Home Care Home

Reflections on the Differentiation of Space in Living and Care Settings

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> "To thee, I'll return overburdened with care
> The heart's dearest solace will smile on me there."
> "Home Sweet Home" by John Howard Payne, 1823

Care Rooms

Care needs a place where it can be provided. This place is generally designed as a structurally limited space such as a room or building, located in a residential house or a care facility. Particularly when care becomes an essential part of life and is set up for the long term – in the case of chronically sick or older individuals in need of care – the spheres of living and caring tend to overlap. Space has to be created so that both appropriate care can be provided and the individuals receiving care can have the design and setup of their living space according to their personal taste and needs. Care and living therefore take place in a common space.

Nursing textbooks published in the nineteenth century describe in detail how patient rooms within the home should be designed and set up to be in line with the medical guidelines of the time. For the sick and elderly who were usually cared for at home during this time period, a very specific environment was to be created that was conducive to the well-being of the patient, from medical and nursing points of view. The main concerns for the design of patient rooms in modern care homes are structural and technical safety regulations. Consequently, as we will see, in the context of design, today's textbooks still emphasize safety in the living and care environment. At the same time, these rooms are not only working spaces for caregivers in an institutional context but also the living spaces of people with very different life stories who are now living together in a new location.

The issues discussed in this chapter are based on work from an interdisciplinary research project[1] that focused on the role of objects in past and present nursing and care settings using an inductive approach. Although working on distinct time periods and with different methodological approaches, the authors soon discovered connections among aspects and themes that led to an intensive interdisciplinary dialogue, which we present the first results of in this chapter. It covers the range of conditions found in patient rooms in a family home in the German-speaking area in the nineteenth century and personal rooms in a care home today in Germany, including both home care and institutions, where people are cared for in the same rooms in which they live. How and to what extent have patient care and personal needs been reconciled in the past and today? And what (hi)stories do these hybrid rooms and their inhabitants tell?

To highlight these (hi)stories, we will first use an excerpt of a field report to provide insights into Anamaria Depner's current research. This special narrative form will portray an example of daily life in care facilities. At the same time, it will lead us to the theoretical and methodological framework, which will then be briefly presented. In the following section, we will use content from nursing care textbooks to contrast the design and setup of care rooms in both historical and contemporary settings. We will then outline the general themes and collate them as part of the results. Finally, we will recommend areas for further research and return to the central question of the influence the care situation has on the design and setup of the room and what it might look like to meet personal and nursing care requirements in the respective contexts.

1 | This article was written as part of this project called "Die Pflege der Dinge – Die Bedeutung von Objekten in Geschichte und gegenwärtiger Praxis der Pflege" ["Care and Things – Objects and their Significance in Past and Present Nursing Practices"] or, for short, "Pflegedinge" ["Care-related Objects"], see Artner et al. The project was supported by funds from the Federal Ministry of Education and Research from February 2014 through the end of January 2017 under the funding code 01UO1317A and D. The sole responsibility for the content of this publication lies with the authors.

Individuals in a Contemporary Care Home: A Double Story[2]

Scene Ia: Mr. Beck tells his story

The room we are going into next is occupied by two men. The bedridden man with the parchment skin (Mr. Adam[3]) is in the rear section of the room. The windows are high up on the wall and his bed extends into the middle of the room. The second resident (Mr. Beck) is in the front part of the room directly to the right of the door. Three photos hang on the wall above his bed. One shows him already at an older age together with a woman of about the same age, and the other two include two children, a boy and a girl. … While Mr. Adam is being attended to, Mr. Beck addresses me, asking who I am, and we begin to talk. I learn that the two younger people in the photos are his children. He tells me that they are all already dead, both his wife and children who they had later in life. His daughter had been sick, but he doesn't say why his son is no longer alive. Mr. Beck says he is "the last one." He was no longer able to manage on his own, but here at the home, everyone is very friendly and he is thankful for what he has. He smiles warmly as he tells his story, and I listen and smile back and ask how long he has been here. "Quite some time. And we'll see for how much longer it will be," he answers and tells me that things could get better again and he would be able to move back into an apartment. Definitely not on his own, but maybe he would find a nice lady who he would get along with well. They do take good care of him here in the home, but it's just not the same. "I'm still doing well," he says as he looks over at the bed where his roommate is lying and adds that he would really like to live in a family again.

