

**Living life in residential aged care:
A process of continuous adjustment**

Submitted by

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Statement of Authorship and Sources

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma.

No parts of this thesis have been submitted towards the award of any other degree or diploma in any other tertiary institution.

No other person's work has been used without due acknowledgement in the main text of the thesis

All research procedures reported in the thesis received the approval of the Australian Catholic University Ethics Committee

Signed:

Date:

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I wish to pay tribute to the residents who live their life in many different ways and through many different circumstances. Many of those circumstances reflect loss: the loss of their home, the loss of health and the loss of friends. Equally, those circumstances reflect joy: the joy of new friendships; of support when they are unwell and of an ability to contribute to the community they have joined. I have been privileged to conduct this study which has led me to a deeper understanding of what we expect of older people. To the staff participants, who work alongside residents as they experience continuous adjustment, thank you for your honesty and openness and for the work you do.

Dedication

To my mother, Sheila Green, who died during the writing of this thesis.

I love you and I miss you.

May you rest easy.

Abstract

Living life in residential aged care: A process of continuous adjustment

Aim

The aim of this study was to examine whether, and how, residents living in residential aged care homes (RACH)¹ become involved in their care, and what areas of their care and life they work to influence or negotiate.

Scope

This grounded theory study, conducted in two Australian RACHs, comprised 24 days of participant observation and interviews with 22 residents and 19 staff members. Data collection and analysis were concurrent, with theoretical sampling guiding the ongoing data collection. The findings revealed a complex set of perspectives, interactions and processes which explain how residents work to live their life in residential aged care (RAC).

Findings

Findings reveal three dimensions of living in RAC: *presenting an acceptable self*, *living a communal life* and *preserving the self*. Three salient conditions can influence these dimensions of living in RAC. These conditions have been named *situational change*, *shaping expectations* and *environmental shaping*. *Presenting an acceptable self* involves activities conceptualised as *getting to know*, *building an information framework* and *deciding how to be*. In these ways, residents learn what is or is not acceptable and to whom. The second dimension of living in RAC, *living a communal life*, includes residents' efforts to become known by *establishing an identity* and *connecting* and *contributing* to the community. In this dimension, residents both *confer* and *gain reputations*. *Preserving the self* includes *maintaining a private self*, *managing their own health*, *accepting help* and *maintaining independence* while at the same time *maintaining a private self*.

¹ The terms residential aged care homes (RACH) or residential aged care facilities (RACF) refer to the same concept and are used interchangeably in Australia. Official Government documents tend towards the term RACH. In this thesis both terms, RACH and RACF, will be used.

Depending on the resident's situation (*situational change*), at a particular time, one or more of these dimensions may be *backgrounded* or *foregrounded*. Loss of family or friends, changes in health conditions or a perception that their values are threatened may lead the resident to focus their efforts on *preserving the self* (*foregrounding*) while *presenting an acceptable self and living a communal life* are of less importance and are *backgrounded*. When a resident is foregrounding *living a communal life*, they may background *preserving the self* and make every effort to be present at community activities. At these times residents may “*act as if*”; they will present as though they are well when they are not.

Additionally, residents' lives can be shaped through interaction with staff. *Shaping expectations* can influence residents' efforts to have their expectations met. Residents use a range of strategies to have an expectation or need met. These strategies include *becoming someone problematic* when the staff and residents' perception of the need are mismatched; *bypassing staff* in favour of approaching a staff member who is perceived to be more amenable to the resident's request, and *calling in a proxy* to act on residents' behalf.

Staff also employ a range of strategies which influence residents' expectations. These strategies have been conceptualised as *gap filling* where the resident has expressed an aspect of their life as missing; *boundary setting* when the staff perceive residents are presenting an unacceptable self and *boundary breaking and collusion* when a staff member perceives an unjust boundary. Additionally, when residents are experiencing distress, staff may work to assist the resident to work through their distress. This aspect of staff work has been conceptualised as *working with tunnel experiences*.

Environmental shaping (physical and structural) provides a third condition which influences how residents live their lives. The influence of the facilities physical layout has been conceptualised as *connecting in congregate places*. Additionally, while the residents may or may not be aware of some dimensions of the structural influences on their life, *the facility culture*, *government legislation* and *staffing levels* and *funding* have an impact on how the residents live their lives. As physical and structural environments are relatively inflexible, this aspect of residential living is

generally less responsive to residents' efforts, requiring a high level of flexibility from residents.

The three processes, *presenting an acceptable self*, *living a communal life* and *preserving the self*, together with the conditions which shape them, (*situational change*, *shaping expectations* and *environmental shaping*), demonstrate that residents are in a process of continuous adjustment. This study adds to the body of knowledge in that it explains the effort that residents put into living in RAC and could serve to assist staff, management and policy makers to examine the ways in which residents are supported to live their lives as effectively as possible.

Why this Study? A Personal Perspective

During my time working in residential aged care (RAC), prior to commencing any research studies, I became aware that residents could unwittingly or deliberately influence their care. For example, it was reported to me that a particular resident was “a dirty old man” who constantly grabbed at nurses when in the shower and smeared faeces. The nurse who reported this during one handover had decided that this behaviour was deliberate and aimed towards the people caring for him. I spoke with a caregiver who had experience with this client, who was living with Parkinson’s disease. After an examination of the client notes, together with staff discussions, I assessed that the client was afraid of falling during his shower, which probably accounted for the grabbing behaviour. Additionally, I assessed that he was constipated which accounted for the smearing behaviour. As the resident had little language, it was difficult to talk with him. We decided on some strategies. First we worked to relieve his constipation. After the success of that strategy and ongoing elimination management, the smearing actions ceased.

Next, we decided that the caregiver showering the resident provide a sense of safety, namely, making sure that the resident held the shower bar with one hand and held a flannel with the other so that he could assist, albeit minimally, with washing himself. During showering, it was also agreed that the caregiver continued to talk to him providing messages that he was safe. There were no further incidents after these strategies were used. From this, and other instances, I found it disturbing that some residents’ actions were interpreted as negative and deliberate; while other residents’ actions were interpreted as pleasant. I had many questions when I commenced my first research study.

As a result of my wondering about how work in RAC was constructed, I commenced my Masters in Health Science (MHSc). For this qualification I examined how registered nurses (RNs) in RAC managed their work. The findings from that study provided some explanation that it was not only the RNs whose perception influenced the work of care staff; it was also the organisational structure that provided a framework for staff work. Where the RN had support to be a leader and the authority to direct care, and their work perspective was focused on person centered care, together with adequate knowledge of client care and adequate staff resources, the

residents were placed firmly in the centre of care and resident actions were considered as indicators that something was wrong, and therefore worth full consideration.

However, when the RN focused on the needs of the organisation or had limited understanding of client needs or worked in an organisation where the structure of care was privileged and staff were pushed to get the tasks of care completed, the story was different. In those instances, the RNs reported that there were times when they ignored residents' cues of agitation in the challenge to meet tasks. Consequently, RNs whose perspective of a person centered care did not match the organisational focus, resigned, hoping to find another facility where their preference for care could be met.

While that study provided some answers, it did not provide sufficient answers about how residents themselves perceived RAC. Neither did it provide explanation of the strategies that residents used to get their care needs met. This became clear when I was conducting field work for another study. During fieldwork a resident, I was talking with, noted a staff member who was on duty that afternoon. She told me that she would need to leave our conversation and go to the toilet because when that particular staff member was on, and afternoon tea was served, she would forget to leave a cup of tea if the resident was not present in the room. As it took a long time to get to the toilet and back, she needed to leave so that she would be back in time for afternoon tea. Later, during fieldwork, I asked her if she often changed what she did according to the staff on duty. She then proceeded to indicate not only her own strategies but the strategies she had noticed other residents used, altered when particular staff were working. I am very thankful to this resident. Her noticing and her explanation of strategies led to this research project for my PhD. I wanted to know more about the work that residents did to meet their needs when living in RAC.

Additionally, I was reminded of a colleague I worked with when I first commenced teaching nurses. We were working with nursing students in their first clinical experience and I was with this colleague for orientation to clinical teaching. He was familiar with this particular facility, which was task oriented and residents were expected to conform to organisational needs. A new resident was questioning staff

and not willing to work to the facility daily structure. He was noisy in his resistance and expected that his wishes to fit his own needs into his new living situation would be met. My colleague indicated that either he would be forced to conform or he would probably become sick.

It would be incorrect to say that only negative events occurred during my work and study involving RACs. I have observed exquisite care which is consultative with the residents and which is focused towards excellence in health and social well being of residents. I have observed staff prioritising care over documentation; a difficult decision to make when documentation and funding are linked.

A different experience awaited me when I stayed overnight in a RAC in the United States. This facility had intentionally instituted a facility culture of “person first”. At this facility I observed RNs negotiating the best time to conduct a care activity with a resident; staff taking their time to talk, discuss and joke with residents; and residents calling a meeting if there was an issue that required discussion.

Reflecting on these experiences, both positive and negative, it became important to me to conduct a research study which gave some explanatory power to the lives that residents live in residential care; hence, this study. Before I commenced this study, I had worked with older people in the community, in acute care and in long term residential care. I was proud to say that gerontology was my specialty. I had studied for many years, shifted between education and clinical work and considered myself effective, compassionate, knowledgeable and skilful – until I came to do this study.

After my first experience of fieldwork and participant interviews I realised that I knew very little about the lives of residents in aged care. What I thought I knew was a small portion of the efforts that go into the work that residents undertake to manage and adjust their lives in this setting. I remember thinking that every nurse would benefit from the experience of really talking at depth to residents, joining their meal times, walking with them and being with them in their activity times. My next question was “How on earth would that be possible?” While this study has provided a compelling explanation about how residents manage their life in RAC, it is not the whole story and so my research will continue.

Chapter 1: Residential Aged Care in Australia

Australia is experiencing a growth in the ageing population as a result of increased life expectancy and a decline in the birth rate. As a result of population ageing, many countries are working to resolve the tension between delivering cost effective health care and meeting 'rights' and quality care requirements. Australia is currently experiencing this tension and continues to take into account the future needs of increasing numbers of older people (The Department of Human Services Victoria (DHSV), 2000; Hogan, 2004; Hugo, 2007; Myer Foundation, 2004). Statistics submitted by the Department of Health and Ageing (DoHA) demonstrate the current and expected increases in the older population:

Around 9 per cent of our [Australia's] population (some 2 million people) is aged 70 years or older. This is expected to rise to 13 per cent by 2021 and to 20 per cent (around 5.7 million people) in 2051. People aged 80 years and over currently make up around 4 per cent of the population and this proportion is expected to increase to 10 per cent by 2051. (2008, p. 1)

An ageing population has led to an increase in the need for residential aged care (RAC). The Australian Institute of Health and Wellness (AIHW) (2009) reported this current increase in the RAC sector: "At 30 June 2008, there were 175,472 residential aged care places, an increase of 5,401 compared with 30 June 2007" (p. iv).

Despite efforts to increase community care, and enable older people to remain in their own homes, there is agreement that the need for residential care for older people will remain. Additionally, as a result of the increase in community care, the current and future projections are that those who enter RAC experience increasingly complex health problems (Andrews-Hall, Howe & Robinson, 2007; Senate Standing Committee on Finance and Public Administration (FPA), 2009). In this chapter, the focus is on RAC delivered in Residential Aged Care Homes (RACHs) in Australia. While not exhaustive, it is intended to provide an overview of the RAC current situation and issues arising out of that situation. This study commenced eight years after major reforms. These major reforms were the result of the introduction of the Aged Care Act 1997 and the Aged Care Principles, 1997. Since their introduction, there have been two major reviews with a third currently in process with the final reporting date January, 2011 (Australian Government Productivity Commission,

2010). While aged care providers indicate a positive response to some of the reforms, there remain significant issues in the structure and the delivery of care in RACHs. These issues will be explored in depth later in this chapter.

The structure of aged care services in Australia

There are two types of Australian Aged Care Services; namely, community care and residential care. Community care is care delivered in the person's home while residential care is congregate care delivered in RACHs. Prior to the Aged Care Act 1997, two levels of residential care existed, namely hostels providing personal care and nursing homes providing 24 hour complex care. With the introduction of the 1997 legislation, these two levels of care were combined and residents living in RACHs could be classified as requiring low level care (previously hostel care) or high level care (previously nursing home care). Facilities can provide for either care need separately or co-located in the same RACH. Those homes providing for both high and low resident care needs are called ageing in place homes (Richardson & Bartlett, 2008). Since the introduction of the Aged Care Act 1997, there has been a shift in the proportion of ageing in place homes and an increase in the number of high-care residents ageing in place (Andrews-Hall et al., 2007; Richardson & Bartlett, 2008). According to the Commonwealth DoHA (2009), of the 158,863 residents in RAC, 114,913 were receiving high level care while 43,950 were receiving low level care at 30 June, 2009.

The Aged Care Act 1997 sets the legislative context for the management, provision and government funding of health services for older people in the community and residential care setting. Funding for RACHs comes from government subsidies and resident contributions with some volunteer or donated care (DoHA, 2008). Resident contributions, decided on asset testing, comprise daily fees for residents regardless of care level and an accommodation bond for residents requiring low level care. The "average accommodation bond agreed with a new resident in 2008-9 was \$212,958" (DoHA, 2009, p. 47). In 2007, "approximately 970 approved providers of aged care held around 54,000 accommodation bonds worth approximately \$6.3 billion" (DoHA, 2008, p. 33). The major proportion of an accommodation bond is safeguarded through a Government Guarantee Scheme and is transferable should the resident transfer to another RACH.

There are a variety of government supplements relating to accommodation and rural and remote areas. Some are towards particular care requisites (an accommodation supplement is provided by government for residents who do not have sufficient assets to contribute to their care (DoHA, 2009). RACHs are required to provide care for concessional residents to maintain equitable entrance for all older people assessed as requiring residential care. Government funding is higher for concessional residents; however, lower than for those who are able to provide a daily contribution to their care. Additionally, higher government subsidies are paid for groups designated as having special needs. These groups include, those who are financially and socially disadvantaged; those who live in rural or remote areas; and those with particular cultural needs, for example “Aboriginal and Torres Strait Islander communities and people from non-English speaking (culturally and linguistically diverse) backgrounds” (DoHA, 2009, p. 57).

Currently, in Australia, residents living in RACHs are assessed as having either low or high care needs. Admission into residential care is through a pre admission assessment conducted by an Aged Care Assessment Team (ACAT) to decide eligibility for entry into government funded RACHs and to determine the level of entry, whether low or high care (DoHA, 2008). Following admission, a second assessment is conducted using required assessment tools. Funding for RACHs is delivered, in the main, through the documentation of residents’ assessed care needs. The higher the documented care need, the higher the funding and the converse for low care needs.

Funding instruments

Since the 1997 legislation there has been a change of funding instruments. Initially, with the Aged Care Act 1997, funding was earned through the Residential Classification Scale (RCS). A resident’s RCS category was reviewed annually and when a resident’s care needs changed. Additionally, RACHs were visited by RCS validators from DoHA to ensure that RCS documentation was congruent with the care subsidy received. Annual review, and at times disagreement between the validator’s and facility assessment, meant that the facilities’ income could be increased or decreased in a short span of time. Because funding was earned through staff documentation, income was volatile and forward planning dependent on income

was difficult. Additionally, staff time taken to attend to funding documentation was onerous. Issues with the RCS as a funding instrument led to a review in 2003 with a recommendation for a change in the funding instrument by Hogan (2004). Originally intended as a relative funding tool, Hogan noted that:

While the RCS was designed to classify residents on the basis of care needs in order to determine levels of subsidy, the RCS Review suggested that it had become the basis upon which an assessment of care needs for the purposes of care planning is made. (p. 209)

The RCS was replaced by the Aged Care Funding Instrument (ACFI) in 2008 (AIHW, 2009). The ACFI was intended to decrease the complexity and time consuming activity required for the RCS and to limit the volatility of the funding instrument so that aged care providers could better predict their financial needs. Instead of an assessment involving eight levels of care need across 20 care components, the ACFI focuses on “those care elements that most contribute to the cost of care” (AIHW, 2009, p. 38). There are 12 questions focusing on three domains of care need which are allocated a degree of care need, high, medium and low. The three assessed components are: activities of daily living, behaviour characteristics and complex care needs (AIHW, 2009).

Quality monitoring

The Aged Care Act 1997 mandates the requirements for quality monitoring which provides accreditation for aged care facilities via the Aged Care Standards and Accreditation (ACSA) agency (Minister for Ageing, 2010). The accreditation process commences with a desk audit and then a site visit reviewing compliance with four standards and 44 expected outcomes. The four standards are: 1) Management systems, staffing and organisational development; 2) Health and personal care; 3) Residential lifestyle and 4) Physical environment and safe systems. Accreditation of an aged care home can be for one to three years with both announced and unannounced monitoring visits in the interim. Sanctions may be placed on RACHs not meeting the standards required for resident care and facility management (DoHA, 2008). Electronic accreditation reports for all facilities are publicly available to assist people looking for a facility placement.

Additional mandated requirements for RACHs quality includes surveillance and monitoring activities. For example, since the introduction of the Aged Care Act 1997, regulations have increased to include compulsory reporting of missing residents and abuse, as well as mandatory police checks for all staff. There has been an increase in complaints investigations and an increase in unannounced visits by the ACSA. The argument put forward in current submissions to current inquiry into caring for older Australians (Australian Government Productivity Commission, 2010) indicate there has been no corresponding increase in funding to meet the costs of these requirements (Aged Care Association Australia (ACAA), 2010; Kendig, 2010).

All RACHs receiving Government subsidies must be approved providers. Approval requires the provider to demonstrate they are suitable to provide aged care in accordance with the regulations and standards of care. Aged care beds are allocated to a facility by government. The quality of buildings and space in RACHs is separate to the accreditation process conducted by ACSA and requires a certification process to monitor compliance with building and space requirements (DoHA, 2009).

Current issues in residential aged care

At the time of writing (2010), the ACFI is under review (Australian Government Productivity Commission, 2010). Submission documents (n= 479) from a range of aged care providers, organisations, professional bodies and private individuals indicate that, despite efforts to match funding with care needs, there are increasing difficulties in providing quality care for residents in Australian RACHs. A tension exists between the changing demographic in RACHs as providers struggle with an increasing complex resident population, the efficacy of the assessment instruments to accurately assess the actual cost of care and an inadequate workforce and skill mix (Anglican Care, 2010; Australian Nursing Federation, 2010; Catholic Health Australia, 2010; Royal College of Nursing, 2010).

The changing demographic in RACHs

Ageing in place is a concept which begins to acknowledge that older people are best served through choice of residence. The interpretations of ageing in place however differ, and the concept is somewhat difficult to define. According to the DoHA, (2009) ageing in place means that older people want to stay in their own homes. For residents in RACHs ageing in place means that, if admitted to RAC, residents want to stay in the facility of their choice. Ageing in place may mean that a resident enters a co-located aged care village where they begin living independently in owned or leased homes and move into residential care as their care needs increase. Regardless of the perception of this concept, there has been an increased focus on assisting older people to remain in their own homes for as long as is possible.

Prior to the shift towards increased community care, older people could enter RAC with relatively low care requirements. As a result of increased community health care services, entrance into RAC is only possible if the older person's care needs are not met within their own home. The outcome is that older people entering RAC have increasingly acute and complex care needs. As reported by the AIHW, at the "30 June 2009 three-quarters of the 157,494 people who had had an appraisal of their care needs in permanent residential aged care were classed as high care, indicating that they have generally poorer levels of health" (p. 320). As noted, earlier in this chapter, there has been an increase in the requirement for RACHs as a result of population ageing. The compounding situation is that of increased complex care needs. Increased care needs have an impact on staffing numbers, skill mix and education.

Funding levels and mandated care quality

The argument from the Aged Care Sector is that government funding is insufficient to meet the quality of care needs for the resident population (ACAA, 2010). As stated by ACAA (2010), "Aged care providers operate in a regulatory environment which imposes increasingly high standards on services and accommodation but strictly controls supply and price" (p. 3).

The efficacy of assessment funding instruments

Aged care providers indicate two problems with the current assessments used to decide funding levels: 1) the inability of the assessment instruments to adequately assess the residents' actual care needs, and 2) the incongruence between the ACAT assessment and the ACFI. Subsequently aged care providers argue that funding does not meet need. The ACAT assessment is used to decide the type and level of health services required by the older person who is assessed. That is, the ACAT assessment states whether the resident requires high or low level residential care or a particular type of community care. Submissions to the review of ACFI argue that the ACAT assessment should be used only to decide the type of care. Aged care providers' experience is that residents may enter residential care assessed as low care, using the ACAT assessment tool, while the ACFI assessments used in RACHs may indicate a requirement for high level care. Equally the converse can occur. The outcome of mismatched assessments leads to an increased need for documentation to support a change in the government funding subsidy and can mean that a resident is using a high care placement which may be required by another resident. In another instance the resident may be admitted as a low care placement with the potential to charge an accommodation bond; however the ACFI assessment outcome may be that the resident is actually a high care resident and an accommodation bond is not applied to high care residents. According to ACAA (2010) this situation of mismatched assessments "increases the administrative burden and creates planning and resources issues for approved providers" (p. 24).

Workforce issues

The reforms introduced with the Aged Care Act 1997 have led to workforce adjustments.

Between 2003 and 2007, total employment of RNs fell by about 1,600 to 22,400, while PC [personal care] employment rose by about 17,500 to nearly 85,000. Employment of Enrolled Nurses [EN] and Allied Health workers (mostly diversional therapists and recreational officers) rose slightly to just over 16,000 and nearly 10,000 respectively (Martin & King, 2008, p. 359).

According to Martin and King (2008), the employment of personal care assistants (PCAs) in RAC has increased from 59% in 2003 to 64% in 2007; while the

employment of nurses has decreased from approximately 36% to 29% in the same period. This shift has been attributed to funding, with RNs being the most expensive staff component (Hunter & Levett-Jones, 2010); the ageing RN workforce (Conway, 2007; Fussell, McInerney & Patterson, 2009); the lower earning capacity of RNs in the aged care sector compared with the acute care sector (Cameron & Brownie, 2010; O'Connell, Ostaszkiwicz, Sukkar & Plymat, 2008); and RN negative perceptions of aged care (Jeon, Merlyn & Chenoweth, 2010; Moyle, Skinner, Rowe & Gork 2003).

Additionally, the role of the health care workforce and models of care delivery have changed. With the introduction of the Age Care Act 1997, the RN role shifted away from direct care towards care documentation to meet the requirements of the RCS and accreditation. The scope of the EN role has increased with the introduction of a medication administration endorsement (Conway, 2007). A mixed method study in six Australian RACs utilising questionnaires ($n=48$ RNs; $n=16$ Nurse Managers), document analysis of job descriptions and 32 semi structured interviews, demonstrated changes in the contemporary practice of RNs working in RAC (Hunter & Levett-Jones 2010). Findings from this study revealed that RNs had shifted from what they termed a “hands on role” to a coordinating, supervising and management role. Deciding an individualised plan of resident care, organising the care team to deliver that care and supervising the quality of resident care were reported as major RN activities carried out within a context of time constraints. Furthermore, participants in this study acknowledged the changed acuity and the need for specialized knowledge to provide adequate resident care. The authors identified that the RN role in RAC is now that of a “specialist care facilitator” (p. 534). Hunter and Levett-Jones (2010) however, also reported that contributing to facility policy and consulting research for best practice to support the specialist aspect of this role were infrequent activities of the RNs in this study. Significant in this study was the presence of some person centered care and an acknowledgement of individual care needs which, the authors suggest, required further development and they urged that “nurses and others who work with older people need to strive to become more person centered in their daily practice” (p. 534). The shift in RN role, the change in resident acuity and the need for increased education to support the gerontological nursing specialty has been reported in other studies (Cameron & Brownie, 2010; Conway,

2007; Hunter, McMillan & Conway, 2007). Currently, in Australia funds have been allocated to undergraduate and postgraduate level scholarships focused on the future and current RN aged care workforce (Fussell et al., 2009). The Hunter and Levett-Jones (2010) study, however, acknowledged the need for further research into RN practice in RAC.

Recruitment into the aged care workforce

Price, Provis, Harris and Stack (2004) reported that negative perceptions of older people, negative reporting of RAC, the nature of the work, and low salaries (O'Connell et al., 2008) were barriers to the recruitment of caregivers into the RAC sector. The sector is facing a staffing crisis and submissions to the Productivity Commissions current review (2010) support this statement (Anglican Care, 2010; Catholic Health Australia, 2010; College of Nursing, 2010). At the completion of the consultative process (July, 2010), 471 submissions had been received (Australian Productivity Commission, 2010). Numerous submissions reported difficulty in staff and decreasing care quality. Martin and King's findings (2008) revealed that the most dissatisfaction that staff reported lay in having insufficient time to spend with residents and in salary levels. Projected increases in the ageing population requiring RAC indicate a compelling need for an increase across all levels of the RAC workforce and suggest "there needs to be a significant effort put into attracting workers to both the skilled and unskilled parts of the aged care industry" (Hugo, 2007, p. 169). It remains to be seen how satisfactory levels of aged care staff can be achieved in the current situation of insufficient time to provide quality care and inadequate staff income as reported by Martin and King.

The shift towards new models of care

Since the introduction of the Aged Care Act 1997, aged care providers have introduced new models of care in order to make effective use of the changing skill mix in RAC and to develop care quality (Arbon et al., 2009; Bail et al., 2009; Halcomb, 2009; Venturato & Drew, 2010). Halcomb (2009) introduced a multidisciplinary case conference involving the resident and their family, General Practitioners, allied health staff and RNs. The case conference model involved pre-conference assessment conducted by the RN using the Comprehensive Medical Assessment (CMA). The RN was also responsible for coordinating the case

conference members. Case conferences focused on “aspects of residents’ care (e.g. medication side-effects, and health status (e.g. presence of a pacemaker and care preferences” (Halcomb, 2009, p. 240). While those involved in the case conference indicated an increasingly effective communication pattern between the resident, family and the professionals, and an increased efficacy of the resident health planning, there were two main aspects which highlighted the need for adjustment. To maintain the case conference process there is a need for RN education in case management skills. To sustain the multidisciplinary case conference process there is a need for RN time allocation to prepare and attend the conference and an adequate spacing of the conferences to enable medical practitioner input.

Venturato and Drew’s (2010) research focused on a RACHF which had changed its model of care delivery over time. The changes were introduced in order to use the skilled RN workforce more effectively. The authors named this model of care the Advanced Practice Model of Care due to the facility focus on developing staff knowledge, capacity and practice. The organisational structure of the care staff has been adapted to include a development path for PCAs; the introduction of RN supervised clinical assists and a shift in the RN role to that of clinical leadership either in clinical care, case management or allied activities, for example, education or quality assurance. An additional shift has occurred in the PCA’s role as education, competency assessments and the potential to progress to a Team Leader position has led to increased role responsibilities under RN supervision. While the research findings report an increase in staff work satisfaction and a shift from reactive to proactive work, the model is still to be evaluated for its impact on quality of care and staff retention. The authors also noted that data was obtained from one resident and acknowledge the need to include residents in the final evaluation of this care model.

A literature review prepared by O’Connell et al. (2008) suggested a tri-focal model of care employing evidence based practice and working from the concepts of relationship centered care within a positive work environment. These authors contended that placing relationships at the centre of the care and work environment will ensure a respectful and dignified approach between residents, families, staff, students and management. Working from evidence based care will assist quality resident care and will be supported with the development of evidence based

guidelines across six domains of care. The vision of the tri-focal model of care is that staff turnover rates will decrease as staff working teams develop knowledge, skills, accountability and respect, and that student experiences in this model of care may attract more graduates into RAC. More importantly, the philosophy of partnership centered care with its attendant values has the potential to improve life for residents in RAC.

Arbon et al. (2009) and Bail et al. (2009) shifted their focus from the current aged care workforce towards the introduction of the nurse practitioner (NP) role in RAC. A new RN qualification, the NP role, has great potential for RAC. These authors reporting on different facets of a larger study, used a mixed method approach, researching the potential for transboundary NPs in RAC. They report that the transboundary aged care NP working across a range of RACs is a cost effective approach toward increasing the care quality in a range of facilities. Additional responses from residents in RAC indicated satisfaction with the NP use of a partnership approach to assessment which assisted resident care decisions.

The presentation of these potential and actual care models demonstrates the effort that aged care providers have made towards shifting organisational, structural and care delivery processes in order to accommodate the current aged care situation in Australia. Not only has the Aged Care Act 1997 led to the need for change, the RN decrease and EN and PCA increases have led to the need to figure out how to make best use of the skilled nursing workforce so that quality of care issues can be met. However, each of these care models cite the need for increased staff education leading to more effective care practices, increased valuing of residents, families and staff, and increased retention of the skilled nursing workforce. Nevertheless, in spite of the efforts to shift organisational structures and develop effective resident care structures, there remains a strong message that current funding streams are unable to meet the requirements of quality care. The reports, research and submissions presented in this background chapter demonstrate the variability in the provision of RAC in Australia.

Resident's rights

Of critical importance is the impact of the current RAC sector on the residents living in facilities. There have been global shifts towards a 'rights' model for older people. The United Nations principles for older persons (1991) stated basic rights and needs for older people and emphasised the right to independence, participation, care, self-fulfilment and dignity (Venne, 2005). These rights underpin the aged care reforms in Australia (ACSA, 2004).

The intended direction of the 1997 Aged Care reforms was towards a cost effective health care service that was respectful of older people's choice, preference and involvement in care (Cullen, 2003). In recognition of resident 'rights', the monitoring process (accreditation) was aimed toward including residents and their families (ACSA, 2004). Some reports suggested that though the accreditation process has improved care (Grenade & Boldy, 2002), older people continue to be in a position of powerlessness in relation to the care providers, have little choice about the need to enter RAC, little choice about which facility they enter, due to insufficient numbers of available beds, and have difficulty understanding the complex system of care and payment (DHSV, 2000; Setterlund & Tilse, 2003). Stack (2003) conducted case study research in a not for profit organisation in South Australia and found that residents in aged care, either due to illness or their condition (cognitive impairment), are not able to be effective care evaluators. Stack also suggested that the very structure of aged care policies in Australia place facility residents in a position of not being able to vote with their feet; while Braithwaite (2001) posited that residents could be reluctant to evaluate their care negatively because of their relatively powerless position and fear of reprisal.

De Bellis (2010) has a strong view that the structural reforms have actually detracted from staffs' ability to provide effective care with the result that many residents are disempowered, infantilised or abused. De Bellis conducted a study using discourse analysis. Data collection involved non participant observation, document analysis and interviews with family and staff. Her findings revealed unsafe and outdated nursing practice provided, in the main, by PCAs with minimal effective supervision. This situation, according to De Bellis, placed both the staff and residents at risk. Care plans were out of date and progress notes were not reflective of actual care, or they

reflected care that was not provided. Additionally, De Bellis reported that labelling of residents and their family was negative and demeaning; and that the environment was noisy, rushed and without cognizance of residents' rest or leisure periods. De Bellis suggested her findings are transferable to other RACHs and recommends the government addresses the following barriers to quality of resident care: "inadequate staffing levels; inappropriate skills and skill mix; non nurses providing complex nursing care and the instrumentation documentation based on nursing care, whereby the burden of funding is placed on nursing documentation that further removes RNs from the bedside" (p. 110).

It is not accidental that this background to RAC in Australia ends with the concepts related to residents' rights and the current perceptions of residents' positioning in RAC. Workforce needs, legislative mandates, funding, recruitment and retention are all central to the delivery of quality resident care in RAC and are an important feature for aged care providers, staff, residents, families and researchers. These features are both complex and perplexing and are aimed toward the delivery of quality care in the cost constrained, staff constrained context of RAC. The models of nursing care, mentioned in this background, focused on care aimed toward the residents; however, few studies involved the resident as a central feature. It could be argued that getting it right for residents can occur if structural, organisational, educational and staffing issues are addressed. Few studies, however, begin with the resident. The focus of this study is on residents and their strategies to live life in RACs. It is my position that we begin with the resident to construct and design aged care facilities which best meet their needs.

Research question

Do older people living in RAC facilities attempt to influence their care and quality of life and, if so, to what end?

Study aims/purposes

Specifically I set out to examine:

1. The strategies residents use to communicate their needs and preferences for their care and life to staff, families and friends.

2. The strategies residents use to communicate their experiences of care, and quality of life particularly in the context of day-to-day communication with staff.
3. How staff perceive and respond to the residents' actions.
4. Whether both staff and families change their actions in response to residents' efforts and how these either support or constrain residents' activities to influence their care.

The original aim of this grounded theory study was to conduct an in-depth examination of whether and how residents in RACHs attempt to influence their care and quality of life. Grounded theory is an emergent research design which adapts and changes according to the issues that appear to be most significant to the participants in the phenomena under study. Thus, while the original intention was to consider how residents influence their care and quality of life, what became significant from the participants was their efforts to live life in residential aged care. The influencing strategies were subsumed into the final core social process namely, that of continuous adjustment. This is explained in more depth in Chapter three.

Significance of this study

There have been many studies examining life in RAC from the perspective of residents, staff and families. These studies reveal that residents strategise to make their life more comfortable or their quality of life more satisfying. Despite this evidence, residents are generally seen as passive, not wanting to make decisions about their care, not having sufficient knowledge to contribute towards care decisions (Stack, 2003), or not "being sufficiently prepared to articulate their own needs, opinions or experiences" (Dewar, 2005 p. 48). Dewar (2005) demonstrated that some residents are choosing passivity as their best action and perceive that their role is to be passive about their care. Furthermore Dewar contended that some residents are strategising to meet their care needs but their activity is not recognised or understood by staff; thus demonstrating that staff resident interactions are variable, change under different conditions and are dependent on both staff and residents perceptions.

This grounded theory study into the nature and role of residents' actions, as well as staff perspectives of and responses to those actions, has a significant impact on our understanding about how residents go about getting their care and quality of life needs met, and how staff respond to their efforts. This study, therefore, informs residents, families, health care professionals, educators and policy makers about effective and ineffective care and quality of life in the context of RAC. The following chapter delineation will guide the reader through the chapters outlined in this thesis.

Chapter 1: Residential aged care in Australia

In this chapter I have presented the Australian context of RAC and the issues related to the delivery of aged care in this country. Submissions presented in the consultation process of a review by the Productivity Commission of Australia (draft report due 2011), indicate that RAC is in a state of crisis with a funding mismatch with the real costs of care; a staffing situation which has seen dramatic decreases in the skilled workforce and increases in the unlicensed workforce; and a consequent concern about the quality of care delivery to increasingly complex resident population. The chapter posits that while effort has shifted toward developing models of care which make best use of resources in a fiscally tight situation, resident care in Australia is variable with reports citing a mix of satisfactory and unsatisfactory resident situations. Literature used in this chapter focuses on RAC in the Australian context and does not include community care processes as these are not pertinent to the research study presented in this thesis.

Chapter 2: Literature review

A review of the national and international literature focuses on residents, the residential care structure and processes, and the workforce issues pertinent to RAC. Congruent with a grounded theory approach, the literature in this chapter was considered prior to data collection and data analysis processes. This literature has been updated; however literature accessed after the study findings is woven into Chapter 8, a discussion of the findings.

Chapter 3: Methodology and methods

Chapter three presents the research process used in this study. Grounded theory methodology was used for this study which focused on residents living in RAC. Grounded theory, as a methodological approach, is discussed followed by issues related to a qualitative research process. Finally, this chapter demonstrates the research process building towards the finding that living in RAC involves continuous adjustment from residents. Participant data is used to demonstrate facets of the methodological approach, issues related to the qualitative research process and findings.

Chapter 4: Overview of findings

The macro and micro details of the facilities, in which this study was conducted, are presented in this chapter. The process of continuous adjustment while living a life in RAC is presented in broad terms. The three dimensions of *presenting an acceptable self*, *living a communal life* and *preserving the self* are described together with the two major conditions which influence those dimensions namely *shaping expectations* and *environmental shaping*.

Chapter 5: Living in residential aged care: A process of continuous adjustment

The three dimensions of living life in RAC are articulated in this chapter. The major concepts within each dimension are detailed together with the subcategories which build toward each dimension. The concept of *backgrounding* and *foregrounding* are demonstrated as residents make decisions about how best to adjust their life as their health changes; as they receive feedback from others or as they perceive their values are threatened. While some staff actions are presented in this chapter the focus, in the main, is on the resident; their perceptions, interactions and strategies as they work to live in this communal setting.

Chapter 6: Shaping expectations: Conditions influencing living a life in residential aged care

This chapter explains how staff resident perspectives are to the forefront of shaping residents lives in RAC. Residents' lives in some or all domains can be shaped through the process of matched or mismatched perceptions about what is acceptable

or whether a resident requires further assistance as their health changes. Explained also in this chapter are the staff activities which have been conceptualised as *gap filling* when the resident and staff perceive they can work together to fill a resident's need; *becoming a proxy* when the resident is unable or unwilling to act on their own behalf; *colluding* when staff perceive a resident has a need and management have denied that need; and assisting the resident in times of immense loss by working at different levels of what has been conceptualised as *the tunnel experience*. Throughout this chapter the process of continuous adjustment demonstrates the shifts and movements that residents experience while living life in RAC.

Chapter 7: Environmental shaping: Condition influencing resident's lives

The final condition which influences residents' lives is the environment. The environment includes the space and place of the facility. Dining room activities are used as an example to demonstrate the impact of environment. Residents may not be fully aware of the work that is conducted towards developing the facility culture towards a respectful and dignified environment for residents. Yet the facility culture influences and shapes residents lives. Additionally residents are aware of some constraints which arise from legislation and influence staff activities which in turn influence residents' lives. The Occupational Health and Safety (OH&S) Legislation is presented as one example. Staff reports of economic difficulties, staffing levels and staff mix are presented as an influence on residents' lives which cause adjustment in care activities.

Chapter 8: Discussion and conclusion

The findings from the research study conducted for this thesis are critiqued and analysed within the thesis and in comparison with literature from the field. I consider the nature of continual adjustment and question whether it is similar to transitions and whether is it time limited. Additionally I question the notion of adjustment as a trajectory and accept that it could be possible to consider continuous adjustments in this way. Nevertheless, I have interpreted continuous as adjustment as I believe it has good fit with the findings. The findings also demonstrated that both resident-resident and resident-staff relationships are central to living life in RAC. In the light of continuous adjustment in the context of relationship, the skills of negotiation are highlighted and examined. I question what it would take to achieve the potential that

exists in supported adjustment through relationship and negotiation. My conclusion is not that a particular model of care be adopted. Instead, I propose that the principles of supported negotiation and a relationship-centered approach because of their inclusive and participated approach are used organisationally for facilities to develop a culture and their own unique model of care which reflects these principles. For this to occur, strong leadership is required together with a willingness to examine the beliefs, values and attitudes within oneself, and with the residents, the families and staff. These are challenging, complex endeavours which take energy and time. To accept such a challenge could lead to very exciting outcomes for all stakeholders concerned, most particularly the residents who live and work in RAC.

Delimitations of scope and key assumptions

The key assumptions underpinning this study are that people are active and interpretive. They take multiple dimensions into account as they meet meaning making life events. People define situations and act out of their definitions. Their strategies are aimed towards resolution of everyday problems that they encounter. This meaning making activity is true regardless of age and is employed by residents in aged care. While the meaning that many people attribute towards RAC residents is that they are infirm and passive, this study set out to explain the many decisions residents may make to become passive. Passivity in this context is an action, a strategy, which arises out of their definition of a particular situation. Many times, residents decide to be proactive or reactive depending on their situational definition. Perspectives for both residents and staff are critical to the meaning making and subsequent action.

As this study was conducted to gain a qualification, it was both context and time constrained. Additionally, in contrast to the original intention, most participants were considered to require low level care. There are four participants who had been assessed as high level care. Given the current low level and high level care residents who live in ageing in place facilities I would have assessed more of the participants as having high level care needs. Nevertheless future studies could include more participants with more high level care needs.

People who have a dementing illness were not included in this study. Therefore the literature and the study are focused on cognitively intact residents. It is my contention that residents with cognitive impairment are also able to indicate their needs; however, the methodological approach used in this study was considered inadequate for this group of residents. I would, in the future, like to conduct a study which does focus on those residents who live with a dementing condition.

Explanatory terms used throughout the thesis

The following have been used in the presentation of these research findings, including the excerpts from interview transcripts:

- Pseudonyms have been used for all participants and the facilities
- Participant quotes end with the participant's pseudonym followed by the line number from the interview transcript. Where the participant is a staff member S is placed before the line number (Pseudonym/SXX)
- Some interviews were conducted over time according to the participants' wishes. Where the quote was taken from a series of interviews, the line number is followed by an alphabetic letter to indicate the transcript (XX/33c)
- F/N: Indicates that the quote was written during fieldwork. The No = the F/N book where the quote can be found
- Concepts arising out of data analysis are italicised.
- [Square brackets] have been used to provide clarity to quotations
- ... Edited words to assist clarity of the quotation
- S/ Z: Australia uses S instead of Z in spelling of some words e.g. Analysing
- Staff: The word staff is used for both the singular and plural
- Slang: Participants in this study have used terms which are particularly Australian and could be considered slang terms. Definitions of these terms are presented in Appendix A

Government department acronyms are wide ranging, and terms used for staff, residents and aged care may be different in Australia. Acronyms and explanatory terms are listed below.

Acronyms/Abbreviations

ACAA	Aged Care Association Australia
ACAT	Aged Care Assessment Team
ACFI	Aged Care Funding Instrument
ACSA	Aged Care Standards and Accreditation
ADL	Activities of Daily Living
AIHW	Australian Institute of Health and Wellness
CMA	Comprehensive Medical Assessment
DHSV	The Department of Human Services Victoria
DoHA	The Department of Health and Ageing
EN	State Enrolled Nurses In Victoria, known as RN Division 2
FPA	Senate Standing Committee on Finance and Public Administration
NA	Nursing Assistant
NP	Nurse Practitioner
OCHR	Office of the United Nations High Commissioner for Human Rights
OH&S	Occupational Health and Safety Legislation which covers all aspects of health and safety in Australia
PCAs	Personal Care Assistants: Unregistered care staff May have certificates for working in RAC
RAC	Residential Aged Care
RACH / RACF	Residential Aged Care Home/Facility The terms are used interchangeably
RCS	Residential Classification Scale
RN	Registered Nurse
VHA	The Victorian Healthcare Association

Chapter 2: Literature Review

Introduction

The literature review presented in this chapter focuses on the concepts which were considered prior to conducting the study presented in this thesis. Rather than conduct a systematic literature review to identify gaps in the literature, in grounded theory methodology, the researcher reads conceptually around the subject and consults the literature throughout the data collection, data analysis and study findings (Corbin & Strauss, 2008). The literature reviewed as a result of the findings from this study is woven into the discussion and conclusions (Chapter eight). While the literature review in this chapter and the background chapter (Chapter one) has been updated, it remains focused on those beginning concepts.

This literature review, therefore, centres on literature related to RAC structure and staffing in the current context of global ageing. The review then reports literature which includes the residents' perceptions of living in RAC before focusing on structure and organisation related to quality of life and how culture change approaches aim towards naming and resolving quality of life issues in RAC. Finally, the review turns to staffing and staff work in RAC. Because living in RAC is complex, some concepts will be repeated, simply because they relate to particular research foci. For example, resident and staff reports can be similar or different when the research is reported from either perspective with a focus on quality of life or culture change concepts. I have left these in place rather than combining them because they demonstrate the development of dominant themes that arise out of research into RAC. As this thesis explains how residents live their life in RAC, the literature review is focused towards the aged care setting.

The challenge of global ageing

Many countries are experiencing a demographic change of increased longevity (Buckley & McCarthy, 2009; Hogan, 2004; Owen, Meyer, Bently, Heath & Goodman, 2008). Additionally, many studies report an increased need for health services by older people (Edwards, Courtney & Spencer, 2003a; Froggatt, Davies & Meyer, 2009; Stone & Wiener, 2001). In particular, for those people over 85, reports

indicate an increased need for relocation into RAC (Edwards, Courtney & O'Reilly, 2003b; Murphy, O Shea & Cooney, 2008). Because of increased community care, which assists people to remain at home, residents are reported to be entering RAC at a later stage and with complex health conditions (Brown Wilson, 2009; McGilton, Bowers, McKenzie-Green, Boscart & Brown, 2009). The increase in the complex needs and the number of people entering RAC has led to an increased need for skilled staff (Castle & Engberg, 2008; Schirm, Albanese, Garland, Gipson & Blackmon, 2005) and higher staffing ratios (Bowers, Edmonds & Jacobson, 2000; Chenoweth, Jeon, Merlyn, & Brodaty, 2010; Letvak & Ruhm, 2010). Paradoxically, the increased requirements are occurring at the same time as skilled nursing staff numbers are decreasing (Nay, Katz, Le Couteur & Murray, 2009; Froggatt et al., 2009).

RAC is beset by negative images of ageing (Sorensen & Black, 2001), and of traditional routine task oriented care in nursing homes (Tyler & Parker, 2010). Research reports present mixed views of nursing home life ranging from poor care, neglect and abuse (De Bellis, 2010) to excellent care that provides a comprehensive, inclusive, respectful approach which is consultative and arises out of a philosophy of person centred care, at the heart of which is relationship (Nolan Davies, Brown, Keady & Nolan, 2004; Owen & National Care Homes Research & Development Forum (NCHR&D), 2006).

