purpose was to audit or check charting to ensure blank spots were initialed and narrative charting was complete. The nursing manager’s place in the formal structure was directly under the DON and ADON. It was the task of either the D.O.N. or Assistant D.O.N. to determine what constituted adequate charting. According to the Assistant D.O.N., this knowledge was developed over time after experiencing state surveys in different facilities. Corporate attorneys also instruct the nursing directors about components of charting to minimize legal risk to the facility.

It is also interesting to point out that I observed management breaking rules as well. State laws require that when an injury, change of mental or physical status, or any other unusual occurrence takes place, the physician and the responsible family member be notified. On the previous evening shift, a nurse at Summer Haven had made a medication error. She gave a man double the dose of a medication he was taking. The nurse, upon realizing her mistake, followed proper procedure in notifying the physician
and family of the occurrence. She charted everything as it occurred in the narrative nurse’s notes. The next day, the Director of Nursing was going around to each nurse in the facility saying, “You are absolutely not supposed to notify the family” of a medication error unless there are serious mental or physical consequences as a result of the error. I said to her that I thought it was required that families be notified of those things, just as they are when a resident falls down or has a cold. She responded with a gruff and unyielding, “Not in this facility you don’t.”

Furthermore, management at Summer Haven tended to not enforce rules that were difficult or inconvenient to monitor as well as those that may lead to further staffing inadequacies. One of the most difficult tasks for management to monitor involved nursing administration of medications at the proper times. It was not uncommon for nurses at Summer Haven to administer medications at unscheduled times despite charting them at prescribed times. The knowledge of what residents this was done for and when to do it was part of the unwritten subculture that employees had to learn in order to complete their jobs. On one occasion, I spent an inordinate amount of time attempting to administer Ativan (a drug for anxiety or agitation) to a resident at bedtime. After she refused the medication over and over, I asked a long time employee of the unit how he gets her to take that pill. He told me that he always crushed it and mixed it in her supper; otherwise, she refuses. He went on to explain it was the only way to get her to take a much needed medication and that sometimes, “the ordered times just don’t work.”

In addition, management had difficulty enforcing rules regarding break times and employee napping on eleven to seven. Management was dependent upon the floor nurses to enforce these rules, but whether the rules were actually enforced were particularly nurse and situation specific. In other words, I observed a few nurses on evening and night shifts enforce rules regarding break times very strictly with the aides. However, I also observed nurses who were lenient in this area. One nurse told me that she liked to take longer than the fifteen minute allowed break when time permitted and that it would be hypocritical to not allow aides the same small pleasure. In addition, I witnessed several nursing approaches to address aides taking a nap during non-busy time during the night shifts I worked at Summer Haven. Night shift aides did often have periodic down
time, though not much. Their problems with allotted time frames came in the morning when they were expected to awaken, bathe (full or partial), brush teeth and hair, and dress 17 or more slow, elderly, often arthritic people in two hours.

The approaches used to address aides sleeping at night were dependent upon several factors. One nurse told me that she always immediately terminated an employee if she caught them asleep, whether they had intentionally gone to sleep (lying on a couch with shoes off) or if they had accidentally fallen asleep (sitting at the desk doing paperwork). The nurse said to me, “If I’m not allowed to sleep, no one else is either.” One night, I observed another nurse merely wake up and warn an aide who had fallen asleep. The nurse later told me that the aide was a good employee who consistently did her job well. That nurse also said, “It would be different if we wanted to get rid of her.” So, in addition to enforcement of the rule depending on the nurse, it was also contingent upon the aide’s reputation as a worker. This is referred to in organizational theory as “idiosyncrasy credit,” where those with higher status or a past reputation of high quality work are given leeway in performance expectations (Alvarez 1972, cf. Hollander 1958). I also noted that same night that there were only two aides on the unit. Termination of the sleeper would have created a further staffing shortage when we were already working with a skeletal staff. This consideration was central to the decision on night shift by the nurse to terminate or merely wake and warn a sleeping aide. While this apparent favoritism of good employees over bad employees was not fair, it did appear to be typical and functioned as a way for nurses to treat rules subjectively rather than rigid and uncompromising. This preserved the nurses relationship with the aides with whom they worked so closely. While management tended to see the rules as black and white, the aides respected the nurses who treated each case individually, taking into consideration the work ethic and attitude of the offending aide. This was further evidence of the informal culture.