A man quite advanced in years shares a room with another resident whose health is much worse. Their living spaces aren't clearly separated and merge together; they constantly have the other person in view. In the above scene, Mr. Beck expresses his hope that he will soon be able to leave the care facility and return to his familiar environment, even if he is quite a bit older and would first have to find a wife, an apartment, and a home. He describes it as though it could very well happen in the foreseeable future and not like wishful thinking. The professional care provided by personnel in a care home and that of a wife or partner – without which, according to his own view, he wouldn't be able to cope – are, in his mind, two essentially different types of care. This distinction doesn't seem to be so important for Mr. Beck, although he does need support; instead, where, and connected to this from whom, he receives support is important to him.

2 | The extracts below are excerpts taken from the research protocol by Anamaria Depner, 2015. For the research context see Depner, *Diskrete Dinge*.

3 | All names have been changed.

Scene Ib: The researcher reports

Mr. Adam initially appears unresponsive and incapable of communication; the way he is lying in his bed with his mouth open and the expression on his face make it look as though he was far away, but when he notices that the caregivers have entered, he manages a smile and turns to gaze at us. He looks pleased. The caregivers begin with the nursing care routine. They first check to see if his absorbent pads need to be changed. Mr. Adam was given a laxative since he hadn't had a bowel movement for several days, but it hadn't yet taken effect. Then they roll Mr. Adam onto the other side, the two nurses working well together as a team. They ask him to "help them" and praise his cooperativeness. One of the nurses, in particular, Ms. Clauß, speaks a lot with the older man who is obviously still quite mentally capable, which is reflected in his facial expression. … since Mr. Adams' skin has become thin and fragile, it requires extra attention. The special bandages meant to protect the skin and allow it to heal are no longer necessary since the situation has improved, but it would still be necessary to apply his cream regularly, at least once a day, Ms. Clauß tells me. … While Mr. Adam is being attended to, Mr. Beck addresses me, asking who I am, and we begin to talk. … After the two nurses are finished with their work with Mr. Adam and we have just said goodbye to the two men (Mr. Beck squeezes my hand warmly and says that I should come again), Ms. Clauß says suddenly, "It finally worked" … and they both return to Mr. Adam. I'm told that the laxative had taken effect and am asked to wait outside as that was nothing for people without training. I leave, whereas Mr. Beck remains in his room.

While Mr. Beck relates things about his life to a stranger who had just come into the room with the caregivers, his roommate Mr. Adam receives care. Mr. Beck tells the story of his family while the caregivers apply cream to Mr. Adam's skin. Mr. Beck talks about moving back into an apartment while Mr. Adam's teeth are brushed. After the conversation with the researcher, Mr. Beck sits on his bed while the caregivers change Mr. Adam's absorbent pads after his laxatives had worked. This all occurs at the same time, in the same room, and in the same space. The room serves as living space for both Mr. Adams and Mr. Beck; it is where both men are cared for, the workspace for the caregivers, and the space where Mr. Adam relieves himself, is washed, and provided with further care. The important point here is that the room is used simultaneously in all of these contexts. This is also reflected in the furnishings. Their personal room in the care home is shaped by the design and set-up required for the care of the residents (Mr. Adam's bed is in the middle of the room so that proper care can be provided) as well as the presence of biographical elements (the photos of Mr. Beck's wife and children that remind him of his previous life as part of a family).

Current State of Research and Methods

The simultaneous occurrence of two situations or states that stand in tension and cannot be resolved by "either/or" but instead can be described with a "both–and" approach can be understood by applying the concept of ambivalence. Recently, several scholars, including sociologist Kurt Lüscher and educationalist Miriam Haller, have discussed the concept of ambivalence in the context of identity-formation processes in old age. Ambivalence is presented as a potential key concept in gerontology (Lüscher and Haller). Lüscher and Haller are concerned with the experience of intrapersonal developments in old age as a function of more powerful and often differing images and discourses of social aging (for example, active aging as opposed to the elderly in need of care). Such ambivalences, however, can also be found in the spatial environment of the elderly in an institutionalized context, where a new narrative for personal identity concepts must be found in and through incoherent object groups.