Residents as evaluators of their care

The dominant societal view of older people residing in RACHs is that they are passive and disengaged (Cook, 2008; Diamond, 1992; Koch, 2000). According to Diamond (1992), however, living in a nursing home is not “an altogether static or passive existence, not just sitting in a chair or lying in a bed ‘doing nothing’ (p. 74). The literature presented here suggests that most residents are indeed active participants in their care, when the opportunity presents.

The global picture of residents as active participants in aged care communities is emerging through culture change movements. The Person First approach (Tischer, 2004); Wellspring (Lohuis, 2004; Stone et al. 2002), the Eden Alternative (Chevremont, Fuchsberger & Miller, 1999; Coleman et al. 2002); My home life

(Owen & NCHR&D, 2006; Owen et al., 2008); Person centered care and relationship centered care (Brown Wilson, 2009; Nolan et al., 2004), have reported increased resident enjoyment with their quality of care and quality of life. These culture change movements focus on residents rather than routines or tasks; and while they have slightly different directions, the residents are considered central to their direction of care practice. This body of research demonstrates that residents do make decisions about how they want to live within the context of an aged care facility; however in some contexts, they may not have the “ability or freedom to execute those decisions” (Cook & Klein, 2005, p. 45). Cook’s (2008) narrative study of eight older people from four English RACs demonstrated that residents strategised to influence their daily life. Her findings included a “typology of resident-led strategies” (p.272). Residents could initiate and implement their own problem solving techniques; initiate a solution which others would implement and participate in the decision making related to their own care in order to “influence their daily life in the home” (p.172). While this study is a timely reminder that staff are many times, unaware of residents’ strategies to influence their life, more detail of the interactions between staff and residents together with the conditions which influence residents’ strategies is needed. Moreover, this paper provides little evidence about how residents become involved as consumers and evaluators of care.

Academics, industry and governments, have examined the mechanisms by which residents can most effectively be involved as consumers and evaluators of their care and quality of life. While the literature reveals consistency about the appropriateness of increased resident involvement in the evaluative processes, some authors question whether this move will increase the residents’ vulnerability and fear of retribution for negative reporting (Braithwaite, 2001; Edwards et al., 2003b; Isola, Backman, Voutilainen & Rautsiala, 2008; Stack, 2003). Cook and Klein (2005) however believed that residents’ situations can be changed and, to this end, suggest that we need to “give more attention to the development of methodologies that address the specific challenges of low expectations, the fear of expressing dissatisfaction or speaking out about their experiences of services, and the power differences between professionals and older people” (p. 45).

Components of resident's care expectations

A more comprehensive understanding about the components of resident satisfaction has developed out of research into residents' preferences and expectations (Chou, Boldy & Lee, 2002; Chou, Boldy & Lee, 2003), for care quality and quality of life (Hall & Bocksnick, 1995; Hamahata, Magilvy, Hoshino & Komatsu, 2004; Kane et al., 2003, 2005). Chou, Boldy and Lee (2001, 2002) developed their satisfaction questionnaire, the Resident Satisfaction Questionnaire (RSQ) from extensive consultation with all stakeholders including consumers. A further cross sectional survey design study to validate the RSQ, involved 1,436 residents from 70 Western Australian RACs. Chou et al., reported that residents measured quality in terms of their immediate environment (their room), the home environment, services related to meals, their degree of social interaction with other residents, families and staff, the quality of staff care and the degree of their involvement in their own care. While this study goes some way towards recognising the multidimensional nature of satisfaction surveys, it does not answer all dimensions of satisfaction as perceived by residents.

Bowers, Fibich and Jacobson, (2001) reported that residents in nursing homes, in the United States, define care quality according to particular expectations or need. Their grounded dimensional study, part of a larger study, involved in-depth interviews with 26 residents from three RACs. The findings from this study demonstrated that residents have different perceptions about what constitutes satisfaction with their care. One group of residents defined quality of care according to the service they received, another group according to the relationships they experienced and a third according to whether their need for comfort was met. Additionally this study reported that residents acted out of their particular definitions of quality and raised the question of the efficacy of standard satisfaction surveys which do not take these three resident positions into account.

On the other hand, the results from further studies from Chou et al. (2003) demonstrated that the dimensions of resident satisfaction could be correlated with further cross sectional survey designs measuring staff job satisfaction (MJS). After analysis of the MJS completed by 983 staff at all levels from a variety of 70 facilities, the authors reported a relationship between positive staff job satisfaction

and increased resident satisfaction. A further study by Shaw (1998) confirmed this relationship in contrast, when Shaw revealed a correlation between staff dissatisfaction and resident abuse. Staff commitment to residents, however, has been cited as more directly related to positive resident morale and satisfaction than job satisfaction (Redfern & Norman, 1998; The Victorian Healthcare Association (VHA), 2004). While there are difficulties in the measurement of resident satisfaction these studies demonstrate that satisfaction with care and quality of life in RAC is multidimensional and complex. However, despite the difficulties in demonstrating resident satisfaction, these studies are consistent in demonstrating that staff have a significant impact on resident care and quality of life.

Thus far, literature reveals that residents can be actively involved as participant consumers, evaluators and negotiators of care and quality of life (Boldy, Chou & Lee, 2004; Miller, 1997; Mitchell & Koch, 1997). In the following two sections, research reports indicate some residents' willingness to provide both positive and negative perceptions and experiences while also acknowledging that, in some instances, fear and consequences of complaining may inhibit residents' willingness to be research participants.

Adjustment towards living in residential aged care

A wide range of literature addresses the energy requirements and the process of learning to live in RAC. Learning to live in RACFs requires a major life adjustment (Choi, Ransom & Wiley, 2008; Forbes & Hoffart, 1998; Guse & Maesar, 1999; Tracy & DeYoung, 2004). Lee, Woo and Mackenzie's (2002) critical review into older people's experiences with residential care placement recorded that older people's negative perceptions of nursing home care has a strong impact on their sense of well being before they are admitted and can intensify their sense of loss and suffering on admission. Research studies have also reported residents' expectations of their care. These studies reveal that residents want to maintain their independence and dignity, be involved in their care, receive high quality care, maintain contact with the outside community, enjoy their surroundings, and have positive relationships with fellow residents (Chou et al., 2002; Duffy, 2001). Unfortunately residents also perceive that these preferences will not be met (Forbes & Hoffart, 1998) and a number of research studies confirm this, revealing unsatisfactory care

and quality of life in RACFs (De Bellis, 2010; Fahey, Montgomery, Barnes & Protheroe, 2003; Koch, 2000; Nay, Garratt & Koch, 1999; Rantz et al., 2003; Shaw, 1998).

Choi et al. (2008) reported, in their qualitative thematic study using in-depth interviews with 65 nursing home residents, that many residents experienced a transitional depression when adjusting to residential care. The transitional depression could range from a few months to two years. Guse and Masesar's study (1999) found that the adjustment occurred in relation to the residents' new physical location, changed relationships with family and friends and the adjustment to new relationships, routines and activities. Tracy and DeYoung's (2004) study, into the experience of adjustment into assisted living, revealed similar themes reporting that while residents do influence choice and control over their social activities, in particular which activities they would participate in or not, they struggled to adjust to their "desired independence and necessary dependence" (p. 30). These authors also reported that admission to RAC challenges residents to negotiate new relationships and that living with residents whose social skills are deteriorating was taxing. The theme of energy depletion continues with Hamahata et al. (2004) who reported that residents require enormous energy during the adjustment process of admission from home to residential care, citing the residents' use of phrases such as "persevere" and "keeping a low profile" (p. 33); thus demonstrating the effort that residents make to adjust to nursing home living. Certainly, this literature reveals that moving into residential accommodation is a major adjustment which can carry with it fear, anxiety and apprehension for some residents. However the literature did not reveal the strategies that staff use to facilitate this adjustment. The following section of this review focuses on residents' reports of living in RAC.

Living in residential aged care: Residents' views

Something of residents' views of living in RACFs is known through research studies including residents as participants. The resident views are variable and, many times, related to the facility structure and ethos; demonstrating that a resident's perception is influenced by his or her experiences of living in residential care. Residents report that they can experience nursing home life as dehumanizing and lacking privacy (Fiveash, 1998); and that they have limited choice about their care and activities

resulting in a poor quality of life (Kane et al., 2003). Choi et al. (2008) conducted 65 in-depth interviews focusing on depression in older nursing home residents. The authors of this study reported that residents experience a high degree of dissatisfaction with their quality of life. Depression or negative affect was reported by 32 of the 65 participants. The participants indicated the triggers for negativity included the loss of autonomy and the need to fit into institutional routines, the experience of social isolation and loneliness, separation from their previous relationships and activities, limited privacy, staffing levels and staff turnover, facility activities which were meaningless and the continual need to face death and grief.

Buckley and McCarthy (2009) focused on the notion of social connectedness for residents living in RAC. These authors defined social connectedness as “the interaction of one person with others, his or her community, groups, and the environment, which offers reassurance and contentment” (p. 390). Their phenomenological study, involving in-depth interviews with 10 women residing in long term care, revealed limited connection with other residents, particularly those with cognitive impairment. However, residents reported close connection with those staff who took their needs into account. Connection with visitors was important in connecting with the “outside world” (p. 392) and “relieving boredom” (Ibid, p. 92).

A mixed method study, involving self report questionnaires and interviews with nursing home residents ($n=686$), reported that the availability of privacy, choice, flexibility and person centeredness assisted residents to feel at home (de Veer & Kerkstra, 2000). Residents have also reported their perception of the characteristics of resident centered care. Eales, Keating and Damsma (2001) interviewed 48 residents in Canadian assisted living facilities. Their findings revealed that resident centered care resided in a setting which was conducive to the maintenance of residents’ lifelong preferences (personalised rooms, activities, security of available assistance and safety); choice of socialisation (preferred level of relationship); and connectedness to the community (family and friends, outings and maintenance of previous community activities). Cook (2008) reported the findings of her biographical narrative research which comprised sequential narrative interviews with eight older people living in four English care homes. The findings from this study demonstrated that older people developed their own individualised personal and interpersonal regime; employed creative strategies for maintaining their

independence, sought assistance of staff, family and friends to put these strategies in place, and had individual input into their care planning and collective input into resident committees. Clearly the maintenance of independence, autonomy over decisions and social connectedness are aspects of residential life valued by residents. Their requests and expectations could not be clearer; while listening to those requests may or may not occur.

Choice, control and autonomy

Davies (2000) presented autonomy as multidimensional and contextually dependent. Conducting an observational study across a range of practice arenas, which included acute, rehabilitation and community health care services, Davies reported variable practices which enable an older person's autonomy. This study was part of a larger study which focused on educating nurses in the care of older people. Researcher observations focused on the presence or absence of the following:

- Offering the older person choice in relation to day-to-day activities
- Providing information or explanations about care
- Eliciting feedback from the older person in relation to actions taken or care given
- Demonstrating reciprocity within the nurse-patient relationship
- Protecting and respecting older patients' and clients' privacy
- Promoting independence in the activities of daily living
- Encouraging participation in care planning (p. 131)

Although this study was conducted in a range of health care settings, some findings do assist in adding to the micro care practices which are important dimensions of choice, control and autonomy for older people, and can be considered in relation to RAC. For example, the nurse resident relationship is central to knowing the resident's perception of choice and autonomy and the extent they are willing to delegate authority to the nurse or not. This notion also holds true when nurses request feedback. In the absence of a positive relationship, feedback may be rhetorical. Additionally decisions can only be made on the information that a person has and that would include the notion of participation in care planning. Thus skill and transparency in the provision of information becomes central to participation in the decision making process. There are some aspects to ponder however. The difference between a patient and a client in this study is perplexing and that difference is not reported. Additionally, I suspect that while privacy is an important element,

regardless of the care model, it can be respected in the absence of an overall notion of providing residents with control, choice and autonomy.

Welford, Murphy, Wallace and Casey (2010) offered a concept analysis of autonomy for those living in RACH. Their model of resident autonomy suggests “six attributes of autonomy” (p. 1232), including maintaining and encouraging resident capacity so that care planning and delegated care needs are negotiated and residents are involved in decision making. Where the resident is living with cognitive impairment, relatives or significant others stand in as proxy for the negotiations and decision. Finally, surrounding these negotiations is an underpinning facility philosophy of flexibility, dignity and respect.

There is some relationship between models of person centered care and an emphasis of choice, control and autonomy for residents living in RACFs. McCormack (2004) suggested that the dimensions of person-centered practice include “knowing the person, values, biography, relationships, seeing beyond the immediate needs and authenticity” (p. 31). He posited that these dimensions, when operationalised, lead to shared decision making between the resident and facility staff. McCormack et al. (2010) presented a person centered practice framework which includes shared decision making as an aspect of person centered processes. This paper however, derived from a larger study, focused on the caring environment and care practices and provided little information regarding how resident choice, control and autonomy was operationalised. Certainly environmental factors are critical to the concept of power sharing which is central to enabling resident choice, control and autonomy.

The tensions between competing requirements have been reported by Hall and Bocksnick (1995) in relation to choice and participation in recreational activities. These authors revealed a tension for residents, the recreational therapist, and the administrative staff, as each group struggled with different aspects of activity groups. In an effort to meet regulatory and facility criteria for providing residents with recreational activities, the recreational therapists were seen to subtly coerce residents to attend activities, while the residents admitted to participating in activities to allay boredom and to help the therapist. In this instance, residents were not necessarily effective in influencing their quality of life, were not consulted about the nature of

the activity programme or asked for an evaluation of that programme. Tuckett (2005) contended that “care providers cannot convincingly address the residents’ needs, interests and entitlement for decision-making, in a time-poor, task-oriented, socially isolating environment with consequent limited opportunity for interpersonal relationships” (p. 223). Persson and Wasterfors (2009) focused on restrictions related to residents’ involvement in decision making and staff responses to resident complaints. They conducted a qualitative descriptive study in three nursing homes using in-depth interviews with 13 nurses. Findings revealed that the organisational structure (staffing levels), the shift schedule, and a tension between regulations (making sure residents’ hygiene needs are met) and resident choice as to the timing of hygiene care, restricted their ability to include residents in decisions. Additionally, staff reported that residents were silent and therefore happy with their situation. Furthermore, staff considered they were powerless in responding to residents’ complaints due to limited time and the volume of work to be achieved during their shift. Consequently, Persson and Wasterfors concluded that staff actions within the context of routine and busyness were influencing the residents’ ability to employ choice, control or autonomy. A tension exists between meeting regulations for residents’ choice and autonomy and access to resources. “While nursing home staff may feel obliged to adhere to political and moral aims, they are also expected to work efficiently in an often stressful workplace” (Persson & Wasterfors, 2009, p. 9).

Residents’ dependence and independence

Older people live in a state of precarious balance between dependence and independence and are continually checking, deciding and acting with regard to the use of health care services (Forbes & Hoffart, 1998). Bowers et al. (2001) revealed some residents’ activities included subtly trading with staff in order that care needs might be met. For example, those residents who perceived ‘care as relationship’ took risks in attending to their own care needs (getting out of bed to attend to their own toileting needs and risking a fall) to assist caregivers and maintain a harmonious relationship. Robinson (2000) reported residents’ work related to their management of urinary incontinence. Residents worked to learn about continence, monitor their health status, improvise in a variety of contexts, speak up about their needs and let go of some activities so that they could maintain independence, avoid embarrassment and get their care needs met for this condition. However, other research into

residential care reports the vulnerability of residents to inadequate care (De Bellis, 2010; Kayser-Jones, 1996, 2000; Tuckett, 2005). Inadequate care impacts quality of life for residents.

Quality of care and quality of life in residential aged care

Assessing quality of life is multidimensional and complex. Additionally, family and residents may perceive quality of life differently to providers and researchers (Bowers et al., 2001). Kane et al. (2005) suggested that “as quality of life concerns increase, the distinctions between quality of care, quality of life and customer satisfaction become increasingly blurred” (p. 2076). Hawes and Phillips (2007) posited general agreement with the notion that quality includes the dimensions of quality care, quality of life, the quality of the environment and adherence to residents’ rights. Others situate quality of care as a dimension upon which quality of life is dependent (Courtney, O’Reilly, Edwards & Hassall, 2009; Isola et al., 2008). Overall, the focus on quality of life is reflective of concerns for poor quality of life experienced by residents in RACFs (Arling, Kane, Mueller, Bershadsky & Degenholtz, 2007). Arling et al. note that the “efforts to address this concern have included stronger regulation, stricter educational standards, and expanded consumer information” (p. 672). It could be argued, however, that an emphasis on meeting regulatory and educational standards, without increased resource, shifts staff focus towards these standards and away from residents and families (ACSA, 2010; Beattie, Cheek & Gibson, 1996; McGilton & Boscart, 2007; McGilton et al., 2009).

Murphy et al. (2007) suggested that assessment of quality of life is both objective and subjective; therefore requiring mixed method approaches across a range of stakeholder perceptions. Their mixed method approach combined a survey of 526 Irish facilities; seven focus groups with managers of RACFs and interviews with residents ($n=101$) and staff ($n=48$). Findings from this study indicated congruence between surveys and interviews within four domains of quality of life namely “care environment and ethos of care, personal identity, connectedness to family and community and activities and therapies” (p. 2174). In some facilities, these dimensions appeared more achievable; however, autonomy and choice, a dimension of care environment, and ethos of care were limited for more dependent residents and in facilities where the ethos was primarily directed towards care routines rather than

individualised care and choice. The authors suggested that it is this organisational feature which is most likely to interfere with resident choice and autonomy. Additionally, along with other literature (Tuckett, 2005; McGilton & Boscart, 2007; McGilton et al., 2009), Murphy et al. reported that staff shortages and staff qualifications were of concern and were barriers to residents' achievement of quality of life. They argued that "older people in long-stay care are more than just patients; they are individuals who deserve good quality of life in an environment that is empowering and person centered" (Murphy et al., p. 2176).

Courtney et al. (2009) focused on the relationship between clinical outcomes and quality of life. Using the Clinical Care Indicators (CCI) and the Australian WHOQOL-100, for 83 residents from four facilities, the researchers reported a relationship between quality of life and clinical outcomes. For example "Hydration, falls and depression were most often associated with poorer resident [quality of life] QoL" (p. 49). Arling et al. (2007) studied the relationship between staffing levels, quality of care and residents' functional outcomes. Results of this study report limited relationship between the staff time spent with residents and residents' functional outcomes in four care process domains, namely: the use of physical restraints, toileting program, range of movement training (active or passive) and activities of daily living (ADL) training. Questions raised by the researchers included whether the central domain, which impacts quality of care and functional outcome, is effective staff deployment rather than staff numbers. Overall, the authors acknowledged the complex relationship that exists between "resident conditions and care delivery" (Arling et al., p. 681).

Reported studies demonstrate a mismatch between what staff perceived they would like to provide in quality care and the practice of delivering quality in long term care. An examination of the literature on nurses' perception of quality demonstrates this mismatch. While notions of the dimensions of quality are congruent with current quality concepts, nurses also perceive barriers to achieving quality. Murphy (2007) conducted a qualitative study with 20 Irish nurses to examine nurses' desire to achieve quality care and barriers to employing those constructs in practice. Her findings reported that the nurses' aim was to deliver care that was individualised, specialised towards clinical excellence and focused on the residents' emotional and

social needs within an environment of flexibility, resident choice and a homely atmosphere. The same participants indicated that such aspirations require strong committed leadership, an adequate staffing level and skill mix, clinical expertise developed through high levels of staff education, and a philosophy of developing and sustaining resident independence. The barriers towards achieving these aims focused on limitations in leadership, staffing levels and skill mix, staff education, and a reluctance of some staff to embrace a change from routine care delivery to resident centered care delivery. Similarly, Isola et al. (2008) reported that nursing staff evaluated the physical needs of residents more highly than their psychosocial needs. Recommendations from this study, as in many studies, included the need to a) strengthen leadership of nurse managers; b) increase staffing levels to facilitate time to focus on care aspects beyond physical care; and c) develop staff skill and knowledge particularly in the area of psychosocial resident care.

The quality of the relationship between residents and staff was reported as a central feature of nursing assistant's (NA) perception of quality (Bowers et al., 2000). Similarly, to other reports (Brown Wilson, Cook & Forte, 2009; McCormack, 2004; Nolan, Davies & Brown, 2006), the NAs in this study reasoned that knowing the patient through relationship led to an increased ability to attend to the resident's preferences, thus increasing an ability to provide comfort and consequently an increase in the quality of care. This goal however was dependent on adequate staffing levels and Bowers et al. (2000) indicated staffing levels are crucial to providing quality of care.

The importance of staff working with family members to assist an older person to live a satisfactory life in residential care cannot be overstated. There have been many research studies which highlight the work that families do to assist staff to know more about their relative, to maintain a caring role in this context and to monitor care practices (Davies & Nolan, 2004; Hertzberg, Ekman & Axelsson, 2001; Kellett, 1998). Relationships between relatives and staff can range from distant and conflicted, to effective and harmonious, with some relatives reporting that they are the initiators of any interaction and some staff reporting their commitment to creating partnerships with both residents and families (Bauer & Nay, 2004; Hertzberg et al.,

2001; McKenzie-Green, 2003). The culture change movements have gone some way to articulating the nature of these potential partnerships.

Culture change in residential aged care

“In the service context, empowerment of consumers means corresponding relinquishment of power by providers” (Kane, 2009, p. 6). In an effort to provide quality care within staffing and financial restraints, aged care providers and researchers have worked to increase efficiency, staff knowledge and skills, and shift the focus of their work from task oriented care; where organisational structures are privileged, to a person or relationship centered approach. These resident centered approaches redirect attention towards an enabling environment for residents and staff. Subsequently, in a person centered approach, the organisational structure changes with the goal of enabling a life enhancing resident environment and increasing the care quality. Further to person centered care, Brown Wilson (2009) reported that relationship centered care extends the concept from individualised person centered care to care and living that contains the elements of person centered care and builds the community through reciprocal relationships. Relationship centered practice provides and welcomes engagement and partnership between residents, families and staff, thus acknowledging the skill and knowledge each brings to their own care and to the community in which they live. The pathway to a change in the quality of care focus, however, is complex with varying levels of success.

The quality of leadership

Some authors conclude that a culture change process can only be effective if the philosophy of a resident centered approach is understood and led by those with authority at the organisational level of RACs (Brown Wilson, 2009; Nolan et al., 2006; Nay et al., 2009). Jeon et al. (2010) proposed that without leadership, from those with authority, change in RAC is not sustainable. They also propose that effective leadership promotes resident well being, high quality care, staff work satisfaction and retention, and reduces expenditure. It would appear from the literature that these factors are noticeably absent in many aged care work environments. McGilton et al. (2009) reported RN staff, who were shift supervisors, described a complex role which included direct routine care work (medication management and wound care); supervisory and organisational work (when front

office staff were off site); administrative work (care documentation to earn funding); and coordinating work with families and multidisciplinary health professionals. In response to their role requirements, the RNs experienced multiple interruptions. In order to manage their work, these RNs extended their day by either coming to work early to plan their day or staying late to catch up with unfinished work. Furthermore, these staff reported twinning jobs to maintain routine care (administering medications during phone conversations with family) and responding to requests as they arose. Those RNs who perceived that they could not manage their work without care assistants, worked to improve the knowledge and skill of those assistants. Interestingly very few staff perceived their role to include leadership. The findings from this study demonstrate the need for organisational and educational support to develop and use leadership skills as well as a reorganisation of the RN role so that they can manage the increasing complexity of work in long term care.

Staffing levels, skill mix, turnover and time

As mentioned previously, in this thesis both residents and staff report that staffing levels and skill mix are problematic when considering quality of life in RAC (Choi et al., 2008; De Bellis, 2010; Halcomb, 2009; Hugo, 2007; Martin & King, 2008; McGilton et al., 2009; Murphy, 2007). Harrington, Zimmerman, Karon, Robinson and Beutel (2000) demonstrated a relationship between staffing hours, skill mix and quality of care outcomes. Stearns et al. (2007) reported a relationship between higher licensed staff levels and reduced transfer to the acute care setting. Most research reports indicate a cluster of factors both lead to and arise out of staffing levels. For example, an Australian study reported nurses job dissatisfaction arose out of inadequate staffing levels and an inappropriate skill mix where some staff had insufficient knowledge and skills. Furthermore job requirements for documentation and the requirements for extra overtime contributed to job dissatisfaction which then increased turnover and impacted staffing levels (Moyle et al., 2003).

Bowers, Luring and Jacobson (2001) reported that nurses strategised to manage complex work in limited time. These strategies included “minimizing the time spent doing required tasks, creating new time and redefining work responsibilities” (p. 484). The perspective of these participants was that quality resident care was not achievable within the time constraints and prevented them from the work which

provided the most job satisfaction, namely spending time with residents. Adding to the discussion, Bowers et al. (2003) found certified nursing assistants (CNA) turnover was related to “a range of organizational policies and practices, including staffing policies, absenteeism policies, training and orientation practices and low compensation” (p. 39). Beyond these factors however, the CNAs reported leaving because personally and professionally they felt devalued.

Staff work in residential aged care

According to Cameron and Brownie (2010) staff work satisfaction is derived from a range of factors, namely the time and ability to develop meaningful relationships with residents and family, employ complex clinical skills in negotiation with residents, and enjoy a positive workplace environment where their professional skills are valued. Additional factors, reported from these authors’ phenomenological study with nine RNs working in RAC, included the ability to have a positive work life balance, the opportunity to debrief work experience and a positive attitude towards working with older people.

The situation for staff in aged care facilities impacts on their ability to work with residents, particularly when the facility organisation is focused on the tasks and routines of care rather than the processes of care delivery (McKenzie-Green, 2003, 2004). Edwards et al. (2003c) coded 2,848 observations of resident – staff interactions with the aim of describing the “current interactional context of a residential aged care facility” (p. 37). The main findings of this study were that residents spent 40% of their time alone and when staff were in attendance, the dominant mode was that of no verbal, non verbal or physical communication. Additionally findings of this study suggested that residents’ dependence was supported and independent activities invoked no comment. As these authors indicated, therapeutic communication with residents is central to effective nursing practice and enhancing the residents’ involvement in a range of domains, namely lifestyle, health care planning and activity decisions.

There have been many reports of staff actions and care practices in residential care which indicate the influence of organisation on the ability to provide quality nursing care (Crogan & Schultz, 2000; Crogan & Evans, 2001; De Bellis, 2010; Kayser-Jones & Schell, 1997). Some research focuses on particular care approaches. The use of residents' life narratives has been reported as assisting the resident – nurse relationship and assisting in care planning aimed towards resident characteristics and preferences (Brown Wilson et al., 2009; Heliker, 1999). Eisch, Brozovic, Colling and Wold (2000) reported the addition of a NP consultant led to an improvement in staff ability to prevent and manage resident agitation. Hanson, Henderson, and Menton, (2002) found that a good death in a nursing home was founded on effective, skilled nurse – resident relationships together with individualised care.

Additionally, there have been numerous studies which examine the efficacy of staff development approaches. These have included education into nurse – resident communication (Caris-Verhallen, de Gruijter, Kerkstra, & Bensing, 1999); education in palliative care and end of life care practices (Abbey, 2004; Ersek, Kraybill, & Hansberry, 1999; Ersek & Ferrell, 2005; Froggat & Hoult, 2002); and assisting residents who experience depression (Tryssenaar & Gray, 2004). Equipping RNs with the complex knowledge and skill of gerontic nursing specialty has been improved through university-facility educational programmes (Edwards et al., 2003; Fear, 2009; Grealish, Bail, & Ranse, 2010; LeCount, 2004). Finally, research studies have addressed features of organisational structures in RACHs. Flackman, Flagerman, Haggstrom, Kihlgren & Kihlgren, (2007) reported an increase in staff assistants' knowledge, effective care practices and staff retention after two years of education and clinical supervision.

Conclusion

As noted in the research presented in this review, facility philosophy, care models and organisation, staffing levels, skill mix and the level of staff knowledge and skills influence residents' quality of life. Quality of life is a complex concept and assessing residents' quality of life requires multiple approaches. The literature demonstrates variability in the care practices, residents well being and subsequent quality of life, with research findings indicating poor, mixed and high levels of quality of life. There is general agreement in the literature that residents and staffs perceptions of quality

of life are similar. Additionally, research findings appear to be in general agreement that quality of life is best achieved in the context of a strong leadership philosophy which recognises the centrality of effective resident-staff-family relationships; develops a flexible structure of care services in an environment which is respectful of all relationships; and assists both staff and residents to partner in decision making processes. It is considered that these dimensions of quality of life need to be examined carefully for 'the how to' aspects of each of these dimensions. Usually such an examination requires a major redirection in facilities structures away from a hierarchical and routine task oriented environment. Additionally, most countries are expressing the complexity of resident conditions at a time when the RN staffing levels are decreasing. The question of how to address these revolving and persistent issues of organisation, structure, staffing and practice is vexing. Multidimensional factors require a range of responses.

Opinions also differ about whether residents are able to influence their care or are passive, powerless care recipients. There is evidence that residents do actively engage in activities to adjust to aged care facilities or to meet their own care needs. Many however, due to their physical health status, need staff assistance to meet care and life quality needs. Residents' interactions with staff can have a powerful influence on their life in RAC. Research has demonstrated a strong link between staff satisfaction and resident satisfaction.

This review demonstrates that involving residents in their care is not a simple matter. Government regulations, how the facility approaches care and life quality, and staff interactions with residents all intersect in some way to influence residents' lives. While some studies presented in this review have indicated the activity resident's conduct in order to manage their life in residential aged care, these studies tend to focus on a particular dimension of life in RAC. Additionally, while residents' influencing strategies have been noted by a range of research studies, they do not provide sufficient depth in relation not only to the residents' activities but also to the way in which the staff or the environment mediate those activities. The aim of this study was to include both residents and staff in order to develop a theory related to residents' strategies towards creating their life in residential aged care.

Chapter 3: Methodology and Methods

Introduction

In this chapter, I first explain symbolic interactionism, the theoretical underpinning for this grounded theory study. The explanation will be followed by a brief discussion on the development of grounded theory. The research design and the research process will be articulated and demonstrated using examples from findings. Considerations for data collection and ethical research conduct will be discussed. Finally the research process and analytic procedures will be demonstrated. These processes and procedures follow those presented by Strauss (1987) and Bowers and Schatzman (2009).

Symbolic interactionism

Symbolic interactionism, a sociological theory of human behaviour, was named by Blumer (1969). Symbols in this sociological theory can be seen as anything that a person gives meaning to and may include people's actions, as well as physical objects, emotions or abstract concepts. For example, almost all residents in this study pointed to physical objects in their room and surroundings as indicative of them, their families, past living arrangements, and representations of their experiences, history, interests and activities.

It's hard, when you're trying to bring such a lot over you know that you want; that you had in the unit over there; whereas you've got one room here to put everything in. But I've got my pictures and that up, as I wanted. They're the five my brothers and sisters [indicating a framed photo]. The last three died in seven months of each other, those three at that end; one died the boy in the middle and the one at the end died less than a month of each other. Oh, it was awful. (Ruth/96)

These conversations in interview taught me about the person, their context, feelings and values. Additionally, participants in this way were introducing themselves to me. The result was rich data indicating the meaning making process represented symbolically.

The central tenets of symbolic interactionism are that people are active and meaning making. Action arises out of interpretations which define situations. Both interpretation and consequent actions are situational and are adjusted as conditions

change. These processes of interpretation, action and adjustment occur as people interact with their environment. During the meaning making process, people take note of particular symbols which have meaning for them; enter an internal dialogue and define particular situations. A significant aspect of this interpretive process is that people consider a situation from the other's perspective. In other words, they work to understand what the other is indicating in the interaction. It is this process of interpretation and action which forms the focus of Blumer's explanation of human behaviour. From the symbolic interactionist perspective, society both shapes and is shaped by the actions of individuals within it. This twinned shaping process is continuous as people interact, make meaning out of their own experience and others' feedback, and decide to continue or adjust their actions (Blumer, 1969; Bowers, 1988; Bowers & Schatzman, 2009).

A grounded theorist using symbolic interactionism as the underlying theoretical perspective takes into account the notion that how a person perceives others, or a particular situation, shapes his or her own interpretation and thus his or her actions. Actions may be adjusted, blocked or in alignment according to shared or misaligned interpretations (Blumer, 1969). The process of interaction, taking the role of the other, the internal dialogue, the interpretation and the consideration of an action is demonstrated in the following quote from Helen. Helen's interpretation was that the comments from other residents were having an effect on them and she considered an adjustment to abate that effect. Additionally, the residents' comments indicate the meaning they made, regarding her fast walk, was that she was a busy person. Thus perception leads to interpretation and subsequent action.

They say to me. "You know, you're very busy." And I thought, "Well because I walk fast". [Then] I think to myself. "Well I really don't need to walk fast. I can walk slowly and it won't sort of have an effect on them when they think I'm running around." I'm not running around. I just haven't learnt to slow down so much since I came here. (Helen /128)

The use of symbolic interactionism as the theoretical underpinning for a grounded theory study kept this researcher focused on data which contained words signalling perspective, meaning, interpretation and action as the above quotation demonstrates. It was this theoretical perspective that imbued Strauss's grounded theory approach.

Grounded theory background

The originators of grounded theory, Glaser and Strauss (1967), articulated this research methodology in an effort to shift the sociological focus of the time from theory verification to theory generated from within the field of study. Doing so, from their perspective, would, among other characteristics, explain processes of action which had “practical actions – prediction and explanation should be able to give the practitioner understanding and some control of situations” (Glaser & Strauss, 1967, p. 3). According to Wright-Mills (1970), history and biography intersect. It would be expected then, that as biographies develop within a changing world, so do researchers’ understandings develop and change; thus new histories and biographies intersect. This process has occurred with grounded theory. The original aim of grounded theory however, remains; namely to develop explanatory theory which has practical application for the society and those within the phenomena under study.

The first development arising from grounded theory, dimensional analysis, originated with Schatzman, a colleague of Strauss and Glaser. Schatzman (1991) first wrestled with the problem of explicating an analytic process for working with data using the grounded theory method. In essence, he suggested that we all dimensionalize situations that we are required to solve and that this process of natural analysis can be used and developed for researchers aiming to develop theory through their data analysis. An additional emphasis which aids analysis, according to Schatzman, is the importance of perspective not only in terms of the participants, but also in terms of the discipline and biographical lens that the researcher brings to the research (Bowers & Schatzman, 2009; Schatzman, 1991). The notions of perspective in developing meaning and taking multiple dimensions of a situation into account to decide actions, positions dimensional analysis firmly within symbolic interactionism. The analytic approach of dimensional analysis will be demonstrated further in this chapter as I articulate the analytic process used in this study.

As students of Glaser and Strauss have conducted grounded theory studies and studied the grounded theory method, they have articulated variations in this research approach (Bowers & Schatzman, 2009; Corbin, 2008, 2009; Charmaz, 2006, 2009; Clarke, 2005, 2009; Schatzman, 1991). Despite the variations, a reading of the recent

grounded theory methodological literature reveals the basic tenets of grounded theory remain, and are integrated with the developing articulation of the method (Charmaz, 2003). The commonalities that are shared in the various approaches to grounded theory are: 1) theory is developed from data; 2) data is derived from the study phenomenon; 3) data is concurrently collected and analysed; 4) analysis begins with initial coding and proceeds with increasing abstraction towards theory; 5) ongoing participant sampling is guided by emerging concepts (theoretical sampling); 6) the use of memos aims to articulate and bring to focus decision points and directions which guide conceptual development; and 7) the theory is grounded in, and explanatory of, the processes that participants use in everyday life.

The contemporary developments include the theoretical underpinning, focus and process of grounded theory. In the main, these developments have situated grounded theory in the interpretive paradigm. Methodologists have more clearly articulated the theoretical underpinning of pragmatism and symbolic interactionism and differentiated between Glaser's and Strauss's approach to grounded theory. Charmaz (2000, 2006, 2009) distinguished between objectivist and constructivist grounded theory and places grounded theory firmly in the interpretive paradigm, with the theoretical underpinning of symbolic interactionism informed by pragmatism. Thus clarity, to some extent, has been achieved between Glaser's post positive approach and Strauss's symbolic interactionist approach to this methodology. Additionally, Clarke (2005) argued for grounded theory studies to be situated within a post modern perspective by maintaining a pragmatist perspective and focusing on the wider context of the social world. "Through integrating the social worlds/arenas/negotiations/discourse framework with grounded theory as a new conceptual infrastructure, I hope to sustain and extend these methodological contributions of grounded theory" (Clarke, 2005, p. xxiv).

Together, with the developments above, the notion that the researcher is objective, as articulated by Glaser and Strauss (1967), is challenged. Bowers and Schatzman (2009), from an interactionist perspective, highlighted the central feature of both researcher and participant perspectives in the interpretive process. Charmaz (2009) argued that data collection is co constructed by researcher and participant and that each bring multiple perspectives to the interaction. Additionally, according to

Charmaz, with an awareness of the co constructed nature of data collection, the researcher works to enter the participants' meaning and action world, while being aware of their own perspective. More recently Corbin (2008, 2009) acknowledged the researcher and participant as bringing their own history and biography to the study. Finally Clarke (2005) emphasised the need for researcher self awareness and urges reflexivity when she stated "we are, through the very act of research itself, directly in the situation we are studying" (p. 12). Each of these researchers call for transparency in the researcher's positioning of themselves in the study and in the interpretive analytic process.

The outcome of these developments for the grounded theory researcher is not that they adopt only one variation of grounded theory. What is important is the transparency of the approach a researcher adopts in the study they conduct. In this grounded theory study, I have taken into account the centrality of perspective, both mine and the participants. I acknowledge a professional perspective, gained from nursing, gerontological nursing and education; a counselling perspective; and a developing sociological perspective. I have employed grounded theory method consistently throughout the study while using dimensional analysis as my analytic tool.

Grounded theory methodology

The aim of the researcher using grounded theory is to build theory grounded in, and arising out of, the phenomenon under study. A theory that explains the processes used by the actors within the phenomenon should have explanatory power that is readily recognised by those participants, while at the same time reflecting the complexity of interactions sustained over time and changing within a variety of contexts and conditions. Grounded theory researchers examine how people act on the basis of their interpretations about events that occur in everyday life (Bowers & Schatzman, 2009). For example, in this study, most residents living in RAC could very quickly describe the general patterns of their days. They could also report how they adjusted those patterns when their health was not optimal. Additionally, their talk included what they do if the staff on duty are, or are not, those they wish to consult about a particular situation. How residents talk about these conditions, which

lead to a change in actions, reveals aligned or misaligned actions and demonstrates the complexity of residents' work of living in aged care.

However, residents are not always aware of the myriad of shared patterns that create the particular climate of the facility in which they live. For example, residents were not always aware of the different perspectives that staff held about their work roles. Nor were they always aware of how those perspectives had the potential to shape residents' lives. For example, many staff participants reported that they did not perceive it was their role to sit with and talk to residents. "That's not your job to do that because they have; like you know, what they call them, occupational carers. That's their job to sit and talk and entertain; it's not the nurses' job" (Julie/S824). In contrast, others held a different perspective. Jo, also a nurse, perceived it was her role to spend time being with residents and found busy times difficult. "Our frustration was not being able to spend quality time with the resident. ... And yes, we do [now] take him out in a wheelchair with his dog, and he plays ball with him" (S171). The implication of these different perspectives, while not specifically stated to the residents, was that actions arising from these perspectives have an influence on the residents. In one case, a resident's need to talk would not be met and in the other, it could be. In this study, grounded theory was particularly helpful for revealing the processes of action in the facilities and providing explanations of how perspectives, conditions and contexts can either support or constrain residents' actions towards living their life in RAC.

Research design

This study was a qualitative interpretive study using the grounded theory method. Data collection included individual in-depth interviews and fieldwork involving residents, families and staff. Grounded theory methods of concurrent data collection and data analysis, comparative analysis and theoretical sampling were used consistently throughout the study. Dimensional analysis was used for data analysis. Ethical approval for this study was sought from, and granted by, the ACU Ethics Committee (Appendix B).

The study was conducted in two aged care facilities with a combined resident population of 121 residents. Participants comprised 42 residents and staff. Individual interviews were conducted with 23 residents and 19 staff. The participant sample included cognitively aware English language speakers. Seven resident participants were men and 15 were women. The staff sample included staff from all levels, namely senior managers, diversional therapists, RNs, PCAs and hospitality staff. Of the 19 staff interviewed, six were employed fulltime, while 13 were employed part time. Those who were employed part time worked from 24 to 30 hours a week. Appendix C includes demographic data for both residents and staff. Many PCAs and hospitality staff were trained in a range of role responsibilities. For example, a care assistant had attended education for working as a caregiver, as a cleaner and as a hospitality assistant. Others were able to carry out the work of caregivers and activity staff. On the whole however, the staff remained in one main work role and shifted roles as required. The demographic data for staff roles indicate their main role responsibility.

Recruitment

Managers of the facilities were asked to deliver a letter to staff and residents who met the inclusion criteria. I then approached staff and residents. Additionally, I met with residents' committees and staff groups to explain the nature of the study. Particular care was taken to gain informed consent and verbal consent (process consent) at each time of interaction with participants. Many residents in RACFs live with age related hearing and visual impairment. Participant information sheets (Appendices D & E) and consent forms (Appendices F & G) were in large type on black and white paper to increase readability. The font has been adjusted to fit page requirements for this thesis.

Exclusions

As this study was for the purpose of gaining an education award, and was time limited, residents with a diagnosis of dementia were excluded. An additional feature of this exclusion is that, while I agree with Kitwood (1998) that residents with cognitive impairment can act on their own behalf and indicate their care preferences, the nature of their communication can be different. The data collection method designed for this study was not suitable for this group of residents.

Data collection methods

Data collection comprised interviews with residents and staff together with a total of 24 fieldwork days; 12 days in each location. Fieldwork visits were conducted twice in both facilities approximately three months apart. Each facility was in a different Australian state and fieldwork visits were alternated between facilities. Fieldwork days usually began in the early morning ending late afternoon or night in order to interview and observe night shift staff. During fieldwork visits, I met with residents and staff, shared meals with residents, interacted in congregate spaces, and joined facility activities and some resident excursions outside the facility. During each fieldwork day, time was set aside to code data, consider emerging concepts and write memos. Memos were also voice recorded when time was busy. In this way I maintained concurrent data collection and analysis during each fieldwork visit and between field work visits.

An emergent research design

Grounded theory is an emergent research design in that the researcher makes ongoing design decisions (Polit, Beck & Hungler, 2001). The emergent aspects of my research design occurred during data collection and data analysis. I made two changes to my original research design in relation to data collection with families and the conduct of staff focus groups. My original intention was to interview family members, if the resident was willing for me to do so. Some residents had few family members and did not wish to take their busy time. Other residents' families were geographically distant. I interviewed three family members but was unable to approach others. Consequently, the interviews with family members were not included in the data analysis or the interview numbers.

I had intended to conduct up to four staff focus groups to explore how their interactions generated data about staff, residents and family relationships. The original research design was that staff be asked to respond to deidentified vignettes about residents' experiences with a research focus on group dynamics. I had thought that such dynamics would reveal the multiple perspectives staff might hold about resident actions and/or silencing dynamics between staff which leads to one perspective holding sway over the group (Kitzinger, 1994). My experience was that

many residents and staff wanted to talk to me, become participants in the study or generally have me around the facility. I had not expected this eventuality. Before the second fieldwork experience was completed, I decided to forgo the focus groups. I had two reasons for this. First, I had already collected interview data demonstrating a range of staff and residents' perspectives. Second, so many residents and staff wanted to participate in the study that I feared the researcher nightmare of drowning in data rather than immersing myself in the data. I admit there were times when I thought the former had occurred.

Focusing on data: Self reflection and memos

“Analysis cannot be done without a perspective” (Bowers & Schatzman, 2009, p. 97). There are two aspects to consider here. Firstly, how the researcher is positioned before and during the study; and secondly, how the researcher works with literature and experience in the field. Researchers can enter a field of study knowing a great deal about the phenomenon they are setting out to study. As a RN who has worked in aged care, taught RNs from aged care and conducted previous research in aged care, this is the situation I was facing in conducting this research. In grounded theory method, the researcher's intent is to interpret the participants' perspective and actions and not the 'received theory' related to the researchers' discipline. For example, as a nurse, I interviewed staff whose talk was about residents' conditions and what they noticed about how those conditions impacted on the residents. I was careful to ask the meaning around *noticing* so that I did not impose my own ideas of what I would expect others to notice. The following quotation demonstrates one participant's noticing activities during meal times. This participant worked in hospitality and care giving.

So if we find anything that we're noticing like they're not drinking enough fluids, they're not having enough fibre intake or having too much fibre intake, if they're not eating as much as what they were, if they've gone off their food, if their behaviour is changing within the dining room, it could be something distressing them as far as, they can't pour their cup of tea or they can't cut their food up like they used to or they're not eating. You've noticed that they're not chewing properly, leaving you know, with plate wastage. We check to see when they come in if they're leaving more and more of a certain food. So they might have problems with their gums and haven't told the PC [personal care] staff and we notice it because they're not eating the harder

foods, not that we have a lot of hard foods, but say a sausage or something like that, they're leaving their protein, their meats and things like that. (Rachel/S33)

During analysis I was required to consider the interpretation I attributed in coding that data. For example, when analysing the staff talk, careful examination of data focused not only on what was noticed but also on subsequent data about what followed the noticing. The pitfall was that, as a nurse, I could easily interpret that staff were actioning what they noticed, when s/he may have merely been noticing without ongoing action. The following excerpt demonstrates the actions taken in response to noticing a change in a resident during meal times.