Management’s enforcement cycles were influenced by several factors. The first of these factors, one that caused an immediate concentrated effort in rule enforcement, was criticism from the corporate office. The facility administrator’s superiors were in the facility to visit one day and commented on a few rule infractions including employees not
wearing name tags and each dining room table not being served at the same time at meal times (in other words, some residents at a table received their meals while others at the same table were still waiting). This prompted an immediate increase in management’s attention to nurses and aides in regard to name tags and meal serving. It was delegated to nurses on evenings to enforce the meal time rules with the aides. This placed nurses in a precarious position as we had to enforce rules and yet maintain a positive working relationship with aides. The corporate leaders also noticed nurses passing medications without initializing them as they were given. This issue also became an area of concentration for management for a period of time.

Complaints from family members or some other incident of unacceptable employee work performance discovered by management also lead to a concentrated amount of enforcement for a period of time. Family member complaints were not all that common at Summer Haven, from my experience. The majority of complaints I witnessed regarded laundry. The event that stands out most was when the wife of a resident was furious because despite her having placed a sign over her husband’s (resident) laundry hamper in his room stating she would wash all of his personal clothing, the aides continued to send his clothing to the laundry department where they were mistakenly bleached, shrunk, or lost on numerous occasions. Her complaints fell upon deaf ears when she complained to the nursing supervisors. They did not take responsibility and made excuses for absent minded aides, while assuring her they would try to keep a closer eye on the situation. The closer watch of the nurses did not stop the laundry problem; therefore, the wife felt her only course of action was to complain to management. This prompted a nearly three week period of each resident’s laundry status as top priority in the eyes of management. While management felt the extra attention was successful in effecting all employees to pay close attention to each resident’s laundry, my observations revealed instead that employees merely paid closer attention to how they treated the laundry of residents with families known for being “very picky.” Actually, families and management alike engaged in selective attention and inattention. Without it, there were too many issues to be addressed.
When affairs were going smoothly in the day to day operations of the nursing home, management then had more opportunity to direct attention to making improvements. In other words, they often sought to prevent rule violations they typically ignored during times when more significant rule violations must take precedence. During times of upheaval, relatively minor infractions, things that did not directly affect patient care, such as wearing name tags or head scarves, ensuring dirty and clean linen containers are placed at least ten feet apart from each other on the same side of the hallway, and aides or nurses having too long finger nails went unenforced. Another issue that went unenforced most of the time surrounded whether nurses locked their medicine cart each and every time they entered a resident’s room. I observed every nurse, including myself, routinely break this rule. Feeling relatively safe that no one would attempt to get in to the cart while briefly inside a room, we left the cart closed but unlocked to save time. Relative lack of enforcement of these types of rules served to decrease conflict in already trying and demanding times for all. However, when business was going along well, management asserted their enforcement role in areas workers often resented and did not accept reasoning for, such as the aforementioned relatively minor rule violations.
CHAPTER 9

WHICH RULES TO BREAK: HOW WORKERS DECIDE

The culture of rule violations at Summer Haven was not accessible in written form nor was it formally taught (or even acknowledged, for that matter) in official orientation programs of all new hires. Therefore, new employees spent weeks or months working, often times, more than forty hours per week before they were able to adopt the unwritten rules, values, and norms of the subculture they had entered. Adoption of this subculture was crucial to the success of employees as corroborated by Bowers and Becker (1992). However, both new and old employees faced difficulties in negotiating their way through their workdays as they had to continually decide which rules to follow and which could be broken.