In the cases we considered, the ambivalence is, in a simplified sense, brought about by the fact that professional care is performed in the same location where the patients live. In the case of care facilities, the place itself has been moved to the margins of society, where the usual rules do not apply. It is precisely because of a care home's distinctive character as a place of professional support for those in need of care that the distinction between workplace and private zone cannot be maintained. But also in historical home-care contexts, professional requirements were imposed upon private dwellings. Fifty years ago, Michel Foucault proposed the term *heterotopia* for these types of social "ambivalent spaces" and at the same time called for these phenomena to be comprehensively researched in their various manifestations (for example, in prisons, care homes, gardens, brothels, and sanatoriums) because of their diagnostic potential for society. According to Lüscher and Haller, *ambivalence* is "defined as referring to the experience of vacillating between polar contradiction of feeling, thinking, wanting and social structures in the search for sense and meaning of social relationship, facts and texts, which are important for unfolding and altering facets of the self and agency" (5).

Does the arrangement of things, which must equally offer space for care and biographical elements, contribute to the fact that although Mr. Beck is content, he would articulate his desire to leave the residential care environment ("to live in a family again")? How does the design of personal rooms in a care home affect the elderly people who live there?

The fact that personal things can be significant for identity in a multifaceted way has been shown in research over the past five decades in ever new ways and from the perspective of numerous disciplines. Pierre Bourdieu's model of subtle distinctions does not head this list, but it is certainly

one of the most influential approaches to objects found in living spaces. In her research on life stories in East Indonesia, ethnologist Janet Hoskins even encountered biographical objects that can stand in as substitutes for people. The cultural psychologists Mihaly Csikszentmihalyi and Eugène Rochberg-Halton, psychologist Tilmann Habermas, and anthropologist Daniel Miller, among other prominent researchers, have substantiated the identity-creating function of personal objects in the context of the home. However, the potential that objects have to define personal space has not yet been given adequate consideration.

In recent years, the interrelationship and interdependency of (everyday) objects and spaces (Rolshoven; Pfaffenthaler et al.) have been addressed in German-speaking history and cultural studies, partly also under specific reference to the object-mediated spatial constellation in daily life (Depner, "Wie der Spatial"; Atzl, "Pflegeräume"; Keckeis, "Raum"; Oswald, "Lieblingsdinge"[4]). Living is seen here as an action that manifests itself in the interaction with personal objects that are used to divide a structurally defined space. When one actively exercises autonomy to arrange these objects, living areas are created. The focus on the identity of the individuals living there and their private needs and preferences is key. To summarize this notion, the philosopher Beate Rössler uses the concept of "local privacy," something that is also addressed by Keckeis, "Dritte").

From a historical nursing perspective, there has not yet been research on room design and setup in the care context, nor have relevant personal objects been examined from this academic perspective. At first glance, the latter is surprising since biographical work today is an important practical instrument used in modern models of care, in which high value is placed on the individuality and self-determination of those receiving care. In the sources that still exist from the past few centuries, the individual fate of patients has not been a high priority; the history of medicine and, to a lesser extent, the history of nursing have focused more on understanding the profession itself and its components rather than on patients. Patient histories used in research in the past two decades have attempted to place the focus on the individuals receiving care, but here neither room design nor objects have played a central role (Stolberg, *Homo*; Dinges et al.). In today's nursing science context, personal and biographical objects are not explicitly considered in overviews of nursing

4 | The latter three sources are based on lectures that were part of the event titled "Raum Ort Ding: Kultur und sozialwissenschaftliche Perspektiven" ["Space, Location, Object: Culture and Socioscientific Perspectives"], workshop conducted by the working group Materielle Kultur [Material Culture] in the German Anthropological Association (GAA) and the Institute of Gerontology held at Heidelberg University on 20–21 Nov. 2014.

theory (see, for example, Meleis) or, for instance, in Erwin Böhm's psychobiographical care model. Environmental gerontology, however, has long emphasized that objects in the living environment should be viewed not only in light of their practical and safety-related aspects but also as personally significant objects (Saup; Wahl et al.; Oswald, "Subjektiv"; Beil). More recent studies from the field of ethnology also describe the features of the relationship between space, objects, and individuals in the context of institutionalized care (Löffler; Depner, *Dinge*). It is in this research that we clearly see the narrative potential of objects that are connected to biographically relevant stories and identity-forming events.

The theoretical basis for this research has recently proven to be quite sound, but not particularly elaborate. Instead of focusing on the social, communicative, or interpersonal space, which are themes that have often been examined in publications over the last few years, our research centers on living situations, the space required, and the design and setup of that space. This is surprising because the "spatial turn" – which has long been and continues to be influential – was a contributing factor to the establishment of the "material turn." When brought together with inspiring concepts from material culture studies, the connection between space, structurally defined spaces in particular, and objects not only is theoretically and historically promising but also offers opportunities for practical implementation in care facilities.