Researcher: Can you give me an example of when you've noticed something changing? Just pretend I know nothing. So take me through it step by step the sorts of things that you did.

S: I'm serving their breakfast. Say I notice that, [a resident], won't eat anything but dry toast for breakfast and he's gone off all the wet dishes. He's not drinking as much fluid. When I ask him what he'd like for his tea, he's only asking for the dry or something very bland for his like main meal and his tea, and you say 'Is anything wrong? Aren't you feeling well?' Or something like and usually, they come around and they say, 'look I've had a touch of diarrhoea and I don't want to upset my tummy, because me tummy's playing up.' And I say, 'oh okay then... well you stick to that at the moment and then I'll go and speak to the person in charge of your personal care and we'll discuss it and we'll see what we can do with your diet and see what's going on'. (Rachel/S46)

Many times, during this study, I struggled with the analytic process working to figure out what it was all about. During a writing retreat, I had the opportunity to spend time thinking about and reflecting on what I was finding and how I was going to write those findings. Soon after the retreat I wrote a metaphorical reflection which, for me, captured the core of what residents were telling me. The reflection is presented in Appendix H.

Entering the field

While the concurrent data collection, data analysis, memoing and the supervisory process might counterbalance the tendency to operate from my own perspective, I prepared myself for entering the field by developing initial memos reflecting previous personal and professional experiences including research experience. Additionally, I reflected on my own attitudes and values in relation to RAC. Schreiber (2001, p.59) referred to this as ‘sensitising concepts’ in that researchers become sensitised to their own position prior to commencing the study. Researchers check themselves against the data they are analysing and can later use the memos related to the sensitising process. In this process, the researcher is checking out and becoming aware of where they are positioned in relation to the study phenomenon. Positioning of the researcher also occurs during the study. The researcher using grounded theory method becomes immersed in two worlds. They work to understand the participants’ world and at the same time maintain enough distance to ask questions that are about the everyday world of the participants (Blumer, 1969; Bowers, 1988). Both processes require the researcher to take the role of other and to be able to reflect on his or her own position in relation to the field of study. Another dimension to consider, which impacts on both these processes, is how literature informs a grounded theory study.

The use of literature in a grounded theory study

An examination of concepts around the field of study can also assist in the sensitising process. The perspective here is that in grounded theory everything can be data that informs or explains the field of study. The researcher is required to have a beginning grasp of literature from that field and a beginning grasp of possible related concepts (Strauss, 1987; Strauss & Corbin, 1998). For example, in preparing for this study about how residents influence their care and quality of life, I read around the concepts of satisfaction, influence, work and expectations from my own and related disciplines to begin to understand how these may be in operation in the field. I did not however, conduct an exhaustive literature search focused on the field of study so that I did not come to the study with too many preconceived ideas.

Literature is not dismissed; it is used differently in grounded theory. During the analytic process, I returned to the literature related to my initial dimensions to inform myself how people operate differently in different constructions and to check whether other research has revealed similar concepts. For example, during early analysis, the communal nature of the facility featured as a significant developing concept. As noted earlier, I perceived that aspects of the resident community were different to, and almost separate from, the staff working in the community. I searched for literature around the concept of community. An example of the literature I read included the notion of community from the perspective of those who are homeless (Young, 1996), relationships in a remote Australian community (Holcombe, 2004), and the perspective of community from couples with physical disabilities (Royce-Davis, 2001). The reading then led me to consider questions in interview and in analysis, which focused on voice, silence, marginalisation, inclusion, power dynamics and strategies employed to live in the RAC community. Literature in this context is data and is informative throughout the study sensitising the researcher to emerging concepts and raising further questions for examination (Schreiber, 2001).

Finally, researchers are connected to the field of study in ways that are often unseen and they are interpreters of data. By becoming sensitised to their own theoretical perspectives and learning to work ‘marginally’ (Park cited in Bowers, 1988, p. 44), that is to become both immersed in, yet distant from the field of study, researchers work to remain focused on the participants perspectives. The use of memos to document their thinking, their questions and decision points about what concepts to pursue, assist this process. Finally using colleagues and supervisors to discuss and challenge findings and decisions are the methods grounded theorists use to ensure that the explanatory theory they have developed has arisen out of empirical data (Corbin & Strauss, 2008).

Data collection considerations: Interviewing

“Interviewing is one of the most important aspects of doing grounded theory” (B. J. Bowers, personal communication, April, 2004). I was not new to the process of conducting a grounded theory research study. I had completed a number of studies prior to commencing this study for my doctorate. During previous studies, including

the study presented in this thesis, I had come to the conclusion that every day in research presents an ethical dilemma. I would like to think that I had come to manage this effectively; however, this study reminded me that every interview creates a new interactional space in which both the researcher and the participant actively participate and decide what to disclose.

Nunokoosing (2005) suggested that there is no such thing as a structured or unstructured interview; as all interviews are structured. Instead Nunokoosing proposed that the interview structure can be positioned along a continuum according to the degree of researcher control where the interviews are either more open or closed. Any interview question regardless of the focus, frames the response. “Tell me about living in residential aged care,” indicated to the participant my interest in their life in this particular context. Additionally, this question provided participants with the ability to control the conversation and choose where they would begin. Without fail, all residents began with who they were in terms of their history, their family, their interests and their hobbies. Who they were as people became significant in the analysis. Self perception mediated many of the strategies participants used to live their life in RAC. For example, some participants indicated that they were shy or they enjoyed people or they were a loner. During data analysis, it became clear that this self perception influenced their position when *living a communal life*, a major dimension of managing life in RAC. Thus, while participants took the lead, the nature of their lead enabled me to understand, more fully, their perspective of self and the world, and fitted with my research intent of staying with the meaning that participants make of living in RAC.

The interview as interaction

From a symbolic interactionist perspective, both the researcher and the participant are active within the interview process. Both researcher and participants have internal and external dialogues occurring. Both also have particular histories, cultures and perspectives which they bring to the interview (Bowers & Schatzman, 2009). Within the context of the interview, both will make decisions about the depth and nature of the interaction (Nunokoosing, 2005).

There is no interview that is without power relationships (Holstein & Gubrium, 2003). On most occasions, the power resides with the researcher. Certainly, the accountability rests with the researcher. The relationships created through this interactional interview space can blur the boundaries between roles of researcher and health professional. While there may be some therapeutic outcomes from a research interview the purpose of the interview is not therapeutic. This idea is echoed by Nunkoosing (2005). My understanding is that when the researcher moves from researcher to professional, they have repositioned themselves; and the aim of the interview has moved from understanding the meaning that participants give to the events in their lives, to a position of assisting and helping in a therapeutic context. As researcher I was very aware that I could, on occasions, find myself in a situation where I have a professional duty of care which overrides the continuance of the research interview. Health professionals are usually skilled in developing rapport and effective therapeutic relationships. Those skills are readily transferable within the health research setting where an effective researcher-participant relationship can be developed in a short space of time. What do we need to take into account in this interactional space? What accountability do we have as researchers in this context? The accountabilities mentioned here include the researcher role, the degree of disclosure, discomfort and the power relationships which exist between researcher and participant.

Researchers who are health professionals make decisions about the boundaries of their interview. During interviews I worked to ensure residents could both hear and see me as much as was possible. Additionally, on a number of occasions, I checked comfort and asked whether the resident wanted to continue. The physical difficulties encountered during interview included listening to residents with weak voices, providing water for those who had dry mouths, sitting at a distance suitable for participant's hearing, and suggesting that the interview cease so that a RN could provide pain relief for a participant. On all these occasions, I was aware that my RN lens provided the ability to consider and respond to these participant situations.

Attending to participants' comfort set the scene for a reasonably relaxed interactive interview and responses during the participant's introduction of his or her life, enabled a rapport between us. There were also risks inherent in developing an interactive space in which intimate details of life were disclosed. The comfort of having someone actively listening and attending can lead participants to disclose more than they would ordinarily talk about. "Researchers have become aware that they have established a relationship with their interviewees which renders the respondent vulnerable, and the researcher responsible" (Hart & Crawford-Wright, 1999, p. 206). Additionally, in interview, participants are constructing meaning and may not have considered some issues before. The researcher's questions may lead them to talk about more deeply personal issues than they had originally planned. Indeed, this has been my experience when conducting this research. There have been instances where participants have revealed very distressing events which occurred prior to entering aged care. There have also been occasions where participants revisited recent losses or distresses which have influenced their lives in RAC. The question becomes whether it is satisfactory that what a participant discloses can be used as text for the analytic process.

There is debate that if someone signs an informed consent to a research project, which has been clearly defined, they will be making decisions about their level of disclosure. On the other hand, if we think of the interview as a construction that is ever developing, how can we consent to something that is not yet fully constructed? According to Smythe and Murray (2000), "in process consent, informed consent is a mutually negotiated process that is ongoing throughout the course of the research rather than something obtained just at the outset" (p. 320). My position throughout the study has been to employ the notion of process consent. During fieldwork and interviews, I constantly referred to myself as doing research in the facilities. If participants became distressed, I would stay present and when appropriate, ask whether they would like to stop recording. In some instances, I stopped recording because the participant's story had triggered long past difficult memories. When the participant became calm, I talked about the recording, informed them when I had ceased the audiotape and discussed the use of the remainder of the audiotape.

There is, however, an additional aspect to this discussion which relates to the therapeutic nature of the interview. Writers have referred to the qualitative interactive interview as having potential helpful properties for the participant as they recount and reflect on particular situations (Corbin & Morse, 2003; Nunkoosing, 2005). On one occasion, during interview, a resident talked about a distressing incident which had occurred many years earlier. Additionally, she recounted an incident of conflict which appeared unrelated and which had occurred in the facility. The facility incident had led her to cease a much enjoyed activity. After the interview, I reassured the resident that I would not disclose details of the initial incident in my research. The morning following the interview, she went out of her way, calling to me down the corridor, to let me know she was resuming the lapsed activity. Her affect indicated pleasure and excitement. The juxtaposition of a research interactive interview and the subsequent shift in activity may have been coincidental; however, her searching, to let me know her actions, indicated to me that somehow talking had made a difference. For me the research process is an ongoing ethical concern as I interact with research participants during interviews and their texts during analysis. Keeping the notion of process consent to the forefront has assisted me to recheck consent throughout the data collection process.

While this study focused on residents, staff were considered an integral dimension of what Bowers and Schatzman (2009) named “What all is involved” (p. 103). Staff, like residents, responded to interview and fieldwork in a variety of ways. Some staff were eager to talk and did not set limits to the interview. Other staff, afraid for their positions, asked me to limit how I reported data. A few staff did not want to be audio taped but permitted note taking. Many staff became distressed and cried during interview as they recounted their experience of work with residents and with other staff. In particular, staff distress occurred as they addressed the gap between what they would like to provide for residents and what they perceived they could provide. Some staff decided to present as compliant with management policies when they perceived the policy to be negative for the residents. Their actions, at these times, were to quietly and privately go against the rules. One example involves assisting residents with personal laundry when management had refused the resident assistance. During times, when I sat talking with staff, I reiterated my position as

researcher and, at times, sought permission to use what we were talking about, if the subject was fraught.

Data collection considerations: Fieldwork activities

This study included fieldwork activities which I named participant observation. I was participating however, in resident activities. When sitting with residents in the dining room, I was receiving care from staff who served me. I experienced the difficulty of interaction between residents during meals; the way in which staff were attentive to, yet also surveilling residents. I was keenly aware that this area was a site of intersecting needs. For the resident these needs were for interaction during meal times. For the staff, the needs were for monitoring, providing medications and delivering global news. While staff needs appeared to be met, residents' needs were more difficult to meet. This aspect of living in RAC is presented in detail in Chapter seven.

My initial fieldwork activities raised some questions. I had entered a world of residents. That world was very different to the world that I knew as a staff member. I struggled with the notion that there were two worlds to these communities: a resident world and a staff world. I was perplexed about if and how these worlds came together. I was also surprised. I had considered I was an effective RN. I began to wonder whether that was so. When residents appeared well and were largely self caring, they had little to do with the staff. When they were unwell, staff were usually present and attentive. Some residents had indicated that they missed the staff attention when they were well and not in need of staff care. They also indicated that staff would acknowledge them as they passed through the facility; however the depth of interaction waxed and waned. Initially, I developed a concept which I named the staff work path in order to figure out when and how residents got to interact with staff. An early dimensional map is presented in Appendix I.

As the fieldwork, interview and analysis developed, I began to see that staff actions actually shape residents' expectations in real and ongoing ways. The shaping was sometimes positive and sometimes negative; occurred in a variety of circumstances and influenced one or more of the dimensions of the resident's life. For example, I noticed a resident who was very quiet during a residents' meeting. Later in interview

he explained his silence. During a previous residents' meeting he had raised a situation and perceived the staff response to him to be demeaning. He complained about that response and thereafter received what he called "the cold shoulder for a fortnight ..." (Abe/317). The consequence of this incident was that the resident withdrew from speaking publicly because he did not want to return to the "black list" (Abe/219). His response to the staff action occurred in the dimension conceptualised as *living a communal life*.

Fieldwork provided added data to resident and staff interviews as I discovered reports of both played out during fieldwork. For example, residents reported that particular staff were attentive, listened to their concerns and acted on those concerns as best they could. I observed these actions, heard them from various residents and staff, and saw the pattern of residents' responses to particular staff. Because of sustained fieldwork, data developed depth and richness as I saw how residents adjust their actions constantly during the course of the day. The previous concept of the staff work path changed as the concept of shaping residents' expectations developed depth and richness and became a major condition that influenced residents' lives in RAC.

Data collection and analytic considerations: Writing the research

The notion of process consent and ethical research behaviour moves beyond the recruitment and interview or fieldwork activities into the writing and publications related to the study (Hadjistavropoulos & Smythe, 2001; Smythe & Murray, 2000). During interview and fieldwork, residents revealed times when they *acted as if* purposefully to hide their actions. Where there was an instance which would have identified the resident, it has not been used in this thesis. Rather, if different actions demonstrated the same concept, the alternative was used. For example, many residents noted that they needed to sign out of the facility and note in writing where they were going. Figuring that it was no one else's business where they went, they would put a false destination. Because this *acting as if* was used by a range of residents, it was used to demonstrate the concept in the findings chapter.

Additionally, the concept could be demonstrated by other actions for different purposes. One such example is *acting as if* residents were admiring the scenery when in fact, they were catching their breath or relieving their pain in order that they could join the community for activities or arrive at a meal on time. *Acting as if* became a prominent feature of *preserving the self*, a major dimension in living life in RAC. The concept also demonstrates how active residents are in meeting their own needs and making decisions about what they do or do not reveal.

Staff also provided examples of responses to residents which could be individualised. To demonstrate the grounding of concepts, examples from field notes and interview data are required. To protect participants' identity as far as is possible, the writing of this thesis required consideration of the concepts as well as careful sifting of interview quotes. On all occasions, the participant need was prioritised over the research. Indeed, qualitative research ethical dilemmas are many, yet an awareness of them is an important researcher responsibility.

Developing a rigorous study – Trustworthiness and transferability of findings

How do we know that our findings are representative of the study phenomena? In grounded theory, the research question must be related to the research aims, be appropriate for the research phenomenon and data collection must follow the logical direction of analysis. The researcher needs to demonstrate that analytic decisions follow directly from the analysis that is grounded in empirical data (Strauss, 1987). All processes contained within the grounded theory method need to be evident in the study documentation and demonstrate this process of internal consistency. Tracking this process is to be able to explain to colleagues and supervisors why particular theoretical decisions were made and how the analysis directed the researcher to ask particular questions of particular participants. Participants also are important for feedback about the study findings.

Member checking

A grounded theory researcher is aiming to understand and explain the processes that participants use in their everyday life. When the researcher has been effective, participants' responses are positive and exciting as they become aware that another has understood their world. A rigorous and well-executed grounded theory research

will demonstrate to the participants their actions, how they change in different contexts, what works for them, what gets in the way and how they experience the outcome of all these factors (Schreiber, 2001). For example, when I spoke with residents about my findings, they could place themselves in various dimensions of living life in RAC. When I spoke about continuous adjustment, one resident pointed out that he had recently given up driving his car and recounted how he was now checking out alternative transport and adjusting so that he could continue to visit friends outside the facility. Another resident told about changing her activities to accommodate her preferences and interest. I have also had the opportunity to present these findings to various groups working in aged care. Their feedback has been positive and they clearly see the processes in action. In another case, a staff member working in the residential disability sector could also see how these processes operated in their area. These responses have confirmed the findings as explanatory and transferrable to similar settings. Transferability in grounded theory relates to the processes rather than a replication of the study. A grounded theory study is not considered to be replicable however the processes can be transferred to other settings. The feedback from a range of colleagues and staff working in other settings demonstrates that they observe similar processes in their setting.

Analytic pathway

Grounded theory analysis has many times been described as ‘messy’ and non-linear. This is because analysis and data collection occur concurrently and analysis directs further data collection (Bowers, 1988; Bowers & Schatzman, 2009). In grounded theory, data analysis begins after the initial data collection. Data are examined line-by-line and coded according to dimensions related to the study phenomenon. In dimensional analysis, Bowers and Schatzman (2009) caution against early conceptualisation and encourage the researcher to stay open in order to ensure rich data which “recognises the complexity of social life” (p. 103). The analytic process involves considering dimensions related to the coded data. These dimensions involve who, what, when questions, as well as details of perception which lead to the meaning that participants’ attach to events as well as the actions and responses which arise out of those meanings (Bowers, 1988; Bowers & Schatzman, 2009; Schatzman, 1991; Strauss, 1987).

Gradually, as shifts between data collection and data analysis continue, the research process moves from a broad examination around the edges of the study phenomena to a focus on the most salient features that participants have revealed about that phenomenon. Initial codes are developed into conceptual categories that are examined for their relationship to each other. Out of an ongoing examination, sometimes involving a return to the original data collection, these conceptualisations are further abstracted into a theory that gives explanatory power to the phenomenon that is the focus of the study. Data collection is usually complete when the researcher is finding no new constructs related to the study phenomena (Bowers, 1988; Strauss, 1987). While grounded theory method involves a particular analytic process that is focused towards building theory directly from the everyday life of the participants, those researchers using dimensional analysis are not directly concerned with a central basic social process. The concern for dimensional analysis is articulating the complexity of social life as interpreted from the field of study (Bowers & Schatzman, 2009).

This study proved to be complex. The three main dimensions of resident's lives have been conceptualised as *presenting an acceptable self*, *living a communal life* and *preserving the self*. Within these three dimensions, residents consistently adjusted within and between each dimension. Added to that, interactions with staff shaped residents' lives leading to further adjustment. Finally, somewhat removed from residents, however also causing adjustment, were the environmental influences which were both internal within and external to the facility. Appendix J is an early diagrammatical representation of the process of continual adjustment. Appendix K is the final diagram of the process of continual adjustment. Detailed findings are presented in Chapters five, six and seven. Because of this complexity, I have chosen one concept to demonstrate the methodological and analytic development which occurred in this study.

Data analysis revealed that residents worked to *present an acceptable self*. The process of analysis involved line by line coding of early interviews, discussion with supervisors and the grounded theory group followed by writing memos (Appendices L & M) and developing diagrams. The following table (page 61) focuses on how residents worked to look good and *present an acceptable self* even though they were

feeling unwell. This initial analysis developed into a concept of *acting as if*. At this stage of analysis, the concept of *presenting an acceptable self* was not fully developed.

Table 1: Looking good feeling unwell

Data	Coding	Concepts	Category
<p>Because you look all right and because you still sort of want to brush your hair and put a bit of lipply on, you know, you're all right, ... But sometimes I say a prayer at that statue, and I walk up that road and say get me back okay, you know, that's how I feel (Esther/907).</p>	<p>Looking good Making an effort Using inner resources Feeling unwell</p>	Adjusting	
<p>People say ... I wish we were as good as you when we're 84. But they don't see me first thing in the morning when I'm struggling out of bed, oh me back, or me shoulder or legs (James/680).</p>	<p>Invisible pain Visible wellness Perceiving wellness (others) Struggle towards action</p>	Putting up with it	Acting as if
<p>I don't think they know how much a little effort causes me to be breathless. I don't tell them that, but I don't and it doesn't matter, I'm managing all right (Sheila/125).</p>	<p>Keeping silent Managing breathlessness Limited reserves Minimizing impact</p>	Presenting as OK	
<p>...it leaves your leg feeling like a pile of old bricks, this one you say, 'kick forward' and the reply comes back half an hour later, 'who me?' ... There's nobody much to tell about it because nobody can do anything much about it. (Geoff/76)</p>	<p>Experiencing disability Keeping silent Perceiving no relief</p>	Feeling unwell	

Congruent with dimensional analysis, the analysis is left open rather than conceptualised early in the process (Bowers & Schatzman, 2009). It can be seen here that early analysis shifts and develops as the researcher looks for the complexity within the field of study. As this analysis developed, it became clear that many residents worked to present *an acceptable self* to the community. However this adjustment did not always include the concept of *acting as if*. Further analysis answered the questions about the purpose of working to *present an acceptable self*, how residents find out what is acceptable and what strategies they use. Additionally, during analysis I examined data where conditions led to residents deciding to forgo the notion of *presenting an acceptable self*. The following memo is an example of this developing analytic process.

Memo: Presenting an acceptable self – Acting as if

In response to the situation of feeling unwell and wanting to continue (not throw in the towel; keeping on trying) **adjustment strategies** are put in place. These include adjusting the pace, timing and sequencing of activities.

Pacing: For example, stopping to admire the garden when losing energy out walking – walking slowly

Timing: Having shower in the evening rather the morning because it takes so much energy and the resident wants energy for morning community activities
(? **balancing energy use**)

Sequencing of activities: Doing more in the morning, then resting for energy increase to have evening shower; Washing hair on particular days

The aim of these activities is to be able to maintain energy and “keep trying”
(R 22)

Avoid particular activities where sitting too long (bingo – hard chairs)

I am not yet sure that these activities are about presentation of self, or about living a communal life or preserving the self. It may be that some aspects of these strategies will find their way into dimensions other than presenting the self.

It may be that acting as if has multiple purposes. Residents and staff have talked about the reluctance residents have to shift into high care and acting as if may be a way of delaying such a shift when the resident is aware that their health is deteriorating and they need more assistance to maintain their life.

Additional data collection and analysis turned to the complexity of the dimension of *presenting an acceptable self* and *acting as if* became a strategy related to preserving the self. Analysis did reveal the effort of *presenting an acceptable self* even when unwell and, *acting as if*, was one strategy; however the purpose for *acting as if* related to *preserving the self*. The next set of analytic questions arose from returning to the initial analysis and included the conditions under which residents shifted their strategies to *present an acceptable self*. Using constant comparative analysis within and between data this dimension began to develop depth and richness. The following analytic questions and table (page 64) demonstrate the dimensions and complexity of this concept.

How do residents figure out what is acceptable? What do they do when they discover what is acceptable? Does being acceptable look different to different staff or residents? When do residents **override** the impulse to present an acceptable self? Using theoretical sampling, I began to interview residents who were relatively new to residential care in order to track the process of “getting to know”. Getting to know was a phrase that many participants used when they talked about entering aged care. The concept of *presenting an acceptable self* remained unclear as analysis led to the concept of establishing an identity and contributing to the community fitted with *living a communal life*. The focus then shifted further into how residents came to know an acceptable self.

Theoretical sampling

As noted previously, the data from the initial fieldwork and interviews generated questions for the ongoing in-depth interviews and fieldwork. Analysis of the concept *presenting an acceptable self* moved to the dimensions of the concept, with a focus on the perspectives of many participants, the actions involved and the consequences. An evolving recruitment process was used, that is, one in which the researcher purposefully recruits participants who can answer questions raised from data analysis. As data analysis proceeded, theoretical decisions were made about which staff or resident role could provide additional data. In the example above, I purposefully sampled residents who were relatively new to the facility. In other instances, I purposefully recruited staff who could provide further information on their perspective regarding residents’ lives.

Table 2: Presenting an acceptable self: Developing concept

CONCEPTS	SUB CATEGORIES	CATEGORIES	CORE CATEGORY
Interacting with other residents		Keeping an eye on myself	
Learning expectations	Getting to know	Deciding how to be	
Watching, noting & asking	paying attention		
Arriving with some knowing			Presenting an acceptable self
Having a job	Contributing	Establishing an identity	
Being helpful			
Keeping an eye on myself	Joining in		
Getting on with it			
Finding a way to complain			
Putting aside own preferences			

Previously, in this chapter, I presented an excerpt about what staff noticed about residents. Because many residents had cited the dining room as a place where they wanted to get to know about the residents and the facility, but found the dining room a difficult and noisy place to enact this strategy, I turned my attention to what was happening in the dining room. The dining room as an environmental influencing condition became a focus of the findings in Chapter seven.

Theoretical sampling, through ongoing interviews, provided participants with the opportunity to describe in detail, their perspectives, and meanings of events, their actions and the consequences of those actions. According to Strauss (1987), all action is contextual. In addition to theoretical sampling through interviews, fieldwork provided the opportunity to gather further data which revealed the complexity of

action adjustment in different contexts and conditions and added richness to the developing concepts. Constant comparative analysis between in-depth individual interviews and fieldwork continued until theoretical saturation of the processes was reached. That is, until no new data about those processes was revealed and I developed explanations of the processes in action (Bowers, 1988; Bowers & Schatzman, 2009).

“What all is involved here” (Bowers & Schatzman, 2009, p. 103)? In the final analysis, the concept of *presenting an acceptable self* led to the categories of *building an information framework*; a recursive process which occurs initially on admission and is continuously adjusted under the condition of resident or staff feedback or changes in the two major dimensions of *living a communal life* and *preserving the self*. Therefore, as analysis developed, categories moved and were adjusted.

Conclusion

This chapter has focused on the principles and processes inherent in contemporary grounded theory methodology. In an effort to present what is a complex methodology I have used a range of examples to demonstrate the methodological and theoretical underpinning of grounded theory. The process of grounded theory is not linear and involves a movement between data collection and data analysis as the researcher works to understand the everyday interpretations and actions of the participants within the field of study. Supporting the researcher’s actions are important notions of the researcher’s ethical responsibility and his or her approach to the collection and interpretation of participant data. Important also are the researcher’s skills of knowing his or herself, reflecting on his or her own position in relation to the data and developing the ability to stay with the participants’ data. The methodological process of this study was supported by grounded theory groups, supervisors and colleagues so that congruence between the researcher perspective and the participants’ data could be maintained thus ensuring the findings were trustworthy. Finally, the use of member checking demonstrated the transferability of the processes explained in this study. There was a second aim for this chapter and that was to lead the reader into the findings chapters. The next three chapters present

the dimensions of living a life in RAC followed by two chapters outlining the conditions which influence the residents' actions towards living that life. Enjoy!

Chapter Four: Setting the Scene

Residents' work of living life in residential aged care: A process of continuous adjustment

I begin this chapter with a description and comparison of the study sites, a broad description of the nature of participants' communal life, and an overview of the theoretical model generated from a dimensional analysis of participants' interviews. The intention of this chapter is to lead the reader into the scene within which this study was conducted and to present a broad overview of the findings. Chapters five, six and seven lead the reader through a detailed explanation of the process of continuous adjustment.

The facilities

Data collection for this study was conducted in two Australian RACHs. Facility one, Weave Lodge, comprises independent living units, a low care area catering for 76 residents and, in the same building, a high care area catering for 30 residents. Facility two, Fen Home, administered and supported by a central corporate body, is low care and caters for 40 residents.

Both facilities are staffed by RNs, ENs and PCAs. Weave Lodge, because of its high care residents, employs RNs, ENs and PCAs over 24 hours. The staff participants' demographic data is presented in Appendix C. Fen Home employs unregistered sleepover staff who can access on call RNs. The sleepover staff work until approximately nine pm and then sleep in the facility to be available should residents require attention. All residents in Fen Home wore vital call apparatus for use in case of need.

Both facilities were not for profit and were aligned to a particular community philosophy, one a spiritual philosophy and the other a veteran foundation. These philosophies were not exclusive and residents were not required to subscribe to the main community focus or the philosophy of either facility. Both facilities were accredited through the ACSA and had received positive accreditation reports at the time of data collection. There were similarities and differences between the facilities.

The physical surroundings were broadly similar; however, there were differences in the pattern of resident connection.

Physical layout

Neither facility was new. Both facilities accommodated single bedrooms with ensembles for all residents. Corridors were long and access to internal communal spaces could be a challenge for residents whose physical condition inhibited walking long distances. Access to gardens and walks was from most residents' bedrooms. In both facilities, residents had the option of caring for the garden or developing a 'potted' garden outside their room. In Weave Lodge, some residents were involved in maintaining a vegetable garden, an activity initiated by the activities department. There were seating arrangements in the garden of both facilities to accommodate residents' varying levels of mobility.

In both facilities, there were opportunities for gathering in a variety of sitting rooms or alcoves. In these spaces residents could meet in small groups, entertain visitors or enjoy solitary quiet time. The facility entrance and the activities area entrance were 'gathering places' in both facilities. It was here that groups of residents sat and talked, read the newspapers, completed crosswords or watched the movement of staff, visitors and other residents. In general, groups of residents were visible wherever there was a 'hub of activity'.

Residents room sizes varied. Some bedrooms in Weave Lodge had adjoining doors for residents who lived together. These couples could choose to use one of the rooms as a sitting room. Rooms were furnished according to the residents' taste and preference so long as they stayed within the requirements of OH&S. Tea making and light cooking facilities were available in all residents' rooms in the low care wards of both facilities but not for the residents in the high care ward of Weave Lodge.

While the physical layout of the dining rooms was different within and between both facilities, the noise impact was similar. The dining room for low care residents in Weave Lodge was noisy due to the close proximity of the kitchen, the size of the room and the polished floor boards. Seating in this dining room averaged four residents to a table and while it could be expected that this size would accommodate conversation, many residents reported difficulty with meal time conversations. The

high care ward in Weave Lodge had a combined activities and dining room and could also be noisy as meal serving was again adjacent to the dining area. Resident interaction in the high care ward was facilitated in the main by staff, as many residents in this ward did not initiate conversation. In contrast, the dining room in Fen Home was slightly less noisy; however, the tables were large with the average seating six residents. Seating at the tables in both facilities was decided by staff though residents could request changes. Dining rooms in both facilities, despite the noise level, were revealed in data analysis as complex dynamic interactional sites for the residents' work of adjustment, connection and or disconnection. For the staff the dining rooms were sites for announcements, medication administration and monitoring of residents' health status.

Place as a pattern of resident connection

Many residents revealed that connection with others was a central feature of their lives. At the time of data collection, connection within the resident community and with the local community differed between facilities. Weave Lodge engaged in a range of external community activities facilitated by easy access to transport owned by the facility. This facility also used an extensive range of volunteers who accompanied residents on individual and group outings, conducted and/or assisted staff with activities (reading and discussion with resident groups) and special projects (a vegetable garden for one resident and individual pet therapy with a number of residents). There were approximately five diversional therapists in Weave Lodge and one diversional therapist in the 40 bed residence (Fen Home).

Fen Home was distant from a major shopping centre, was serviced by a public bus route and did not own a bus for group outings. At times residents from Fen Home joined with other facilities for outings. The diversional therapists accompanied some residents for shopping but in the main external outings were dependent on residents' ability to access the public transport system, afford a taxi or have family to take them out. In both facilities, very few residents had access to their own car to facilitate access to the local community. In both facilities some residents were too unwell to go out and their work of creating a life was focused on activities within the facilities.

Consequent to residence size and easier access to the local community, Weave Lodge had a different pattern of engagement to Fen Home with residents knowing some, but not all, people by name. Many people went out during the day from the low care area and their interests were external to the facility. For example, some residents were very involved with the local church. Additionally, some residents in this facility had moved from the independent units and continued previous activities with their friends still living in those units. For example, one resident took part in a weekly group activity which had been going for 10 years and had commenced prior to her admission to long term care. Others regularly visited friends still residing in the co-located units.

Fen Home, with limited access to the local community, was more internally engaged and connection to others focused, in the main, within the facility. Except for outings with family and friends, many residents spent their days within Fen Home. This facility had its own chapel, used on a daily basis by the majority of the residents. In this facility, with 40 residents, residents knew each other, though the nature of connection varied from acquaintance or conflict to deep friendship.

Communal life

Each aged care facility is a community. Regardless of whether residents have lived a communal life previously, the facility in which they currently live has its own unique culture. Findings from this study demonstrate that residents in aged care facilities live in a diverse community. There are various levels of engagement within the community. Relationship and connection can range from distant to close or angry and conflicted. Relationships can be of short or long duration. Depending on how they present themselves, residents can become insiders, outsiders or a mixture of both conditional on residents they are with at any particular time. They may be gathered in and valued by other members, tolerated or marginalised and isolated.

For some, living in this community provides opportunity for relationships with others; the ability to manage as independently as possible; a dwelling of safety and security and a measure of freedom. For some, living in the community has led them to feel wanted; yet for others, living in the community can be lonely and distressing. For all residents, living in this community projects a number of meanings to

themselves and to the outside world. It means that they cannot live in the place they have previously called home and it means that they are ageing. The one commonality which binds all members is that they are old. They see how ageing impacts various community members and they know their present and their future is vulnerable to health deterioration. Nevertheless, many residents continue to work hard to be a part of their community in some way.

Living a communal life involves living with difference. As one participant stated “you know it’s all stages of ability or disability ... and of character also” (Ruth/245). Learning the facility’s culture, what can and cannot be done, and maintaining a balance of being with others while living their own lives, both inside and outside the facility, involves effort. Energy is put into developing connection with others and looking for and finding meaning in helping each other. They find satisfaction in belonging to external interest groups and maintaining family relationships. At the same time, they navigate conflict and disruption with other residents and staff; face their own physical limitations and experience the major losses which go with having friends of the same age. Nevertheless, participants in this study continued the work of creating a life. This work was captured in the words of one resident who said it’s about “not throwing in the towel” (Esther/921). The three dimensions of living life in RAC: *presenting an acceptable self*, *living a communal life* and *preserving the self*, are broadly explained in this overview and demonstrate residents’ continued efforts related to “not throwing in the towel”.

Adjusting to create a life in residential aged care: A broad overview

The process of creating a life in residential care and adjusting that life is ongoing, dynamic and complex. Residents’ work to create a life comprises three major dimensions namely, *presenting an acceptable self*, *living a communal life* and *preserving the self*. Day to day adjustments occur in these three dimensions as residents strategise to live life in RAC. However major adjustments to recreate the life currently lived occur where there is a risk involved in continuing to live the current life or where the potential to expand their current life arises. At these times, residents enter a dialogue, either with others or within themselves, to decide what they are going to change in the life they are currently living.

Presenting an acceptable self, living a communal life and preserving the self

The three processes of *presenting an acceptable self*, *living a communal life* and *preserving the self* operate together to create a life for residents in aged care. From the time of admission residents enter a process to decide how they are going to present themselves to others. They work to discover the rules and the expectations required for communal living. They watch, notice and ask about timing of activities, and general patterns of life in the community. In particular they notice interactions between residents and between residents and staff to work out what is or is not going to work for them. From observations and interactions with others, they decide how they are going to interact with this new community. For example, one strategy towards presenting an acceptable self involves *acting as if*. Strategies for *acting as if* include being friendly when they would rather not be, attending activities which would not be their preference and modifying their behaviour according to other's feedback. One participant reported that, subsequent to feedback indicating she talked too much at meetings, she worked hard to keep quiet during meetings, thus adjusting her preferred way of being.

While the nature and intensity of community engagement is varied, residents strategised to connect with others in the setting in some way. One resident, new to a facility, noted that she needed to adjust her waking time so that she could attend to her personal requirements before breakfast. Her purpose was to connect with others during meals. Sometimes her strategy worked and sometimes it did not. For example, this resident described 'the silent table' in the dining room (Ruth/180). She reported that she found it difficult to get to know people when they did not talk. She could not adjust the table seating, so her alternative strategy was to get to know people during facility activities, at the various 'gathering places' for residents and when meeting people along the corridor where she was living.

Presenting an acceptable self, *living a communal life* and self perception are connected. Some residents described themselves as 'loners'. They reported that they did not go to the activities centre and had few close friends. Yet during fieldwork, I noted that the residents who self referred as 'loners' acted toward others respectfully, engaged in conversation with residents, helped other residents at meals and used humour to talk with residents they reported as 'not all there'. Thus while the notion

of loner was how they saw themselves, these actions constitute a level of ‘engagement’ with others. They *presented an acceptable self* when *living a communal life*. One example involved a resident who described himself as a loner; yet when walking to lunch indicated that he wanted to walk down a particular corridor so that he could “look in on his mate who wasn’t well” (F/N No. 2).

Living a communal life involves relationship development and reciprocity. In this study, reciprocal actions indicate the need for many residents to be able to give as well as receive. Residents take on jobs formally or informally. Some examples of recognised jobs include setting the table, assisting to prepare the chapel for religious services, delivering the morning paper to residents’ rooms and becoming a resident representative to management. Informal jobs included taking the responsibility to welcome every new person into the facility; standing up in defence of those who cannot talk for themselves at residents’ meetings, encouraging residents to join a particular organisation, making cakes in their room to share with other residents, doing shopping if they are going out, and making cards to sell for charitable purposes. Additionally, residents assist people who have difficulty walking or who have difficulty remembering times of events or directions to particular places of activity; those who had impaired vision and those who were not feeling well.

Preserving the self is the concept developed out of the residents’ work to meet their own individual needs. These needs included attending to their current health status, maintaining integrity with their particular values, setting boundaries to protect their privacy and maintaining a sense of self by maintaining connection with their family, friends and their life history. Residents’ connections to their life history involve bringing remnant activities to their life situation. For example, while one participant could no longer build his miniature railway, he still had the trains from that railway in his room.

Continuous adjustment

Residents report the need to adjust between *presenting an acceptable self*, *living a communal life* and *preserving the self*. At times one or more dimension of their life is foregrounded while the others are backgrounded. For example, if on one day a resident is not feeling well, *preserving the self* is foregrounded. Residents might

continue to *present an acceptable self* and attend meals in the dining room however may draw back on their usual level of engagement in the facility. The degree of foregrounding or back grounding was usually dependent on the degree to which the resident attaches importance to *preserving the self*.

Another example of residents shifting back and forth between the three dimensions of living life in RAC demonstrates how a threat to a person's sense of self causes a shift in their self presentation and engagement within the community. One resident talked about her strong sense of justice and fairness. When she perceived that her justice value system was being violated, she would work to preserve it. At these times, she would be public in her arguments with management or with other residents as she debated what she perceived to be justice issues. Her need to preserve justice outweighed her need to *present an acceptable self*. There were consequences for deciding to present an unacceptable self. While the resident did have strong connections within the facility, and engaged with the community on many levels, she was labelled as 'difficult' by some. The three dimensions, *presenting an acceptable self*, *living a communal life* and *preserving the self*, work together to create a life; and daily fluctuations cause a foregrounding of one or more dimensions and a backgrounding of others.

While some adjustment may be time limited, as a resident's health needs lead to a temporary adjustment, other adjustments change the pattern of the resident's life. The following example is illustrative of a major life adjustment. For one resident deteriorating osteoarthritis (health condition) changed her pattern of living. Her life shifted as her condition deteriorated and she was unable to leave the facility without assistance. As a result her activities were more focused towards the aged care community. Any outing now required assistance from family or staff. Life was adjusted for both her and the family and was noticeably different to her previous pattern of activity.

I remember I went over one day to catch a bus when my leg was getting really bad and I couldn't get on it, and the bus driver was apologising to me and I said, 'it's not you,' I said, 'it's me, don't worry about it.' But when I was coming home ... I walked in through the gate and the tears were running down my face. I felt a real fool ... and I thought, "Gee fancy not being able to get on the bus to go out". (Nancy/451)

The resident herself worked to set the parameters of what would change and what would not change. For example, she refused wheelchairs during outings. Outings became restricted to specialists meetings and previously enjoyed lunches with a family member ceased. The family shifted celebrations to the facility as the resident was unable to climb stairs into the family home.

Under these conditions, residents work to figure out how they will deal with changed circumstances; and the outcome is a changed pattern of living. They take up some ideas, they discard others. In the example above, the idea of a wheelchair was discarded. The resident in this example was determined to remain independent despite an increase in dependence “I find it difficult to ask for things to be done for me because of my independence” (Nancy/839). She was fully engaged in the resident community, taking part in activities, talking with friends, being active on behalf of other residents and when necessary, retreating to regain energy (*preserving the self*).

I don't like being shut up in a room all the time. If I'm ill yes, I'll stay here a week a fortnight if I'm ill, but if I'm well I want to be out doing things you know, so I go and do things. (Nancy/1010)

Conditions which shape residents lives

Two major conditions influence residents' lives. These are shaping expectations and environmental shaping. When either or both of these conditions are operational, the consequences result in the resident's life becoming enhanced, restricted or simply changed. Shaping expectations occurs in interaction with staff. How staff and residents perceive particular expectations works to shape residents' lives. When perceptions are matched, dialogue, negotiation and agreement are straight forward. However when perceptions are mismatched, residents use strategies aimed towards meeting their expectations. Additionally residents and staff together can realise resident expectations when, in dialogue, staff discover residents have assumed that an activity is not possible and staff are aware that it is.

When residents have an expectation to which staff are not responsive, their strategies include increasingly strident actions to meet the expectation resulting in becoming someone problematic. They may bypass particular staff to work with a staff member they perceive will be more accepting of their expectation or need or they may call in a proxy to act on their behalf (either family or staff) or they may decide to withdraw the expectation.

When residents, in dialogue with staff, talk about particular gaps in their life for example, missing their garden, staff can set about filling the gap by providing container gardening outside the resident's room. In another example, staff negotiated with family for a mobility scooter to assist a resident who was withdrawing from communal engagement due to deteriorating mobility. In these ways, some staff work to enhance residents' lives.

Staff also shape residents' lives by setting boundaries to residents' behaviour if they perceive that behaviour to be unacceptable, colluding with the resident if they perceive the facility rules are not meeting a resident's expectations or needs and working with the resident during times of loss and distress.

Environmental shaping

Residents adjust their lives continuously in relation to the environment in which they live. They change the timing, pacing and pattern of their day according to the spaces they need to traverse and the energy required to move from place to place. Many residents find short cuts to preserve energy or act as if they are admiring the garden when, in fact, they are stopping to relieve pain or catch their breath before moving towards the activity they are aiming for. Additional adjustments occur as residents encounter legislative requirements. For example, because of OH&S legislation, residents are asked not to assist a resident who is stumbling or who has fallen. Some residents adhere to that request, others ignore it. This condition demonstrates intersecting needs between staff and residents requirements as each figure out the tension between agreeing to rules, regulations and legislation.

There are aspects of this condition which, though distant from the resident, influence the residents' work to create their lives in RAC. The culture of the facility; the efforts to improve resident staff interactions; inadequate funding; staff education, recruitment and retention were all cited as problematic for the facility and an influence on residents' lives. For example, many staff reported being frustrated with the time taken to document resident care as required for funding. They also reported frustration with staffing levels, skill mix and negative staff responses to residents. In most instances their reports focused on the influence of these frustrations on residents.