It is necessary now to address how employees responded to these cyclical enforcement patterns. I observed that employees tended to follow certain rules during periods of high management attention and then return to previous patterns when the increased attention waned. In general, employees at Summer Haven followed rules when not following was not easily hidden, in action or in consequence. This was somewhat heightened when the rule was something management cared a lot about, such as the immediate response to the family complaint about laundry or maintaining a proper turning and cleaning schedule for bed bound residents to control or prevent pressure ulcers, in opposition to things management cares less about such as workers taking three extra minutes on their breaks or wearing more than the officially permitted one earring in each ear. I do not intend to suggest employees did not continue to break rules during
periods of enforcement. Increased management enforcement did not mean that the rules did not continue to be broken. Instead, it meant that they were broken either more discreetly or more openly during the cycle of waning enforcement.

The degree and cyclical nature of management attention to rules were not the only factors determining which rules were followed, disregarded, or ignored. Consequently, workers had their own views about which rules were important and which were not. Workers at Summer Haven consistently followed those rules which they believed were medically necessary. Examples of these I observed at Summer Haven included aides and nurses not checking blood pressures on the arm of the side where a mastectomy had been performed, which helps to prevent development of lymph edema or extreme swelling in the arm, and keeping heads of beds for bed bound residents elevated to at least a 30 degree angle to prevent aspiration pneumonia. I observed workers, nurses and aides, consistently break the rule stating caregivers must wash their hands before and after care. On the other hand, it was viewed as redundant and unnecessary to wash hands before giving care, especially if the worker had just come from another room where they had washed hands after care. And on occasion, when extremely pressed for time, workers broke rules they felt were important but too time consuming at that time. At Summer Haven, these included nurses skipping eye drops, aides giving sponge baths rather than showers, and aides not putting on TED (supportive stockings to prevent swelling in feet and legs) hose with morning care.

It is important to note, as well, that the residents themselves played a significant role in determining which rules were broken and when. Residents who had the cognitive capability to complain if an employee skipped tasks the residents saw as necessary typically did not have those tasks skipped. An example was showers. There were times at Summer Haven when a resident was clean enough to have a shower skipped in favor of a quicker partial bath, but the shower was indeed given because the resident knew it was his shower day and would have reported the offending aide to a nurse. Furthermore, the resident’s physical condition contributed to which rules workers broke in giving care.
Often times, arthritic residents were very slow to walk, which created further time delays. So, aides would often put residents in wheel chairs to take them to the rest room despite an existing care plan requiring the resident to walk to and from the restroom.

In addition to following or not following rules based upon medical beliefs and necessity, workers at Summer Haven also made decisions regarding rule adherence to avoid conflict with coworkers, supervisors, or management. These more self-serving reasons may even have been the most influential reasons for rule adherence at Summer Haven, partially due to a lack of long-term relationships developed between caregivers and employees as a result of a high and quick employee turnover rate in the facility. Most often, aides followed rules of practice or ignored rules allowing their job to appear better performed to avoid coworker and supervisory conflict, as these peers were the ones most likely to notice lackluster job performance. Aides and nurses alike made an effort to complete their work to a minimal acceptable standard that was understood and accepted by a majority of employees, in order to maintain peace and avoid reprimand from superiors. Workers complied with the cycle of rule enforcement by responding to the varying desires of supervisors and management regarding which rule was enforced at each particular time. I observed employees at Summer Haven refer to these as “the rules of the week.” One day, an aide was sitting in the nurse’s station for a short time talking to me while I charted when she heard the click of heels on the tile floors in the distance indicating the Director of Nursing (DON) was approaching the unit. The aide said to me, “I better go now. Don’t you know ‘no aides in the station’ is the ‘rule of the week’?” I had heard that very piece of information during report from the off-going nurse that morning. I agreed she had to go at that point. The last thing I desired as a new employee was to have the D.O.N. catch me blatantly not adhering to the rules she was currently enforcing most strictly. This is evidence showing how employees depended upon one another to convey the intricacies and details of a subculture in constant flux to which employees must adopt or else fail to perform adequately in the job.
In spite of workers' typical attempt to avoid conflict by following or ignoring rules, I also observed Summer Haven workers following or ignoring rules in order to provoke conflict. Aides used this tactic as a form of rebellion, as first observed by Nancy Foner (1994a, p. 88). Often times, they utilized this as a method to show the supervisors and/or management that the work load was impossible if the rules were followed as management said they should. For example, night shift aides on a particular unit at Summer Haven each were required to awaken, give morning sponge baths, brush teeth and hair, and dress their 15 to 18\(^1\) assigned residents. On any given morning, three to four of these 15 to 18 residents are scheduled for a shower or bath in the whirlpool. The difficulty in completing this task was not the acuity of care or actual difficulty of the task; instead, the difficulty arose in that aides had only two hours to complete the tasks.