In the framework of the "Pflegedinge" interdisciplinary research project, we, along with our colleagues, have been focusing on care-related objects, which include all the objects that are purposely or unconsciously used in the context of care (Artner et al.). As established at the "Raum Ort Ding" interdisciplinary workshop in Heidelberg in 2014, they are also essential for setting up care rooms (Atzl, "Pflegeräume"). Objects always require space, no matter if it is for their use or storage. In the middle of the nineteenth century, when the objects used for care began to be mass produced, the question of where these things should be placed became pressing. Where should they be laid out? Where should measuring instruments, care materials, and increasingly specialized supplies be kept and stored? How close or far should they be located with respect to the place of care? To what extent do they contribute to the design and setup of the room where care is required? What specific impact do these things have on a care room?

On Home Care and Care Homes

Patient Rooms in a Family Home in the Nineteenth Century

In the nineteenth and early twentieth centuries, most older people were looked after and cared for in a home environment.[5] If they didn't have family, the only possibility was to consign them to poorhouses or hospitals, although by the beginning of the twentieth century, hospitals no longer served as multifunctional facilities (Murken; Verein für Krankenhausgeschichte). Older people who also needed to be cared for were to be found in the entire family setting. If care was necessary, the guidelines for optimal care included in nursing textbooks until the early twentieth century were to be followed. The design and setup of the room described in these written sources was the best possible situation recommended by doctors, but many people were certainly not able to implement it. However, a description of the theoretical ideal emerged to which caregivers could aspire. In addition, the first nursing textbook, which was written by Florence Nightingale, published in 1859, and well received in Germany, emphasized the importance of patient-room design and efforts to provide an adequate environment.

At first glance, it is surprising how much space – about a quarter – was allocated to these depictions in medical textbooks that date back to the beginning of the nineteenth century (e.g., Dieffenbach; Gedike). In the early twentieth century, such information was greatly reduced and found only in textbooks that also emphasized home care (e.g., Leo). For example, the ideal patient room derived from one of the first textbooks, written by the physician Johann Friedrich Dieffenbach in 1832, includes architectural aspects as well as the design and furnishings of the room. Beginning with the location (preferably in the quietest part of the house and facing east or south), the room should also be simple and practical to clean and disinfect, and, if possible, the windows and doors should not be opposite one another, in order to avoid drafts. The best option for heating was a tiled stove. If the elderly or sick patient agreed, the bed would be put in the middle of the room so that caregivers could have access from all sides (54–55). Ideally, the bed should have an iron frame. The choice of bed was of paramount importance for elderly and critically ill individuals for the following reason: "A patient's bed is their world – they live in it and cannot escape it. It is the first and last thing in our human life; newborns are laid in a bed and those who are dying do not like to leave their bed" (55, our translation). Horsehair mattresses, deerskins, pillows, bed covers, and foot supports were recommended in every case. Gas and oil lamps offered patient-friendly

5 | This remains true for German-speaking countries, where about three-quarters of all individuals in need of care are still cared for at home.

lighting, not too dark so that proper care could be provided, but not so bright as to disturb the person lying in the bed. An overbed table, side table, commode, and a comfortable upright chair with arm rests should be included, as should an ordinary table and chair. There should be an adjoining room where supplies that are not always needed or shouldn't be kept in the patient room can be stored, such as bandages and bedpans (30–69). Making it possible for the patient to read seems to have been important. For example, patients were offered reading supports and lamps (see, e.g., Böhme; Lees).

The recommendations found in textbooks did not discuss personal items in detail; the room design was based exclusively on medical and nursing care requirements; individual needs were not mentioned. The recommendations were for a room in a house that had to be set up differently or entirely remodeled. In this process the room took on a different character, and at the same time the patient or elderly person with limited mobility would no longer or hardly ever leave this room. Although the smells and noises of the house, its inhabitants, and the view through the window remained the same, the environment was changed from the original living situation. The need for care in all its facets imposed on the living area and created the ambivalence and heterotopia described in the research context here.