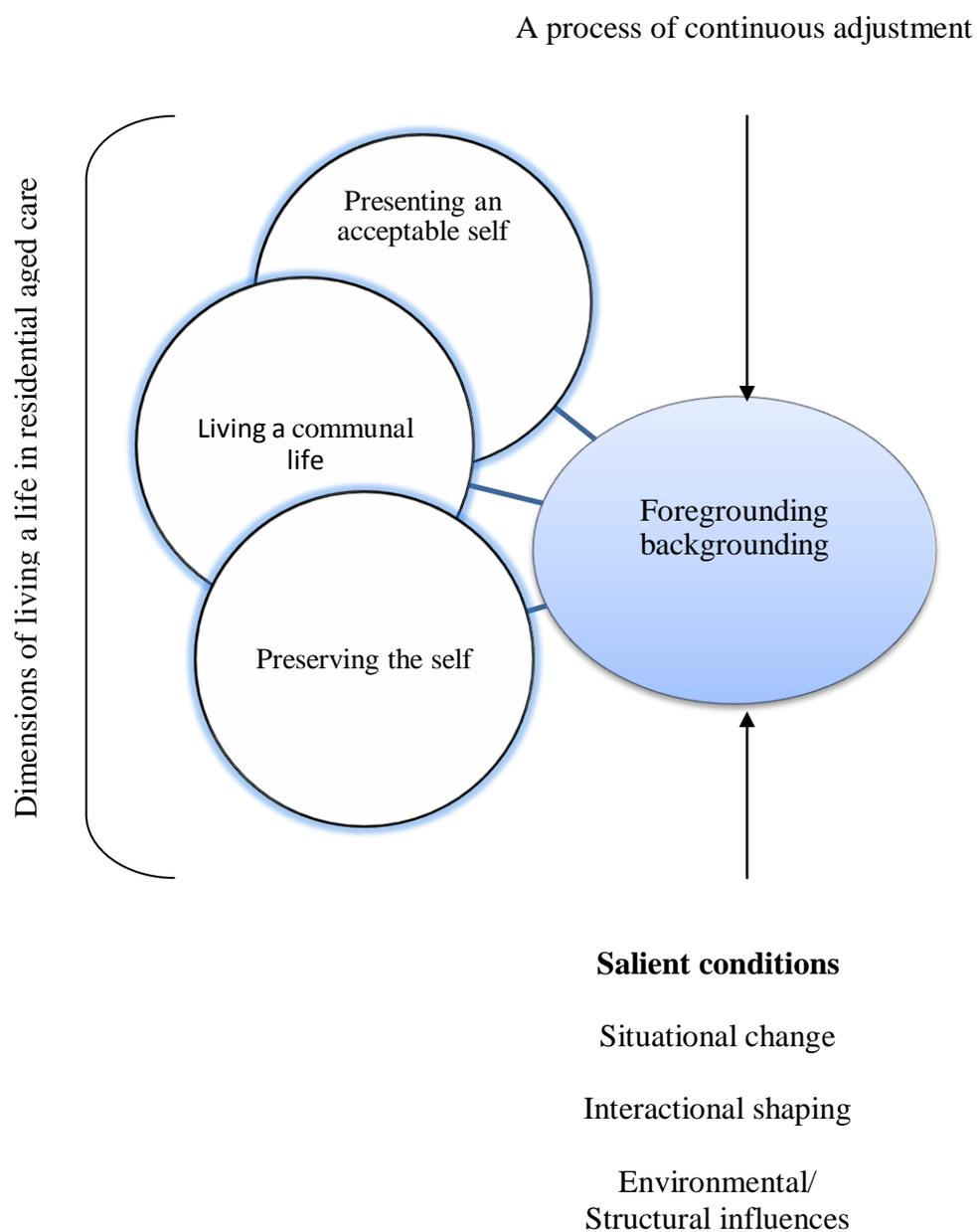
Conclusion

Creating a life in RAC involves *presenting an acceptable self, living a communal life and preserving the self*. Changes in everyday living can shift either one or a combination of these dimensions to the background or the foreground but may not change the way in which the resident lives the life he or she has created. A major change in these dimensions however, will shift the resident to adjusting to recreate his or her life pattern in the facility. Additionally, two major conditions influence and shape residents' lives. These include the shaping of residents expectations and environmental influences which shape the pattern of life. No participant was immune from the continual work of figuring out how to adjust their life in response to these influences. Each adjustment uses energy and requires some level of active negotiation and the development of new strategies. These findings, which are explained in more detail in Chapters five, six and seven, demonstrate that rather than being passive receivers of care, residents in aged care facilities are active and engaged with living communally and working to create their life in this setting.

Chapter 5: Living Life in Residential Aged Care: A Process of Continuous Adjustment

This chapter commences with the theoretical abstraction of the core process: *Living a life in residential aged care* and is followed by an in-depth explanation of the three dimensions of the core process: 1) *presenting an acceptable self*, 2) *living a communal life* and 3) *preserving the self*. This process is depicted in Figure 1.

Figure 1: Living life in residential aged care



The salient condition of situational change will be presented in this chapter while those of shaping expectations and environmental and structural influences which shift the process of living a life in residential aged care will be presented in Chapters six and seven. What is significant in the findings from this study is the continual adjustment that residents make, in order to live life in RAC.

Residents work to *present an acceptable self* to fit in, in some measure, with *living a communal life* while at the same time *preserving the self*. These three dimensions overlap and each interacts with the other. Participants demonstrate that their attention, at times, involves measures of all three and at other times, is directed to one dimension of their life. When residents experience the condition of situational change, namely a change in their situation, one dimension may be foregrounded while the others are backgrounded. The constant shifts between these dimensions demonstrate the effort that is required from residents while living a life in RAC. Each dimension has sub dimensions, involves residents' energy and can have a range of outcomes depending on the resident's decision making.

Presenting an acceptable self comprises sub-dimensions of building an *information framework* in order to get to know what is or is not acceptable. From the information framework, residents make decisions about how they are going to be and adopt a range of positions as they present themselves to other residents and staff in the facility. Information frameworks are developed as they interact within the facility and comprise foundation knowledge and subtext knowledge. Residents develop their information framework deliberately, incidentally and experientially in the process of getting to know. Information frameworks are developed over time and are adjusted during situational change. *Presenting an acceptable self* by getting to know, as a result of developing an *information framework*, may be influenced by residents' pathways to aged care, their perspective of aged care and their self perspective. These influences may facilitate or interrupt the residents' information framework and limit or expand their ability to live a life in this setting. Therefore, residents get to know, in varying degrees, what is acceptable and, consequently, craft the self they decide to present to the community. The process is circular and the decisions residents make influence *living a communal life*.

Concurrently with getting to know, in order to *present an acceptable self*, residents are *living a communal life*. The sub dimensions of *living a communal life* are *establishing an identity, connecting and contributing*. The processes involved include negotiating situations, gaining a reputation, adjusting and positioning the self within the community. Residents take what they know, integrated with their composite self, and establish an identity and announce who they are by their words, actions and presentation in communal living. The communal identity that residents present may well be different to their private identity and may belie their true thoughts and attitudes towards other residents and staff. When announcing their identity, residents present a composite self comprised of their current learning, their individual and personal history, and their self perceptions. The composite self is modified, changed and adjusted depending on who they are interacting with and how they have decided to live life in the facility.

The second sub dimension of *living a communal life* is that of connecting with the community. Residents connect with others to different degrees from very involved, cluster involved, passively involved and marginally involved. There is a relationship between the resident's self perception and the depth of their connection to others in the community. There is also a relationship between some residents' perception of others expectations in the community and their involvement in activities, leading them to take part in activities because they perceive that it is expected, especially by staff. Finally, a resident's connection to the community can be influenced by situational change, increasing ill health, improving health or loss of connection. Situational change then can expand or contract the degree of community connection in which a resident engages.

Additionally, residents *live a communal life* by contributing to the community in a variety of ways. Contributions may be public and thus visible, or private and not so visible. Contributions include taking on jobs around the facility, being involved or present at residents' meetings, and advocating on others' behalf. Private contributions include gifting others by assisting residents with mobility or way finding, shopping, and visiting residents who are unwell.

Living a communal life by announcing an identity, developing a range of connections and contributing, residents gain a reputation from others but also confer a reputation on others. Reputations may be positive, negative and mixed, and relate to a resident's attitudes, behaviour, physical or cognitive attributes and impairments. Reputations may also be conferred on a group of residents. Residents may or may not be aware of the reputation they hold. This process of *living a communal life* can be fraught as residents shift their perceptions of others, receive feedback from others and consequently further develop their information framework and decide to adjust their position within the facility.

However, for some residents, *preserving the self* is foregrounded during public forums. When some residents perceive an aspect of communal life is not just, they take the risk to speak out publicly. In doing so, their perceptions may or may not be met. When their speaking out publicly is not received by others, or by staff, the resident continues and *rocks the boat* or *withdraws* and *becomes silent*. For these residents, it is more important that they maintain what they perceive to be integral to them rather than adjust their presentation. Thus, the dimensions of living a life in RAC interact and influence each other.

Preserving the self includes the sub dimensions of *maintaining a private self*, *managing their own health* and *establishing a private space*. Maintaining a private self involves sharing intimate life details with selected others, maintaining what is perceived by the resident to be their values and integrity, reflecting on life before and now, and maintaining personal interests and hobbies. Sharing life details, with selected others, serves to reinforce the resident's identity while also creating a space where he or she can figure out how to solve particular problems.

To manage their own health, residents decide the pace, structure and timing of their day so that they can do what they choose during that day. Self care may be shifted to the evening in order to preserve energy for the morning. Times of rising and going to bed, similarly, are aimed towards ensuring energy is used to the best advantage. Most residents aim to balance the maintenance of independence with accepting help. Residents focus on getting their needs met, particularly when their health maintenance requires staff assistance. When the resident's perceived need matches the staff perception of that need, residents' needs are met without problem. When

perceptions are mismatched, residents increase their efforts to meet their needs and in doing so can become someone problematic. As mentioned in the previous paragraph, sometimes a resident who rocks the boat publicly can gain a reputation as someone problematic and can experience difficulty getting many needs met.

Establishing a private space focuses on the physical domain which residents furnish to their own taste, set boundaries to entry for some and invite others in. Boundary setting can be open or subtle and include pretending to be going somewhere in order that a resident is not admitted to their room. Residents report ownership of this space and resist staff attempts to change their space. Differentiation is made between my home (my room) and the home (the rest of the facility). It is in this space that residents perceive they can be their true self. The space, however, is open to staff and in this sense becomes a shared space and intersects the resident's notion of my home.

Experience in all three dimensions leads to further learning. The process is circular. For example, during the process of working to get needs met, while *preserving the self*, residents further develop their information framework as a result of experience and may adjust how they present themselves in the future. Additionally, residents may decide that the effort to maintain these three dimensions of living life in RAC is not worth the gain; and may then adjust their position within communal life and become someone who interacts with everyone on a superficial level while they spend most of their time alone. Finally through all dimensions, residents *act as if*. A resident's health may be deteriorating however to maintain his or her privacy, and to avoid transfer to another facility, he or she will *act as if* they are well. Similarly, though residents may have private negative thoughts about another resident or a staff member they will *act as if* and greet the person or joke with them, and generally present a positive regard for that person.

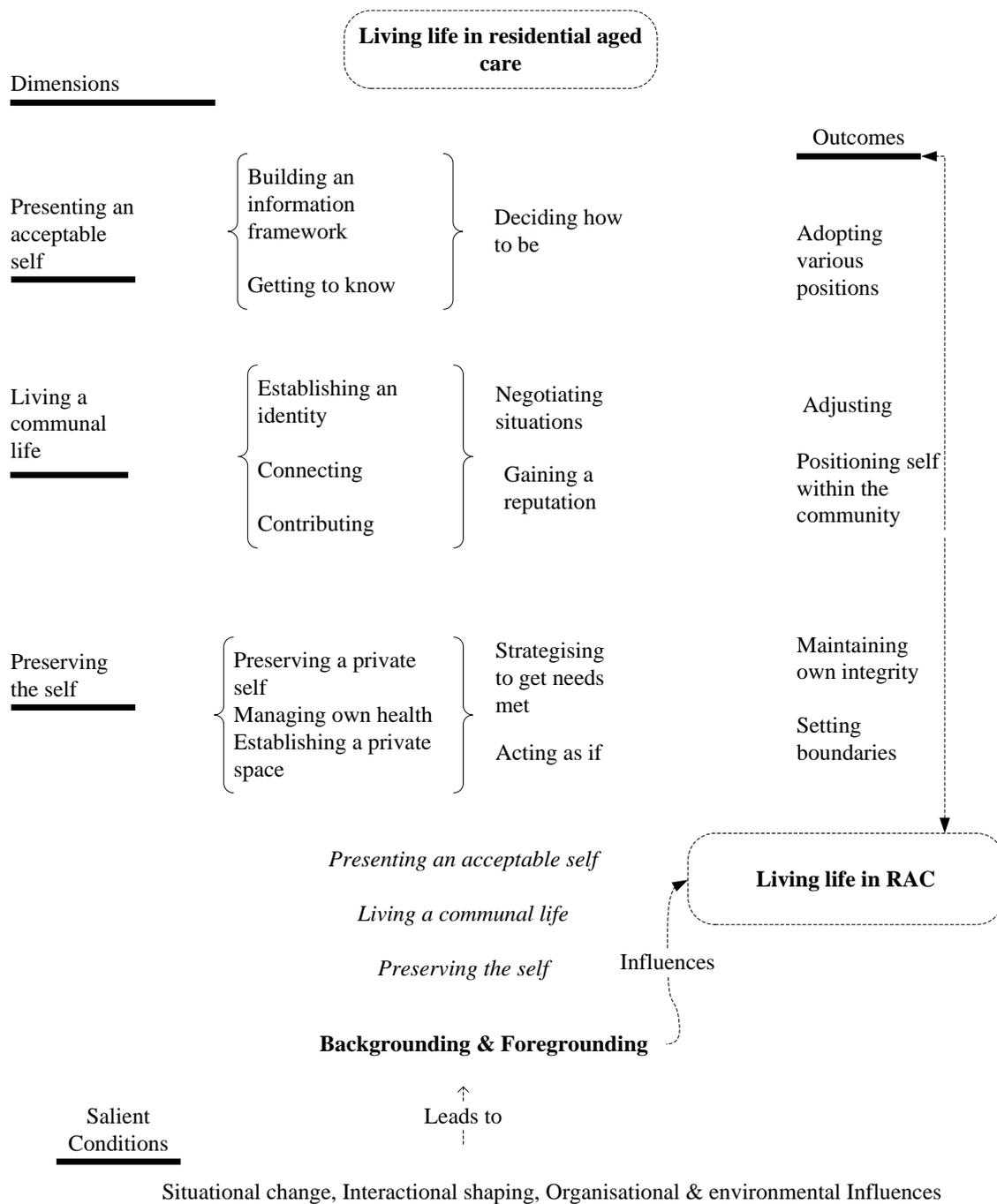
The three dimensions of living a life in RAC, then, can be seen as continuous and ever changing in terms of the nature and degree of each dimension. Regardless of how long residents have been in residential care, situational change, for example, their own deteriorating health, the loss of friendships and family through illness or through conflict creates a feedback loop where each dimension requires adjustment. A resident may have been very involved in *living a communal life* by connecting at a deep level with others, contributing by

being very involved and maintained their own personal space. The same resident's health deterioration or loss of friendships can lead to withdrawal from communal living and shift them towards building his or her information framework further as he or she figures out how to adjust his or her life to accommodate the changes. Thus how they *present themselves*, and *live a communal life* while *preserving the self* will all undergo periods of adjustment. It is almost as if a new life needs to be created for some residents. While the resident's need to adjust may be visible, and spoken to other residents and staff, it may also be that the resident *acts as if* while privately experiencing major adjustment. Figure 2 (page 81) outlines these dimensions of creating a life in RAC. The three dimensions of living a life in RAC will now be presented in depth.

Presenting an acceptable self

Presenting an acceptable self, while living in RAC, is a phased process which begins with admission and, for most, continues, although in different forms, for the duration of their residency. Presenting the self is a dynamic and complex process where observing, checking, assuming and acting are strategies used by all participants to differing degrees. This dynamic process is dependent on interaction with the facility environment and those who live and work within the facility. Presenting the self carries awareness that others in the community will see and judge, and that can influence how satisfactory life might be in the facility. Consequently, the purpose of their efforts towards *presenting an acceptable self* reflects the communal nature of life in RAC. "I like to be there [at activities] for various [reasons], you know to be part of the establishment" (Helen/347). During fieldwork, I asked a resident how she was, as on the previous day she had been unwell with a cough. She replied that she was much better because the previous night she had burrowed beneath the blankets and had a "good cough". This resident chose not to present herself as unacceptable because she perceived that people "don't like to hear you cough so it's best to do it when no-one can hear because it is not nice" (F/N No1).

Figure 2: Creating a life in residential aged care



Understanding what *an acceptable self* is arises out of learning about the setting they are living in; for example, ‘*getting to know*’ other residents’, rules and expectations and ‘*deciding how they are going to be*’. In other words how they are going to *present an acceptable self*. Ruth encapsulates the dimensions of adjustment which begins with getting to know.

I think that it’s the experience ... of moving and the adjustment to make to a new place, even the surroundings of the place and to get to know people and then the program and the timetable, the whole lot, and what’s expected of you. (Ruth/482)

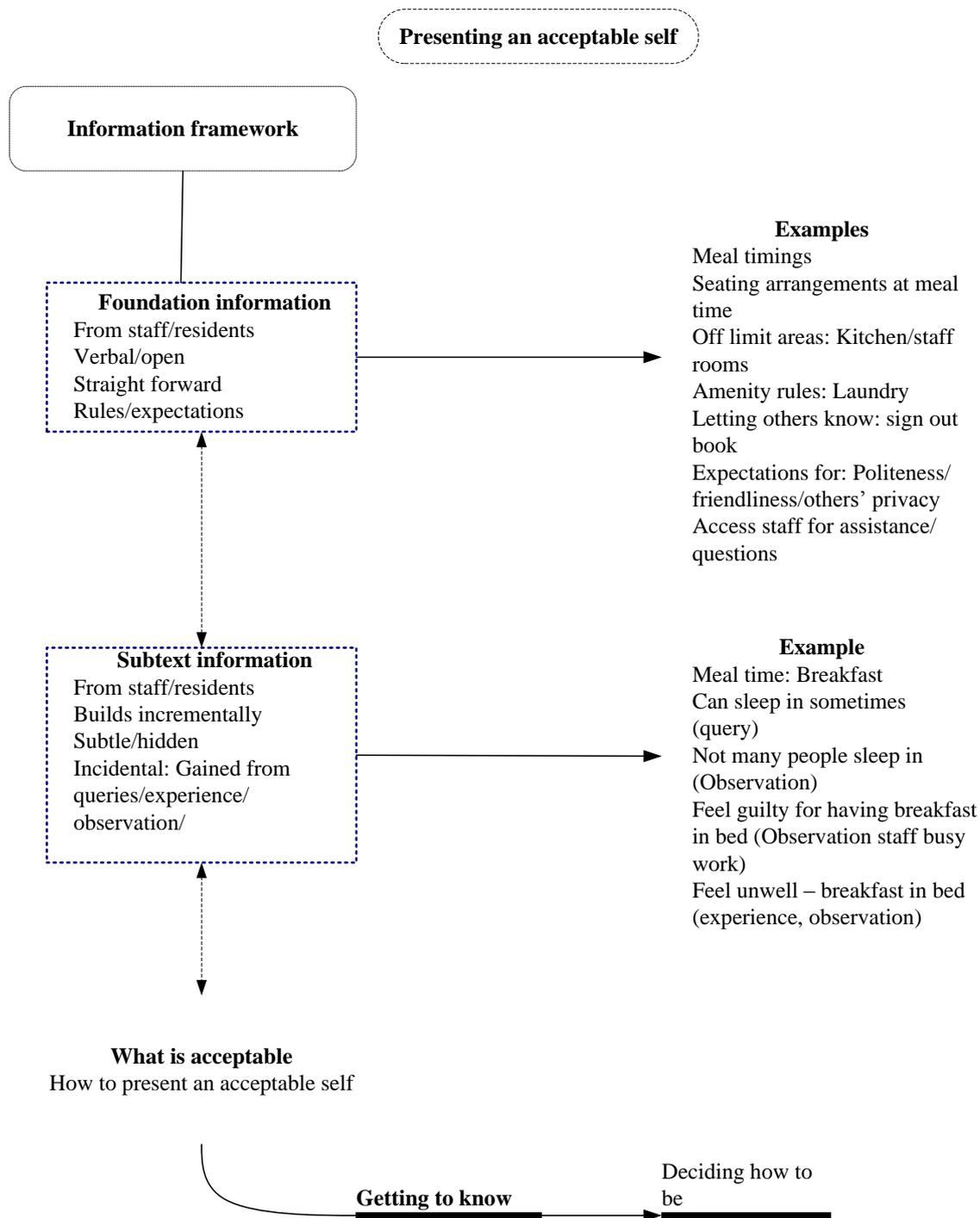
Getting to know

Residents learn the many ways to be acceptable or unacceptable and in doing so *build an information framework* commencing with *foundation information*. Foundation information is that information which is clearly communicated, open and comprises the expectations, boundaries and essential ‘how to’ information. This information is gained incrementally and once foundation information is somewhat established, participants begin to figure out the subtleties contained within that information and thus develop their information framework. This subtle information, conceptualised as *subtext*, comprises the variation and range of information which engenders a depth of knowledge about the facility from which the resident makes decisions about how to be; namely how to present his or herself in the setting. The information framework continues to develop as the resident’s situation changes while living in the facility. Figure 3 (page 83) represents the information framework.

Getting to know: From information framework to knowing.

Newly admitted residents report their need to become familiar with routines, rules and expectations, other residents, staff, activities and the usual ways of being in the facility. New residents focus on getting to know usual patterns of living in the facility; in essence what is acceptable and what is not. Foundation information, helpful for creating a pattern of living from learned expectations, includes the nature of communal activities: the variety of available activities and how to access information about those activities.

Figure 3: Development of an information framework



Important to residents also, is knowledge about how to attend to personal needs; for example, who distributes personal mail and how they do that, how to access to laundry facilities and which staff member can assist with different needs. Foundation information provides beginning knowledge about those aspects of life in the facility that assists residents to begin to pattern their own life. They learn the layout of the facility, the purpose of particular sitting rooms and the placement of their room in relation to the rest of the facility as well as the daily pattern of the facility. Consequently they begin to figure out the timing of their day for communal and personal activities.

Getting to know: Learning the subtext

Subtext information is additional information not always available to the resident when they first enter the facility. Subtext information can be subtle and at times hidden and becomes visible as the resident questions further or makes mistakes. Additionally residents learn from observing other residents. While joining in the daily flow of the facility the resident begins to learn the not so obvious 'subtext' contained within their current information framework thus also learning what is and what is not acceptable behaviour and to whom. For example, a resident knew breakfast was at a particular time (information framework) and, in order to make that time, was getting up earlier than she was used to. She assumed that she was required to have breakfast in the dining room or go without. When she inquired about sleeping in (gaining subtext information), she discovered further information about what she could or could not do.

You're up every morning, and one morning I wasn't up till quarter to seven and they came in and tapped on me to get up you know. "It's quarter to seven. Are you getting up?" And another morning: "Are you coming to breakfast?" So I thought, well, when do you get a sleep-in? ... She [staff member] said you could sleep in **sometimes**. (Ruth/541)

An additional subtext in the information framework yet to be discovered by Ruth, and reported by other residents, was that sleeping in, while acceptable sometimes, could be perceived to be disapproved of unless a resident was not feeling well. As Sheila notes, she has adjusted her life to fit what she perceives to be acceptable while she notes that other residents strategise to stay in bed or struggle to get up.

And I try to get up, when I would rather stay in bed and have no breakfast at all, if I stayed in bed, but you're regimented here... I haven't had a regimented life for a long time... I know some people pretend they're sick — because they want to loaf in bed... I know some people here who should be in bed and they're not, they struggle. (Sheila/96c)

A second example of information framework, developing into subtext information, concerns activities within the facility. Foundation information is that activities occur at particular times, are of a particular variety and are not compulsory. Residents can choose which activities they attend. Subtext information reveals that some activities cost money (trips external to the facility and bingo). Further information reveals while activities are not compulsory, not taking part at all can raise concern from both residents and staff. Thus residents learn that an acceptable self is one who can demonstrate some acceptable social activity in their life. Staff work to encourage social activity and gradually the resident, on learning this information, decides the nature and degree of social activity they wish to be involved in.

The main point of the first couple of weeks is comfort, feeling like they're belonging, this is their home. After that I might just wriggle in — I've got her coming to exercises now; that's the first little step: she's down to the exercises. (Gemma/S235)

A further example, explaining the development of the information framework, focuses on making suggestions or complaining. Foundation information is that open and anonymous complaints or suggestions are welcomed and listened to. Subtext information reveals a range of acceptable complaint behaviours; that anonymity is difficult to achieve and that complaint response time varies. From these examples, it can be seen that it is usually within the subtexts of framework information that perceptions of acceptable or not acceptable presentations of self are learned and enable decisions about how the resident is going to be in this setting.

Getting to know: Deliberate, incidental and experiential learning

How residents begin to deepen their information framework is varied and includes deliberate (seeking information), incidental (noticing and observing) and experiential (having experience of making a mistake or getting it right) efforts. Some participants are deliberate. "I opened me mouth and asked. No good sitting around and waiting for people to tell me" (Jane/270). New residents ask questions of other residents and of staff as they come across new situations, as in the example of Ruth asking about

sleeping in. Incidental learning occurs in two ways. Residents observe particular incidents and interactions, together with the consequences of those actions, and they come across information incidentally during overheard conversations. For example, Ruth found out incidentally about a dimension of activities in the facility when she heard others talking about it. “Well I’ve only found it out from, oh, I suppose, from voices you know speaking and mentioning it...” (Ruth/506); and Zoe learned “just from circulating in the home” (158). Sheila observed the outcome of a dispute between residents thus learning from the incident that public disputes were not acceptable behaviour: “They tolerate each other now. They’ve been moved from the table” (Sheila/634). Experiential learning occurs as residents interact with other residents or staff. Grace (681) learned not to complain as a result of a resident’s response to her: “I made a remark one day and [a resident], said “you know [your group]... are the most critical people in this place.” So I put my horns in and I thought well, the end of that.” Experiential learning in this instance indicated to the resident that to be critical was not acceptable. What do residents do with what they have learned?

Deciding how to be: Crafting the self

Residents’ attention to others’ interactions and the meaning they make of it, influences their own crafting of ‘self presentation’. Reflecting on information about how others perceived her, Helen decided to think about adjusting her walk because she “did not want to have an effect on them [residents]” (130).

They say to me you know, you’re very busy. And I thought, “Well because I walk fast”. [Then] I think to myself “Well I really don’t need to walk fast. I can walk slowly and it won’t sort of have an effect on them when they think I’m running around.” I’m not running around. I just haven’t learnt to slow down so much since I came here. (Helen/128)

Many residents report that they observe complainers or whiners and moaners do not get much attention from staff when they complain: “I’ve seen it in other people; the whiners and the moaners don’t get a great deal of attention” (Sheila/170). From observing conflict and responses to other residents, participants decide not to complain in an unacceptable way, thus presenting an acceptable self. Frank’s description reflects the essence of most participants’ decisions about complaining.

“But you can’t just complain and complain and complain. ...I personally and I think most people, don’t want to become known as moaners and complainers” (136).

In most instances, where the participants used the word complaining, they were referring to complaining to staff either about an aspect of service; the environment or other residents or staff. Residents, however, were also careful not to complain to other residents or to be seen as a moaner; thus presenting a self that they perceived to be acceptable to others. Helen was mindful not to talk about her medical condition. “People don’t want to hear your organ recital, do they” (Helen/113)? The self that residents decide to present to the facility arises out of their learning.

As a result of developing their information framework, residents learn what is acceptable and what is not. That does not mean that they always decide to do what is acceptable. Some residents are subtle in their decisions to maintain particular boundaries and resist the rules of the facility or the requests of other residents. Decisions are made to be polite and, if residents do not reciprocate, to leave them alone (Nancy/283; Frank/17); to set boundaries about who comes to their room (James/1289); to greet people they pass in the corridor (Ester/166; Faith/280); to monitor themselves in terms of what they say and to whom (Frank/174); and to ignore some of the difficulties of *living the communal life*, for example, the frustration of not being able to have the food how they would prefer it (Frank/186) or living with people they would not normally choose to live with (Joy/267; Ruth/191). In all these ways, residents perceive that they are *presenting an acceptable self*; acceptable to themselves and to others.

Conditions influencing the presentation of an acceptable self

There are, however, conditions which influence the degree to which residents can undertake the complex process of living a life in RAC. These conditions include the situation surrounding their entry into aged care, their self perspective and their perspective of aged care. While these conditions impact how the residents present themselves, there is a flow on effect through the two remaining dimensions, namely *living a communal life* and *preserving the self*. For example, if resistance to entering aged care influences the resident towards isolation, their information framework can be limited. Consequently joining the community and engaging with others is limited.

On the other hand the resident may spend more time ‘dwelling with the self’ to find meaning in their changed circumstances. The focus on one dimension of living a life (*the preservation of self*) and limited attention to the other two dimensions (*presenting an acceptable self* and *living a communal life*) demonstrates the foregrounding and backgrounding process characteristic of the core process of creating a life in residential care. For example Therese (136), a new admission, was reluctant to enter aged care. “I’m perfectly happy alone; don’t want to be shackled up with other people.” She rarely spoke to other residents and did not attend activities. Therese focused on preserving the self (foregrounding), in the hope that she would return home. She paid little attention to any notion of creating a life in this setting (backgrounding).

The conditions under which a resident enters an aged care facility have an impact on the degree to which they connect with the community. Some residents experience limitations such as illness, a number of moves prior to the availability of a permanent place, reluctance for the move, previous experience of respite care and a negative perception of how they themselves will react to living in a communal situation. Others however recognise that this is the right move at the right time. Some residents fit within both dimensions. For example, a resident might recognise that this is a right move for them; however at the time of admission are unwell and therefore have limited energy for creating the life in the facility. Other participants find entering aged care a relief and they embrace their new life with vigour. For others, reluctance for this move holds them back from connecting with the community.

Regardless of the condition underpinning the move to aged care there does not appear to be a particular time frame in which residents report a sense of inclusion in the community. Rather it appears that the conditions in operation, at particular times, mediate the length of time taken to connect with the community. Some residents perceive that they are still not part of the community after a number of years. Geoff (300), a resident of three years, perceived that he was “Living in the same area; I won’t say I live with them”. Other residents perceive they are fully involved and leading a satisfactory life after a few months. Helen (24) a resident of four months was very engaged with those around her. She knew most residents by name; could describe residents’ situations; had taken on two jobs within the facility; had developed a pattern of attendance at particular activities and had decided who she

would help and who did not seem to respond to her help. Life in RAC was satisfactory for her. “I am very comfortable here... it’s a family situation” (Helen/123). Helen reported knowing and feeling comfortable with the facility prior to her admission. Geoff reported simply that it was time and it is “what you do” when you are not well.

Access to knowledge

When residents had time to investigate their future home, their perception about entering aged care was generally positive, usually because they had investigated a number of facilities, already begun developing their information framework and had chosen the facility that suited their needs. “I said, ‘It’s not the most stylish looking place but I can tell you that there is no hostel ... kinder than this’” (Frank/750). Prior knowledge of the facility was gained in other ways and this knowledge led to their choice of facility. Some residents used respite care to gain experience of the facility. Others had readymade connections gained from living in an independent unit co-located to the facility. Additionally, residents gained familiarity by visiting friends who were already resident and volunteering at the facility prior to admission. For this group of people, prior knowledge (a partially developed information framework) enhanced their ability to create their new life.

For others, the entry to residential care was abrupt with little time to investigate the facility context. When the admission was abrupt, the cause was usually ill health or family disruption. “Mum I’ve got to ask you to leave. To be told you stress somebody else... So I said “Oh well, we will try and get in right away” (Elizabeth/299). When the admission is abrupt, residents initially use their energy to regain health or come to terms with their changed situation thus efforts towards creating a life can be limited. “So I’ve been settling down just gradually. ... The first week I just couldn’t and I was too sick” (Ruth/89). When the admission is abrupt and the resident has little foreknowledge of the facility, the information they have is limited. “I didn’t know you were even allowed to bring your bed in” (Elizabeth/283). These residents know very few people and their information framework development is more gradual; consequently, the time taken to create a satisfactory life is protracted. For some residents initially reluctant to join residential care, life changed in positive ways as they experienced relief in the form of extra assistance and as they

discovered friendships. In the main, however, under the condition of unwellness or reluctance to be in residential care, the time taken to create a life was lengthened.

Being known

It is not only the new residents who are continually learning and adjusting the presentation of the self. Long term residents receive feedback, experience particular situations and adjust how they present themselves. For example, one resident worked hard to overcome an interpersonal conflict and, on reflection, decided to connect more effectively to others in the community. Others received feedback that they were impolite and adjusted their presentation; that they were 'stuck up' and joined more games that they were not keen on, or were told they were too independent and decided not to change. Feedback was not only external. As life changed for residents, their internal feedback about their changing situation indicated that they needed to present themselves differently. For example deteriorating health meant that residents, formerly independent, now needed to request help. One resident discovered that she could no longer cut her own food and required more assistance. Another resident realised that she could no longer drive and needed to find alternative transport. The outcome for these examples was that the resident presented a self that was different to the previous self; and in some cases the outcome was that of limitation in getting to know how to negotiate their changing condition.

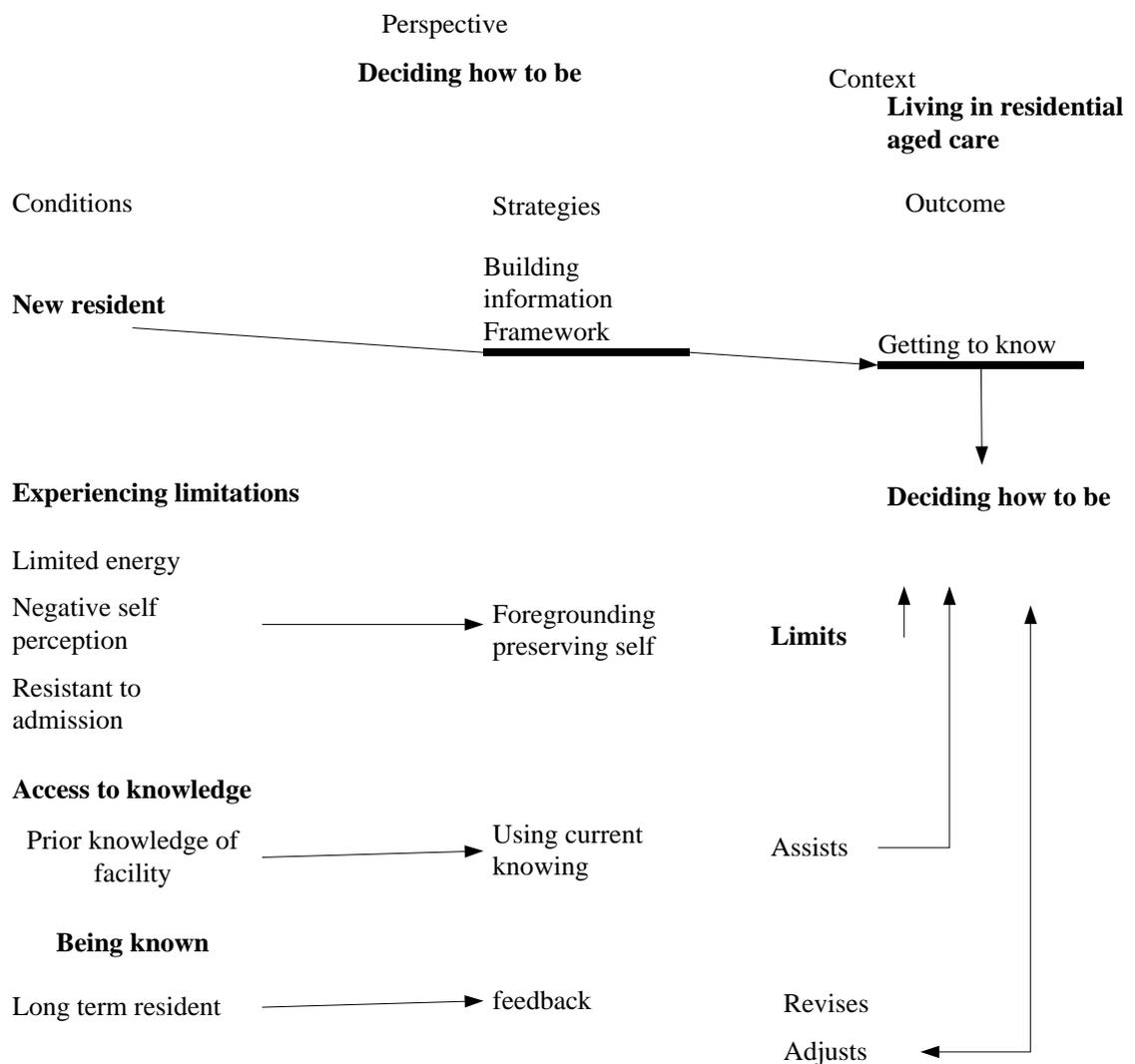
Situations impacting admission to an aged care residence

The pathways into aged care for these participants are varied. Discussions about moving into residential care can be initiated by the participants themselves; by health care professionals; by family and by friends. The conditions which led decisions to be made included an increased need for further care; geographical or emotional distance from family; unwillingness to be a burden on family; or to accompany an ill relative. Additional conditions which influenced the resident's move into aged care were whether the admissions could be deliberated upon over time or were abrupt. Some residents had time to prepare for their move and investigated a number of facilities to determine their destination thus their entrance to the facility was deliberated over time. Other residents because of ill health were admitted from the acute services or temporary accommodation while awaiting a permanent bed in a

facility. In some cases, these residents had relocated to numbers of aged care facilities while awaiting permanent residency.

Presenting an acceptable self then is aimed towards creating a life which is communal. Residents, through an ongoing process of developing an information framework, get to know what is and what is not acceptable. Creating a life in residential care is about connecting to the community of residents and staff. Figure 4, below, outlines the process of deciding how to be.

Figure 4: Conditions influencing residents’ decisions of ‘how to be’ in residential aged care



Living a communal life

The people are all friendly and happy ..., because you meet all the different characters, some are willing to speak to you and some are very quiet and ..., some are not able and ... it's all stages of ability or disability, whichever, and of character also. ... I have to get, not so much get used to because I know that's part of life, but I mean, accepting it now in my life: this is my life and they're the people I'm living with and they're the ones, I have to get used to that type of thing. As regards being friendly... that's no problem ..., but it's ... you've got to allow for people themselves and they don't know me. Until they really know me too; that kind of thing...yeah. (Ruth/370)

Living a communal life is the second dimension of living a life in RAC. This dimension demonstrates the presentation of multiple selves (the composite self) which have been partially developed from making meaning out of what residents have learned in the new setting; partially out of their individual and personal history and partially out of their self perceptions. *Living a communal life* and connecting with others causes residents to shift and adjust in different and varied circumstances. The process resembles that which residents go through when learning what is considered acceptable and presentable in this facility. The resemblance is in the building of the public self in interaction with the community. The focus in this dimension is on connection namely, interaction, involvement and engagement in the community. By their very actions and interactions, their words and their presentation, residents announce their identity, connect with the community from a range of positions and contribute in some way to communal life. In doing so, they become known by other residents and gain a reputation. From that point it is possible for residents to negotiate between their sense of self (the composite self) and their reputation, if they become aware of it. This can be problematic as residents' purpose in engaging with the community is to live a life which is satisfactory for them. Engaging with the community is bounded by the environment of the aged care facility and a resident's identity and reputation is influenced within this context. It is important, however, to begin with a description of the processes that comprise *living a communal life* before moving to the conditions which influence the variations of community engagement.

Living a communal life: Establishing an identity

Residents perceive themselves in particular ways and this influences how they announce their identity to the community they are entering. Residents described themselves variously as a passive self; a social self; an involved self or a healthy self; and sometimes a combination of these selves. In all resident interviews, there were many references to their past self. These past selves modify, to a greater or lesser degree, when they join the resident community; however the past self is always some part of the composite self which is presented to the community for the purpose of being acceptable and creating a life in this setting. The composite self then is a self with many components, not all of which are immediately apparent. Some aspects of the self are brought forward from the past, some are newly created in response to communal living and some are how they have always been. The composite self is recognisable in a number of interactions. What is notable is that residents modify their public presentation to gain acceptability and *live a communal life* while also attending to their individual concerns in various ways.

While some residents describe themselves as passive and not involved in what goes on around them, there is, in the main, some action that demonstrates connection to the community. Residents talked about not joining in particular activities, being polite but not the initiator of conversation, being helpful and generally being acceptable even though they did not necessarily enjoy communal living. James (715) describes himself as being “far better ... sitting in a corner with a glass of beer and watching all the rest of the world go by. I’m not a good mixer.” He did, however, indicate that some change needs to happen when *living a communal life*. “You’ve got to be prepared, even though I don’t; you’ve got to be prepared to mix” (James/1155). James does, however, perceive that the acceptable self to most, but not all, is the one he presents on a daily basis. This self that James presents to the community, aiming towards living a communal life, is one of friendliness, helpfulness and humour. Yet the composite self is more complex than that presented.

Whether they would accept me or not, because I’m the sort of character you can either hate or like. My attitude is I’m always trying to laugh, and maybe some people might object to that you know, and what would I do then you know. But that’s my philosophy actually to try and smile a bit. (James/932)

Peter's self perception is "I'm a loner" (108). However, while his comments during interview were negative about others, he *presents an acceptable self* by not complaining and being polite to others; thus presenting an outwardly polite self. Peter's strategy appears to be one of responding, but not initiating, and holding his negative perceptions of others to himself. "If a conversation begins, you will talk to anybody and everybody, but that's an end to it, you don't seek them out to talk again, no" (Peter/472). However, during fieldwork, I noticed that Peter demonstrated connection to others when he looked in on a fellow resident who was unwell, thus revealing a caring concerned self. Zoe in contrast presents an outgoing and active self within the community.

See they have plenty of things going here ... and I joined in things here and made friends. I take it all in my stride. ... I was glad to move in here, because ... I didn't have the company there [previous residence].
(Zoe/147)

In interview, however, Zoe recalled a difficult and testing life history (the past self), a sense of isolation from family (the lonely self) and a strong faith (the spiritual self). While the social and spiritual selves are announced to the community the past and lonely selves are not.

The following participant quote demonstrates the past self, the healthy self, the involved self and a strategic self. Sheila, a scholar, was used to being in a position of authority. She is articulate, forthright and experienced in management. Her interests are wide and varied and her life in the facility is busy and she announces her healthy self: "I'm reasonably healthy and I look after myself" (Sheila/167). Sheila is also aware that her ability to articulate clearly and authoritatively (her past self) is not always accepted by others and aims to present a more acceptable self while not letting go of the articulate and authoritative self.

Well they always tell me ... I take over at a meeting. And I said I was going to be quiet and I didn't say anything, and I didn't. But when I went outside and I was talking to [the manager] I said something to her you see about [a problem]... I said I'm not telling you who it was but it was one person who works here at weekends — that wasn't giving anything away because they all have to take turns — and I've noticed that since then it's improved a lot.
(Sheila/288)

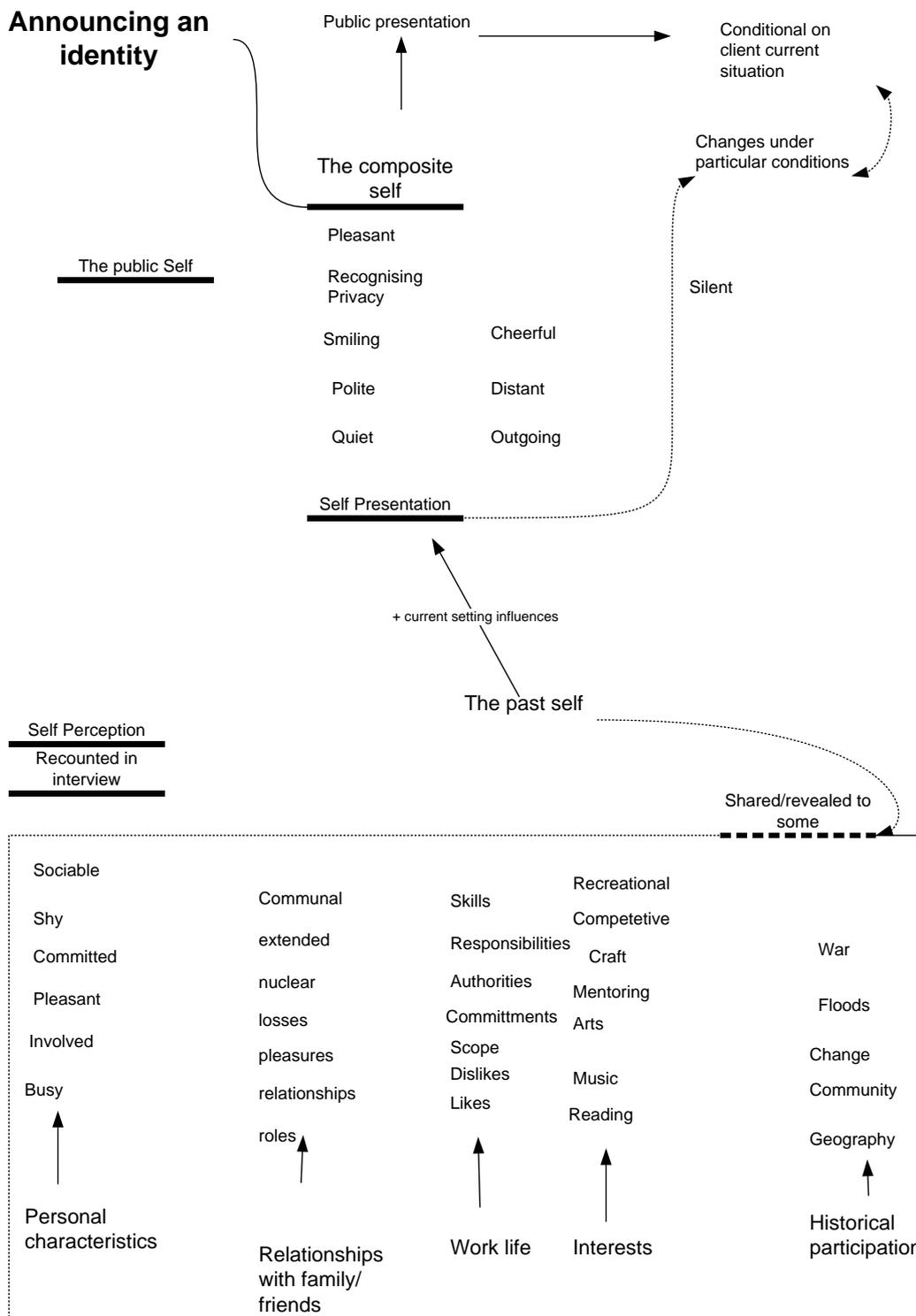
Announcing the identity then involves a composite self which is modified for the purpose of being acceptable in the community. The acceptable self arises out of the residents learning about the range of acceptable behaviours preferred by most in the facility. A combination of these selves (the composite self) interacts with communal life. Figure 5 (page 96) demonstrates this composite self which is not static; however does arise out of the self they were on entering their current setting.