The facility rule dictated that residents not be awakened before five am; therefore, aides had two hours to give all necessary care to the residents plus clean up after themselves as they went along. This means the aides had approximately six and one half to eight minutes to care for each resident, not counting time for preparations, hand washing, clean up, travel time from room to room, or extra time needed in the morning by slow, arthritic, elderly people. I heard day shift aides complain to night aides about beds not being made and sometimes, a few residents with wet Depends when they came on at seven. It was impossible, without creating shortcuts and skipping some tasks, for night aides to complete their work to the satisfaction of the on-coming day aides who were often harsher critics than management. The informal sanctions imposed by day shift aides including gossiping about the night aides, lack of willingness to overlook any small tasks left undone, and the more immediate derision and verbal abuse were far stronger incentives for night aides to complete the work than any formal sanctions imposed after a significant time period of inadequate job performance. Workers concerned with how co-workers and supervisors viewed them experienced role conflict as they sought to get their work done adequately while also satisfying the on-coming shift

\(^{1}\) Current Ohio law requires nursing ratios of no less than one aide to every fifteen residents. Often times, the nursing home was indeed out of compliance (Ohio Adm. Code 2004b).
(Goffman 1959). Consequently, it was not uncommon to see aides awaken residents at four am, dress them, and lay them back down to reduce the task demands between five and seven. As a result, sometimes, in an attempt to prove the workload was not feasible, the night aides followed every rule to the letter in a sort of spiteful rebellion against the day shift workers. They were not near as done with their work as usual. The rebellious following of rules lead to a significant conflict and a meeting between some night aides, day aides, the D.O.N., and the administrator. Though I was not present at the meeting, I understood the outcome was positive in favor of the night aides who should not have to awaken residents any sooner than five am. The day aides were instructed to complain a little less, and a rotating “get up list” was made determining which shift was responsible on which days for performing morning care on which residents. The “get up list” was an attempt by management to decrease the workload on night aides during five and seven in the morning, thereby encouraging them to follow more rules since they would have fewer residents to care for.

The next reason I observed leading to rule violations at Summer Haven was a bit different from Foner’s (1994a; 1994b) results suggesting workers are only able to give compassionate care to residents “on stolen time.” While I did notice employees break rules, especially those regarding time frames, to allow time for compassionate, personal care, I did not observe employees doing this in secrecy. Instead, it was something they were proud of. As previously reported, Summer Haven had a very fast rate of employee turnover, which resulted in very few long term relationships between residents and their aides or nurses. I observed the shift supervisors actually praise employees who spent time with residents even when it put them behind in completing the rest of their work. One supervisor offered the following comment regarding a nurse taking extra time with an emotionally needy resident: “Amy is so good with the residents and the families too. There may be things she does she shouldn’t or things she should she doesn’t, but you always know she cares so much about the people.” While I do not imply management
approved of workers spending so much time with residents that they consistently performed their job at an unsatisfactory level, I did observe management observe caring employees in a somewhat proud manner.

As a result of and perhaps due to the high turnover rate of employees at Summer Haven, staffing issues were customary. The facility was forced to use a medical temporary staffing agency to fill positions for nurses and aides on each shift on various units. Use of agency staff presented further issues of rule violations as agency workers were not familiar with the residents. My observations of agency nurses at Summer Haven show they fell in to two main categories. The first was made up of those nurses who make a sincere attempt to complete work within time frames while also completing as many of the tasks as possible. This type of nurse was ordinarily honest in reporting the tasks she was and was not able to complete. It was impossible to go onto a unit for the first time and pass medications and do all charting and treatments for 48 patients in the proper time frame. I was in this category and spoke with other agency nurses who agreed it was a very stressful position to be in when you cannot get all of your work done despite an honest attempt to do so.