Personal Rooms in a Care Home Today

Nursing textbooks today include far fewer recommendations on how to design and set up rooms in private homes for individuals in need of care. Instead, these texts focus primarily on the professional context of a care facility, and the design and setup of these rooms are addressed only marginally at best. The comparative example here (Menker and Waterboer) from a historic source emphasizes safety in the sense of how to best minimize tripping, falls, and sources of injury; it is thus representative of both current nursing instruction and classic gerontological literature in which objects are reduced to their potential role as aids or obstacles. To this end, the nursing textbook considered includes the following recommendations for private households: Special attention should be paid to ensure that the apartment or house includes enough handles throughout as well as a door viewer and an emergency call system. Steps or thresholds will need to be bridged with ramps, and dangerous carpets and cords should be removed (Menker and Waterboer 613). To reduce safety risks in care homes as much as possible, "mirrors," "loud noises," and "too many colors or patterns and color contrasts" should be avoided, a "maximum freedom of movement" should be ensured, and rooms should be marked with "familiar symbols and pictures" to facilitate orientation (613). Alongside the requirement established in 1832 that the room should be simple and easy to clean, today minimizing fall hazards and barriers is emphasized.

In various sections in modern textbooks under the rubric "Setting up the living environment," we find more advice on how best to design and set up resident rooms. They should not be "lacking stimuli," "bare," or "depressing"; curtains, carpets, bed linens, and the like should have warm but subtle colors; pictures and photos can be useful in the design, as can "objects that have meaning for the person concerned" (Menker and Waterboer 378–79, 613, 704). Many passages emphasize the fact that it is important to have plenty of natural light as well as good artificial light. The position of the bed is repeatedly identified as relevant for well-being, stimulation of bedridden individuals, and also peaceful and deep sleep. Access for the caregivers and a sense of security for the people who are sleeping are problematized as possible conflicting needs when it comes to the positioning of the bed (581–82). In the context of this type of room design, both "stimulating" and "calming" effects are often desired.

Unlike the past, today we have a good understanding of how to put these principles into practice. What do these rooms look like, then, when it comes to their practical implementation? The middle of the room is usually left empty and the rooms are not carpeted. Individuals receiving care should have freedom of movement, and caregivers should have space to carry out their work with the help of aids such as a commode or lift. Bandages, absorbent pads, and other such materials are still (at least as much as possible) stored outside of resident rooms and brought into and out of the rooms on a nursing cart by the caregivers – another reason that good accessibility and a certain amount of free space in the room are necessary, if possible close to the bed. Beds that used to be fixed in one place have become mobile; they now have wheels and can be adjusted into many different positions, and they are no longer located in the middle of the room because greater consideration is given to the occupants' habits and their need for a feeling of security when they are sleeping, as well as to changes in work procedures as a result of the increased mobility of the bed. If required, the bed can now be moved much more easily so that it can be accessed from all sides. As with the information provided in the historical sources, most beds today also have a significant inventory. In addition to blankets and pillows, a variety of materials are present to be used for positioning purposes and to keep the bed dry. Objects a resident uses often are placed together next to the bed, usually on a side table or nightstand. With Lawton (qtd. in Oswald, "Lieblingsdinge"), we can speak of an accumulation of important objects as "control centers." It is precisely here that we find collections of objects that are frequently used, relevant to care, or of biographical or personal significance. A few additional biographical or personal items are placed on the walls of the residents' rooms or, less often, on their bookshelves.

In summary, we can single out the following two aspects: first, the interior design found in the modern care facilities we visited as part of our empirical research follows the few recommendations found in current nursing books to

the greatest extent possible; and second, the current core issues related to room design and setup – for example, that proper care can be administered in the living area – correspond with the historical topics, even if, as we will see next, the content, implementation strategies, and common interest groups show significant differences. We would now like to discuss some of these points of overlap in more detail.

Points of Overlap in Individual Care-Home Rooms

On closer examination, a number of questions arise, for example, about involved parties and interest groups, power and knowledge distribution, distribution and implementation of areas of competence, and the right to privacy. At this point, we do not want to bring up general social debates and discourses or the general pursuit of political and economic interests that often are discussed without observing the particular situations. As a result of our inductive ways of looking at the significance of objects in nursing and care settings, we want to focus on the aspects that become apparent in each spatial situation and show them by comparing a remarkable similarity over times and settings. We want to shape these ambivalences and heterotopias in the past and today by using this very particular perspective. This approach is a fundamental part of home-care (hi)stories.