Engaging with the community: Connecting

All participants in this study indicated that living in an RAC was different from anything they had previously encountered. “It was very different ... when I came here, yes; I found it sort of a bit overwhelming at first” (Joyce/39). However participants clearly made efforts to create a life within what had become their permanent residence. How do residents achieve this? Residents engage in and contribute to the community in some way. Connecting to others assists residents to become part of the community they live in and in some cases means that residents puts aside some of their own preferences in order to join in.

Participants position themselves on various degrees of engagement in the facility: from involved, cluster involved, passively involved to marginally involved. Involved residents enter all facets of facility life. They know most people’s names and contribute during communal times, for example at meals, formal and informal activities, and meetings. They make friendships and spend times with friends during community quiet times. Cluster involvement constitutes picking and choosing a level of community engagement. This includes contributing during communal activities but only those activities they choose. So this group of residents may attend meetings and are pleasant as they greet people; however only become fully involved at certain times. Passive involvement includes those residents who attend because they perceive “they’re supposed to” (Jane/72) or because “that is what you do” (Geoff/561). They are at most community activities but not always involved in those activities. Though they talk about enjoying the company, they remark that they have no real connection with people in the facility and do not know very many of them by name.

Figure 5: Announcing an identity: The composite self



Joy had been resident for two years and was observed to be at most facility activities. During interview, however, she noted that “I don’t know anybody really, you know. Not to say they’re my friends” (Joy/82). During fieldwork, I noticed that this group of people tend not to initiate conversation but are looking, watching, observing and taking their turn during activities.

Those who connect with the community, from a marginal position, will talk at meals, have one or two friends and know some people; however, they will tend to engage in activities external to the facility or not at all, while at the same time presenting a polite and smiling self to the community. Abe reported a time when he was able to leave the facility and did so on most days. “I could get out ... nearly every day I’d walk ...sometimes I wouldn’t get back till after lunch; I’d have something to eat out” (Abe/97). At the time of interview however, he was no longer well enough to continue this activity. Although Abe had some friends to chat with, his connection to the community was limited: “Well virtually I only mix with a couple of them ...I’ve always been a bit of a loner. I couldn’t imagine going down there playing bingo ... that type of thing” (Abe/194). The following table (page 101) demonstrates the broad pattern of engagement in relation to the resident’s self perception namely, the composite self. These are very broad patterns and not all residents fit neatly into one pattern. However there are indications that the resident’s self perception has an influence on the presentation of self and the degree of community connection.

Engaging with the community: Contributing

Regardless of how people position themselves, in community engagement, most participants reported or demonstrated that they contributed to the community in some way. Contribution to the community can be public or private and can occur deliberately and incidentally. Public contributions are activities undertaken by residents which are open to the collective resident group and includes setting tables, delivering newspapers, collecting mail and pharmacy and distributing to the community, readying spaces for community spiritual services, making and selling crafts for charitable purposes, assisting the activities person for communal activities, becoming a proxy representative (presenting requests on behalf of people who do not wish to speak publicly; advocating for another resident even though it would not be

their preferred wish), and voicing suggestions to resident meetings, for example, difficulties encountered in the environment (gardens, pathways, steps, shelters).

Table 3: Relationship with self perception and degree of community connection

Degree of engagement	Interactions	Self Perception	Outcome
Involved	Interactive, involved in most activities and interactive at all these activities	Social, outgoing	Finds life satisfying on the whole
Cluster involved	Picks and chooses	Social however on more limited scale	Finds life satisfying on the whole
	Engaged in some activities		Finds life boring
	Has deep and superficial friendships		Misses friends and previous life
Passively involved	Attends most activities however does not interact unless spoken to	You do what you have to	Puts up with it Few friends in facility
Marginally involved	Does not attend activities	Loner, not a good mixer	Focuses on friends outside the facility
	Is pleasant		Will mix if they have to – when not able to leave facility
	Few interactions		
	Polite to others		

Aside from meetings, public contributions are not solicited by the facility administration but arise out of the resident community. Public contributions can be passed on deliberately from resident to resident, can be offered when a resident sees that another resident is having difficulty, or can be something that no one is currently doing that the resident believes needs to be done. As one resident perceives they are becoming too tired to continue, they pass the job to another. “I couldn’t do it

anymore, the whole lot ... I suggested that she did that and took charge so that's what she's doing, she's happy" (Sheila/ 409). Serendipitously, other residents see a gap and begin filling it without communication to others: "I just took it over when [resident] couldn't do it" (Abe/602). Finally, residents decide to liven up the facility at weekends by playing music in the shared communal areas.

Personal contributions are those contributions which assist some residents, however are not public or not seen as 'jobs' around the facility. Residents contribute in a myriad of ways. These include watching out for others for example, noticing if someone is not at an activity and reminding them, running errands for residents when they are out shopping, visiting fellow residents who are sick and making conversation when they would rather not. "It makes a difference to them talking, and you stop and listen and have a bit of a joke about it. You know, you could just ignore them" (Abe/742). Additional personal contributions include guiding new residents around the environment and into the facility pattern and gifting others. For example Esther baked cakes in her microwave and "I'd give him next door a bit, one of the ladies a bit" (742).

Whether the contributions are public or personal, most residents contribute to the community in some way. While there is a difference in the type, nature and degree of contribution and regardless of their positioning, involved, clustered or marginal, residents connect with others. For example, after Peter's interview I walked with him through the facility. Peter, whose talk about his activities and other residents demonstrated a passive position within the facility, asked if we could go a particular way because he wanted to look in on someone who was not well. His actions demonstrate some personal contribution to the community he lives in; even though he perceives he is living in a facility where there is little communal connection. By these actions of announcing an identity, positioning within the facility and contributing, residents become known and in becoming known gain a reputation.

Conferring and gaining a reputation

In contrast to announcing an identity, which is a personal construct including a resident's self perception, conferring a reputation is what residents think about other residents and gaining a reputation comes from other residents. The process of

conferring a reputation arises out of the actions that the resident observes and understands in interaction while announcing their identity, connecting with the community and contributing. Conferring a reputation involves attaching a meaning and labelling others' actions and interactions. The labels can be positive, negative and mixed, and relate to a range of resident characteristics, physical, cognitive, personality, and behavioural. Some labels arise out of a condition, particularly cognitive impairment. Others arise out of how the resident manages a visible physical impairment. Additionally reputations arise out of the resident's interactions with others. Reputations can be conferred quickly or they can evolve as further experience leads to a more complex set of labels. For example, during interview a number of residents mentioned a particular resident as being someone with a sharp tongue. Staff also alluded to this resident during their interviews. The resident herself said that she had a way of speaking sharply. Consequently, the resident also perceived that she had few people in the facility to whom she could relate. However the resident was also seen as loyal and committed to her husband and family.

The purpose of conferring reputation is that a resident decides the level of interaction he or she will have with particular residents. Reputation conferring and gaining is a dynamic process and applies to individuals and groups. While the process of conferring a reputation is dynamic, residents may not be aware of the reputation they gain, although at other times the reputation is communicated directly. "The resident across the table said they think I'm very spoilt" (Therese/73).

During interview residents talked about the characteristics and conditions of other residents in the community thus conferring a reputation. Others' cognitive disability was used to indicate paucity of available friendships and self comparison. "Some are as silly as wet weeks and ummm the only one ... I used to be able to have a sensible conversation with ... she died" (Elizabeth/90). "Well virtually I only mix with a couple of them. A lot of them, they wouldn't know what you're talking [about] you can't have a proper conversation with a lot of them" (Abe/172). Those with physical disabilities also earn a reputation and in most cases labelling was followed by a positive judgment about helpfulness, courage or a negative judgment about how they handle their disability. The following quote was related to the reputation of a vision impaired resident. "She's extraordinary I think and she's always so interested and happy you know ... but she does get upset... I think she's an inspiration really"

(Joyce/558). In contrast, others with impairment can earn negative reputations. “Well there are a lot of people here who whinge all the time. I’m talking about, oh my poor leg ... it’s in the other, oh ... I can’t walk, I’m terribly ill; this sort of thing” (Sheila/174).

Some residents are labelled by their personality or particular characteristics such as the ability to keep a confidence. “We know that she doesn’t say anything that I tell her and I don’t say anything that she tells me” (Sheila/666). Others simply earn a reputation by their way of presenting themselves, thus, reinforcing that the way in which one presents can be acceptable or not. Reputations arise out of personal appearance, temperament, intelligence and independence. “She’s a dear old filly ...” (Therese/79). “He’s got one jacket on and he’s never, ever, worn any other ... He had chicken ... so he picks that up with his hand and eats it: Puts his teeth in his pocket first” (Peter/390). “He’s a brilliant man — a wonderful fellow” (Helen/490). “A nice person, I feel I can talk with her” (Zoe/258). “We’ve got very nice you know gentlemanly men here, you know. They’re all very careful, and they try to help themselves” (Joyce/49). “You do get ... two or three who are very difficult to get on with, but they’re only among themselves. ... They are abusive to each other and one, almost violent” (Sheila/603). “She starts getting nasty of a morning when she wakes up” (Joy/284). Esther (527) had a recent conflict with a resident and perceived her negatively. “She’s in everything but the bath”. Others responded negatively to input at resident meetings or to the appearance of authority that some resident enjoyed. “Well they’re a clique and they get together and they sort of say it and it’s done. Well that’s not right” (Esther/15).

The same two, like a couple of parrots: how good things are and this and that ... I don’t take any notice of them myself because it’s the same thing every residents’ meeting. It doesn’t go over with me anyhow. (Abe/344)

Reputations can have the consequence of enhancing or limiting opportunities for connection with the community, thus reinforcing that an acceptable self is well presented (clothing and grooming), with a pleasing temperament (pleasant, nice and trustworthy) and appropriate actions (table manners) and being involved without taking over; while the converse are not representative of an acceptable presentation. Thus reputations earned can distance residents from the community, and from each other, as residents decide who is acceptable and who is not.

Conditions of mismatched perceptions

Reputations can position people differently to their self positioning within the facility. Sometimes, there is agreement between the self identity and the reputation, particularly when the reputation is positive. At other times there is a mismatch and the reputation conferred is at odds with the resident's self identity. For example, Frank lost friends because he did not like going to memorial services held in the facility. The reputation conferred was one of disrespect for his fellow residents and a resident who had been his friend stopped talking to him. Another resident stopped sitting at his table in the dining room for the same reason. An identity is about self perception and a reputation is about others perception. Mismatched perceptions can impact the depth of connecting and contributing and can ultimately influence the life that the resident wants to live. Residents can spend time reflecting on feedback and decided to accept the other persons label, change their actions or ignore the perception. A resident stopped talking to Faith. "She says I'm rude" (Faith/179). As a result, Faith ceased some well loved activities; sought advice from others about her behaviour and became deeply reflective of the situation which caused her much distress because a long standing relationship had ended and she did not perceive herself to be rude. Another resident took up a formal activity she did not enjoy because she heard that she was perceived to be "stuck up". On the other hand Frank did not respond when others viewed his non appearance at memorial services negatively. These strategies demonstrate that mismatched interpretations can lead a resident back to figuring out how they are going to be. Information is added to their framework, in this case information about themselves and the resident after getting to know others' perceptions of them make decisions about how they are going to respond.

Preserving the self

In contrast to the previous two dimensions of *presenting an acceptable self* and *living a communal life*, *preserving the self*, for most residents, is about maintaining privacy, intimacy, physical health and their personal environment. *Preserving the self* includes sub dimensions of: 1) maintaining a private self, where the self is revealed to others by storying the past and the present with the purpose of becoming known to a few chosen, making meaning of their life and figuring out actions and responses in

their communal life; 2) managing own health, by making preferences known and adjusting to accommodate physical changes; and 3) establishing a private space, by putting their own touch to their room and setting boundaries to maintain privacy.

When *preserving the self*, residents employ a strategy which is shared across all dimensions in order to *preserve the self*. This strategy is conceptualised as *acting as if*. The public face residents' show, in order to *present an acceptable self* while *living a communal life*, hides the complexity of the preserved self. *Acting as if* is a strategy employed to indicate to the community the person is fine when they are not fine or that they are appearing to do one thing while they are doing another. The preserved self is shared with a few chosen people and can be thought of as a space which is alive with thinking, reflecting and acting. This dimension of *preserving the self* enables the resident to balance the public and private self in the creation of their life in RAC.

Maintaining a private self

When maintaining a private self, residents reveal their past and their current self to select others. While this is a presentation of self, such presentation is not public and is only revealed to chosen others or reflected on in the privacy of their own space. Residents announce the multiple roles they have enacted during their life and for some still enact: wife, husband, sister, brother, father, mother, worker, helper, friend, confidante and at times counsellor. They compare and contrast the past with the present as they note what has been lost and what remains. Residents, in their talk, indicate what they can still do. For example, residents talk about driving, continuing to care for a relative also in the facility, using the computer, organising activities within the facility, going to the library to continue researching subjects of interest, going out for meals, playing the poker machines, reading, listening to music, developing abilities with crafts, playing board games with friends, attending religious activities, gardening and staying in touch with those they love. Many times, they bring their reflections into their current life as they figure out meaning in the privacy of dwelling with the self.

In my other life shall we say, I always had plenty to do around the house and ... the garden ... and I had a couple of interesting hobbies ... Well it was pretty much of a dead stop there because ... a lot of things I had been doing I can't do anymore... I can't blame anybody else because I just come into me room here and sit quietly here. (Geoff/349)

Stories of the past reveal love and joy; of marriage and friendships.

Your family grows up with you and you're close, very close, ... but the closeness isn't really plain to you ... you know it's there, but you take it for granted, but when you move into a place like this you miss all sorts of little things... I've got ... great grandchildren ... and they've brought such a lot of joy into my life. (Nancy/671)

Also reflected on, and revealed, are achievements in domestic and paid work, study, scholarship, volunteering and hobbies: "I used to sit on the stairs at night and you know, with a lamplight and I wrote a thesis for my Masters degree" (Grace/240). "When I look at it, my life's four stages ... I was on the land ... I joined the [military] I was a public servant ... this is the fourth phase. I find this one very hard to accept" (Dominic/41). Stories of loss and courage, war, tragedy and relocations during life were retold and figured out in the context of a long life. "We were very good friends. We had a lot of fun together and I knew she was dying sooner or later; but not so soon. However she did" (Ellen/347).

When I retired my wife was very sick and it kept me in for a good while and a couple of friends... died and I don't have many friends now... I'm ready to go ... I've got no quality of life now, in my opinion. (Abe/118)

Congruent emotions are evident during the telling of the story. The range of emotions includes smiling, laughing, sadness and crying. Many stories move to the present with an acknowledgement of what has changed and what is the same and, in some cases, how they have changed their mind about some aspects of life. "Going back over my life I know how I thought about old people. Until you're old, really old, you don't understand. I didn't" (Frank/4). Included in present reflections are comments of what is missed and still grieved for in the company of a chosen few or in the privacy of their own room.

I'm the only one left of five friends and we were all like this you know, we're all deep friendship; I'm the only one left, they've all gone, died, most of them. So, this thing happens and that's what happens when you get old. But sometimes I talk to myself. I sit on that bed and talk to myself. All of a sudden, sometimes I cry. (Sheila/802)

The shift goes backwards and forwards during the telling as past, present and future are considered and reflected on. There are consequences for maintaining the private self. By telling the story, residents become known to selected others, identity is reinforced, unfinished grieving can continue or resolve and residents can figure out their response to particular facility situations. “Looking back over my life of course there’s things I wish I hadn’t done... Things I wish I had done but I hope that it will be ... forgiven those things I shouldn’t have done. So there you are” (Frank/996). Additionally, talking to someone confidentially provides the opportunity to reveal difficulties in order to consign them to the past. “I think it’s better to get it off your chest because you can’t get it off your chest to everyone ... I’ve had all I needed to get off me chest, I really have and I’m grateful” (Esther/139).

A fieldwork incident indicated that talking, and being listened to, can lead the resident to figure out alternative solutions to particular situations. One participant, during interview, told a story never told before. To my surprise the following day the same resident stopped me to say she had returned to an activity she had left years ago. She was excited and smiling and eager to move one. Yet during interview, all the resident had received was careful listening. Maintaining the private self reveals a complex interiority which is shared with few people. Sometimes those chosen are friends in the facility. “Sometimes I go to [friend] and ... We let off steam” (Sheila/665). Other times, it is staff. “It [conflict] sort of worried me for quite a while, and I talked to one of the RNs [registered nurses]” (Faith/265).

While some residents can no longer sustain their past interests and hobbies, other residents bring aspects of their past into the active present. “I loved her [wife] dearly... Yes. I say goodnight to her. — and she helps me [now]” (Dominic/533). Finally, residents’ current abilities are reinforced by including in these stories what they can do. “That’s a waste of time to me [organised activities such as bingo]. And that’s only because I’ve been trained to work and to learn all the time and that’s what I still do” (Sheila/439).

Managing own health

People say, all my friends say to me, I wish we were as good as you when we're 84. But they don't see me first thing in the morning when I'm struggling out of bed, oh me back, or me shoulder or legs. (James/531)

When attending to their health, residents adjust to accommodate their physical disabilities and work to balance independence with assistance when required. In response to the situation of feeling unwell and wanting to continue as part of the community, residents adjust. These adjustments include timing, pacing and sequencing of activities. For example residents find a place to stop when walking long distances to facility activities (pacing). Timing of activities includes deciding to shower in the evening because morning showering takes too much energy and means that the daily activities are more difficult to achieve. "I shower at the end of the day at 6, because if I showered in the morning, I'd be worn out to get myself up there [communal areas]" (Esther/25). Sequencing activities means doing some activities in the morning and then resting to enable more energy for the evening. Avoiding energy drain or painful activities leads to decisions not to attend activities because chairs are too hard or the bus trip is too long. These activities can take energy and exacerbate feelings of being unwell.

The residents with physical disabilities reported always feeling weak (Esther /33) or experiencing constant arthritic pain (Nancy/448). Additionally residents reported difficulties arising from conditions related to the gastrointestinal (Sheila/420; Ruth/25), cardiac (Peter/118; Abe/161; Ruth/166), and respiratory (Sheila/161; James/113) systems; as well as the aftermath of cerebro vascular accidents (Esther/486; Ellen/66; Alf/95; Grace/114), and physical trauma sustained earlier in life (Helen/153). Residents also experience a cluster of these conditions. For example, Sheila experiences mobility difficulties from arthritis, breathlessness from cardiac and respiratory conditions and pain from a gastrointestinal condition. Many residents indicated that they experienced a sense of weakness, breathlessness, anorexia and/or pain on a daily or regular basis. These conditions limit mobility, flexibility and endurance. Residents report "running out of steam real quick" (Esther/20). "Yesterday morning I was totally exhausted. I went down to [unprepared church service] ... so I had to tell the [minister] about that. By the time I came back

from doing that, I couldn't breathe" (Sheila/116). "My legs are swollen from having a heart condition. I've got me walking stick there but even with the walking stick I've found it hard" (Joyce/119). Added to these current conditions, residents report an awareness that their condition could change suddenly. "The heart could give out anytime" (Ruth/166). "I woke up one morning in bed and tried to turn on the light behind the ...and I couldn't move" (Ellen/49).

Accepting help and maintaining independence

Because you look all right and because you still sort of want to brush your hair and put a bit of lippy on, you know, you're all right, or I go for a walk instead of sitting at bingo, you know, you're all right. But sometimes I say a prayer ... and I walk up that road and say "get me back okay", you know, that's how I feel. But then I guess that's — now how could I put that? I don't know, but I think that's still trying. Not throwing in the towel. (Esther/618)

Balancing the need for help with maintaining independence is another adjustment strategy. Residents accept help when they are unwell but work to maintain independence when they are well. While residents reported a range of difficulties and disabilities, they are also definite in reporting that they are relatively healthy. For example Joy is wheelchair bound which she reports as difficult to come to terms with. She requires staff assistance for personal care and for movement around the facility as she does not have the strength to wheel herself. Nevertheless Joy reports, "But I am very fortunate. I have my good health. You know" (76). Many residents report accepting staff help for some aspects of their care and not for others thus maintaining independence. "They've helped me in the past, but when I can do it I want to do it. So it all helps to live normally, doesn't it" (Esther/567)? Other residents report a sense of security that assistance is at hand if they require it while also indicating that they rarely require such help. "I don't get a lot of attention, because I don't normally need it... The moment that they know I'm not well, they're ready to do for me" (Frank/90). Residents also report finding it difficult to balance assistance with independence.

I've always been independent ... I couldn't cut my toast you know and I thought it was a terrible thing to ask somebody to come and cut your toast, but it was getting that way I was pulling it apart, I just couldn't cut it so I asked someone to come and cut my toast and I felt terrible you know just asking them that (Nancy/804)

Exacerbation of current conditions and experiencing increasing difficulties leads to some residents requesting assistance from staff. Requests to stay in bed, for pain medication, for meal assistance, for personal care and for contacting medical staff, are reported as received easily on most occasions.

I said: [to PCA], “I can’t come down for tea tonight... the pain is too bad.” And she said “Oh that’s quite all right I’ll bring something up for you.” So she brought something up, and then said “the doctor’s coming tonight, I’ll get him to see [you]”. (Sheila/33)

Most residents choose who they will ask for assistance when they need it. Their requests can be according to staff role, as in the case of Zoe who approached the maintenance staff because her bed was exacerbating back pain; or a particular caregiver or registered nurse they feel comfortable talking with; or directly to their doctor. Residents describe staff as extremely caring (Sheila/112) and loving (Elizabeth/126). Staff actions include being quick to respond to illness (Frank/120) and attentive to changes in abilities and condition (Ruth/ 215).

When working to maintain their physical health, residents adjust their activities and work to balance independence and the need for assistance. Their purpose in employing these strategies is to *preserve the self* while creating a life in RAC and, in the main, the strategies are carried out within the private sphere of their life where their personal environment is perceived to be their domain of authority.

Establishing a private space

“When I first came here, Oh, you know, It was just a new and different world altogether and something I’d never experienced you know just living in a room; one room that was yours” (Joyce/588). The resident’s bedroom was perceived by almost all participants as their place in comparison to the facility which is everyone’s place. “The moment I say I’m going home, well I do think of this particular spot [his room], but no, I don’t, when I’m going to the dining room, well it’s a part of **the** home” (Frank/45). Residents’ rooms are referred to as an area where the resident has authority and control. “Well I own this room, and each person in here owns their own room ... We change them if we want to but nobody else changes them” (Nancy/14). In their rooms residents can personalise their surroundings to their own style, taste and life. Reflected in residents’ rooms

are their past and their present. “And I’ve got quite a few of her things. I’ve kept this cabinet because [my wife’s] last hobby was china painting. I’ve still got a few pieces left” (Frank/31). Residents work to create their style of comfort in their room. For example, they bring furniture from their home, bedspreads, curtains, photographs, crockery, microwaves, computers, plants, books and music in order to make their room their own. In this way, residents create some of their own personality in their room.

Additionally, residents set boundaries. They are very clear that this area is their own preserve. “Once that door’s shut, this is mine” (James/1000). There were spoken and unspoken rules for privacy learned as they build their information framework. For staff the spoken rule was that no one entered a room without requesting permission, usually by knocking. During fieldwork, I observed that this rule was adhered to on most occasions. Other residents also knocked before entering another’s room. However, when some residents perceived that a boundary was being crossed they found some way to announce their right to privacy. One resident’s response to a person who entered their room without permission was: “[Cynthia] this is my room’... But I think people do value their privacy and value other people’s privacy on the whole, staff and all” (Joyce/590). James however, was firm but indirect.

So I thought to myself, oh, no, this is a bit of cheek here. I’ve got to stop this before it goes any further. So I said to him ... “Sorry, I’ve got to go out and do a bit of shopping so I got up and turned the television off.” That was the only way I could do it. (James/1328)

Acting ‘as if’

This strategy employed by residents crosses all dimensions of *preserving the self* and intersects with the dimensions of *presenting an acceptable self* and *living a communal life*. *Acting as if* is an internal process where residents choose between their own privacy and their public presentation. Maintaining a private self and managing their own health, accepting help and maintaining independence, and living according to their own style in their room are, in the main, private activities; though some aspects of those activities become known to other resident and staff. The purposes of *acting as if* vary. Some residents’ purpose is to maintain privacy. For example signing in an exit book that they are going one place when they are actually going another place; other purposes are to continue to present a public self which is

healthy either because they perceive others do not really want to know, or they do not wish to be a moaner or they perceive nothing can be done anyway. For example, residents stop in particular places along their way to communal activities to relieve pain, get their breath back, or rest their legs. They do not tell others why they are enacting these strategies. They *act as if* they are OK. “The staff: I don’t think they know how much a little effort causes me to be breathless. I don’t tell them that” (Sheila/125). *Acting as if* can serve to avoid conflict as in James’s strategy above of deciding to go shopping in order to set a boundary. In all these ways, residents maintain a private life in the midst of a communal life.

Conclusion

These three dimensions, *presenting an acceptable self, living a communal life and preserving the self*, together with conditions which influence these dimensions, explain how residents work to create a life in RAC. The mix of public and private life demonstrates a need for community and a need for privacy and time to be alone with a few chosen friends. In order to have some separation between public and private, residents *act as if* and choose how and with whom they share their intimate self. These findings demonstrate the immense work that residents do and the energy they employ towards creating a life. Two major conditions can impact all three dimensions of creating a life in residential care. When residents expectations are or are not met, the life they have created can expand or contract. Additionally the context and the environment of an aged care facility can cause residents to adjust their life creating strategies. These major conditions will be fully explored in Chapters six and seven.

Chapter 6: Shaping Expectations: Condition Influencing Living a Life in Residential Aged Care

This chapter focuses on how residents' expectations are shaped by resident staff interactions. When this condition is operational, the decisions which staff and residents make, and the actions resulting from those decisions, can be life limiting or expanding, in some aspects of the residents' lives. What is important in this condition is that the outcome of resident or staff strategies influence how the resident thinks about, and acts toward, current and future situations in which the resident perceives a need or expectation. In this chapter, I have included the notion that residents' expectations include the expectation that their needs will be met. The condition, conceptualised as shaping expectations, is presented conceptually followed by a detailed explanation.

Residents work to get their needs met. However, staff perspectives about what residents need can be aligned or mismatched with residents' expectations for that need to be met. Additionally, while staff may recognise that the resident has expressed a need, if they perceive that need is not appropriate, they will reject a resident's efforts in getting their need met. Perceptions are important in this condition. Both residents and staff interact and respond according to their perception of what they consider necessary for a particular event.

Residents may state their need or expectation directly. When both staff and residents perceive the need to be reasonable, both staff and residents may work cooperatively. Working together, they discuss, negotiate and come to a solution that meets the resident's needs. Alternatively, both staff and residents may not agree that the need is appropriate and become involved in resistant strategies. In these situations, residents find they are in conflict with staff or meet a direct refusal to their stated need or expectation. Refusal may lead to residents withdrawing their request or working forcefully to meet their expectation, and becoming someone problematic.

Staff initiated activities may be indirect in that the resident is not aware of staff activities towards facilitating a change in residents' current efforts to live their life. Staff activities may also be direct where they work with the resident to find solutions

or expand possibilities. Consequently staff are a major influence on either limiting or expanding the residents' ability to live their life in RAC.

Staff perceptions and actions that shape resident's expectations

Staff initiate indirect and direct strategies to influence the lives that residents live in RAC. These strategies are enacted during group or individual activities. Staff strategies may arise out of residents' stated expectations or from their own perspective that a resident's life needs to change. The change that staff perceives may be deliberate towards expanding the resident's life in terms of their health, physical activity or social interaction. At other times, staff may influence towards curbing what they perceive to be a negative mode or interaction.

Staff strategies include working cooperatively by negotiating, discussing or colluding with residents, and boundary setting if they perceive residents have become inappropriate in their actions. Additionally, staff use gap filling strategies when they perceive a resident has an unmet need. Gap filling strategies can include guiding the resident towards more engaged communal living, encouraging towards a particular activity for which the resident has expressed a longing, listening carefully when the resident expresses a sense of isolation, complaining by proxy on behalf of a resident or referring the resident to a senior staff member when the staff perceives they are unable to assist.

Some staff work at deep levels of interaction when the resident is experiencing emotional distress. This aspect of staff work has been conceptualised as working with the tunnel experience. Depending on the level of staff skill, they may stand at the entrance of the tunnel using strategies of lifting a resident's mood; walk some way into the tunnel using strategies of listening and caring concern; or walk with the resident as they come to terms with the crises they are experiencing. The latter involves strategies of listening, working with anger and distress, exploring the degree and extent of the resident's grief response and being available to the resident for periods of time as the resident works through the changes in his or her life.

In contrast, some staff also use resistant strategies. They may focus on physical tasks and not interact with the resident, or work slowly to meet a resident's expressed need when they do not agree with that need. Finally, staff may use compelling strategies

by creating situations where the resident has little choice but to do as staff wish or refusing a resident's request without a full exploration of that request. The degree and nature of staff initiated strategies depend on: a) the staff perspective about their work boundaries, b) whether the initiation is to set a boundary for a resident or group of residents and, c) whether they perceive that the resident is distressed and they can do something to assist.

Staff efforts can shift residents to a variety of positions. Residents can recognise possibilities they had not considered in the past, can become satisfied that they are in safe hands, can gain benefit from being listened to or become dissatisfied and perceive that they are of no interest to the staff at all. Staff strategies when encountered by residents can lead them to rethink the way they live in the facility. Their rethinking may result in some dimensions of their life being expanded or limited. In these ways, staff influences shape residents' lives.

Residents' interactional strategies with staff

Residents also use particular strategies in their efforts to get their needs met. The resident's efforts together with staff responses also work to shape residents' lives. When residents work to get needs or expectations met they use a range of strategies in reaction to staff responses. They may use cooperative strategies which include discussion, negotiation and/or a consideration of new possibilities. These strategies can be met with considerable success when staff and resident's perceptions match.

When there is a mismatch of perceptions between staff and residents, and residents' needs or expectations are not met, resident strategies shift from cooperative strategies to alternative strategies, escalating or resistant strategies which may include one or a series of the following strategies. Alternative strategies include complaining, bypassing particular staff, calling in a proxy to act on their behalf or withdrawing into silence. Escalating strategies include forceful repetition of the need or request and agitation. A resistant strategy includes becoming problematic or *acting as if* they are attending to staff wishes while doing the opposite.

During the process of meeting particular needs or expectations, residents foreground the dimension from which the need arises. For example if the need is individual and related to the situational change of deteriorating health, preserving the self can be

foregrounded. Interestingly, however, the foregrounding may occur only with the staff involved in the negotiation. If the need is expressed in a public forum, then *presenting an acceptable self* may be backgrounded and the resident can present a different, and sometimes unacceptable, self to the community; and consequently become known as someone who rocks the boat. Successful strategies, whether cooperative, alternative, escalating or resistant, lead to satisfaction while unsuccessful strategies can lead to resentment and distress.

Figure 6 (page 118) demonstrates this condition when it is operationalised.

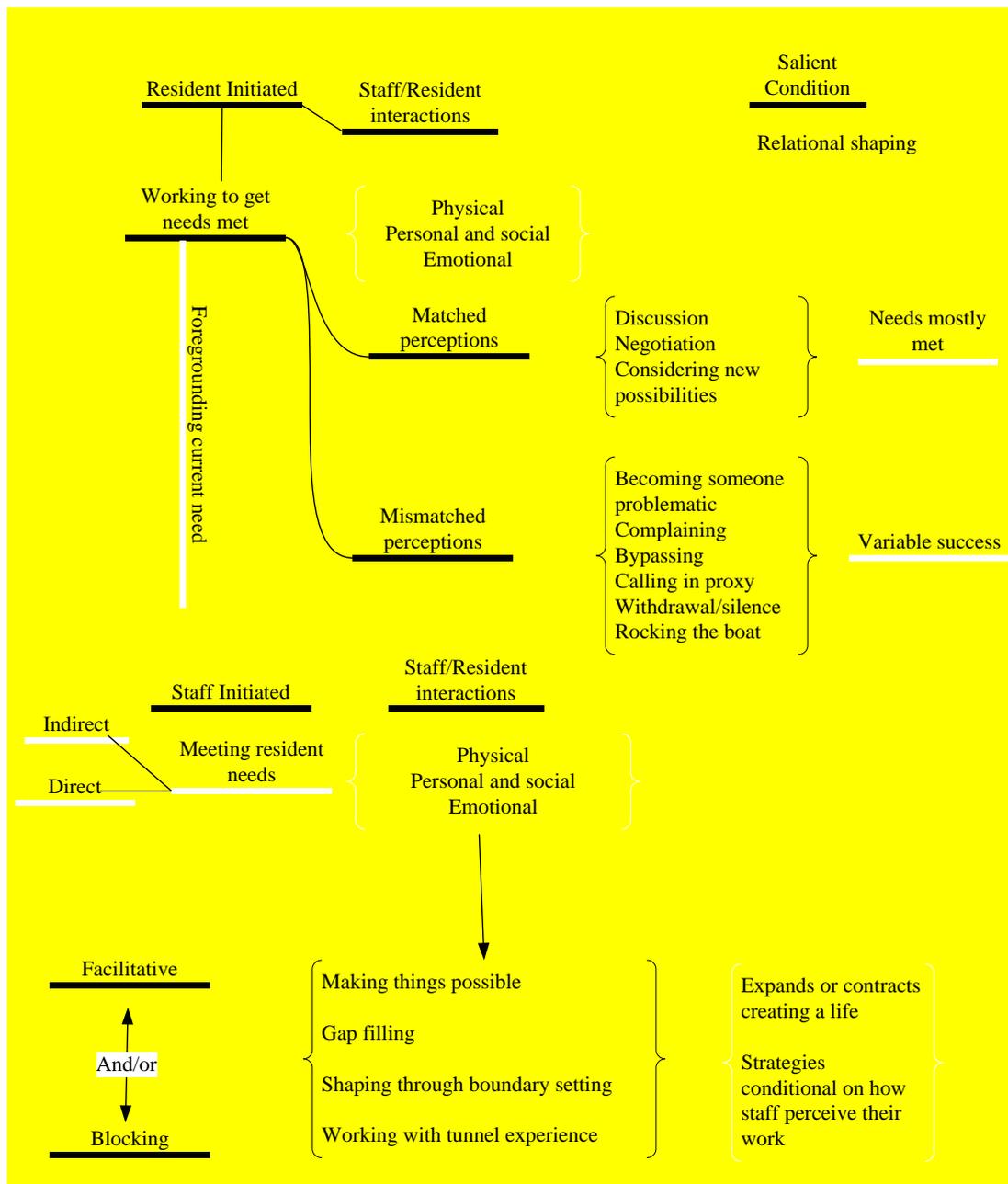
Resident expectations of residential aged care

What expectations do residents report? They report expectations for their health, personal and social needs. For example, participants expect that their health and medical needs will be met where possible; that staff will be interested, caring and will take time when attending to their needs; that assistance will be available when required; that they will be reassured when addressing their concerns; that they will be treated with respect and acknowledged particularly by management; that they can speak up for themselves without negative consequences; that they have family contact and support; that they will be able to join activities within and outside the facility if they choose; that they will be able to help others; that everyone will be treated fairly and equitably and they will maintain a measure of independence. These expectations are played out within the context of an aged care facility where a number of people live supported by health care workers and health professionals.

Staff shaping: Residents' work to resolve needs or expectations

When residents perceive an unmet need or expectation, whether for assistance with a health problem or an expectation to be treated in a particular way, they commence actions to meet that need. Resident strategies can shift and change; in that strategies used in one context may differ from those used in another context. For example a resident may complain privately to staff about a health need not met but choose not to complain and remain silent about his or her dissatisfaction with the activities programme.

Figure 6: Staff shaping



Residents learn through experience what works best for them and their strategies shift in response to that experience. For example, Abe overheard staff figuring out who had made an anonymous complaint and had accurately pinpointed that it was him. He decided, then and there, to withdraw and not to complain again. The consequences for him were resentment and dissatisfaction that no matter what he tried, he seemed to be on the losing end of things. He no longer had an expectation that his needs would be met, in some areas, while holding onto the expectation that his nutritional needs would be met.

When residents meet a negative response, what was perceived by the resident as a straight forward request, can be followed by a more forceful request. If these two strategies are not successful, the resident may either withdraw and give up, or employ further strategies such as threat, anger, agitation or resistance, resulting in the resident becoming someone problematic. The experiences of successful and unsuccessful strategies are taken to future incidences as demonstrated by Abe's decision not to complain. Information frameworks are further developed and as a result expectations shift during interactions with staff as experience is gained and residents learn the range of options open to them.

Differences in resident strategies can be seen in a range of situations. At times those differences may be subtle. For example, becoming someone problematic is usually, but not always, private and focuses on individual interactions with staff. On the other hand rocking the boat is usually a public strategy employed at resident meetings or in public places for the purpose of changing some aspect of the way in which the facility works or complaining about how problems are solved within the facility. On the surface, becoming someone problematic can be allied to rocking the boat in that rocking the boat can lead others (resident and/or staff) to confer a label on someone as problematic. This process can be seen in the example of Esther who was challenging during resident meetings (rocking the boat) and was labelled by some staff as being someone problematic.

Matched or mismatched perceptions between residents and staff: The example of managing physical health

Residents are aware that their health conditions, which many times led them into aged care, are likely to deteriorate or exacerbate from time to time (situational change). During those times, they require increased staff assistance. Some residents report confidence in staff presence when they are unwell. “I realised that everybody was here to help. I only had to push the button; within a couple of minutes there’d be somebody to help” (James/281). Additionally, they report staff ability to make proxy decisions when the resident shifts the decisions to staff. Staff responses to these situations serve to reinforce and expand a sense of safety thus meeting residents’ expectations that help will be available.

I wasn’t going to make up my mind about anything ... [The RN] said, ‘the ambulance is coming ... You must go to hospital’... as soon as I got to hospital I found out I had double pneumonia... But if they know and think there’s anything, the slightest thing that could be wrong, they will treat it. And that’s very good here. (Sheila/142)

However these two situations, of staff effectively responding to resident need and acting as a proxy for resident decisions, are dependent on matched perceptions between the staff and the resident. That is whether staff perceive the seriousness of the illness, or staff and resident agree or recognise the need for extra assistance.

When residents have an expectation of staff assistance to meet health needs and their perception of that need does not match the staff perception, the situation can become very different. Shared perceptions between staff and residents can mean that expectations of need are met, while mismatched perceptions can mean that assistance is not forthcoming or is not the type of assistance that the resident wants.

Meeting expectations for health in the context of mismatched perceptions

When resident expectations are not shared by staff their life can change. Mismatched perceptions may be about resident and staff roles, about whether or not a health condition exists and about the nature and degree of assistance required. For example, some staff perceive that residents do their own medication ordering while residents perceive that it is a staff role.

I complained once about the medication ... on the papers they give you...schedule 2, part 2, item 7... medical appointments even dental appointments, and medication ...they should do that. I was chasing some medication up ... and the girl said 'ring the doctor yourself'. Now it wasn't for me to ring the doctor, it was for them. (Abe/275)

Additional to staff roles, mismatched perceptions can occur when the resident and staff have different perspectives about the seriousness or the nature of the resident's particular health concerns. Under these conditions, residents requests to have meals in their room, to have mattresses changed because of back problems, to have access to a doctor, or to have staff listen to their situation are not met in the way that residents expect. In response, residents employ a number of strategies to solve the problem. These strategies include bypassing the staff; waiting until a staff member in whom they have confidence is available; calling in family as a proxy to request assistance on their behalf; complaining to management, family or friends; withdrawing and giving up. For some residents, depending on the context and importance they place on the situation, their strategies escalate as they persist in working to get an acceptable staff response. Pursuing these strategies can lead the resident into becoming someone problematic.

Becoming someone problematic

Dominic's bed was causing him back pain. At his request, the mattress was replaced. When the pain was still not relieved he requested a second change of mattress which was slow in coming. Initially, requests were made calmly, repeated calmly but with more force, and then moved to threat and anger.

I'm not getting back into that mattress, it's ruining me back and I'm not getting back into that mattress'. So I said, 'I'll just go and sleep in the dining room'. (Dominic/80)

Dominic's plan, if his threat did not work, was to complain to management, a strategy not required as his mattress was changed. At these times, residents are not concerned that they are presenting an unacceptable self to staff; they are foregrounding the process of preserving themselves. They do, however, maintain how they *present an acceptable self* to other residents. So on one hand they bypass being acceptable to staff in order to get their needs met, and on the other, they maintain being acceptable to those not involved in the situation of conflict. Sometimes becoming someone problematic can result in having a need met. At other

times, becoming someone problematic can have the consequences of earning a negative reputation within the facility community as evidenced by other staff or residents negative comments about or to them. The following quote demonstrates a negative label attached to a resident who had become someone problematic and who had reported a serious problem. “Oh it’s just [a resident] shit stirring’... and until [another staff member] stepped in, it wasn’t taken seriously” (Anita/S729).

Bypassing strategies

In an effort to reduce mismatched perceptions residents employ bypassing strategies. For example, Faith put up with increasing symptoms of diabetes (polyuria and polydipsia) for two weeks when her doctor and the staff member she trusted were on leave. She spoke with the doctor on his return, was diagnosed and treatment commenced. “The RN: well she’s just a person I like, very much. The others are very nice; there’s nothing against them...but somehow or other they don’t seem to catch up with what you’re trying to tell them” (Faith/835). The consequence for Faith was that she stopped going places where she was not sure of the amenities because of her undiagnosed and untreated diabetic condition. Thus, *preserving the self* and *presenting an acceptable self* was foregrounded while *living a communal life* was backgrounded. Similarly, Esther first tried to approach and then bypassed staff to contact a specialist when there was a mismatch between her and staff perceptions about her deteriorating health status.

She said, “Well it’s no good ringing your doctor because he’s away”...I said “I’ve been down to see you three times”... [She replied] “Oh, well maybe better luck today.” ...I thought, “Well bugger you.” And all I wanted was a little bit of reassurance and someone to say, “Well, look we’ll start with — we better ring the eye doctor and see what he says.” So I did that very thing ... [visited him in his office] and he told me, “you’ve had another stroke”. (Esther/49)

Bypassing staff in order to get needs met can be risky in that staff on duty may be unaware of the resident’s failing health and unrelieved discomfort can limit the resident’s activities to live his or her life.

Calling in a proxy

When residents do not perceive that they have someone they can approach, and they perceive they are unable to wait, they may shift towards using a proxy. A proxy is

someone who advocates on the resident's behalf and may be family or staff. For example, a resident approaches a kitchen staff member about a personal concern. The staff member, with the resident's permission, talks with the appropriate staff member to address the resident's concern.

If they came to me and they were concerned about a ...problem, or they have problems with their family or something that I thought was a concern...I usually ask ... 'would you like me to speak to [manager] or ... would you like us to try and help you with this problem?' Nine times out of ten, yes; sometimes they say no. (Rachel/165)

In addition to staff, family members can become proxy representatives to assist the resident to have a need met. Residents vary in their willingness to use family as proxy. Some residents, not wishing to cause trouble, do not call in family about what happens in the facility. "No, we don't worry each other, we're independent. He knows I'm not gonna worry him for nothing" (Peter/507). For some residents the facility and the family are perceived as separate and problems are only shared with family if problems in the facility become too distressing. For example, Joy was experiencing some anger from another resident. In interview she reported that "I haven't told her because it's purely the business here ...you know" (233). Joy went on to say that she might contact a family member if the situation became more difficult. Other residents call on family.

My daughter rang ...and said 'could I have a tray in the room?' and I was told, "No, doctors have got to order trays". But as you get on a bit you get wiser and you say, "No, doctors don't order trays at all". (Esther/59)

In these instances, and others, residents' words demonstrate that in situations where their concerns are advocated by family, resolution does not necessarily follow. However residents' words also demonstrate that they work towards not creating a problem for families. Additionally as Esther noted, expectations and strategies shift as experience and ongoing development of the information framework grows.