The second category of agency nurses included those who did not attempt to do all of the work and also did not hesitate to admit they made no attempt to complete the work. One agency nurse told me during a lunch break that she was merely “a warm body.” She went on to say she believed the management did not care how much she got done as long as she did not hurt anyone in the process. This again, was based on her perceptions of the illness at hand, allowing her to justify her actions. She expressed to me that her philosophy on agency nurses was that they were not intended to do a good job; instead, they were merely present to do a minimum amount of work until “regular staff can be there to take care of things the way they want them done.”

Continuing on short staffing, I suggest it created temporary (or not so temporary) crises that increased tensions between task demands and time thereby inducing workers to break rules they normally followed. Work performance and extent of rule violations of regular nurse employees and the two categories of agency nurses were affected by the effects of chronic short staffing. First, I observed regular staff nurses spending time
explaining or assisting agency nurses which created a more significant time demand for the regular nurse. I experienced two regular nurses at Summer Haven did not hesitate in expressing agitation at the necessity of having to do more work or spend time helping to “make up for agency” staff’s lack of familiarity with the facility work culture. Others were much more understanding and grateful that the agency was able to cover the shifts at all. The extra time spent with the agency nurses or spent giving direct care when the unit was had too few nursing assistants created a severe deficit of time for proper completion of her own tasks. Consequently, the only way she could give the appearance of work complete was to break more rules than would normally be broken on a day when the time constraints were fewer.

Next, nurses in the two agency categories were also affected by an unremitting staffing crisis. The first category of nurses was indeed forced by time constraints to break rules they normally would not. I observed these nurses skip treatments, vitamins, and initializing medications long after administration, along with other violations due simply to the lack of time to complete the tasks. Regular employees were unable to complete their work due to lack of time, but agency nurses who were unfamiliar with the facility and its residents were at a further disadvantage. The second category of agency nurses at Summer Haven who intended to do a minimal amount of work from the outset admitted doing even less work when staff was short on the unit. The same agency nurse who referred to herself as “a warm body” also told me that when her units were short nursing assistants, she took her time more than usual so as to appear too busy to help the aides. Moreover, short staffing created poor care and increased rule breaking, whether it was intentional to avoid extra work (as in category two agency nurses) or category one and regular nurses who attempted to complete the work but could not when the already impossible task to time ratio was further increased.

During the almost three months I spent working at Summer Haven, it seemed that patterns of rule breaking made necessary by circumstances most of the time became habitual, which lead to many workers performing tasks in the habitual manner even when time permitted the proper procedure be followed. Chronic short staffing coupled with unfeasible task to time ratios had lowered the acceptable work standard over time. New
employees had trouble adopting the substandard level of acceptability, but over time, they either adopted those subcultural values and habits or ceased employment. At Summer Haven, I did not perceive that employees, who broke rules in the habitual manner, even on occasions when there was enough time, were not often very good employees. Instead, the standard that was acceptable during the typical times of short staffing, whether due to call offs or facility policy, become ingrained as the acceptable standard at all times. Employees did not feel they were doing a disservice to residents by routinely breaking rules such as using Peri-Wash to cleanse a resident instead of soap and water or a nurse still giving some medications at five pm that were not scheduled until nine pm. They completed care as they normally did and then used the extra time to either spend some extra time with residents or take longer breaks, which serve to bolster morale in a job that was mentally and physically grueling.