Involved Parties and Interest Groups

Which parties exerted or continue to exert influence on the design and setup of care rooms? In the early nineteenth century, physicians first addressed and, most importantly, tried to influence room design and setup. Caregivers, the second group, were to implement these requirements as best they could and defend these against the third group, which includes other relatives, neighbors, and friends. If it was realized, this also meant that physicians gave caregivers authority within the hierarchical structure of the care situation.

Today, the parties involved in the design and setup of the living area of an older person in need of care are quite different. Physicians are no longer directly involved, whereas family members who are involved have even more influence. As we were conducting the surveys, we frequently heard that the objects in the room were placed or arranged as the family members had wanted. In Germany, there are also many structural, safety, and legal regulations, for example, in the form of *Pflegegesetze* (federal nursing-home regulations) and various *Länder-Heimrechte* (state laws). To expand on this topic would fill an entire book, as German bureaucracy is very well known for its attention to detail. It is important to keep in mind that with this development,

new abstract but powerful parties, such as a number of legal institutions, care organizations, health insurance companies, and their evaluating authorities (for example, home supervisory authorities) become involved in the design and setup of living spaces.

Power and Knowledge Distribution

The historical literature primarily emphasizes the duty of care that caregivers are entrusted with. That duty is closely connected with the distribution of organized knowledge within the constellation of individuals involved in the care situation. The patient was considered to be in need of protection and was dependent on the help of the caregivers. In the best-case scenario, the caregiver took the patient into their care, while the physicians were responsible for the diagnosis and for conveying the necessary information to the caregivers, who then took this into account. In the textbooks, we read again and again about the danger of causing "a fatal cold" or "a fatal scare" (Dieffenbach 33) by not observing proper procedures or using care-related objects correctly. If a patient came close to dying because the caregiver failed to observe the procedures, this would undoubtedly result in the caregiver being morally accused, if not disciplined by losing his or her employment. In the nineteenth and early twentieth centuries, trained caregivers found knowledge in textbooks to enable them to properly observe procedures in order to eliminate fatal threats. However, in this early phase of the development of the caregiver profession, knowledge production was exclusively the domain of the physicians who produced the medical texts. The individual experience of the caregivers themselves was deemed unimportant.

It is the same today. Physicians have the competence to order the necessary treatment, and the caregivers are still the ones who know how to implement this treatment. In addition, there are now numerous guidelines and standards that these two groups must follow. In practice, however, the regulating institutions mentioned above are, along with the physicians, not regularly present at the caregivers' place of work. When addressing the issues of power and knowledge, this must be kept in mind. The material logic of used objects in specific situations and the special characteristics of resident rooms often require that particular adjustments be made. In conversations and interviews with caregivers, we heard that this often resulted in uncertainty. Occasionally, instructions are unclear, and sometimes they are difficult to understand or are contradictory. Concern is heightened when the structural conditions of the rooms cannot be brought completely in line with legal requirements, for example, as in the case of safety regulations. The possible consequences for an individual's own professional future or the evaluation of the facility are threatening and engender fear. In addition, the regulations for the use of aids and care-related

objects and the preparation, handling, and other interaction with these create uncertainty at times, and these regulations are followed with the utmost care. Ensuring proper use of these objects is a decisive factor in the design and setup of personal rooms in a care home.

The Historical Implementation of Areas of Responsibility

Prior to the early nineteenth century, bedside medical care often involved a large group of people who gathered around the bed of the care recipient and discussed and negotiated medical diagnoses and therapeutic procedures. Neighbors, family members, healers, and sometimes several physicians all participated in this communication process (Atzl et al.; Stolberg, "Kommunikative"). Since caregiving was not yet a separate profession, physicians considered it especially important to train everyone who had a key role at the patient's bedside in order to decrease the number of people involved in administering care. At the beginning of the nineteenth century, the situation changed and the medical and nursing care of the patient or elderly person was placed in the hands of specific individuals. Rest and a limited number of visitors became important, and the caregivers were charged with regulating these. But physicians maintained control, if not complete responsibility.