Living with the status quo: Withdrawing and silence

For some residents their own perceptions can interrupt their strategies to request assistance when required. "Oh, well I wouldn't complain about it; if they don't want to do it, they don't do it" (Abe/275). When the resident perceives that nothing can be done for their condition, or when regardless of their request their need will not be

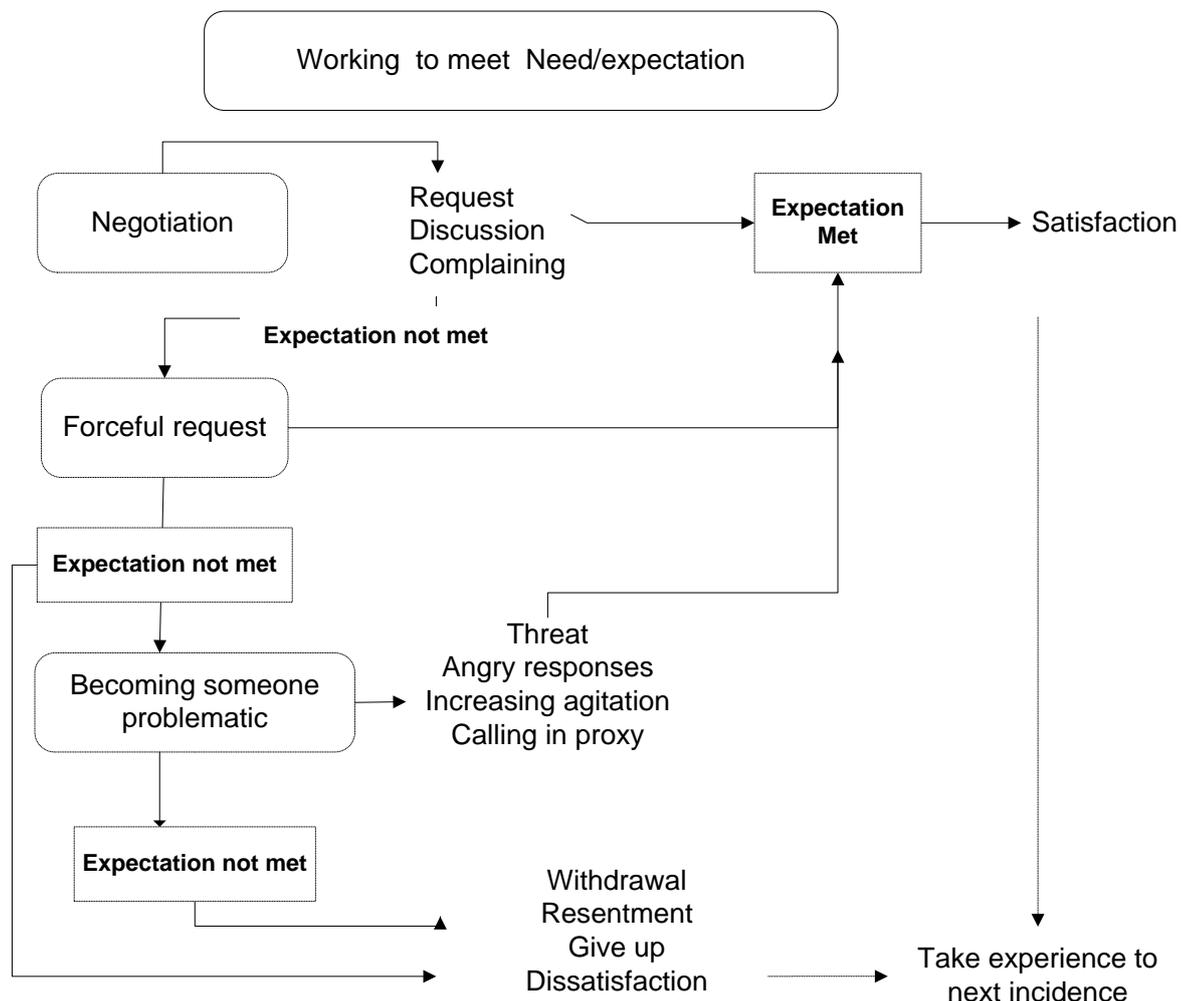
met, they become silent and their needs do not become known to staff. Residents have adjusted their expectations or they have come to a decision which may not match staff perception; but they do not test whether agreement is shared or not. “There’s nobody much to tell about it [pain] because nobody can do anything much about it... so we just put up with it” (Geoff/57). Once again, the potential for mismatched perceptions leads to a failure of meeting health care needs. By becoming silent residents limit the possibility that there may be relief for their condition.

Consequence

The compounding consequences of resident strategies to meet their expectations for health care can be myriad. First; the presence of constant discomfort can limit their ability to join with the community and live a life that is satisfactory to them. Second; escalating responses to staff can lead to staff resistance to respond effectively to their expectations for health care. As seen from the examples provided in these findings, resident expectations are shaped by these staff interactions. Consequently, they can adjust, change or have their expectations reinforced depending on the outcome of resident strategies to have their expectations met. The following diagram (Figure 7, page 125) demonstrates the process in action.

Working to meet personal and social needs and expectations

While residents employ many of the same strategies of negotiation in getting their personal and social needs met, becoming someone problematic can be more public and the resident can present what is perceived as unacceptable behaviour in some aspects of their life. I have conceptualised this public conflict as rocking the boat. The expectation to have social and personal needs met rests mainly in the dimension of *living a communal life*. Residents have expectations that they will be able to join with the community in a way that enables a satisfactory social life. A social life includes not only enjoyable activities in interaction with others, as well as having sufficient privacy for their own interests, but also the ability to use public areas of the facility and to have opportunity to take part in resident decisions about the facility.

Figure 7: Working to meet need/expectation

Negotiating

Residents negotiate to make life more comfortable for themselves and others. These negotiations usually take place during resident meetings where residents can raise issues related to comfort (seating throughout the facility); aesthetics (gardens and how they are attended); food (suggestions about the meals) and dining (suggesting an alternate layout for a dining room table so that residents can interact more fully during meals); safety (lighting and pathways); and life enriching moves (deciding whether to have pets in the facility or not). These examples demonstrate negotiations which have been satisfactorily resolved and met residents' expectations. Consequently, residents develop a sense of satisfaction that difficulties can be

resolved and this knowledge can enhance their ability to live their life in residential care by using negotiation strategies. For example, Frank reported expectations that he could negotiate in meetings and that a carefully considered written complaint would be met on most occasions (134).

Rocking the boat

Resident meetings and resident behaviour in public places however, are also sites for complaint, conflict and distress. Rocking the boat occurs when residents choose to argue and disagree publicly; and thus, run the risk of presenting a self that is unacceptable to some. Residents choose to rock the boat when they perceive a lack of fairness to all. “It would be all right if I didn’t rock the boat. But I rock the boat because I think it’s genuine and it’s necessary” (Esther/480). Residents choose to rock the boat when activities appear to be geared towards a particular few residents, thus excluding others (Esther/41); when residents do not behave how other residents perceive they should (Frank/197; Elizabeth/379) or when residents publicly comment on expectations not met (Abe/307). Staff response to a resident’s boat rocking activities can lead to further complaint to management and an ongoing sense of not being acceptable. “I said I don’t like being spoken to in front of a room full of people like that... But after that I got the cold shoulder for a fortnight” (Abe/304).

The consequences for rocking the boat can be ongoing as residents find themselves out of favour with staff, as in Abe’s example, or with other residents as in this example from Frank. “He got very nasty with me... and I’m not good enough to be spoken to now” (Frank/200). Abe reported that consequent to this incident of public embarrassment followed by the ‘cold shoulder’ from staff, he had decided to remain silent in future because he wanted to avoid getting on “the black list” (Abe/ 219). Other residents report not caring about the consequences of rocking the boat. Therese, a reluctant admission, would often call loudly for staff and publicly demonstrate agitation, anger and insistence when her expectations were not met. “I thought, you bitch, why should I do what that bloody woman says? She’s a lovely girl, nothing wrong with her I suppose, but I resent bitterly being told I couldn’t [use a facility amenity]” (Therese/380). Therese also reported that other residents and staff thought her “spoilt” because they perceived that her strategies tended to result in getting special attention.

While some residents take the consequences of rocking the boat, change their strategies or simply do not care about the consequences, other residents work hard not to rock the boat. Their strategies resemble the strategies used to meet their expectations for assistance in managing their health and include becoming silent and withdrawing or using a proxy on their behalf and being careful about how they complain.

Direct and indirect relational shaping

As a result of the work, of either residents or staff to meet expectations, residents' lives are shaped and adjusted. Staff shaping may be direct or indirect and residents in response may acquiesce, push back or reflect on new possibilities. The outcome may influence the very life that the resident is working to live. Direct shaping activities include: having one to one activity sessions between a resident and staff member, as well as, encouraging, guiding, telling, listening, suggesting, setting clear boundaries and excluding residents until behaviour changes. Indirect shaping activities include subtly facilitating an increase in social interaction between residents without the resident knowing the intent of the action, setting up activities which leave the resident with little choice about participating, reporting resident behaviour to others in authority without the resident's knowledge, talking about resident negative attributes when alone and *acting as if* the resident is okay when they are with the resident. "The staff do sit there and speak about them behind their back when they shouldn't...but they go "that's the way he is...and they don't treat him any differently" (Sophie/ 367). The shaping in the latter instance (i.e. staff *acting as if*) is demonstrated in staff reports about how residents are treated. Some staff report that a resident's reputation might result in different behaviour toward a resident or, as reported above the perception is that it will not. Negative perceptions however can be passed onto other staff during handover as reported by one participant.

The night nurse said umm 'Oh that bloody woman. She's always whinging about something' and I was shocked. I had to actually make a point of... 'Are you going to deny her medication because you see her as a whinger?' (Heather/855)

As well as staff awareness, resident interviews reveal an awareness of staff responses to something they have done. Some residents talk about being in the "black books"; being ignored or not getting needs met.

Staff initiated shaping activities

Staff perceptions differ according to how staff understand their work. For example, some staff think that their work is to provide physical care; while others perceive that their work includes attending to the residents' emotional needs. In the former instance, the staff focus is on ensuring comfort and in the latter, the focus shifts to including encouragement in the social and emotional facets of life. Shaping comes to the fore when residents' perception of their individual and communal life becomes known to staff or staff decide that residents need to be doing things differently to enhance their life. A staff member may think they are expanding a resident's life and health by leaving them no option but to engage in an activity when in reality they are removing their choice for involvement in that activity.

So we try and switch off the TV in some periods in the day... We've noticed that other people that don't normally join in the activities will join in because they think; Oh well, we've got nothing else better to do; we might as well join in. (Toni/S166)

In this instance indirect shaping may be perceived by a staff member as facilitative of the residents' efforts to create a life in long term care. At the same time, residents may perceive that a staff member is blocking their efforts to have choice.

Shaping residents' lives: Gap filling

Gap filling strategies are aimed towards creating something of what the resident misses or to provide an opportunity for the resident to talk about what they would like for their life. Gap filling strategies are direct and cooperative for the resident and the staff. For example when a staff member, in conversation with a resident, discovered that she missed her vegetable garden, she worked with the family to have a tomato plant provided for the resident to tender. "She did get a lot of enjoyment out of that" (Jo/S404). Staff and residents agreed to provide a pet for a resident who was missing that aspect of his life. Staff initiated a plan for a resident who was becoming isolated because of increasingly limited mobility. The family in discussion with staff provided an electronic mobility aid so that the resident could rejoin the community.

She drives down to meals; goes out in the garden and looks around... We've made a huge change in her life altogether... she's out and seeing people and chatting and she's happy and bubbly. She was getting a little bit down in her room. (Jo/S729)

Other residents report that staff step and commence gap filling activities, in when there is no one else to assist the resident.

Well, I didn't have anyone to do any shopping for me and the cook said, 'give me your list and I'll do it.' See. So she does it. I had some clothes to get rid off and one woman, who works here, said, 'I know that I can give them away to somebody'. And so she did. (Sheila/119)

While it is not possible to completely fill the gap in a resident's life, some staff work to do what they can in the situation. Access to external facilities are not available to all residents and consequently, some residents find expectations not met because their social life is more limited as a result of moving to aged care. "I'm bored to tears. ... I can't go out because I've got to go by transport ... and I've got nobody to take me out; just to get out in the open you know: oh, it's terrible" (Letty/424). Letty's strategy was to report her now limited activity and at the time of interview, staff initiated gap filling which involved assisting her to develop some craft skills. This response helped her meet the expectation to fill time but did not meet her need to be "out in the open". In a myriad of ways some staff who perceive or learn about a facet of life that is missing for a resident will work to fill gaps that enrich and realise potential in the resident's life thus facilitating the resident's own work of living that life.

When they [activities staff] see that a resident hasn't particularly had anyone visit him for some time ... they'll go and just do a one-on-one. So they'll talk to them and play a game with them ... Usually these are the people who are more isolated or there's a behavioural problem, or they don't quite interact as well as the others. (Sophie/S66-70)

Gap filling opportunities also arise when residents are interacting with staff during group activities. Staff initiated shaping activities assist some residents to perceive possibilities for their life when they had assumed that those possibilities were no longer possible. Discoveries of what residents would like to do arise when residents and staff discover assumptions together. For example, a conversation about ballet led to the possibility of attending a concert.

We found today the[ir]ears pricked up when we mentioned the ballet. They said that would be an exciting thing to go to, and they really had great ideas about how wonderful that would be; so we're going to go. (Toni/S52)

In this instance the possibilities were considered in interaction. The staff member did not realise the residents would like to attend the ballet and the residents had assumed they could not. Additionally interaction brings forth possibilities for life enriching activities when residents suggest possibilities to staff. For example, out of a conversation about being outside, ideas for picnics were stimulated and the staff decided to encourage those ideas. Other possibilities arise when staff realise discontent within the residents.

We've increased stepping it [activities] up now because we feel that it's necessary and it's very important to give them a bit more interesting things rather than saying "we're bored. What can we do? We just sit here and watch the TV". (Toni/S109)

Gap filling strategies which have the potential to shape resident's lives then can be direct or indirect and discovered intentionally or accidentally. Consequently some staff will adjust their own activities so that what was missing for the resident is filled in some way. They do this by working with other staff, family and the resident depending on the activity for which they are aiming.

Shaping residents' lives: Setting boundaries

Presenting an acceptable self is learned through a continually developing *information framework* and, as noted previously, there are times when residents choose not to present an acceptable self. Other residents discover interpersonal boundaries through their interaction with staff. When a resident or group of residents are not acting in an acceptable way, staff set boundaries; and in some instances, threaten to ban them from the group or suggest they find somewhere else to live. For example, one staff member indicated that "we're not going to put up with this [unacceptable behaviour] and suggest that there are other nursing homes around if she's not happy here" (Annette/S300). Residents who step outside the acceptable frame receive information that develops their *information framework* and sets a boundary of how they are expected to be. This is not necessarily how they would prefer how to be. One resident learned what is perceived to be unacceptable in interaction with a staff member.

I want to be able to help you and I'm happy to help you at any time, and talked about all the issues that I'm happy to help him with, his health issues or his you know transport to the doctors or whatever he complains about, but,

I don't appreciate ... you being rude to me in the corridor in ... being rude in general ... and I explained to him how it made me feel; it made me feel sick; it makes me feel angry. I'd go home thinking, well why do I want to work there if people are going to be rude. ...I explained again that I wanted to be on friendly terms and wanted to be able to help him but I can't do that if he's going to be rude to me. So, an hour or two later, he came round and apologised. So, that's how I dealt with that one. (Annette /S332)

In addition to talking to the residents about their behaviour, staff document the behaviour in resident notes and repeatedly talk to those in charge until the residents concerned is spoken to about their behaviour.

I said [to management] 'No, this is really not on. It's not good and this is really difficult to manage in an activity where this is happening... If they are going to come to activity, then they have to abide by...being helpful and being in tune with the other people'. (Toni/S190)

Should residents be perceived to be unacceptable, for example inappropriate physical touching of staff, additional boundaries are set. Staff then work in pairs when performing personal care and limit their conversation with the resident.

Boundary setting is not always obvious or clearly stated. When residents do not appear acceptable to staff, or staff perceive they are too busy, staff can be observed to be dismissive or slow in their responses. Residents do, however, talk about these instances with staff members who listen and observe residents' responses to these situations. These staff then work to protect the residents from boundary setting that is perceived to be inappropriate towards the resident.

They say that when they've come up to the others, they feel very dismissed and then they don't go near them. They [the residents] don't go back near them [the staff]. They get into trouble. ... They are treated like children then...they have been made wait while the nurse is sitting there chatting on the phone to somebody and that makes a big difference to that person's behaviour. They'll be roused on 'I'm busy'. They will be walked past. They'll be ignored and made wait like sort of punish them... It's like withholding. (Heather/S298)

Boundaries can be initiated by staff who work to protect the resident when staff responses have been unacceptable.

One of the staff was quite rude to a resident, and it really, really upset this resident. Anyway she told me about it and I said, 'well do you want to write a complaint or, you know a comment form?' And she said: 'oh, no, no, no,' but

I felt strongly enough that it had upset her enough, so I wrote it out myself and handed it in. (Sandra /S48)

Breaking boundaries and collusion

When both the resident and a staff member perceive that a boundary is unfair, they will join together to collude and break the rule without others knowing. Staff activities to break the rules are dependent on having a good relationship with the particular resident; perceiving resident's need differently to administration (for example, washing personal sheets after management has said they may not and meeting resident outside the facility after being told not to do this); perceiving that residents' requests are reasonable; enjoying resident's enjoyment of outings and seeing the system as unfair on the resident. On the occasion where staff agree with management, their approach to residents is to work to shape the resident's behaviour toward acceptability.

While *living a communal life* and learning the dimensions of *presenting an acceptable self*, residents do meet conflict with other residents and staff. Sometimes that conflict becomes public, either because of the noise of angry confrontation or the place in which the confrontation occurs. One conflict reported by both residents and staff during interview involved an altercation about the garden; another involved a disagreement about the use of a facility amenity. A third involved the behaviour of another resident which was perceived as aggressive and unacceptable. In these instances management became involved in rule setting in an effort to limit the conflict. Staff responses were varied. In one instance, they ignored a difficult resident. In another they insisted that only particular staff members worked with the resident. In a third instance a staff member colluded with one of the residents involved and secretly broke the rule because they perceived the rule was causing further distress to the resident.

I just couldn't see a problem, and they're paying to be here, and she's always done it her whole life, so why make her stop doing something that she's always done... No, I don't tell her [manager]. I would rather them be happy because this is their home, it's not my home, it's their home, let them be happy you know. (Olga/S108)

These staff activities shape resident behaviour and resident behaviour shapes staff responses. Where staff collude however, without management permission, they run

the risk of having a reduction in their work hours if the collusion is discovered. This particular activity is not taken lightly, by staff or by management, and those staff who report their collusion also report anxiety about the consequences; a possible cut in their work hours and subsequent loss of income.

Boundary setting is, in the main, a staff activity. It can be direct or indirect and work to influence the residents' lives. In some instances boundary setting towards residents is clear and unambiguous. In others it can be subtle; yet still set a boundary. Some boundaries are perceived by other staff to be inappropriate and those staff will then work to advocate for the resident and the boundary set is towards staff rather than the resident. Finally when staff perceive that a particular boundary is not acceptable to them, or the resident, they will collude with the resident to break the boundary. It can be seen from these findings that negotiating how to live a life in RAC moves within the three dimensions of *presenting an acceptable self*, *living a communal life* and *preserving the self*. These dimensions however are constantly adjusted as residents meet the condition of expectations for their needs to be met. In response staff can work in a way that can enrich and develop further potential to the resident's life or set a boundary which the resident then needs to acknowledge, in order to live in RAC. Shaping expectations is a major condition which impacts on residents' efforts. Just as residents' self perception can impact their own efforts, staff perceptions impact residents as well.

Staff perceptions: The impact on residents

Staff interviews revealed a keen awareness of residents' moods particularly in relation to their grieving connected to situational change, namely, leaving home, losing abilities and experiencing the death of family or friends; as well as being geographically or relationally separated from family. Additionally staff, at times, revealed the meaning they make of residents' grief experience.

I think there's a grief process. There's every time you lose an ability you've got, you lose ... because that was part of you. Now you can no longer function doing that, you build up an internal resentment. (Gareth/S538)

Staff initiated strategies act to shape the resident's affect or mood by creating a space for listening; filling gaps reminiscent of home and shifting residents to a lighter mood. These strategies are dependent on staff perceptions, staff time and their skill

level. Some care staff report that it is not their responsibility to sit and talk with clients or indicate that sitting with residents is not allowed. "I got into trouble for sitting in their rooms and talking" (Anita/S657).

No, that's never been encouraged. That is considered wasting time, you know that's not your job to do that because they have ... occupational carers... it's not the nurses job. (Joy/S1089)

For some staff, the idea of communicating with clients does not seem to fit with their notion of care giving responsibilities. Both residents and other staff have reported times when staff deliver food and rush by without acknowledgement or discover the resident's abilities through another caregiver as in the following example.

I... said "hello, how are you doing"? [To the resident]
 "All right" and [the resident] just kept talking.
 She [caregiver] ... said: "I didn't know he could talk".
 And I said, "Why"?
 And she said: "well he's never said anything".
 I said "Have you ever spoken to him"?
 And she went: "No."
 Well, I said "If you don't talk to him he's not going to answer you".
 (Gareth/S80)

Additionally, residents report negative consequences for them when staff do not communicate.

At times you'll get an odd little feel there's no interest in you. ... You see I'm a reasonably sensitive person ... but it'd be much nicer if they just say a few words, if they're running late or they're busy, and they are busy at times...because it's just that they walk in and pfft! Gone; it leaves me cold.
 (Frank/419)

However, staff report frustration when they are busy and unable to take time from physical care to sit with residents. In these instances some staff report twinning activities and their strategy is to lift the resident's mood while attending to their physical care.

I've learnt how to talk when I'm working... I ... have a way to sort of cheer them up and have a bit of a joke with them... I can always make them laugh and have a giggle... I can always lighten that mood. (Gareth/S102)

On the other hand some staff stand back when a resident's affect is anger and agitation; while other staff accept anger as a bad day and do not change what they do.

In this way staff shape the resident's affect because negativity can lead to more reluctant care if staff perceive they are continually at fault and the resident's feelings are not explored.

That influences her care because really, she wasn't a pleasure to look after, not that people need to be a pleasure, but it was just a lot harder work than it needed to be and I can see that, in the end, influenced her care. (Cassie/S37)

In the instance quoted above, the staff member had been working with a client who was described as manipulative and who was continually asking for assistance rather than being independent. Staff strategies in the situation were that they tried to anticipate the resident's need, set boundaries about how often a bell would be rung, wondered at each occasion whether the need was genuine and thought about, but did not ignore, the resident's call for assistance.

Findings reveal that staff differ in their strategies relating to residents' feeling and mood. These different strategies arise out of perceptions about their work responsibilities, the requirements of management for their work and their reaction to negative resident responses. The strategies include not responding to negative reactions; creating time to listen; joking to lift moods; twinning mood lifting with physical care; acknowledging grief and working to fill gaps in residents' lives. The outcome of these strategies is that residents' lives are shaped both positively and negatively.

Shaping expectations: Working with tunnel experiences

When residents' grief is deep and mood lifting is insufficient to deal with their situation, staff responses remain varied. This grieving experience has been conceptualised as a tunnel experience. Staff either stand at the entrance of the tunnel (that is acknowledge the surface of the resident's problem); walk as far as they know what to do (do what they can); or walk with the client through the distressing experience (work through the client's distress). These staff strategies shape the resident's affect. When these opportunities are not available, or residents do not reveal the depth of their grief, they walk this experience alone. However, during situational change, when grief is deep and ongoing, and when a resident is faced with a friend or family member's death and when a resident experiences deep depression

or when the staff decide that the resident must relocate because of increasing care needs, the above strategies are insufficient.

Findings from resident and staff interviews demonstrated a myriad of staff responses. As described above, some staff perceive that they are not responsible for more than lifting a resident's spirits. Others perceive that stopping to talk and listen to residents is not their job. For some staff entering the tunnel to guide the resident is not an option. Staff enter various aspects of the resident's grief. Those staff who do work to guide a resident through very difficult times respond by standing at the entrance of the tunnel and acknowledging the grief.

When he died obviously I was heartbroken and I was sitting in here and one of the staff came in and she said to me, "cheer up [James]", so I said to her how I feel deep down, so she said "Even you need a little bit of TLC sometimes" and she put her arm around me shoulders. And that's the sort of rapport I've got with them here, you know. I can't speak highly enough of them. (James/224)

But you chat with them and reassure them, yeah, that's all you can sort of do. (Jo/S818)

While these actions indicate an acknowledgement of the resident's grief experience, they may not be sufficient in some situations. Other staff enter the tunnel; that is, they walk as far as they are able, in order to do to work with a resident's serious grief. In these instances, they usually recognise that they need to refer the resident to a health professional because they do not have the skills required for the situation. Other staff work through the tunnel; that is, they work deeply to facilitate difficult aspects of grieving and depression. Finally some residents do it alone; that is, they live with their grief and do not seek professional assistance.

Residents' may experience long term grief which may lead to depression. One staff member noted not only the deep depression residents' experience, but also the acceptable self that a resident will present when the reality could be very different (*acting as if*).

The depression is so rife here of people that appear to be OK. They put on this face, but somehow I know. I ask a different question and I get the response I need to hear 'cause I can see umm ...I get disappointed then, when

it's seems to be that it always waits for me because no one else can talk about it. (Rebecca/S118)

During interview residents revealed their private self. Their talk was associated with situational change, namely, leaving home, losing physical abilities and losing a family member or a friend due to death. Perspectives of leaving home and the grief experienced was not necessarily time limited and not usually public. Their grief was evident during interview when residents worked to make meaning of their current living arrangements. Residents consistently reported the loss of space "something I'd never experienced you know just living in a room, one room that was yours" (Joyce/589). They recounted the pain of leaving home. "I just couldn't cope with [leaving]. That was very emotional for me, and saying goodbye to the place ... it'd been really home for me" (Ruth/289). Interestingly, these meaning making efforts were not noticeable as residents interacted within the community. *Acting as if* seem to keep grief and loss private. Dominic interacted with other residents pleasantly; attended activities and remained connected with friends whom he went out with. In spite of this, Dominic's grief was evident from a range of comments during his interview. The following is one example of his situation.

I found it very hard to accept the fact that I was here for the rest of my life. I found that very hard... I felt that I was useless and just a burden to everyone, and I bet it'd be much better off if I wasn't here. I would just go out into the bush somewhere and die out in the bush, where I was no trouble to anyone. (Dominic/451)

Dominic said that he talked to one or two people about some things but did not talk in depth about his feelings. As with many residents, he was doing it alone. In comparison, a staff member reported that she walked as far as possible and experienced a sense of failure when she could not change a resident's situation.

I haven't succeeded in trying to get her to do anything, and she's sort the next of my list about the walks now that we're starting to get a little bit of time...but it's very difficult. I find it very hard. And then you feel you failed, you know. You want to sort of make things better for her you know, and happy, but it's hard. (Jo/S729)

Walking through the tunnel with deeply distressed residents involves facing issues with them, working to get professional assistance when necessary and having the skill to work through difficult communication. Some staff report that they recognise

situational change in the important connections that a resident loses either through death of someone close or through conflict. Staff also report a change in a resident's connection to the community; a change in physical abilities, or a change in their expression. Additionally they report some knowledge of the collective resident response to some major events which assists them to anticipate that a resident will need assistance; for example, when the residents become aware that they may need to move to another facility or into a high care section of the current facility.

They think that they're going to death row, basically. They think that that's the end of the line, and they'll resist it, they'll be really upset about it and angry. They see that high care, as the end of the line really, that that's it; point of no return. (Annette/S11)

The staff skills required include the ability to listen and respond to these serious matters and usually occur in the registered nurse domain; however as demonstrated here, even when professional help is available, it may not be effective. The following excerpt demonstrates the client and staff situation.

I said "How were you since you attempted suicide" and he said "Well who are you to care? And you're the only person that's mentioned the word" and I guess that hit home to me that this is what we do. We skirt around dying. We skirt around suicide. We skirt around lots of things and then we pass it on to the next shift and the next shift and the next thing, a fortnight later the communications pretty poor or people just aren't game to address these deeper issues. So because of that [mentioning suicide], he's been quite open to me, talking to me...I found out that he was still contemplating suicide only this time he was going to do it properly and we talked about avenues of support umm and I said "What about the psychiatrist you saw in ummm [hospital after the suicide attempt]?" and he said "No one talked to me". So I was pretty aghast that no one talked to him ... His face lights up and it's not because he's seen me, but he knows he'll be listened to. (Rebecca/S77)

What comprises these difficult situations? In some instances, as above, it is depression. Other situations include deteriorating health which will require a resident to transfer out of the facility or to the high care section of a facility; negotiating between residents who are in conflict; setting boundaries when a resident's behaviour is inappropriate towards staff and listening to, encouraging and guiding a resident who is unwilling to accept his or her residential life.

To begin the work of guiding residents through difficult times, staff often initiate the difficult conversation. Many times, as the above quotation demonstrates, they are working with residents who no longer expect that their needs will be attended to or

that the staff member will do anything to help. Alternatively, they will be working with clients who they are in a sense rejecting and shifting to another level of care or the resident is experiencing a family crisis. “Some people come to me to speak to me confidentially about — they have concerns — it’s basically financial abuse, they have concerns about their families robbing them” (Kitty/S34). Consequently, staff working in these situations work with the resident’s reluctance, anger, agitation and distress. “I’m spending a lot more time with [resident] trying to support her mentally and emotionally during this difficult transition time ... at times she’s been quite bitter about it; a bit angry; disappointed” (Heather/ S162).

The tunnel experience, and the ability to work through it, is dependent on having a person listen and respond appropriately. Residents do talk to close friends; however, some residents do not talk until their situation comes to light, as in the example of the resident who attempted suicide. One staff member noted that residents might provide hints that all is not well when they use a physical illness as an opportunity to talk. That staff member also noted that this strategy is not always effective and, as reported previously, taking cognizance of a resident’s life beyond physical care is not perceived to be in the domain of most staff. Regardless of the outcome, or the process, walking accompanied through the tunnel influences the residents’ ability to face some of the distressing facets of their past and their current life.

Conclusion

Residents work to create a life. The three major dimensions of *presenting an acceptable self*, *living a communal life* and *preserving the self* are in continual adjustment. Not only do resident to resident interactions influence these dimensions but expectations shaped through interaction with staff serve to influence the life residents are creating. Some shaping can enhance residents’ lives while other shaping can negate their efforts. What is notable in these findings is that residents’ lives are complex and while a resident presents one’s self to the community (either acceptable or not) both the open and hidden dimensions of what is missing from their life have the potential to be filled under this condition. To further complicate their lives, the next condition of environmental and structural influences reveals additional aspects of living in RAC which can further influence residents’ lives.

Chapter 7: Environmental Shaping: Conditions Influencing Residents' Lives

In this chapter I explain how the environment of the RACF shapes residents' efforts towards creating their life. The environmental influences include the physical space of the facility, the facility culture, and legislation governing the environment. Only those aspects of these dimensions that were mentioned by staff or residents during interview are used in this analysis. Findings reveal both staff and residents perceive that these environmental dimensions impact staff, and influence residents, as staff adjust to the organisational, structural and legislative requirements placed on them.

The importance of the physical space

The physical layout and the use of space influences residents to pace and sequence their day and work to connect with the community while also preserving the self. Residents use physical spaces to connect with each other in various congregate areas; some formal (activities rooms and dining rooms) and some informal (gardens, foyers and small lounge areas). Additionally, residents use spaces to maintain physical health (walking in the garden), to preserve the self by connecting privately with oneself or with close friends or relatives (gardens, bedrooms and small lounge areas). According to the time and patterning of the day, residents adjust their timing to present themselves in these spaces at particular times when they wish to attend formal activities (meals and group activities) or informal activities (sitting together in the foyer). Additionally some residents purposefully position themselves in particular spaces (by the dining room to get to meals early) in front of the activity room (in preparation for formal activities) and in the foyer (awaiting an outing or congregating with other residents). Further, in public places, residents *act as if* in order to minimise the effort of getting to the place for which they are aiming. These strategies demonstrate that the physical spaces in the facility can serve the resident in some way to live their life and in others to adjust their life so they can traverse the physical space.

The facility culture

Intertwined with the physical space is the culture of the facility where staff work to develop homelike atmospheres, encourage a social life for residents and work to maintain positive relationships between residents and staff. When staff do not respond to the expected practices associated with creating a positive relationship, other staff step in to encourage a behavioural change. Resident input into the culture of the facility is gained by way of survey and feedback regarding preferences. When the facility is perceived by senior staff to be too institutionalised, measures for changing the culture are put in place and staff are educated towards the expected way of working in the facility. Staff activities towards this end may not always be visible to residents and may be initiated by senior staff. Nevertheless the aim of senior staff is that these strategies will enhance residents' lives.

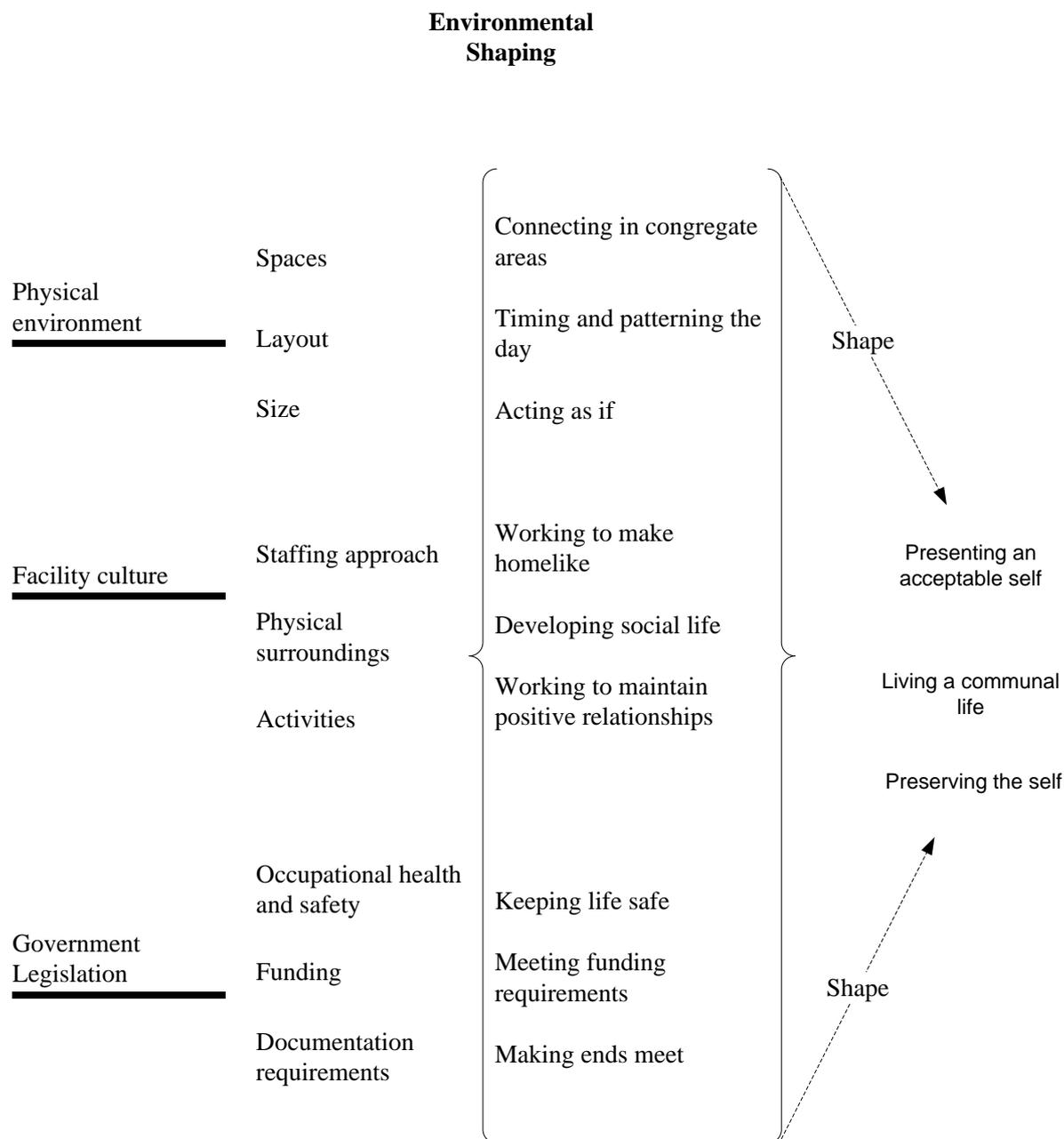
Legislative requirements

Underpinning these two dimensions, and in some instances one step further away from residents, the government legislative requirements for aged care facilities influence funding, staffing and residents. Some of these influences directly shape residents lives, while other influences are indirect. The staff strategies in this dimension are aimed towards keeping life safe for both residents and staff as required by OH&S legislation; making ends meet by meeting funding requirements for documentation of client care. Documentation was reported to drive funding and to make ends meet, senior staff work to ensure staffing quality and numbers while at the same time setting boundaries when staff do not meet the requirements of the facility culture. These three dimensions of environmental shaping are demonstrated in Figure 8 (page 139).

The physical environment: Connecting in congregate areas

The structural and organisational aspects of the facility can either facilitate or create a barrier to resident's work to connect with others. These findings demonstrate that residents connect with each other in formal and informal facility spaces. The purpose for congregating in particular areas, however, is not always for the purpose of connecting with others; though connection may happen in the process.

Figure 8: Environmental shaping



For example one resident positioned herself outside the dining room about 20 minutes prior to meal time. During fieldwork she was observed to talk with others who passed and directed some residents to particular places depending on the time of day. In conversation however, the resident pointed out to me that her main purpose of positioning herself in this space was to be early to meals and then she could leave early. She also noted that the staff were used to her and, while they did not permit

others into the dining area ahead of time, they always permitted her entry. Thus while the resident was using a particular physical space to meet her dining needs (*preserving the self*) she was also connecting with others (*living a communal life*).

Initiating activities: Shifting residents' mood

The main congregate areas in both facilities were the activities rooms, the dining rooms and the foyer. Residents would sit in the foyer in groups. Some connected with each other; others read the newspaper, while others noted the comings and goings in the facility. Activities in the foyer area could turn into a group activity either resident or staff initiated. One resident introduces music from time to time.

Anyway we had no music for New Years Day, and Australia Day I got one of the staff to carry mine down [to the foyer] so we had a bit of music and they said, 'Oh gee that was great,' all those old Australia Day songs brighten up the place. (Esther/232)

At times staff members initiate activity at weekends when staffing is limited and the facility quiet. For these activities, staff use whatever space is available.

We thought, God the weekends are dead boring. They've got nothing to do. So we started up bringing in DVDs and going down to the assembly room and we made popcorn; we'd write it on the board... I'd go 'today's movie is Audrey Hepburn in such and such; it starts at 1 o'clock' ...now they're getting a bit bored with that so I'm thinking that we might change it to one of the lounge rooms ...and I'm thinking, well maybe five to ten people might watch the movie, but they might like to sit a nice big lounge chair and have it set up, you know ... it all depends who's on weekends and what kind of personality they've got, to how much fun the residents have you know...sometimes they might say like, 'I'm bored', and I'll be sort of up the hallway and I might do a little dance, and I'll say 'let's all pretend we're on a cruise ship and do you realise that ... This is a ballet rail' ... just having fun with them... I just get them laughing and it's all relaxed. (Yvonne/S224)

At other times, however, residents find that they are unable to use space in a way they would prefer. Residents usually meet with visitors in their own room or in a private lounge. One resident's request to use the activities room to have a private lunch with a family member was denied. At the same time the resident noticed that the same room was used privately for another group of people. This perceived inequity led to the resident rocking the boat publicly at a resident meeting and privately in a fierce conflict with senior staff.

Adjusting to work within the physical environment

The physical environment itself is shaped by the decisions staff make about the environment; for example, where activities happen or who sits in particular places in the dining room. The physical environment is also shaped by decisions about the timing and pace of activities, meals, and care activities; and changes according to the level of care. For example, having separate dining areas for people in low or high care. Using particular spaces and moving through the physical space for activities, meals, meeting people and any number of other activities can be problematic if the resident has a condition which limits the amount of energy they have available to them and/or their ability to walk distances. One dimension of developing the information framework is learning the 'rules' associated with engaging in the facility spaces as well as the timing of those engagements as their life activities are mediated by staff availability at certain times. For example, if residents require assistance with hygiene prior to leaving their room, they time their activities to coincide with staff availability or as noted previously shift the activity so they have the most energy available at the time they are wanting to negotiate a distance. When negotiating distances, *acting as if*, comes to the fore as the resident preserves the self while appearing to be connecting to the community. For example when the resident has long distances to walk to access the facility amenities, or work in their private garden, they plan how they are going to do that without becoming too breathless or causing themselves too much pain as in the example of Sheila who *acted as if* she were looking at the garden when she was stopping to catch her breath. Additionally, distances and health status shape the timing of the residents' patterns as they figure out the time it takes to move from one activity to another.

I suppose when they're coming up to lunch or something, they'll plan their trip whether they sit down and they have a rest halfway up the hallway, because it is quite a long way, or go through on a short cut... I know a number of residents will cut through that way [pointing] to cut the distance short. So, the first thing I do when I get in, in the morning: I make sure that door can open. (Sandra/S455)

Additionally, dining room spaces and the spaces where residents' meetings are held rebound noise and create difficulties for those with hearing or sight impairment and consequently interfere with the potential for connection. To explain how congregate spaces are used I have focused on the dining room which demonstrates the multipurpose strategic nature of this space for both staff and residents.

Physical layout: The dining room as an example

The dining room for residents is ideally a space for developing an information framework by getting to know, *living a communal life* by connecting with others and *preserving the self* by maintaining their own health. The dining room is also a space for staff who use this space to make announcements, monitor residents' health, provide care and concern and protect residents' sense of self. The dining room, in both facilities in this study, did not always meet residents' needs or expectations; however, was a useful space for staff to meet their perceived responsibilities in relation to residents. Residents reveal that the dining room during meal time is not a place for the aesthetics and connection that many residents would prefer. The dining room is a place of misleading communication and a place for the mutual observation of other residents and staff. In both facilities, residents were assigned a place in the dining room.

In an effort to increase the ease of interaction in one facility, a group of residents requested that their table configuration change so that they could talk more easily to each other. The table changed from a wide square to a long rectangle. Talk and interaction with residents during meals, regardless of table configuration, was difficult. Noise levels and resident conditions interfered with conversation and connection. Resident interviews indicated that the dining room was a site for 'getting to know'; yet did not fill this need.

A man near me ..., he doesn't talk unless I speak to him. Then the lady next to me is a poor old dear soul and she's doubled over like that and because she doesn't talk. Then the lady around the corner doesn't talk; the next one does, she'll talk if you talk and then [a man] up the top and I'll say something, he says he hasn't got his hearing aid in; I thought 'well why don't you wear your hearing aid.' So another time...I thought; 'oh he's got his hearing aid in'. So I started to speak to him and he said; 'I can't hear right down at the end of the table'. So they call that the silent table, so they tell me. So I thought, 'how am I gonna learn the names round the place if I'm just gonna sit at the silent table'. (Ruth/180)

Additionally, the dining room is a centre for misunderstandings that can impact on the resident's relationships. "A woman at my table; she thinks I'm rude ...you can't talk much at the dining room, because it's loud; everything's loud; the music's loud" (Ruth/344). Ruth went on to describe a conversation fragment where misunderstanding as a result of personal disability and environmental influences made for nonsensical conversation. "I said to her: 'have you had your census paper?' She said: 'I didn't get any mail today.' 'No; your census, from the government.' 'Taxation? No.'" (Ruth/346).

In addition to the influence of physical layout of the dining room on residents' lives, the dining room is also a site for monitoring, caring, comfort, observation and decisions about fellow residents by both staff and residents. Residents can be faced with difficulties about another resident's presentation in the dining room which can influence their ability to build relationships with other residents. "Well there's one man, he'll pick up the piece of fried fish in his hands and eat it, and then he'll pick up chips and eat it, and he's got knives and forks" (Peter/384). The difficulties which arise when residents observe each other can be at odds with the resident's perspective of acceptable behaviour. "I am sure they put all the helpless ones at my table" (Elizabeth/264). This very notion that another is unacceptable can make it difficult to build and maintain relationships. Many times during interview, Peter would voice limited friendships with others and follow with an example of dining room behaviour. Though in interview he did not state this as a cause, there was a relationship between his perception of others and their dining room behaviour.

But I'll never understand why they come there and get their toast or whatever it is, and take it back to their room and eat it. I don't know; I can't fathom that out... it just reminds me of a dog taking ... he has this and he goes somewhere else to eat it, you know. (Peter/430)

In an effort to make dining experiences pleasant and enjoyable, residents do request changes. Though some residents ask for change, they also demonstrate a reluctance to rock the boat. "I did ask to move from my table And then I thought, 'well if I go to another table I might have to put somebody out'. So I didn't bother, I've just left it for the time being" (Helen/25).

For staff, the dining room is a place for protective strategies in their care for residents, as well as a place where they could monitor residents' health and comfort. While staff decided who was to sit where, they took a number of dimensions into account, for example the personalities of the residents and other individuals at the table. Their efforts were directed towards finding a satisfactory seating place for one resident while not offending the other residents at the table.

Sometimes a resident might be too shy to say they want to shift, ... we might say to the other residents that are ... indignant about it, because they think it's them... well they didn't like sitting under the air conditioning or the fan, or they need to be close to the door because they can't walk that far, they have bad eyes... you just make up anything to assure the person that it's not them, when it is them, you know. So yeah, you just keep it very cordial and we don't offend anybody. (Yvonne/S77)

In addition to protective care, staff use the dining room as a place to observe residents. They note what they eat and drink; whether they are managing to cut food and chew it; whether they appear to be as usual or unwell or whether they are interacting with others. Their observations are very full and their sense of responsibility for noticing residents level of wellness and doing something about it is evident as demonstrated in the following quotation.

So from the kitchen we have a big responsibility of making sure that the residents are all getting an adequate diet but keeping within their guidelines for their medical histories. So we also... participate in their care plans as well. ... if we find anything that we're noticing like they're not drinking enough fluids, they're not having enough fibre intake or having too much fibre intake, if they're not eating as much as what they were, if they've gone off their food, if their behaviour is changing within the dining room, it could be something distressing them as far as, they can't pour their cup of tea or they can't cut their food up like they used to or they're not eating; you've noticed that they're not chewing properly ... plate wastage we check to see when they come in if they're leaving more and more of a certain food, so they might have problems with their gums and haven't told the PC [personal care] staff and we notice it because they're not eating the harder foods, not that we have a lot of hard foods, but say a sausage or something like that, they're leaving their protein, their meats and things like that. (Rachel/S33)

And the response to resident changes can mean that an exacerbation of illness, when noticed in the early stages, can interrupt the trajectory of that illness. While residents are not always aware of this level of surveillance, such actions can assist the resident to get on with their life.