At times, I did notice some employees procrastinate too much and then have to break more rules than usual in order to complete their work. The most notable occurrence was on a particularly short staffed day when only two aides were assigned to a floor to care for 48 people. They procrastinated at the beginning of the shift, commiserating with each other and with me (the nurse) about the dismal staffing situation. By the time they did get started with their work, they were behind further than usual. On a usual shift, they had to break rules in order to get done, but on that day, they had to cut more corners and break more rules than usual. This meant that instead of cutting corners in some resident rooms, they had to cut them with nearly every resident. On a procrastinating day, there was no time for resident/staff personal interaction. Instead, the interactions were only for direct physical care, which was carried out in an increasingly hurried manner.

A contradiction appears to exist between workers having too much work and too little time to do it, yet they procrastinated on days when they were further short staffed and pressed for time. In my observations at Summer Haven, it became clear that the occasional procrastination practices were not at odds to the main point of my argument that workers have too many tasks to perform in the allotted amount of time. As an alternative, I proffer that the procrastination in times of severe stress functioned to help raise or maintain worker morale even though they had to then cut more corners and break
more rules than usual. In addition to providing a coping mechanism, the procrastination also seemed to provide the workers with a slight sense of control in a situation where they actually had very little control. The habituation previously discussed lead to a lower standard of care from which employees based the decrease in care brought about by occasional procrastination. In other words, workers were basing their judgment of whether it was acceptable to perform substandard work on occasion in order to maintain morale in the intensely stressful workplace on a lower standard of what was within acceptable limits. They could not do all of their work on a fully staffed shift; therefore, doing a little less on a short staffed day seemed satisfactory. Workers sought to protect their mindset and mental ability to do the work with occasional procrastination, as one aide suggested, "Even when we're short like this, we take care of 'em enough, and in the end, it won't matter if I get started now or a half hour from now."
CHAPTER 10

CONCLUSION

This paper has shown that there were three types of rule breaking observed at Summer Haven Nursing Home. They involved adjusting official time frames, deviating from official procedures, and even omitting some tasks entirely. Workers were forced to break rules and create shortcuts as they attempted to complete a list of tasks that was too long for completion in an eight hour shift. Management enforced rules cyclically and selectively, while employees adjusted their work performance in turn. Again, employees often possessed views of the rules different from management’s views. They broke rules they felt were unnecessary or too demanding, while also breaking rules in order to provide more compassionate, personal care. Finally, workers also habitually broke rules in times of extreme stress on the job in order to cope and maintain morale through extra time spent commiserating with other employees.

This research helps to fill the literature gap between official rules and actual practices of nursing home workers. Gubrium (1975) suggested management often looks the other way when employees break rules, and this research further illustrates how management enforces rules in a selective and somewhat predictable cyclical manner. Diamond (1992) and Foner (1994a; 1994b) briefly acknowledged that nursing home workers systematically break rules, but they did not examine those rules in depth as done in this current research. Finally, Bowers and Becker (1992) did address rule breaking and how not every employee is able to adopt the work culture in order to successfully maintain employment. They suggested the shortcuts adopted by workers are based merely upon
visibility versus invisibility, but this paper further shows that the relationship between rules and practices are more complex and based upon an incessantly changing, interactive relationship between management, employees, and residents.

Results from this research indicate that workers do care about the quality of care they give, but their own most pressing needs such as maintaining their employment play a significant role in determining how they carry out their work. Workers desire to perform their jobs in a manner consistent with rules and regulations they understand the necessity for, but they also find themselves in search of ways to protect morale and control their work load in a situation where the demands are greater than what is possible. Nursing home workers at Summer Haven sought ways to break rules in a consistent manner that would not compromise care in a manner detrimental to the immediate health needs of the residents. However, I did not find they often considered the long term effects of continuous systematic rule violations.

Future research investigating worker awareness and concern with long term effects of rule violations would contribute to fill the void in the nursing home literature in this area. It is possible that changes in nursing home policy, regulation, and enforcement patterns are indicated to protect the growing number of residents in the nation’s nursing homes. Workers also are in a precarious position when they cannot perform their duties without violating numerous rules each time they report for duty.
LIST OF REFERENCES


Ohio Administrative Code. 2004a. Chapter 3701-17. “Infection Control.” Rule no. 11 (C) (1) (b), (d), (e), and (f).