The New Right to Privacy

Privacy, intimacy, and shame began to be mentioned more often at the start of the twentieth century and are now common themes in textbooks today. It is thought proper to carry out the various basic activities of our daily life such as food intake, elimination, personal hygiene, and sleeping in different, structurally separated rooms intended for these purposes. Some of these daily activities can be performed in company, whereas for other activities that would be unacceptable. Caregivers are encouraged to adhere to these social conventions in care situations as much as possible. But with regard to private space, the line is blurred between the living space of the care recipient and the workspace of the caregivers in order to accommodate the organization of work – and to the detriment of personal privacy.[6] In the extract from the research report included above, we see how a bedridden person receives food, has personal hygiene carried out, and even eliminates in the same room where he spends his days. And in the same room, feces are removed and patients are cleaned and sometimes dressed in new clothes. This overlapping of space – compared

6 | Research into the "commode" object by our colleague Lucia Artner is a prime example of how the positioning of care aids can change the understanding of space between a living and a working space (Artner and Böhringer).

to what is common practice in our society – culminates in the double use of a room that is home to two individuals. The room belongs to Mr. Adam just as much as it does to Mr. Beck. And that is also the case in the moment in which Mr. Adam is attended to by the nurses after he has had a bowel movement. Mr. Beck doesn't leave the room then; instead, he "stays in his room." There seems to be no struggle or contradiction between his privacy and Mr. Adam's.

But what qualifies a room as a private space? As Rössler argues, "Privacy isn't only created in rooms when I have authority over who is allowed to enter but also when I can organize the space for myself so that the objects in the rooms have a certain order and that specific objects are present that make the room have meaning for me, personal meaning" (Rössler 255–56). A large degree of "local privacy" that can be connected to a room the residents set up themselves is therefore crucial for a comfortable atmosphere. It is important that very specific, meaningful personal items that were selected independently, for whatever reasons, are present. The experience of the self and defining one's own individuality are elements of privacy and a comfortable ambience. Living spaces need room for private and personal (hi)stories as well as the identity of their residents.

But in the course of history, personal and biographical objects in resident rooms have been rare, and very seldom have they been chosen and placed by the residents of the rooms themselves. Place is found, in particular, for those objects that are needed or required to carry out nursing-care procedures, but even private things are often used for the purpose of care. In the inventory of personal rooms in a care home, what materializes is the history of the technical and professional progress of nursing care, not the history of the residents. Indeed, the latter seems to be interchangeable. It should be as simple as possible to make space in these rooms for the next person in need of care who moves in with their own life story – and as few objects as possible should have to be taken out.

Currently, "quality of life" and "well-being" (e.g., Kruse) are increasingly becoming the focus of research and are seen as an approach to working with care-home residents, especially with regard to people with dementia. Care homes, in line with current endeavors, should become more of a home in the sense of a self-directed "home sweet home" and not in the sense of an other-directed "care home." This can succeed only if the objects of self-narration that strengthen identity are provided with more space. It is essential that the residents are more involved in the selection and arrangement of these objects and that the normative-nursing or regulating-legal view puts aside its paternalistic entitlement.

Conclusion

Comparing our research results reveals aspects that have considerable influence in the design and setup of care rooms in both the historical and modern contexts. The parallel is that care rooms in the past were and today still are geared toward providing the most ideal care situation and work structure and ensuring an efficient workflow. The main focus is the care "choreography," which is clearly central and focused on the care needs of sick or frail older individuals. These needs alone seem to be emphasized, because both in the ideal situation of private rooms in a family home in the nineteenth century and in personal rooms in a care home today, the focus has been on proper nursing care. For this care, the meaning of which can be measured by economic means, the fate of the individual seems to take second place. Two hundred years ago, the focus was on improving the overall care situation for patients and developing guidelines to ensure adequate care. Today, the concerns include the cost of placing older people in living situations outside of the family, demographic developments, and the high demand for places in care homes, all of which have greatly influenced the design and setup of living spaces that must also serve as care rooms for every type of care situation. For the design and setup of these personal rooms in a care home, regulations and requirements from external institutions come before the individual's daily living needs and habits.

In work situations with a medical focus, personal items have not historically been emphasized in the literature, even if care is being provided in private rooms. Today, personal things are ascribed the role of potential stimulators, but they are then pushed to the edge of rooms; sometimes, the only space to be found is on the walls. The fact that resident rooms are primarily workspaces for caregivers in an institutionalized context, but that at the same time they are also still private living spaces for people, can be seen in only limited form in the teaching texts presented – and therefore also in the discourse-forming and practice-formative media. Considering and researching the hybrid function of these rooms more closely from the perspective of the employees and especially the residents is an area that we see as promising future research.

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