I don't go and intimidate them. I just sit down on their walker or a chair next to them and I say, 'you know, are you on a diet or something this week, ... I'll try and ...make them at ease, and then usually ... they'll come around, if they can, and if you find that they're more confused when they're talking to you, well you think ... it could be UTI [urinary tract infection], ...you've got to try and pick this up...So that's our job as well to watch them and monitor them, like the personal care and the managers and everyone else... Each department, even the cleaners and the laundry, they see something that's not quite in the norm, then they report it and then we can work on that, because they're not forthcoming a lot of the time and they [residents] sometimes don't understand what's happening to them either. (Rachel/S62)

As well as being a focus for protective care, monitoring, and observation, the dining room is also a site of care and concern. Outside of meal time hours, in one facility, I observed residents wandering into the dining area to sit in the quiet, have a cup of tea or talk with staff. Additionally in the same facility, each resident had their own pot of tea prepared to their preferences, had their food likes and dislikes remembered, were invited to help with table setting and had their condition taken into account when they crossed the boundaries. Because of OH&S regulations, residents in either facility were not allowed into the kitchen for their own safety (facility rules and policies). During fieldwork in one facility, I observed a resident walk into the dining room and then into the kitchen calling out the name and number of a horse race. The staff member quickly wrote down the name and number and then suggested that the resident move back to the dining room from the kitchen area. The staff member said to me "I know she broke the rules and came into the kitchen but if I interrupted her she would have forgotten what she wanted. That's why I wrote it down quickly and then I took her back to the dining room" (F/N No 2). This type of interaction, and its acknowledgement of the resident expectation and need, was observed many times during fieldwork; thus demonstrating that while meal times can be noisy, chaotic and confusing for some residents, outside of meal times the dining area can also be a place for quiet and discussion. These activities serve to reinforce the residents' efforts at creating their own life in this setting. In the main, however, for residents in both facilities, the dining room as a source of interaction and enjoyment was limited and the intersection between meeting staff needs while also meeting residents' needs could be seen as one area where staff needs were given precedence. During fieldwork, Sheila's parting words to me were "You know what I miss the most? A meal around the dining table with friends, a bottle of red wine and fierce debate" (F/N No 1).

The facility culture

In these findings, working to develop or maintain the facility culture includes strategies to make the facility more homelike, working with residents to develop a stimulating social life and working to maintain positive relationships between residents and staff. Environmental shaping in this dimension is aimed towards improving the residents' quality of life and their enjoyment of living in RAC. One facility in this study was working to introduce a culture change, for example: "changing the language, changing the culture..." (Sophie/S147). The second facility was working to maintain the facility as the residents' home.

I believe it is their home. ... and they not only have a right to have it as their home because they pay money, but because morally this is where they live and we're guests, we come and go but this is their home. (Heather/S134)

Improving the quality of life in a facility was reported as making the facility more homely, ensuring that staff speak respectfully to and about residents, increasing the level of social and interest activities, introducing pets into the facility, increasing the number of one on one activities with residents and being part of a family although a different family.

I think it's about participation and feeling part, of the hostel family. It is a different environment to what you'd have in your own home ... So, I think it's a very different way of life, but you need to feel part of that family. (Heather/S298)

The dimensions of homelike were somewhat difficult for staff to articulate. For some staff homelike was described in terms of what was not homelike. For example not institutionalised, "we try hard as we can to make this place a little more like a home and less like an institution" (Sophie/S138). Furnishings and the physical surroundings were also reported as a dimension of homelike "Like eventually plants, animals, things to make it more homely... try to change the way our staff think so they're not coming to work, they're going to someone's home" (Sophie/S231). And as another staff member reported, making it homelike included the introduction of pets. "The activity staff bring in their own animals and [another staff member] brought in birds and there's a canary ... and they sing, they're really lovely; we've kind of adopted a cat outside" (Sandra/S946). A further dimension of homelike included resident contributions to *living a communal life*.

I think they need to feel valued and wanted, and so therefore we have some residents that like to come and help in the dining room to set the tables. Others ... they'll go down and assist... in the activities room in little ways, but ways that they're able to manage to help her. And they feel very valued. (Heather/S426)

The main dimension that staff perceived to be homelike was staff resident relationships. Staff reported an aim for all staff to have a particular approach to residents, achieved through improving staff education about language use, ceasing conversations between staff while attending to a resident and ensuring resident privacy. "Changing the language, changing the culture... Making sure that they don't say 'I'm going to go and do [resident]' they say, 'I'm going to go and help [resident]' or something like that" (Sophie/S141). Another staff member focused on the notion of allowing residents a freedom of choice and respect.

Some ... residents prefer the privacy of their own bedroom, so that privacy at all times is respected. I hope that ... you'll see each and every staff member, knock on the door and ask for entry before they come into their rooms. Because people may not want to go to bingo... they might just want to stay in their room and read a book, or watch telly [TV] or have nap, or whatever. (Heather/S308)

The invisibility of staff intent

Culture change was aimed towards improving residents' lives; however, while residents were reported to be positive towards having pets in the facility, few residents or staff, introduced the words culture change. This demonstrates that in some instances, residents may be unaware of the efforts of staff towards shaping their environment. For example, residents may be unaware of the degree to which management works to ensure that staff actions towards residents are respectful. Those staff members working toward culture change articulated their purpose and at the time of data collection the change process was in the early stages.

The reason we've done it [introduced a culture change] is because we want to make sure that this place is not like a hospital ..., to increase the life of the residents and make it more beneficial to them, that they live longer, be happier while they're here. (Sophie/S242)

On the other hand, the culture in the second facility was considered to be established though maintenance of that culture was constant and ongoing

We have our good and bad days here like any family does... basically I like to treat others as I'd like to be treated myself... it is a very intimate little facility and they just talk amongst each other and, just share what's going on their lives, in their home. (Heather/S527)

Staff perceptions of the culture of the facilities were articulated in life enhancing terms. Their aim was towards enriching the residents' lives and to this end they described activities that could assist a resident to connect with the community (group activities, informal activities and contributing) and to preserve the self (promoting choice, privacy and respect). These strategies however are not necessarily obvious to all residents and have not arisen out of a negotiation of residents preferences.

Government legislation

Underpinning environmental shaping is government legislation. Policies and regulations in the facilities are required to reflect the legislated requirements for safety, resident care and funding. To achieve these ends, staff negotiate or set boundaries in terms of any risk to staff or resident safety. They document care planning in a way that meets funding and individual residents' requirements and conduct quality programmes to demonstrate adherence to legislative requirements. In both facilities, staff indicated that funding was limited and staffing numbers and quality was at risk. Consequently there were times when staff busyness and staff perceptions of their role shaped the degree to which residents could live their life.

Occupational health and safety (OH&S)

Legislation related to risk and safety as enacted through the OH&S legislation was cited by both residents and staff as an influence on what they could or could not do. This condition is, in many instances, inflexible and influences each of the three dimensions of creating a life in residential care: *presenting an acceptable self*, *living a communal life* and *preserving the self*. The influences then create a wall which is difficult for the resident to ignore.

Risk

To preserve the self many residents establish a private space to create their preferred style of living in their private rooms. It was in their rooms during field work that they showed me curtains, furniture, plants, photos, books, writings and hobbies which reflected their personalities. Residents think about their room as their own personal space. When Frank talked about home, the picture in his mind was of his room; when Nancy talked about her room it was in the context of owning her room; and when a number of residents talked about their room, they reiterated that no one could interfere with their room. The OH&S legislation however, is the vehicle whereby staff could complain about clutter and lack of safety for themselves and thus persuade management to intervene to insist that residents declutter their room before staff would clean it. Some negotiation of risk was reported by staff while other risk and safety issues were stated as not negotiable. Not negotiable issues related to staff safety and usually involved the withdrawal of services, particularly in the situation of cleaning cluttered rooms. In these instances, staff reported that “OH&S does actually override residents’ rights” (Heather/S613).

Risk negotiation involved, in some instances, informed consent, discussion and a resident decision which absolves the facility of safety issues for any injury.

They make that decision themselves. I suppose then you could say ... you’re at risk; ... I mean we’ve got things like risk release forms and all that, but [it] doesn’t make you feel any better if something does happen. (Annette/S132)

The term “participative overriding” was used by another participant when OH&S issues surfaced. The strategy here involved discussion with the resident and with the resident’s consent, the family. The discussion focused on staff safety when cleaning a room or, as in another case, the resident’s safety to self medicate and details of the risk to the resident or the staff were explained with a request for cooperation. Where medication is concerned, the doctor is involved in determining the resident’s safety and any outcome is documented so that the facility can demonstrate their adherence to legislation. Where the issue is room cleaning, the staff limited their cleaning activities until the resident complied with their request.

I tried to negotiate with the resident about rearranging furniture or asking families to take some things home... or on one occasion just explaining, to both the resident and her daughter, that we would only be doing certain areas such as the bathroom floor and a little bit of light dusting and changing of the bed linen; that we would no longer be vacuuming the full bedroom ... [the resident was] probably a bit angry I think; that her own personal space had been changed, altered, invaded. Because, really, that is their little world, their bedroom, isn't it? (Heather/653)

Residents report an awareness of OH&S legislation and that they expect to be able to help others. The facility management and staff insist, however, that OH&S legislation means that they are unable to help if a client has health problems. Some residents abide by the rule with difficulty; others do not abide the rule. Consequently residents decide between rule requirements (decluttering their room) on some occasions and their own personal expectations on other occasions. Finally, however, for some residents learning to be acceptable involves *presenting an acceptable self* to staff by abiding by some unmovable rules. Thus, in response to environmental shaping, residents are expected to *present an acceptable self* to management by having an uncluttered private space and to avoid OH&S risks to themselves and staff by standing aside if a resident falls. In spite of this, residents do break the OH&S rules when living a communal life.

Please don't do anything ... So, as much as you love to care; don't do it [assist a fallen resident]. (Gemma/S280)

They've told us we're not to do it. If we fall or she falls, we're in bother you know. But it's hard not to do it. (Esther/336)

I don't... I've got to help her, if you know what I mean. (James/343)

Meeting funding requirements: The risks to resident care

"It's very expensive, and where we are not for profit, we only get from the Commonwealth, and we don't get the funding ... It's a bit of a juggle (Kitty/S435). Other environmental influences are reported to be restrictive of staff work and therefore of resident care. The staffing environment reported by both staff and residents includes staffing numbers as well as staff qualities and staff pace of work. Additionally staff report that funding and legislation interferes with their ability to spend time with residents. They cite documentation as one dimension of interference and staffing numbers related to funding as a second dimension of interference. In

order to attract sufficient funding to meet costs, staff report the need for effective documentation. There is a tension in staff reports regarding documentation of resident care. These reports indicate that documentation is for funding rather than resident care; that they do not read residents' documents unless they have to and that documentation takes time away from resident care. Their strategy then is to recognise the need for funding and document while not using that documentation for actual resident care unless they wish to make a point.

I believe that the majority of the documentation we do is for funding, not for resident care. We can have an entirely appropriate and adequate resident care plan and exceptional documentation that I believe, would meet the continuity of residents' care. The documentation that's completed in this, and probably every other facility, is to meet the validator's expectations; so that we can maintain the funding to stay open, which is a disgusting situation, because it takes staff away from the residents. When they're sitting there writing notes for an hour or two, they could be out there giving resident care. It's all about dollars. (Heather/S759)

Additionally, income from residents' bonds is based on an income assessment. Those residents who have insufficient funds are admitted by legislation as concessional residents. Consequently, concessional residents do not add to the finance pool of the facility. "We've got too many concessional residents and it's getting to the point where I'll be directed to take no more concessional residents because we don't have enough bonds; we don't have enough income" (Kitty/S472). Funding impacts staffing and impacts residents both directly and indirectly.

Regardless of the funding pool, or the funding earned through resident documentation, senior staff in the facilities are consistently working to make ends meet. The focus for funding then turns to recruiting and retaining staff, ensuring the staff skill is of a satisfactory level, and looking to other avenues for saving money. One facility has worked to ensure that care staff are educated in multiple roles (personal care, diversional therapy, kitchen work and cleaning), thus ensuring an ability of staff to switch roles in times of need. The other facility is working through the issues of work roles and segregation between roles.

We're paying too many people; wasting resources with GPs [general medical practitioners] who don't get paid enough to come here, and then just say 'go to the hospital': I'm a big champion of the nurse practitioner: can I pay one? No. So basically I'm all full of piss and wind. (Kitty/S472)

While staff recruitment is difficult, the perception of senior staff is that they are employing people for important work, which requires quality people; however, paying them inadequate salaries. “It’s not unreasonable what people ask for and you’re embarrassed about what they’re paid really, ... you can earn more in Woolworths, it’s awful” (Kitty/S457). Additionally, senior staff report that they are concerned about a number of issues. The adequacy of the staff they employ and then educate, the problem of maintaining staff, and the skill set of those staff they employ while maintaining boundaries of quality care.

I hate the fact, in my job, is the constraints on money because you want ... I know the difference between good care and bad care, and I know the difference about who’s functioning and who isn’t; but the thing is that you get so short staffed and so desperate; ... there’s people ... we’ve been desperate to keep and I’ve terminated because they’ve done the wrong thing and that’s the message you want to send to people, but then the other side, is then you can’t attract anybody else to the job, and that’s why the aged care industry is in all this mess. You know you get all these people who are just, you know, transferring from one; they just recycle themselves through all the facilities. I won’t take anyone without a police check; I won’t take anyone unless they give me the name of their last immediate supervisor and a phone number. (Kitty/S496)

Some strategies that staff employ include requesting more funds from the corporate body when clients are unwell and require further staff care, and transferring residents to high care if they are in a low care space, but require nursing at a high level of care (nursing home). “Because of ... funding, staffing, just skills; there does come times that we have to let people go ... [to a high care facility]” (Heather/S238). Additionally, when required, and staff are not available, families are called in. “I’ve worked with the families and the families have been able to work with the resident, or be with the resident overnight” (Heather/S245). At these times, staff focus on physical care of the resident and become frustrated at their inability to attend to needs beyond physical care.

You’ll get that resident that will talk, and talk and talk; and you know they’re lonely, and, you do feel bad; and you try to work and talk to them at the same time, but it’s really hard, if you’re in the bathroom, and they’re in the bedroom, and they’re partly deaf anyway, so yeah. It sounds dreadful I know, but like you know, there’s certain duties that you’ve got to perform during the day, and that’s what you’re actually paid to do, you’re paid to clean. (Sandra/S505)

How do these situations shape resident's ability to create the life they want in RAC? Consistently throughout these findings, examples of staff unavailability demonstrate that residents have some awareness when staff are just too busy, or do not have the capacity to respond to their needs. Residents talk about staff being constantly busy and their response to the absence of staff relationship.

No, I'm not blaming her, she's got work to do, but it'd be much nicer if they just say a few words, if they're running late or they're busy; and they are busy at times. (Frank/146)

This unavailability of staff is particularly noticeable for residents who are unable to mobilise without staff assistance, or who would like more assistance from staff than they are able to provide, due to the busy nature of their work in times of staff shortage. At these times, residents work to recognise the demands placed on staff and withdraw any complaints they may have.

Well, especially here, they're very short staffed. Actually, I can understand people not wanting to work in a facility like this because you see some very difficult people you know, residents. I used to often say, they'd have to be bloody saints or bloody insane to work in a place like this. So, it's a difficult job and I appreciate what's done for me. (Zoe/243)

However, while residents do recognise some aspects of the physical space, the culture of the facility and the legislative requirements have an impact on staff work; their activities towards creating their life can be shaped by these environmental aspects. Some residents bypass the rules and regulations as in the case of OH&S rules. Others comply and restrict their activities and space in acknowledgement of staff busy work. Additionally, as is seen in residents' life creating strategies, they are met with a complex array of staff attitudes and approaches regardless of the legislative requirements and regardless of the facility culture. For residents negotiating how to live a life remains complex, at times enriching and at others limiting.

Conclusion

There is a thread running through these findings. That thread reverberates through the three dimension of living in RAC; namely, *presenting an acceptable self*, *living a communal life* and *preserving the self*. The thread relates to staff work and staff availability and is drawn taught by funding and regulatory requirements.

Additionally it is related to residents' and staff expectations and perceptions of residents, work roles and work routines. The physical space can cause residents' to use energy moving through the facility; to pattern their days so that the energy adjustment is minimised and to hide the effort these activities engender. Alternatively, it may cause residents to cease an activity in order to *preserve the self* thus limiting opportunities for contribution and connection while *living a communal life*. Opportunities for *living a communal life* are also limited by the staff use of the dining room as an arena to meet their need for client care. Thus one of the most important aspects of residents' health can paradoxically be at risk as limited pleasure in the dining experience limits their nutritional intake.

When resident care documentation is for the purpose of funding, it becomes inadequate for resident care as the funding tool is directed towards relative care needs as opposed to individualised resident care needs. Additionally, as staff report, there is a frustration that documentation is about funding and actually shifts the focus from resident care to funding care. This situation is more problematic in the presence of staff shortages and staffing skill levels. Fewer staff working to achieve the same level of care is noticeable to residents who adjust their expectations and not interrupt the staff even though they want a relationship with staff thus *presenting an acceptable self* from their perception.

Finally OH&S legislation sets boundaries for resident care, interrupts residents' perception that they are in control of their room and their life and creates a tension for staff. What appears to be important here is the degree of negotiation that takes place. For some residents, not entering a negotiation means they simply break the rules. Others report frustration at not having their preference met.

Environmental influences on the other hand can be positive. Residents use spaces to connect with other residents and some report the pleasure of group activities (*living a communal life*); some enjoy reflective times in the garden and the privacy of their rooms (*preserving the self*). What is problematic is that due to environmental influences, the potential for living their life can be limited.

Chapter 8: Discussion

Introduction

In this thesis I set out to explain how residents influence their life in RAC. What I found was that to influence their life, residents continually adjust their actions, their pattern of living and their interactions with residents and staff. Grounded theory is an emergent design which shifts and moves in relation to the issues that are raised by participants. The main issue raised in this thesis was that residents were working to live their life in RAC. To do so required continuous adjustment. The findings from this study demonstrate the complexity of residents' lives in RACHs and explicate in depth, the strategies that residents' use to live their life in RAC. Importantly, the study demonstrates how residents were active in living life in RAC even while they, at times, seemed passive and silent. Furthermore the findings reveal how some residents responded when thwarted in their efforts to live their life. This discussion will focus on the process of continuous adjustment which occurs in the three dimensions of living life in RAC together with the conditions which influence those dimensions, namely, the shaping of residents expectations and environmental influences. The questions raised in this discussion relate to the principles underpinning effective staff-resident relationships together with an examination of the person centred care and relationship centered models of care. Finally the discussion will consider the context within which RACFs face resource challenges in relation to staffing and funding.

Living in residential aged care

Residents in this study worked at living in RAC. The work involved the three dimensions of *presenting an acceptable self*, *living a communal life* and *preserving the self*, that when considered singularly are significant and when considered in concert, are even more significant. The residents' work occurred in intrapersonal, interpersonal and environmental interaction as residents figured out how best to act in a range of situations and with a range of people. Information was taken in and considered. A decision was made and actions decided. The decisions included *deciding how to be* and the actions were focused towards how residents *announced their identity* in order to *present an acceptable self* that fitted with *living a communal life*. Further decisions were made when *preserving the self* needed to be prioritised.

For example, on admission Ruth was unwell and simply did not have the energy to think about presenting herself or engaging with the community. For Ruth the work of *getting to know* commenced some time after admission and repeated hospitalisation. In Chapter five, the three dimensions *presenting an acceptable self*, *living a communal life* and *preserving the self* were explicated in depth, demonstrating that living life in RAC was by no means simple or passive.

The three dimensions of living life in RAC also overlapped so that at the same time as a resident was *building an information framework*, by gathering *foundation* and *subtext information*, they were learning about *living a communal life*. This recursive process built in breadth and depth for all participants regardless of length of stay in the RACH. The consequences for some residents, over time, were that as they *got to know*, they had information to argue in particular situations. Recounting the development of her knowledge, Esther's initial request was refused with an incorrect explanation and future requests of the same nature were countered as a result of having a developed an *information framework*. "[I asked] 'Could I have a tray in the room?' And I was told, 'No, doctors have got to order trays'. But as you get on - a bit you get wiser and you say, 'No, doctors don't order trays at all'" (42). *Getting to know* the facility, the community, what was acceptable and what was not, and for whom, took time. New residents were introduced and shown around the facility; however orientation to their changed living circumstances appeared to be short-lived.

Becoming a resident in residential aged care

There is a wealth of research indicating that "becoming a nursing home resident is a life-defining event" (Bland, 2005, p. 8) involving major adjustments (Choi et al., 2008; Forbes & Hoffart, 1998; Guse & Maesar, 1999; Tracy & DeYoung, 2004). Researchers have described the admission to RACFs as potentially traumatic (Davies, 2005); difficult and emotional for residents and families (Sandberg, Lundh & Nolan, 2001); and as "the most significant relocation for older people" (Lee, Wood & Mackenzie, 2002, p. 19). The participants in this thesis also considered their admission into RAC as a significant event whether they were experiencing the event; or for long term residents, whether they were remembering the experience of the event. The process of admission to RAC then is a major life event which requires a major adjustment. The process I have conceptualised, in this thesis, is that of

continuous adjustment. I argue that adjustment does not cease and residents in RAC face continuous adjustment.

Meleis et al. (2000) presented a middle range theory of transition developed from a range of research studies across change events including illness and relocation. Davies (2005), citing Chick and Meleis, defined transition as “the passage or movement from one state, condition or place to another” (p. 237). Is continuous adjustment the same as transition? Certainly it holds some dimensions of the theory developed by Meleis et al. Similar to Meleis et al. this thesis presents *continuous adjustment* as including both multiple and singular, sequential and concurrent change events. Additionally, the research rising out of this thesis demonstrates *continuous adjustment* for residents in RAC as ongoing and not necessarily time limited. Meleis et al. however, contended that the transitions which informed their middle range theory were eventually time limited with the outcome of “mastery and having a new sense of identity [which] reflected healthy outcomes for the transition process” (p. 24). I cannot make that claim from the findings presented in this thesis. I can, however, suggest that the type and nature of *continuous adjustment* is variable; and while some mastery of *getting to know* in the initial stages of admission to aged care can lead to knowing the facility, routines, other residents and staff practices, the daily adjustment of changing health and continued loss for residents, indicates that for people in aged care, adjustment continues.

While Meleis et al’s. (2000) middle range transition theory includes the multiplicity of transition types, patterns and properties, the conditions within which transitions occur, response patterns and outcomes, Davies (2005) suggested Meleis et al’s. theory required “adjustment to recognize the contribution made by relatives themselves to positive outcomes” (p. 658). Unfortunately, this thesis also holds that omission. Residents did indicate the helpfulness of family, the absence of family and some strategies enacted by family on their behalf. Others did not enlist family help with adjusting to particular situations. Certainly, an examination of resident-family-staff relationships would have added depth to the findings. However, in the context of this research, family participants were not included.

Cook (2008) however, acknowledges the continued adjustment that residents encounter after the initial admission into a RACF. Additionally, Cook reinforced the notion that contrary to popular belief, residents are active and strategic in their efforts to “live as active biographical agents who were instrumental in shaping their own life in a care home” (p. 27). Cook presented three residents typologies. First residents who independently implement influencing strategies; second residents may initiate strategies and enlist others to carry out their strategies and third residents’ negotiation with those in the environment in order to plan and figure out how to act to achieve those plans on a daily basis. Similar to the findings presented in this study, Cook has named and identified resident strategies and has emphasised the importance of staff awareness, knowledge and support for residents to achieve their goals. Central to both Cooks study and this thesis is the notion of negotiation, shared decision making and inclusive relationships between residents and staff.

Supporting the above notions, Meleis et al. (2000) emphasised the importance of staff awareness of all dimensions of the transition process in order to support people through the upheaval that occurs. Certainly there is a demonstrated need in this thesis for awareness, knowledge and staff skill, to support the *continuous adjustment* required by older people living in RAC. Staff participants, in this study, did not refer to admission; yet most residents did. This omission could have been influenced by researcher questioning. In the early data collection and data analysis process, interview questions were open to enable the participant to raise issues they perceived to be significant. I however, did not follow up questions of admission to the facility with staff once I became aware of the critical nature of the admission process. These findings therefore cannot say definitively that staff were not aware of the enormity of the entry to RAC for residents. I can say however, that I did not note during analysis that staff were aware of the significance of this event.

Staff were certainly aware of new residents and some strategies were used to assist residents. For example, one resident indicated his fear of entering the dining room as a new resident. A staff member, aware of his discomfort, accompanied him to his first meal in the facility. Additionally an activities staff member reported that she waited until she perceived residents were more settled (a few weeks) before inviting them to come to activities. Pre admission conversations with residents and families

were reported to cover all aspects of life in the facility. Resident data and staff data however, indicate differences in the significance of admission into RAC. With staff, the data reflected admission to RAC as an everyday routine occurrence where some introductions and monitoring continued for a short time. With residents, the data included the magnitude of the move into RAC.

Residents' data demonstrated a concurrent process of leaving, surrendering and entering during the time after admission. Leaving included leaving home, friends and their community activities (exercise and or hobby groups, civic organisations, and places of spiritual belonging). Surrendering included surrendering to deteriorating health and receiving assistance; surrendering loved objects which no longer fitted and surrendering the freedom to choose how they patterned their day, when they ate and what they ate and finally, for many, a surrender to living communally. Many times admission into the facility had been due to deteriorating health of the resident or a spouse. At the same time, as the residents were experience the leaving and loss, they were experiencing the entering phase of moving into residential aged care. Entering RAC involved effort to figure out the new while grieving the past.

Analysis of residents' data led to the concept of *getting to know* and the processes feeding into *getting to know* were conceptualised as *building an information framework* and *learning the subtext*. Residents got to know by deliberately asking for information from staff or other residents, both incidentally by being in a situation where they observed staff residents interactions which alerted them to appropriate and inappropriate resident actions and experientially by making a mistake which was pointed out by either staff or other residents. The conclusion I reached when analysing these resident strategies is that they occurred in a context where orientation to the facility was short lived and time limited, while the residents' strategies to *get to know* were incrementally gathered over time. Moreover, I argue that the process of *continuous adjustment* relates to living in RAC during the admission process and beyond.

The public nature of living in residential aged care

Few residents in this study had previous experience of communal living. Most residents' past experience was of living in a nuclear family and/or living alone. Even for those with prior communal living experience, life in RAC was different. In the words of Ruth:

It's a very homely place; the lovely staff and then the people are all friendly and happy but that way too, because you meet all the different characters, some are willing to speak to you and some are very quiet and you know, and some are not able and you know it's all stages of ability or disability, whichever, and of character also. But some are more outgoing and others are more retired and quiet and so forth. So there's just something that you, I have to get, not so much get used to because I know that's part of life, but I mean, accepting it now in my life: this is my life and they're the people I'm living with and they're the ones, I have to get used to. (242)

It's an enormous task for residents. Life for the residents in this RAC was public even though they had options for some privacy in their own room. Activities and meals were communal. Routines and patterns of life were to a greater extent, shared. Surveillance by other residents and by staff was ongoing. Thus, at the same time as *getting to know*, they became known and their characteristics were categorized resulting in the *conferring and receiving of reputations*. Residents talked about how they were known. They talked about others telling them they were 'stuck up', 'taking over', 'being spoilt by staff', 'having a sharp tongue', and 'creating trouble'. When residents were aware of these labels they worked, in some cases, to reverse their reputation. Interestingly, few residents reported positive labels attached to themselves, and appeared unaware that many residents and staff conferred positive labels on them. For example, they told me about other residents who were fun, friendly, helpful, inspiring, trustworthy, dependable and smart. Negative labels, for some, could be problematic for living life in RAC and required the resident to reflect on what they were going to do about them. As reported in Chapter six, Abe's decision in response to negativity from staff was to become silent. Miriam's decision in response to a negative label of 'taking over' was to talk quietly to staff where others could not hear or see her continued leadership activities. Frank's decision in response to his negative label for not attending memorial services was to ignore those who conferred the label. These labels were conferred in response to a public action by the residents and caused some adjustment.

The nature of privacy in residential aged care: Preserving the self

The work of living in RAC continued in the private confines of residents' rooms and in the resident's intrapersonal thinking. While interacting with other people, private identity work was ongoing as residents reflected on who they were, who they are now and who they are going to become. In the process of *preserving the self*, residents *storied the past*, to make meaning of both the past and the present. Frank reflected on how, in the past, he had inappropriate expectations of an elderly relative. "Until you're old, really old, you don't understand. I didn't" (Frank/22). Frank's reflections included his past life, his mistakes, his regrets and his joys, together with his experience of declining abilities and increased social isolation. Other residents reflected on their diminishing circle of friends who had either died or whose condition had deteriorated significantly. In their private space, their room, residents cried, laughed, visited with friends, cooked, read, listened to music, continued with craft and learning, watched television and ordered their environment to reflect their preferences. When confronted with deteriorating physical abilities, many worked out how to *manage their own health* while staying independent. In all these ways, the residents' room was a respite from the public arena in which they lived.

Yet, to some extent, this space was also shared. Privacy was matched with the need for staff assistance with hygiene, dressing, mobility, meals and cleaning. Monitoring activities were also conducted in a resident's room when the resident's health was deteriorating or if their room was cluttered to an extent that contravened OH&S legislative requirements for safety. The boundaries of public or private became somewhat blurred when the competing demands of legislation and care practice meant that very little was actually private. Similar to these findings, Mullins and Hartley (2002) also indicated that there is less privacy for residents in RACFs. In a more forceful statement Baker (2007) when comparing the notion of home with traditional nursing home facilities said "privacy is a thing of the past" (p. 30). *Preserving the self* has elements of both the private and the public dimensions of living life in RAC. For example, *rocking the boat* was a public action which arose out of the residents' internal value system. The concept of *preserving the self* presented in this study, is different, yet has some similarities to the same concept named by Ryvicker (2009).

Ryvicker (2009) conceptualised the preservation of self in terms of how resident-staff interactions enhanced and supported or demeaned residents' sense of self. Her ethnographic study raised important questions in relation to the dilemma residents' faced when integrating their institutional and personal identity. According to Ryvicker, "in the context of the nursing home, residents are caught between two institutional identities; the identity of the autonomous adult and that of the ill, dependent person" (p. 13). Residents' work in this context is to actively negotiate these identities as well as integrate them with their own sense of self. In this thesis the *preservation of self* includes identity, values and strategies residents use to maintain independence. It could be argued that residents who negotiate, argue, *rock the boat* or *become someone problematic* are demonstrating agency. Ryvicker conceptualised examples of reciprocal resident assistance as personal agency; while I have conceptualised similar examples as *contributing* and *connecting* and have situated these in the dimension of *living a communal life*. There are, however, remarkable similarities in these two studies which, while conceptualised differently, demonstrate the ongoing work of residents in RAC to maintain their own sense of self and their values. Yet, one main difference between these studies is that Ryvicker focused on participant observation over two years to examine staff practices which influenced residents' preservation of self; while the study, in this thesis, focused on residents and staff interviews with limited participant observation (24 days). Nevertheless both studies have demonstrated the work of living in RAC is ongoing.

A process of continuous adjustment

Residents in this study shifted strategies in their everyday life while living in RAC. These strategies sometimes involved a change to the previous pattern of their life, as in the case of Nancy who discovered, two years after admission, that her mobility had changed and she could no longer navigate the steps to the bus. Nancy, who described herself as a very independent person, could no longer leave the facility without assistance. The result for her was to return to adjust her *information framework* and figure out how to live her life mainly within the facility environment. On another occasion, Nancy discovered that she no longer had strength in her hand to cut up her meals. These continuing losses involved a return to figuring out who she was now and how she could manage her independence while also accepting help. As she talked during interview, it was noticeable that each change required an immense

adjustment on her part as she worked out how to *present an acceptable self, live a communal life* and *preserve the self*. Other residents recounted adjustment changes. In some instances the adjustment occurred in the moment and was of short term and involved a prioritization of a particular dimension of life that was important at a particular time. For example, Esther would *preserve the self*, on a number of occasions, if she felt a threat to her sense of justice and equity. On those occasions she would background *presenting an acceptable self* and foreground *preserving the self* by publicly *rocking the boat*. Thus, there were a myriad of situations which led residents to make long term or short term adjustments to their usual way of being.

Does adjustment end?

Kahn's (1999) ethnographic findings also revealed the ongoing nature of residents' adjustment in RAC when he concluded that "making the best of it represented a concerted and continual effort to reframe and reconstruct the social environment" (p. 130). A different perspective however was reported by Lee Woo and Mackenzie (2002a). Similar to Meleis et al. (2000), resident participants in Lee Woo and Mackenzie's grounded theory study on adjustment into RAC were reported to traverse four stages in order to regain normality, namely, "orienting, normalizing, rationalizing and stabilizing" (p. 670). Normality, according to Lee et al. occurred when the resident achieved a life as close as possible to life before admission. During data analysis for the study, reported in this thesis, I was challenged to think about resident adjustment as a trajectory. On each occasion that I reconsidered the concept of continuous adjustment, I could not find a time when adjustments were completed; thus kept returning to the recursive nature of the adjustments that residents made. For example, the most settled resident who reported a deep love of his life in RAC, stating that it was the best move he had ever made, became excited during member checking. He pointed to the adjustment note on my diagram telling me he was exactly there. He could no longer drive and was now figuring out bus routes so that he could still continue some of his activities. Not having independent transport was a major change in his life requiring a reconsideration of the timing, pacing and conduct of his activities. Additionally, data analysis revealed that residents who had been living long term (over three years) in RAC consistently indicated that this was not like their previous life. For example one resident, of over six years, said "you're regimented here... I haven't had a regimented life for a long time [referring to pre

admission days]” (Miriam/97). While residents had adjusted to some aspects of their living environments, the findings for these participants indicate that the life lived in RAC did not achieve the normality that participants reported in Lee et al.’s study. As Abe, a resident of three years, reported “It’s a different life altogether” (Abe/168).

The findings from this thesis explicate the actions involved in adjusting. Adjustment called on energy which was not always available to residents in sufficient quantity. Many resident participants, in this study, lived with chronic conditions and their conditions fluctuated many times without warning, leading to a sudden change in how they lived life. These residents referred to the tenuous nature of their life. In Ellen’s situation, it was a sudden stroke: “I woke up one morning in bed and tried to turn on the light ... and I couldn’t move” (40). How did residents respond to the myriad of challenges that occurred on a frequent basis? In order to effect adjustment, residents foregrounded the dimension/s of their life which required adjustment and backgrounded other dimension/s of their life. I contend that adjustment does not end and that residents are active in their strategies to deal with situations that cause adjustment.

Acting as if

Residents in this study did not always declare their changed situation to the facility staff. In some instances when they did, they had mixed reactions from care and concern through to folk remedies or an unsatisfactory response. In the instances where residents did not choose to declare a change in their situation, they acted *as if* all was well, when it was not. The residents provided a range of reasons to explain their silence. Some residents did not think anything could be done to assist them. Maintaining independence was considered important and some residents talked about asking for help only when they decided they needed it and only for as long as they needed it. Others did not wish to be seen as a complainer and some chose silence to avoid that label. An additional reason was that some residents did not wish to transfer to another room or another facility if their care needs required more constant staff input. Together, with the above reason for *acting as if*, residents indicated a reluctance to interrupt busy staff and a preference to *bypass* particular staff because they did not perceive those staff would be helpful. *Acting as if* was a useful strategy in a range of resident situations and if residents chose that strategy, then that was

their right and at times afforded them some privacy. However, if the strategy was chosen because residents saw staff were busy or had previous experiences of an ineffective response, their choice was not necessarily free and arose out of a structural deficit in the RACF.

The negative consequences of *acting as if* are that opportunities for pre-empting a serious condition can be missed and the resident can become extremely unwell. When residents perceive that nothing can be done about their situation, additional opportunities for health maintenance or assistance to work through a situation of functional decline, distress, boredom and loss, are limited. There is detailed research which points to the relationship between health, social connectedness, well being and quality of life (Nolan et al., 2006; Owen & NCHR&D, 2006) If the resident-staff relationships do not engender information sharing and negotiation, then staff do not have information about what a resident prefers, wants or needs, and negotiations to find a solution are limited. Resident- staff relationships therefore are influential and central, in many instances, to effective adjustment strategies.

Resident-staff relationships

The residents and the staff participants in this study reported a range of resident-staff relationships. The nature of the relationships could change and were considered absent, dismissive, conflicted, harmonious, concerned and equal. Some resident participants reported the ability to negotiate their expectations and needs or to negotiate on behalf of another resident. Additionally, residents reported some inclusion in decision making, for example, deciding on a micro scale to have a meal in their rooms or on a macro scale having input into furniture purchases for the facility. At the same time residents also noted what they did when a request or expectation was not listened to or met. In some instances, their strategies led to their *becoming someone problematic*, or *rocking the boat*. In other instances, the resident disengaged, *withdrew* and became silent and, at times, resentful. Consequently, some staff-resident relationships were difficult and stressful.

Limited staff connections were difficult for residents, particularly when meals were delivered without interaction; when staff dismissed residents' concerns; when residents felt demeaned in public and when they were not acknowledged by staff

members as they traversed the facility. Their efforts to live life in RAC were easier when staff shared stories of both homes, listened to their concerns, worked to solve problems with them and stepped in where there was no family to help. This staff group did recognise and listen to residents' talk about the gaps in their life and discussed ways to fill those gaps; conceptualised in these findings as *gap filling*. In these instances staff worked with residents by providing an opportunity to grow vegetables, arranging concert trips, negotiating mobility support and providing weekend entertainment to name, but a few of the staff strategies. Residents talked about instances of staff working together with them and reported a close connection to staff. Staff also talked about these activities and recognised the contribution their action made to the residents' quality of life.

When some residents were experiencing a significant ongoing distress which was in relation to their own or their family situation, some staff supported, listened and provided effective assistance. These times have been conceptualised as *tunnel experiences*. These were resident experiences of loss, health deterioration or in one instance a suicide attempt. The strategies staff used in both *gap filling* and *tunnel experiences*, however, were dependent on individual staff rather than arising out of a strong facility philosophy about individualised and relationship centered care. Residents would soon learn this and some began *bypassing* some staff in preference to others in order to receive assistance. At other times, staff initiated communication, created an environment for residents to talk through their situation.

Perceptions of resident-staff relationships

Differences existed between staff regarding their role and the degree and nature of their relationships with residents. Some staff talk was negative as they referred to residents as difficult, frustrating or stirring up trouble. Other staff talk was positive and included resident characteristics and abilities and demonstrated an understanding of the residents' contexts. There were staff who thought their role was to provide physical care and to concentrate on work routine rather than spend time talking with residents. A dilemma occurred for staff who considered their role was to problem solve with residents to find best solutions in particular situations. For this staff group, being short staffed or having a heavy workload interfered with their ability to walk and talk with residents. In some cases, staff who had a close connection with

particular residents were cautioned by management to maintain some distance. On occasion, this led staff and residents to collude in order to maintain the relationship. As this study demonstrates, in individualised circumstances, staff and residents could figure out situations effectively. That residents employed negotiation strategies was indicative of trust in an individually consistent and effective staff-resident relationship. In circumstances where a resident had an effective relationship with a staff member, they experienced supported adjustment. Residents in RAC will experience the need to adjust. The question here is whether it is sufficient that residents need to rely on individual staff to assist them as they encounter adjustment situations, if they choose adjustment. Clarity of work role and a consistent philosophy of relationship-centered care could provide further choice for residents, and increase life satisfaction for residents and work satisfaction for staff. This discussion now turns to the influence of leadership, structure and models of care in RACFs.

The context of residential aged care facilities

The facilities in this study were both accredited by the ACSA. Data analysis of interviews and fieldwork notes revealed an overall direction towards care and concern for residents and for staff, which was not always evident from staff and residents' data. One facility, in an effort to improve resident-staff interactions and to create a 'homely' environment had adopted some features of the Eden model. Talking about the Eden model, staff revealed their efforts to change staff language towards working with residents rather than doing for residents. In the other facility, staff also reported the importance of dignity and respect for residents. Efforts were made to ensure residents' privacy in both facilities and during fieldwork I consistently saw staff knocking before entering a residents' room. I saw few instances of staff conflict with residents even though it was pointed out to me that particular residents were to be avoided because of their behaviour and negative remarks about residents were made to me as I walked the corridors with staff. Many times, I observed staff passing residents in the corridor, smiling, stopping to talk and acknowledging the residents by name.

The intersection of resident and staff needs

In both facilities, data revealed an intersection between resident and staff needs. This was particularly evident in the dining room where dining room aesthetics intersected with the staff need to provide nutrition and monitor residents' activity. In these instances, while care and concern was evident, there was little acknowledgement that the dining experience for residents was a site for *getting to know, connecting, contributing* and *living a communal life*. Residents did *connect* and *contribute* as best they could. They assisted other residents to tables, helped with anticipating needs for residents whose sight was compromised and in some instances, were able to converse over the noise. Most residents, however, reported the meal experience as problematic due to noise levels and sometimes the physical capacity and eating behaviour of other residents. The dining experience, for most residents was a barrier to their efforts to *live a communal life*. The residents' sentiments could be gathered into Ruth's experience of wanting to *get to know* but sitting at the silent table.

In part, the dining experiences in both facilities was due to the built environment where dining rooms were large and kitchens were in close proximity; thus compounding noise and activity, which for many residents caused a negative environmental press. On the whole, dining rooms were used to eat and leave. The dining experience reported here is similar to that reported in the literature. Additionally it is in direct contrast to the recommendations, also reported in literature, where the suggestion is that an atmosphere for dining needs to be convivial, aesthetically pleasing, unhurried and providing sufficient quiet that social interaction can occur. When these elements occur in the RACF dining experience, residents sense of self worth, independence and dignity is enhanced (Pearson, Burghardt & Nay, 1997; Stabell, Eide, Solheim & Solheim, 2004) and residents thrive (Bergland & Kirkevold, 2007). This is where intersections occurred in the findings reported in this thesis. Staff had work to do during meals. Residents were assisted to the tables, medications were administered, announcements made, meals delivered followed by clearing, cleaning and assisting residents out of the dining. This work led to many staff being present in the dining room, conducting a range of different activities during meals. Thus noise was compounded and dining rooms were noisy busy places rather than sites for interaction and pleasure.

Bergland and Kirkevold (2007) wrote that “positive peer relationships contribute to wellbeing and life-satisfaction” (p. 1296). Their descriptive explorative study was aimed toward examining the relationship between peer relationships and thriving in RAC. Pertinent to this discussion, the authors found that social events in the nursing home acted as barriers rather than enablers of peer relationships. Bergland and Kirkevold reported organisational structures, for example, sequencing meal serving so that residents began and finished at different times, as an interactional barrier for residents in their study. Residents cited other residents’ physical capacity as an additional barrier to interacting at meal times. Similarly to Bergland and Kirkevold, researchers’ report residents’ physical incapacity interferes with resident interactions during meals (Anderrson, Pettersson, & Sidenvall, 2007; Pearson et al. 1997). Stabell et al.’s. (2004) findings indicated little social interaction during meal times and suggested that staff shift from routine tasks of delivering meals to encouraging social interaction. Stabell et al. state that “monitoring the patient’s food and fluid intake has always been a primary nursing responsibility, but checking the patient’s well-being, in the form of his or her self-esteem, may be overlooked” (p. 678).

These findings, considered in the light of dining experiences in the study I conducted, fitted with the notion that meal time, potential sites for developing relationships, acted as barriers on most occasions. Noise and place have not been a feature in the previous studies; however they were a feature for residents in the study I conducted. Furthermore, these findings suggest that there is resident work which could be enhanced by dining experiences. This work includes *getting to know, living a communal life, connecting and contributing*. As long as resident and staff needs continue to intersect, and staff needs are prioritised over the resident needs for interaction, the work of *living a communal life* will continue to be difficult to achieve in the dining room. My argument here is not that these intersections cease. There are many areas in facility life where intersecting needs between residents and staff occur. My argument is that such intersections require negotiation and inclusive decision making so that staff are aware of residents’ work and residents are aware of staff work. Such negotiation could lead to effective problem solving so that both needs are met or at least understood. To do so however, requires a direction away from hierarchical decision making to shared negotiation and decision making within a visible and active philosophy of care.

Philosophy underpinning work directions

While staff talked about valuing residents and working in aged care, there was no reference to an overall philosophy which guided staff-resident relationships. Certainly there were strong organisational messages that residents were to be treated well and with respect. Care and concern was evidenced in the analysis of staff data. Some staff, in the facility working to introduce features of the Eden model of care, were aware of the efforts to change the environment and staff practice, but many staff were either unaware or dismissive of these efforts. Residents' data indicated they were aware of the dominant model of care, citing examples of busy staff and the need to stay within the routines. In both facilities there were instances where task and routines were, in the main, fixed and with minimal room for flexibility.

Leadership in residential aged care facilities

It is significant that the variations in resident-staff relationships, revealed in this study, were present in a context where a constant message during staff interviews was that the facility was home or home like for residents, and staff were the guests. It is my argument that effective resident-staff relationships are a critical aspect of aged care work, particularly when residents are confronting difficult situations which require continuous adjustment.

Staff have the ability to shape residents' expectations and this study revealed episodes of both effective and ineffective staff-resident relationships. Literature from the field indicates resident-staff relationships can be enhanced if the facility leadership staff recognise the importance of resident-staff relationships to improvements in resident care and the environment in which it occurs (Brown Wilson, 2009; Conway, 2007; Moiden, 2003; Wilkinson, Meyer, & Cotter, 2009).

The notion of resident-staff-family relationships in RAC has been a feature of research studies aimed towards improving resident's lives and staff work lives. The concept of person centered care (PCC) has been examined extensively in the literature (Boumans, Berkhout, & Landeweerd, 2005; Dewing, 2004; Ford & McCormack, 2000; McCormack et al., 2010); although described in various ways. Nay, Bird, Edvardsson, Fleming and Hill (2009a) described PCC as containing

essential elements of “the need for a recognition of and connection with the *person*, a focus on the person’s strengths and goals, an interdisciplinary approach, and recognition of the centrality of relationships” (p. 109). Wilkinson, Meyer and Cotter (2009) also emphasised that PCC involves “an interpersonal process, taking place within a system of relationships, which affords dignity and respect to others” (p. 25). There is some debate however about how PCC has been interpreted. This debate centers around the arguments that the notions of PCC, in its original form, was intended towards personhood within the context of relationship; and that current interpretations of PCC foster a level of independence and individual autonomy which is difficult for older people to achieve. Additionally, rather than individual and autonomous, the essence of PCC is relational and reciprocal (Nolan et al., 2004; Nolan et al., 2006; Marquis, 2002; Wilkinson et al., 2009).

Nolan et al. (2006) suggested a shift towards relationship-centred care using the Senses Framework would provide an enriched RAC environment for residents, families and staff. The Senses Framework includes six senses, namely, a sense of security, continuity, belonging, purpose, fulfillment, and significance applied to the particular aspects of each group; that is residents, families and staff. The Senses Framework and relationship-centred approaches to RAC have best application when the culture applies to all stakeholders. As argued by Wilkinson et al. (2009), “staff cannot be expected to provide care based on dignity and respect if these are not part of the overall culture of work life and endemic in how teams work” (p. 27). The research presented in this section of the discussion demonstrates that effective relationships between residents, families and staff are an important factor for work in RACFs. Additionally, the research findings point to the importance of an environment and a facility culture where all relationships demonstrate interdependence, respect, dignity and transparency (Brown Wilson, Davies & Nolan, 2009). Both residents and staff, in the findings from this thesis, perceived, at times, they were of limited value. Staff reported they were not listened to; feared the loss of work hours if they did not do as directed; and complained about workload expectations. Residents, as reported previously in this thesis, talked about limited interaction with staff and demeaning or negative staff responses. These comments however were not from all staff or all residents, and not from all residents in relation to the domains of living life in RAC. For example, some residents’ adjustment was

related to their own deteriorating health which led to strategies for *preserving the self*. Other residents, in response to a negative response to their reported need, presented an unacceptable self to staff; however remained *connected to the community* in other areas of their life.

It would be simpler to suggest that facilities need to adopt a particular model of care. I am mindful, however, of McCormack's (2004) statement that "the challenges of everyday practice means that we shouldn't chase after an ideal of person-centredness, but instead strive for a constant state of 'becoming more person-centred' in our practice" (p. 37). Dewing (2004), focusing on the nursing application of a range of conceptual frameworks, questioned the efficacy of conceptual frameworks related to PCC for their applicability in practice. Conceptual frameworks, she argues, are useful for nurses to develop their understanding and practice; however, she also suggests that the complex dimensions of personhood and the skills to work in relationship, keeping personhood at the forefront, are complex. McCormack et al. (2010) using the Person-Centred Nursing Index (PCNI) evaluated nursing outcomes of person-centred practice (PCP). These authors emphasised the environment in RACFs and ongoing practice focused learning within and between staff are crucial elements for the development of person-centred relationships. Brown-Wilson (2009) examined the factors important to the application of relationship centered care and concluded these were "leadership, continuity of staff, personal philosophy of staff and contribution of residents and families" (p. 177). The questions this literature raises in relation to the findings reported in this thesis are firstly, how do we achieve a situation where residents' adjustments are acknowledged, accepted and supported in a way that means they can access support if they choose? And secondly, how do we achieve the skills, knowledge, leadership and care structures which take into account the notion that residents' lives are going to change while also working to enhance residents' skills, abilities and capacity to remain engaged with, rather than isolated?

There is a third question. How do we achieve this within resource constraints which include diminishing a RN workforce in RAC, increased expectations for meeting regulatory requirements, and funding which has been reported to be inadequate? These are big questions to which I do not pretend to have all the answers. Yet, the

findings of this thesis give us some insight into how we might begin to address these questions. For example, that residents and staff could recount instances where relationship was effective and the instances where they could discuss and negotiate residents' needs demonstrate staff skills. The findings demonstrate and detail residents' consistent adjustment strategies. Having some knowledge of the effort residents put towards adjustment can lead to an increase in staff awareness about the need to develop supportive skills for residents, if residents so choose. Additionally, these findings can assist leaders in aged care to consider work practices which act as a barrier to the residents' efforts to live their life. Finally, it is important that regulators become more aware of the stretched conditions reported by staff in these findings.

Acknowledging residents adjustment processes

McGilton and Boscart's (2007) study found staff perceived the resident-staff relationship was central to knowing the resident, so that residents' needs and emotions could be taken into account during care delivery. Staff participants in McGilton and Boscart's studies included reciprocity as a positive factor enhancing resident care. Reciprocity involved negotiation and partnership between the resident and staff. Resident participants prioritised the relationship in terms of being with a staff member who was interested and listened to the resident in the role of a confidante. Residents also considered their relationship with staff was enhanced when the staff member was dependable and took the initiative to meet the resident's preferences and likes and have the resident's "best interest at heart" (p. 2152).

The research literature, and the findings presented in this thesis, demonstrates that some staff have the skills and ability to know the resident and to be sensitive and receptive to the residents' adjustment processes. Sometimes it is RNs or ENs and sometimes it is unregulated staff. Sometimes, staff are able to negotiate a solution or provide support while a resident experiences loss or difficulty. At other times, unregistered staff will refer a situation to a RN perceiving that the residents' requirements are beyond their scope of practice. What these staff appear to have, is an approach or an attitude to practice in RAC. At other times, what the unregistered staff have is an empathy towards residents which drives them to consider solutions in negotiation, and sometimes collusion with residents. What some RNs have could be

seen as well developed negotiations skills with the knowledge of how to work through very difficult circumstances with residents. This was obvious in the situation of the resident who had attempted suicide and another resident who was contemplating suicide. Both registered and unregistered staff displayed negotiation skills in their accounts of residents' situations, some of which were confirmed in the residents' data. So relationship centred care, as demonstrated in these findings, includes an acknowledgement of a resident's context, in some cases an ability to talk about and figure out a negotiated or shared solution, and in others an ability to work at a deep therapeutic level. Therefore there are levels of staff-resident relationship which require different education and knowledge. That these staff received management support for their activities was variable. Certainly some RNs were singled out as effective in working with residents in deep distress. The ENs and unregistered staff who worked at understanding residents' contexts did not appear to be recognised by management and some reported they were cautioned for their close connection with residents. If the facilities did adopt a principle of resident centred care, and staff consultation, education and skills were developed in a supported environment, then perhaps residents would receive appropriate support during their adjustment situations. Again, this solution is not simple. Such an approach would require a major rethinking of the focus for RAC.

The compounding factor of staffing and funding

Staff, management and resident participants in this thesis were keenly aware of the difficulties associated with inadequate staffing levels, skill mix and funding. They were not alone in this awareness. The health care context within which they were working (staff) and living (residents) was experiencing an increase in resident complexity and dependency level (Andrews-Hall et al., 2007), as well as difficulty in recruiting and retaining staff (Moyle et al., 2003; Venturato, Kellett & Windsor, 2007). Certainly, as these findings demonstrate, the senior staff participants seemed challenged. Staff articulated their vision for a high quality effective service, together with the reality that staffing to the level and quality was a significant factor in not being able to achieve their vision. In many ways they were right in thinking that the task ahead was a challenge to residents' quality of life and quality of care. Low staffing ratios and high workload have been demonstrated to interfere with effective resident-staff relationships (McGilton & Boscart, 2007), and the quality of care in

RAC (Bowers et al., 2000; Bowers et al., 2001). The absence of effective staff-resident relationships is indicative of a systemic problem. To be responsive to residents' adjustment processes, staff need to be adjustable. Structured routines and tasks and inadequate staff skill mix and/or staffing numbers do not lead to flexible work practices which have been demonstrated to be more effective in achieving a person centred approach in RACFs.

The way forward

Rather than adopting a particular model of care, the variation in RACFs and the variations in the community that surrounds them, I would suggest an incremental and consultative approach to change in RAC. This approach would mirror the concepts proposed in *My Home Life* (Froggatt et al., 2009) introduced in the United Kingdom. Central to this approach is consultation and negotiation with all stakeholders, residents, families, staff and providers in partnership with educators grounded in the reality of the RAC context. This is not an easy solution. It takes time to develop the concepts of recognizing residents' contexts and learning negotiation skills (Wilkinson et al., 2009). All levels of staff need to be involved in considering how their RACF works best. Debates, reflection and action in Wilkinson et al.'s (2009) study led to changes in leadership, care practices and work satisfaction. I have long believed that a philosophy of care decided in consultation with staff and residents has the ability to direct practice. This does not deny the complexity of these processes. In reality, such deliberations highlight the complexity, the challenges and the skills required to work effectively in an environment of resident-staff relationships. The model of care that emerges from a combination of deep consideration, learning and discussion should lead to changes in perspective, transparency, skilled practice and satisfaction for all involved.

Interpersonal relationships are important at any time of life when people experience difficult circumstances. This is compounded as people age and their usual support structures may not be available, or they wish to minimise the perceived family burden. It would seem, therefore, that those who are living in RAC have both the right and responsibility to engage where possible with those who are central to their care. Staff have a professional responsibility to engage with residents in relationship. To enter a relationship with residents could increase staff awareness of resident's

adjustments and decisions could be negotiated if the environment was shifted towards a more flexible rather than a routine of care approach.

This discussion has covered aspects of RAC issues related to the findings from the thesis study presented here. It would seem that the continuous adjustment revealed in these findings is acknowledged in findings related to transitions. Transitions however have been reported as eventually complete in contrast to my proposition that adjustments for older people living in RAC are cumulative and ongoing. Findings indicate that becoming a resident in RAC was a major life event whereby residents were involved in twin efforts of leaving and entering. The work of learning the new facility was immense as residents adjusted to their new surroundings often in the midst of grief. Research reports acknowledge the immensity of the residents move to RAC; however have not always acknowledged the twinned entering and leaving process, in the depth presented in this thesis. Living in RAC, revealed in these findings, was assumed to have a public and private arena where residents could retreat to as they wished. These findings indicate that there were public areas where residents' intrapersonal work continued as they figured out who they were and how they were going to be in the facility. Additionally the private was not always private as residents' care needs and OH&S legislation meant that some aspects of 'my room' became shared. For various reasons, some residents to maintain privacy in relation to their situation, *acted as if*. That is, they gave an impression that they were fine when they were not. At the heart of many residents' adjustments were resident-staff relationships. When residents perceived that staff were open to listening and negotiating their situation, they would connect and problem solve together. When residents perceived the opposite, they would, where possible, remain silent and bypass particular staff and seek a staff member with whom they could discuss situations. The literature on relationship centred care was inclusive of family within the resident-staff relationship. Unfortunately, this study did not include family as participants.

I then shifted focus towards the context in which the study took place. Much literature points to principles of care which are inclusive of resident and family participation in care and decision making, within an environment which has flexibility rather than fixed routines of care. The introduction of these principles of

care are complex requiring time, education and change; yet, they are important if residents and staff are to work together to support adjustment. Such principles require staff to develop relationships with residents and families. To do this, negotiation skills are required. Some staff in this study demonstrated the ability to consider the resident context and to work through challenging situations with residents. This demonstrates that supported adjustment is possible and needs to be developed to encompass a more cohesive approach towards building negotiation skills within inclusive and interdependent resident-staff relationships.

Finally, in considering the way forward, the discussion turns to the context of aged care. The current aged care industry in Australia, similar to many other countries, is experiencing a diminishing RN workforce, difficulty in an adequate skill mix and limited funding resources. The way forward is towards incremental change which incorporates the principles outlined in relationship-centered care. When this occurs, the model of care with the underlying principles is developed in consultation with staff, residents and families. This is best achieved in partnership with educators who can lead an effective negotiating process so that the model of care which emerges is that which fits best with particular RACFs.

Strengths and limitations

Since commencing this study, I have discussed the findings with a range of people. On all occasions I have received responses which result in lengthy conversations. As people have talked about their experiences of working in or having a family member in RAC, I have recognised the concepts explained in this study. The strength of the study is the detail of residents and staffs' perceptions, interpretations, deliberations, strategies and consequences. These findings have shown that while a qualitative study is not replicable, the processes are transferrable to similar situations. The results of this study demonstrate that educated and skilled staffing is required for effective care practices and can serve to inform regulators of the complexity in aged care work.

The family perspective

That the families are not represented in this study is a limitation. I do not dismiss the importance of families in their support of residents in RAC. Rather, because I could not interview families, I chose not to include them in this study. My research design was that I would only interview families if the resident agreed. Their reluctance to bother families is indicative of their care and concern. Thus, rather than assume the importance from other studies that do involve families, I have chosen not to include them in this study. I strongly believe that if a resident is cognitively intact, and chooses not to involve their family in any research endeavour, that is their right. While residents did not agree that the researcher contact families, primarily it was out of respect for the work that families already do to support residents in RAC. There were a few other reasons for this omission. Some residents were reluctant to request more from their family. For some residents, family were geographically distant and interviews would not have been possible. Finally, some residents did not want the family to know about their life in RAC and did not wish to have them interviewed. As only three family members were interviewed, they were not included in the study.

Exclusions

This study did not include residents who live with a dementing illness. I am experienced in working with this population and intend to conduct future research in this area. I judged that the research design and the time available to complete the study would not be the best suited for such residents.

For similar reasons, I did not consider including Australian aboriginals in the study. Indigenous people have a right to decide research approaches best suited to their needs and to conduct a study for the completion of a qualification did not seem appropriate for a population who has experienced the negative effects of colonization. I do not, however, rule out future research which is conducted in partnership with Australian aboriginals.

Conclusion

Most communities hold people who have a range of personalities and ways of living. An aged care facility is no different. The residents in this study described themselves variously as loners, as loving company; as people who through life circumstances have learned to effectively use spare time, and people who have focused on work life and need to learn how to use their leisure time. There were those who had never lived their adult life with people and those who have always lived with people; those who lived in nuclear or extended families and those who had experience of communal living. There were a variety of beliefs, values and visions not all which dovetailed easily within the resident community. For example, there were differences in religious values, cultural values and perceptions of how things should be done. There were vast differences in previous life styles, problem solving methods (indirect complaining, direct complaining, hinting, silence, consulting on problems, pulling others into their problem solving and doing it alone) and ways of relating to other people (ignoring, engaging, dominating, waiting for others to initiate relationship). The common factor between these participants living in a RACF was the need for assistance and compromised health and wellness.

In essence, residents in RAC encounter a situation of continuous adjustment in their efforts to live their life. When faced with a myriad of situations, they figure out their best strategy to solve situations that arise. Sometimes those strategies are effective and sometimes they result in a negative outcome. What is important is the effort and energy that residents employ as they work to live their life in RAC. When the situation calls for it, residents focus on a dimension of life that is confronting them. It may be that they want to be acceptable and work towards *presenting an acceptable self*. It may be, in a particular situation they wish to engage with the community and they will focus on *living a communal life*, which includes *presenting an acceptable self*. Alternatively it may be that a resident is confronted with a situation which causes them to *preserve the self* and in response they may present an unacceptable self as they stand up for values which they perceive are threatened. In another situation, they may background *presenting an acceptable self* and *living a communal life* in order to conserve energy and maintain their health. Additionally, in these three dimensions of living a life in RAC, residents' expectations, in interaction with staff,

may be expanded or contracted causing them to rethink and adjust themselves and their situations. The surrounding environment influences how residents live their life. The physical environment and the structural environment of the facility together with legislative requirements on the facility can intersect residents' needs with facility needs. Because of the source of the environmental condition, this aspect of residential living is less flexible in response to residents' efforts and requires residents to be flexible in response to the environment.

The findings from this study demonstrate the complexity of living in a RACH from the residents' perspective and from the staff perspectives. The process of meaning, action, interaction and adjustments provide explication of the activities that residents' employ to live their life in RACHs. Additionally, the findings add to the body of knowledge in that it demonstrates the influence of organisation, structural and societal environment on both residents and staff. Knowing the efforts that residents use to continually adjust their lives has the potential to guide education and practice to develop the complex skills of negotiation. The logic of my argument in this thesis is that effective relationships between residents and staff best occur within an environment where a relationship centered philosophy is led by effective leadership, which establishes flexible care structures within which staff are encouraged towards flexibility and negotiation with other staff, residents and family. For flexible structures to be enabled, work structures and funding to enable effective change requires policy changes. If these are established, residents could experience support during their adjustment, should they choose to do so. The participants in this study along with the many submissions to the Australian Productivity Commission have demonstrated their powerlessness for change within the current government funding schemes. Even if the funding of RACH was increased, there remains a recruitment issue for staff whose reimbursement for work falls behind other professions and workplaces. Change will take time however change to the care practices, staff education, facility work organisation and philosophy is vital if we are to value the contributions older people have made to our Australian society.

Finally, the work that residents do to live their life is applauded. They face many changes in the leaving home and entering RAC; they figure out their best position or

response whenever they can; they adjust continually as they work to present *an acceptable self, live a communal life and preserve the self.*

In the words of Esther

“It’s about not throwing in the towel”

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Appendices

Appendix A: Alphabetical Explanation of Australian Acronyms and Terms

Appendix B: Ethics Approval

Appendix C: Participant Demographic Data

Appendix D: Resident Information Letter

Appendix E: Staff Information Letter

Appendix F: Consent Form – Resident

Appendix G: Consent Form – Staff

Appendix H: Reflection on Findings

Appendix I: Early Dimensional Map

Appendix J: Initial Model: Residents Work

Appendix K: Final Model

Appendix L: Memo – Residents Work of Presenting an Acceptable Self

Appendix M: Memo – Residents Work Interpreting Others' Presentations

Appendix A: Alphabetical Explanation of Australian Terms

Silly as a wet week	Australian slang term: Usually the saying is "Slow as a wet week". The term has changed over time and means that a person does not make much sense
In everything but the bath	A busybody
Not throwing in the towel	Not giving up
Whinger	Whiner, an intolerable person given to unnecessary complaints
Rouse	Australian slang term: castigate; criticise severely
Piss and wind	Australian slang term: futile exercise

Appendix B: Ethical Approval

Human Research Ethics Committee

Committee Approval Form

Principal Investigator/Supervisor: Prof Barbara Bowers Melbourne Campus
Co-Investigators: Dr Michelle Campbell Melbourne Campus
Student Researcher: Barbara McKenzie Green Melbourne Campus

Ethics approval has been granted for the following project:
How aged people living in residential care facilities influence their care and quality of life
for the period: 8th March 2006 - 30th March 2007
Human Research Ethics Committee (HREC) Register Number: V200506 33

The following standard conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans* (1999) apply:

- (i) that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:
 - security of records
 - compliance with approved consent procedures and documentation
 - compliance with special conditions, and
- (ii) that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:
 - proposed changes to the protocol
 - unforeseen circumstances or events
 - adverse effects on participants

The HREC will conduct an audit each year of all projects deemed to be of more than minimum risk. There will also be random audits of a sample of projects considered to be of minimum risk on all campuses each year.

Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.

Signed:  Date: 9.3.2006
(Research Services Officer, Melbourne Campus)

Appendix C: Participant Demographic Data

Length of time since admission

Length of time	Number of residents
< 1 Month	2
< 6 Month	5
1 yr	3
2-3 yrs	3
3-5 yrs	6
6-9 yrs	3

Resident age range by decade

Age Range	Number of residents
60s	1
70s	4
80s	12
90s	5

Staff age range by decade

Age	Staff Number
Not provided	4
20s	1
30s	0
40s	6
50s	8

Staff roles

RN	5
EN	2
PCA	5
Allied Staff	3
Hospitality	4

Staff gender

Female	18
Male	1

Staff hours of work

Full time (32-60 hrs wk)	6
Part time (26-28 hrs wk)	13

Note: The six full time staff were managers

Length of time working in RAC

Not provided	2
Less than 2 years	4
Between 4 – 10 yrs	9
More than 10 years	4

Appendix D: Resident Information Letter

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www.acu.edu.au



Australian Catholic University
Brisbane Sydney Canberra Ballarat Melbourne

INFORMATION LETTER TO RESIDENT PARTICIPANTS

TITLE OF PROJECT: How residents living in aged care are involved in decisions about their care and quality of life

SUPERVISOR: Professor Barbara Bowers

STAFF SUPERVISOR: Dr. Michelle Campbell

STUDENT RESEARCHER: Ms. Barbara McKenzie-Green

COURSE: PhD

Dear Resident,

You are invited to take part in a research project about living in a residential aged care facility. The purpose of this project is to examine how residents work with staff and family to make decisions about care and quality of life.

Previous research has shown that in Australia, as in other countries, aged care services are working towards including residents and families in decisions about their life in residential aged care. There is little known however about how staff, families and residents work together to meet residents' preferences for their life in residential care.

Your participation will assist us to understand the issues, successes and challenges faced by older adults and families in everyday life in residential aged care. We hope to report the results to assist other aged care facilities to know how residents, staff and families can best work together.

Participation in this project will involve:

1. Having either one or a number of short audio taped interviews about your experiences as a resident in an aged care facility. You will decide the time and place of interviews.
2. Indicating whether you are willing for me to interview a family member of your choice

I will also be collecting data on the pattern of everyday activities of the facilities in this study. To do this, I will be spending time in the facility talking to staff and joining activities with the residents, families and staff. I will not be with any residents during times of private care. I will be putting together examples of some of my observations to use in the group interviews to give staff an opportunity to talk about what they think is happening in the examples. All examples will be compiled from the facilities in the study and will be changed so that no staff member or resident can be identified.

Should you find that, as a result of the interview, you become distressed; a free and confidential counselling service is available. In this event, Dr. Michelle Campbell, the Facility Manager or I will have the contact details.

Participation in this research project is voluntary. You can withdraw from the study at any stage without giving a reason. Refusing to be involved will not be detrimental to you and will not affect your care or your life in the facility. Confidentiality will be maintained during the study and in any report of the study. All participants will be given a code and names will not be retained with the data. Individual participants will not be able to be identified in any reports of the study, as only aggregated data will be reported.

If you have any questions about the project, before or after participating, please contact the Staff Supervisor, Dr Michelle Campbell, on telephone number 03 9953 3184 in the School of Nursing, St Patrick's Campus at the Australian Catholic University, 115 Victoria Parade, FITZROY 3065. Before commencing, you will have the opportunity to ask any questions about the project.

This study has been approved by the Human Research Ethics Committee at Australian Catholic University. In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the Student Researcher and Staff Supervisor have not been able to satisfy, you may write to:

Chair, Human Research Ethics Committee
C/o Research Services
Australian Catholic University, Locked Bag 4115 FITZROY, VIC 3065
Tel: 03 9953 3157 Fax: 03 9953 3315

Any complaint will be treated in confidence and fully investigated. The participant will be informed of the outcome.

If you are willing to participate please sign the attached informed consent forms. You should sign both copies of the consent form and keep one copy for your records and return the other copy to the principal investigator. Your support for the research project will be most appreciated.

Barbara McKenzie-Green, Student Researcher
Dr. Michelle Campbell Staff Supervisor ACU HREC Ref No: V200506 33

Appendix E: Staff Information Letter

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Australian Catholic University
 Brisbane Sydney Canberra Ballarat Melbourne

INFORMATION LETTER TO STAFF PARTICIPANTS

TITLE OF PROJECT: How residents living in aged care are involved in decisions about their care and quality of life

SUPERVISOR: Professor Barbara Bowers

STAFF SUPERVISOR: Dr. Michelle Campbell

STUDENT RESEARCHER: Ms. Barbara McKenzie-Green

COURSE: PhD

Dear Staff member,

You are invited to take part in a research project about working in a residential aged care facility. The purpose of this project is to find out more about how residents work with staff and family to have a satisfactory life in a residential aged care facility.

Previous research has shown that in Australia, as in other countries, aged care services are working towards including residents and families in decisions about their life in residential aged care. There is little known however about how staff, families and residents can work together to meet residents' preferences for how they wish to live in residential care.

Your participation will assist us to understand the issues, successes and challenges faced by older adults, families and staff in everyday life in residential aged care. We hope to report the results to assist other aged care facilities to know how residents, staff and families can best work together.

Participation in this project will involve:

- Taking part in an audio taped focus group with up to 7 other staff from the facility
- and/or
- Taking part in an individual interview that will last up to one hour. The individual interview will be conducted at a time and place suitable to you.

I will also be collecting data on the pattern of everyday activities of the facilities in this study.

To do this, I will be spending time in the facility talking to staff and joining activities with the residents, families and staff. I will not be with any residents during times of private care. I will be putting together examples of some of my observations to use in the group interviews to give staff an opportunity to talk about what they think is happening in the examples. All examples will be compiled from the facilities in the study and will be changed so that no staff member or resident can be identified.

Participation in this research project is voluntary. You can withdraw from the study at any stage without giving a reason. Refusal to be involved or withdrawing during the study will not be detrimental to you and will not affect your employment in the facility. Confidentiality will be maintained during the study and in any report of the study. However, if you are willing to take part in a group interview comprising between 4 and 7 staff members, the other group members will know you. I will be asking that the group members maintain confidentiality of what is disclosed in the group but I cannot guarantee confidentiality for the group interview.

All participants will be given a code and names will not be retained with the data. Individual participants will not be able to be identified in any reports of the study, as only aggregated data will be reported.

If you find you are distressed after any interviews conducted during this research, you will have free and confidential access to the EAP services provided by your facility. If you have any questions about the project, before or after participating, please contact the Staff Supervisor, Dr Michelle Campbell, on telephone number 03 9953 3184 in the School of Nursing, St Patrick's Campus at the Australian Catholic University, 115 Victoria Parade, FITZROY 3065. Before commencing, you will have the opportunity to ask any questions about the project.

This study has been approved by the Human Research Ethics Committee at Australian Catholic University. In the event that you have any complaint or concern about the way you have been treated during the study, or if you have any query that the Student Researcher and Staff Supervisor have not been able to satisfy, you may write to:

Chair, Human Research Ethics Committee, C/o Research Services
Australian Catholic University, Locked Bag 4115, FITZROY, VIC 3065
Tel: 03 9953 3157 Fax: 03 9953 3315

Any complaint will be treated in confidence and fully investigated. The participant will be informed of the outcome.

If you are willing to participate please sign the attached informed consent forms. You should sign both copies of the consent form and keep one copy for your records and return the other copy to the principal investigator. Your support for the research project will be most appreciated.

Barbara McKenzie-Green
Student Researcher
ACU HREC Ref No: V200506 33

Dr. Michelle Campbell
Staff Supervisor

Appendix F: Consent Form – Residents

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INFORMED CONSENT FORM - RESIDENTS

TITLE OF PROJECT: How residents living in aged care are involved in decisions about their care and quality of life.

SUPERVISOR: Professor Barbara Bowers

STAFF SUPERVISOR: Dr. Michelle Campbell

STUDENT RESEARCHER: Ms Barbara McKenzie-Green

COURSE: PhD

Participants section

I (*the participant*) have read and understood the information in the letter inviting participation in the research, and any questions I have asked have been answered to my satisfaction. I realise that I can withdraw my consent at any time.

I agree to take part in an audio taped individual interview

I agree/do not agree for my family to be invited to take part in this research

I agree that research data collected for the study may be published or provided to other researchers in a form that does not identify me in any way. I agree to be contacted by telephone if needed to arrange a mutually convenient time to conduct an interview.

Name of participant:
(Block letters)

Phone:

Signature:

Date:

Research Student: Ms. Barbara McKenzie-Green

Signature:

Date:

Staff Supervisor: Dr Michelle Campbell

Signature:

Date:

Appendix G: Consent form – Staff

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INFORMED CONSENT FORM – STAFF MEMBERS

TITLE OF PROJECT: How residents living in aged care are involved in decisions about their care and quality of life.

SUPERVISOR: Professor Barbara Bowers

STAFF SUPERVISOR: Dr. Michelle Campbell

STUDENT RESEARCHER: Ms Barbara McKenzie-Green

COURSE: PhD

Participants section

I (*the participant*) have read and understood the information in the letter inviting participation in the research, and any questions I have asked have been answered to my satisfaction. I realise that I can withdraw my consent at any time.

I agree/do not agree to take part in an audio taped individual interview

I agree/do not agree to take part in an audio taped group interview

I agree that research data collected for the study may be published or provided to other researchers in a form that does not identify me in any way. I agree to be contacted by telephone if needed to arrange a mutually convenient time to conduct an interview.

Name of participant: Phone:
 (Block letters)

Signature: Date:

Research Student: Ms. Barbara McKenzie-Green

Signature: Date:

Staff Supervisor: Dr Michelle Campbell

Signature: Date:

Appendix H: Reflection on Findings

The cone shell as a metaphor for living life in residential aged care: A process of continuous adjustment

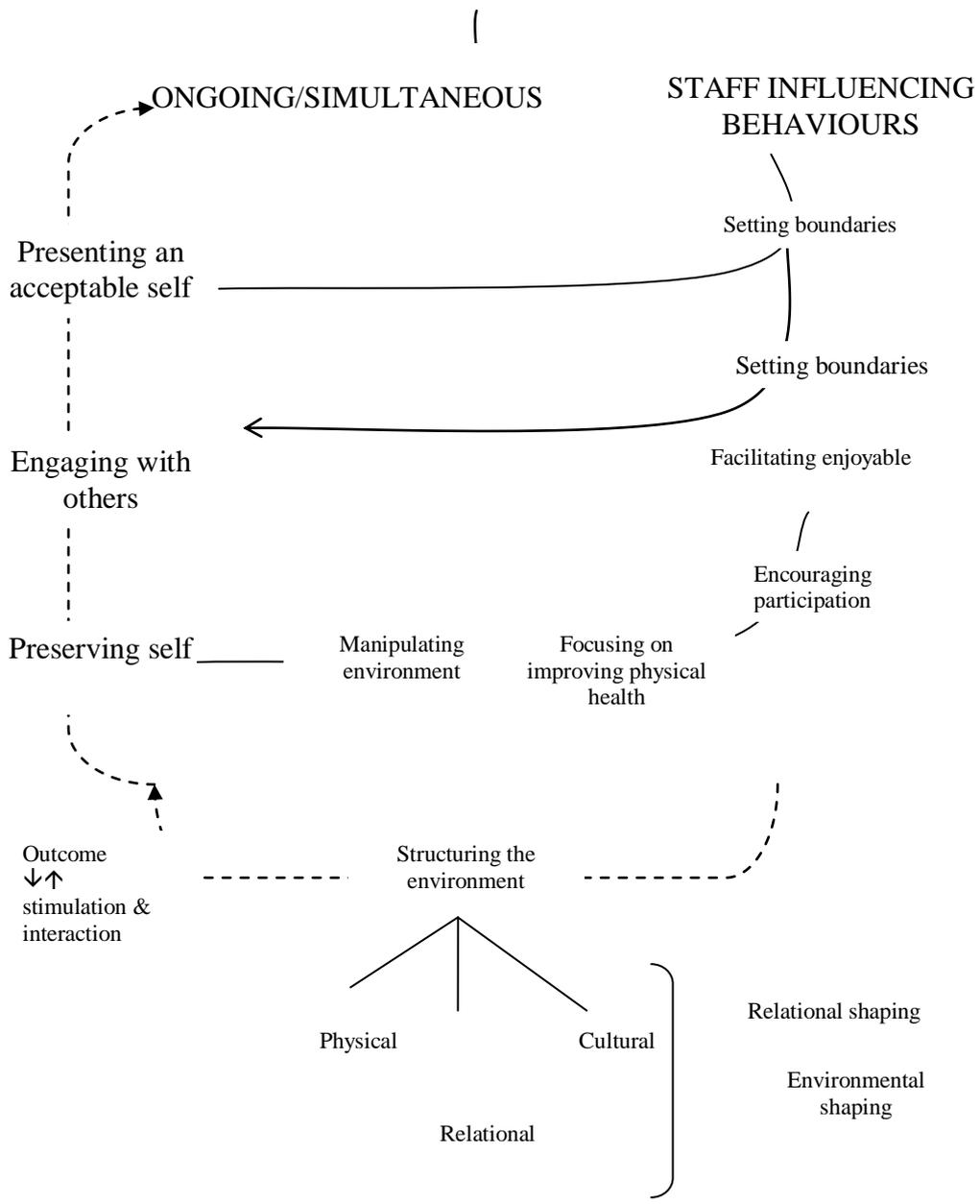


The findings from this study are complex and understanding may be easier if I begin with a metaphor to provide an overview of the processes involved in living a life in residential aged care. While metaphors do not stand up to deep scrutiny on all levels, there are some aspects of this metaphor which can reflect the continuous processes residents employ to create a life.

A cone shell is taken from the beach, its usual and natural place of being. So too have the participants moved from their usual and natural place of being and belonging to a residential community where the habitat and the context of being is, for many, vastly different from their previous life. There are three dimensions to creating a life in residential aged care. These are *presenting an acceptable self*, *living a communal life* and *preserving the self*. The outside of the shell shows a myriad of tones and colours, yet the shape itself is defined. The tones and colours are representative of all the shades of a 'presentable self' that can exist within the defined edges of the aged care facility. The furrows are representative of the strategies that residents use to live in this setting with a diversity of people. Those furrows are not uniform, have bands which segment at different and in ever decreasing unequal spaces. This difference yet

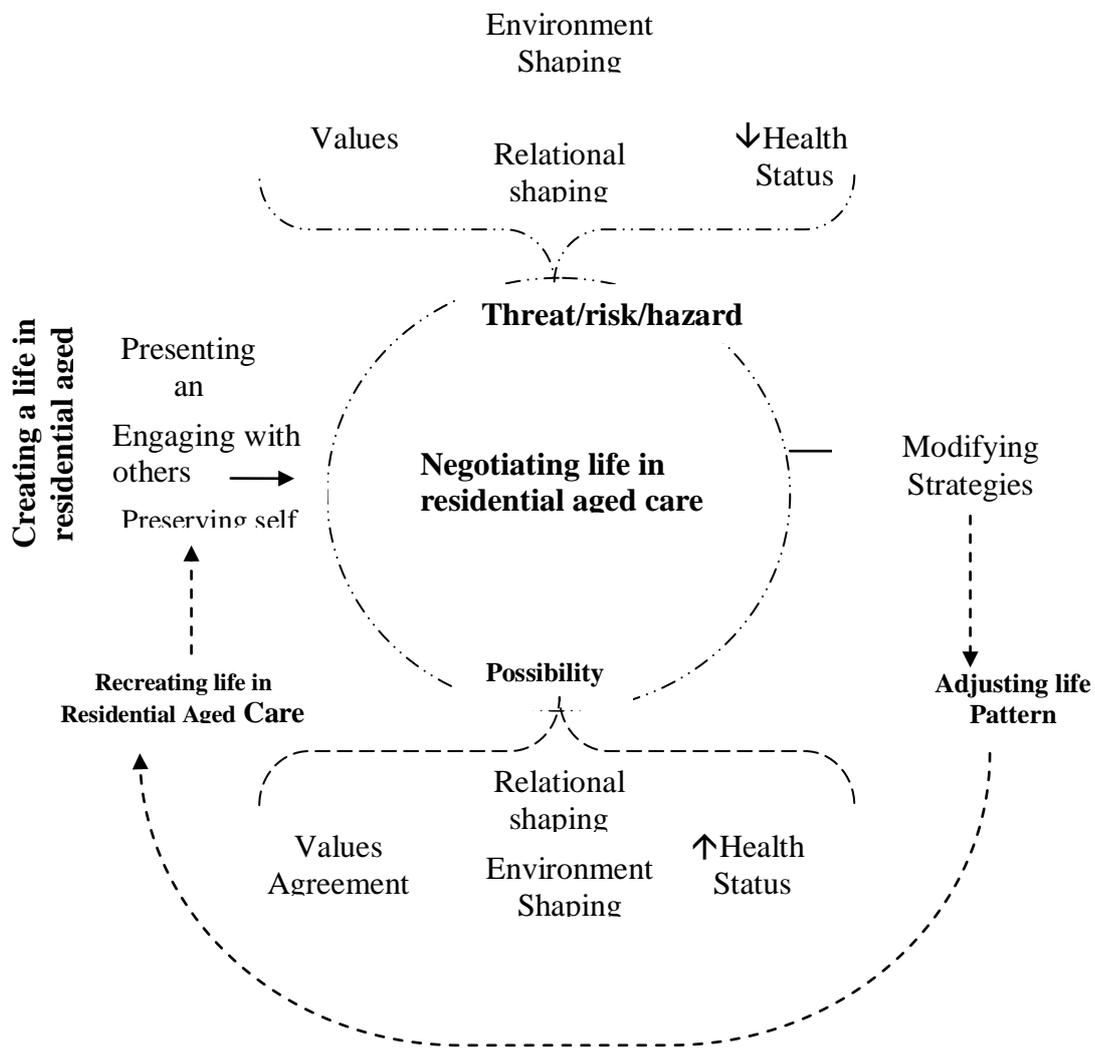
uniformity represent the times of smoothness, wellness and satisfaction, along with times that are rough and difficult in the creation of life in residential aged care. The shell comes to a small point. Many residents refer to residential aged care as their last place before leaving life. The centre of the shell is hollow and hidden and represents the efforts that residents make to preserve some sense of privacy, intimacy with the self and others and where they 'act as if' in order to resist some rules, to look well when they are not well and to be with the self that is not on public and professional view. The idea of acting as if is, for many, a strategy to avoid movement to another facility. The thought of getting to know another facility is daunting, and for some, not a thinkable proposition. Finally, the environment surrounding the shell in its natural habitat has an influence on shaping that shell. So too in aged care, residents are shaped by the ebb and flow of aged care legislation, the facility structure, the physical environment and interactions with staff.

Appendix I: Early Dimensional Map



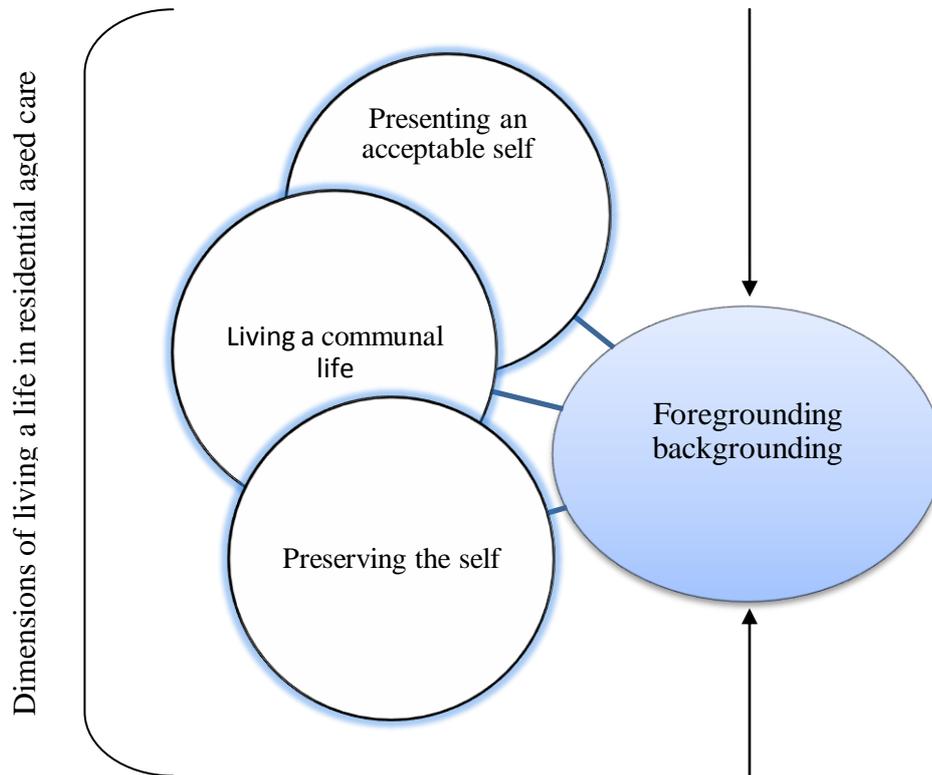
Appendix J: Initial model: Residents work

Residents work - adjusting to create a life in residential aged care



Appendix K: Final Model

A process of continuous adjustment



Salient conditions

Situational change

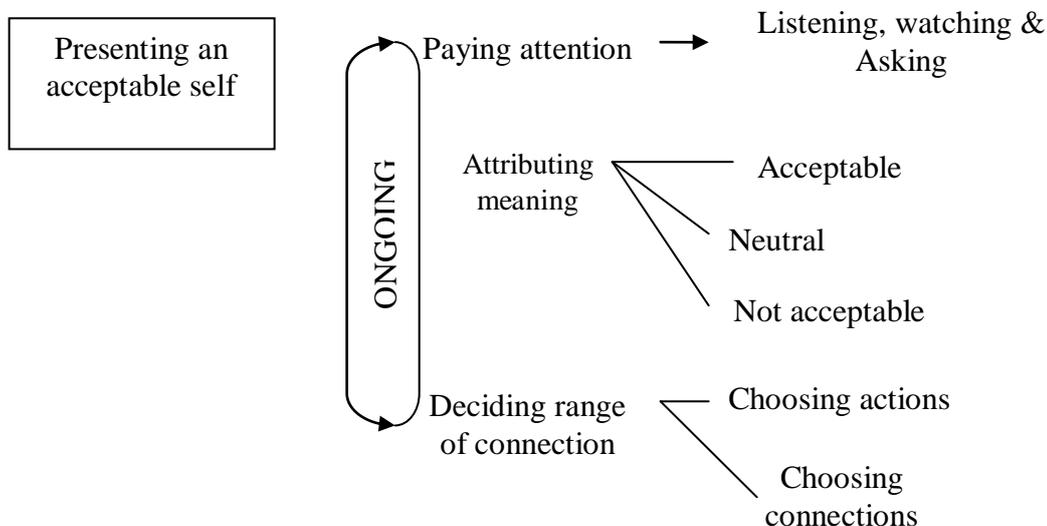
Interactional shaping

Environmental/
Structural influences

**Appendix L: Memo – Residents Work of Presenting an
Acceptable Self**

Residents work at presenting an acceptable self. To do this they find what an acceptable self is by **paying attention** to what is going on. They then figure out what is acceptable and what might not be acceptable. From this knowledge, decisions are made about the degree of acceptability they will present in a variety of situations. Decisions are made about the **range of connections** they will make with others and the extent to which they will join with or engage with the members of the community. These decisions are closely related to **preserving the self**. The extent to which residents experience reasonably satisfactory communal living is dependent on the personal and organizational resources available to them and the congruency of their interpretations, decisions and responses. The process of engaging with the disparate community is ongoing requiring the resident to adjust and modify across a variety of situations.

Questions that I need to consider is how residents learn to present an acceptable self. Under what conditions do resident shift these strategies and become someone unacceptable? How do the strategies change and adjust? Do residents perceive variations of what is acceptable?



**Appendix E: Memo – Residents Work Interpreting Others
Presentations**

Resident presentations	Actions	Resident reported interpretations	Concept	Outcome
Friendly, nice	Helping others, doing jobs for others, making jokes, greeting everyone	Nice person	Presenting an engaged self	Gathered in
Busy	Walking fast, doing jobs around the facility, talking to everyone.	Too well - pushy	Presenting a well and engaged self	Tolerated
Tired Quiet	Walking slowly, eating little, engaging minimally	Droppy, draggy	Disengaged presenting	Observed, watched
Silent	Not talking, not responding to resident overtures	Weird	Silent presenting	Left alone
Confident, articulate	Spoke up at meetings, reading, listening to classical music, talks at dining table	Stuck up	Presenting an articulate self	Marginalized
Apprehensive	Sight impaired, difficulty with way finding, eating, distressed at impairment	Needing help	Presenting a tentative self	Guided ,Valued

Presenting the self is a public and gradual process which begins at the time of moving to the facility and continues until the resident leaves or dies. How to present oneself begins with assumptions about how to be in this setting without an accompanying experience or history of being in this particular setting. The process of presenting the self continues to develop as experience leads to familiarity about how an ‘acceptable self’ is perceived.

Presenting the self is a mutual, dynamic and complex process where observing, checking, assuming and acting are activities conducted by the new resident and the current residents.

How a resident presents themselves is interpreted in a variety of ways by the other residents. For example, a resident who looked well and walked fast was seen by other residents as being too well for residential care (tolerated). A resident who looked unwell was seen as “all droppy and draggy” by another resident (observed). A resident who was articulate and forthright was reported to be “stuck up” (avoided). Yet another who was sight impaired was seen to need help and received that help from a number of residents (guided). Finally a resident reported to be ‘a nice person’ was greeted by everyone with smiles and talk (gathered in). Individual interpretations of a resident’s presentation were also heard as collective interpretations which influenced how residents engaged with each other in the community.