Strategies older New Zealanders use to participate in day-to-day occupations

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Juanita Murphy

[Signature] [date]

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Abstract

This exploratory study investigated the strategies that eight older New Zealanders use to enable participation in day-to-day occupations that they need or want to do, in their homes and the community. The types of strategies older people use to overcome barriers to participation and manage limitations are not widely known or reported. Exploring strategies for participation employed by older people is important because the majority of older New Zealanders live in the community and their numbers are growing, and projected to reach 25% of the total population by the year 2051 (Ministry of Health, 2002). New Zealand's Positive Ageing Strategy (Minister for Senior Citizens, 2001), advocates for a society where people can age positively, where they are highly valued and their participation encouraged.

The literature relating to occupation, participation and health was explored, and provided some evidence that older people are developing strategies and, with some education, are able to manage their own health conditions. The assumption underpinning this study is that they are equally able to manage strategies for participation, particularly those devised by older people themselves.

A qualitative descriptive methodology was used. The participants were selected following a presentation to a group of older adults and snowball recruitment. They were aged between 73 and 98 years old and were receiving assistance to live in community, which was taken to indicate they had experienced some limitation in, or barrier to their everyday activities, in response to which they might have discovered or developed coping strategies. Interviews were conducted in the participants' homes, and analysed using a general inductive approach.

Four main categories emerged; strategies for keeping me safe, strategies for recruiting and accepting help, strategies for meeting biological needs, and strategies for conserving

resources. Overarching themes of managing and getting on with it, sprinkled with a sense of humour by some participants was present in the attitudes of many participants.

The study revealed that this group of older people can and do use strategies to enable occupation in their everyday lives, which differ from those recommended by occupational therapists and other health professionals. This finding suggests that health professionals, policy makers and educators have much to learn from older people. The provision of help to older adults should take into consideration the importance of social interactions, not just the physical needs. There is a need for transport to be more readily available and affordable for older people to attend occupations that meet social needs. Health professionals complement the strategies developed by older people, and finding ways to combine the strategies should be developed. Listening to older adults' current ways of managing and working with them to develop alternate, yet acceptable methods will provide a challenge. Health professionals should take a greater role in advocating for the social and transport needs of older adults. A self-management approach in education for older people, using peers and making use of existing education groups in the community and health system, is suggested. Education of those who engage with older people, such as carers, family, health professionals and community groups should include developing their skills in assisting older people to identify their strategies and developing strategies for the future.

Chapter One: Introduction to the Study

Introduction

This study explored the strategies that eight older New Zealanders use to enable participation in day-to-day occupations that they need or want to do. Occupations are the "ordinary and familiar things that people do every day" (Christiansen, Clark, Kielhofner, & Rogers, 1995, p. 1015). Examples include eating breakfast, talking to the neighbour, feeding the cat or going to work. Day-to-day occupations are those which individuals expect to be involved in as part of their ordinary routine. Participation has been formally defined as "the involvement of a person in a life situation" (World Health Organization, 2001 p. 10). In effect this means the performance of everyday activities within the person's current environment (World Health Organization, 2001). The assumption within the International Classification of Functioning, Disability and Health (ICF) is that disruptions to body functions and structures, arising from health conditions, can result in restrictions in participation. Equally, factors in a person's environment can, through their absence or presence, limit functioning and create disability, thus hindering participation. Environmental factors are the physical, social and attitudinal environment in which people live their lives (World Health Organization, 2001). Strategies are the practical plan of actions that the participants use to overcome these impairments or reduce the impact of any barriers they encounter.

At the outset of the study I suspected that the types of strategies people develop were to overcome any changes in body function or structure, as well as to counteract any environmental barriers that might hinder their involvement in their occupations. For older people who live in their own homes in the community, increasing frailty and other age-related factors increases the likelihood of experiencing difficulty with the physical, cognitive or social aspects of occupations that have previously been accomplished with ease. My personal observations of older people in my family indicated that some strategies were being used. For example my great-aunty who lived alone set up a phone call to a family member every morning and evening to check in, and engaged someone to

mow the lawns when she was no longer able to push the mower and empty the catcher full of grass. My work as an occupational therapist with older people had also shown me that older adults can be resourceful in the ways they chose to manage ongoing participation in occupation.

The type of strategies older people have devised in order to overcome the challenges they experience in living their daily lives are not widely known, or reported, yet these strategies may influence the success and the quality of life they experience in their chosen environments. My research question was: What strategies do older New Zealanders use to participate in day-to-day occupations that they need or want to do? Before interviewing the participants, I explored the background literature relating to occupation, participation and health. In order to establish how the strategies might be used by others I also explored self management strategies, chronic illness and older people, to supplement my understandings of the kinds of challenges older people might live with, and to explore the assumption that older people are able to effectively manage complex aspects of living, as evident in studies of their ability to manage a chronic health condition. I employed a qualitative descriptive approach to uncover and describe the strategies that were being used to manage everyday challenges in daily occupations. A qualitative approach is useful when seeking to understand more about a phenomenon of which little is known. An underlying assumption of qualitative research is that people have their own realities, shaped by their past experiences and interactions, and pass on this knowledge through telling and doing (DePoy & Gitlin, 1994; Patton, 2002).

Why this study?

Many older people in New Zealand live in the community and many of them receive support to do so. This assistance varies from a family member assisting with the groceries to more formal arrangements such as home help and personal care assistance put in place through the local health services. People who receive support of some kind were recruited to participate in the study, because receiving support was assumed to be indicative of difficulty with performance or barriers to participation. Accordingly, people receiving

support were assumed to have cause to devise or adopt strategies to support participation that may not be apparent in older people who do not experience difficulty. There is little documented information, other than anecdotal, about how older adults manage to participate in their daily occupations. The purpose of the study, therefore, was to illuminate the strategies that are being used by people to manage participation in occupations. There was an expectation that in gathering this information, a foundation will be laid for the development of mechanisms to share effective strategies with other older people, to their potential benefit.

The broad societal context of the study is the vision espoused in New Zealand's Positive Ageing Strategy, which advocates for a society where people can age positively, where they are highly valued and their participation encouraged (Minister for Senior Citizens, 2001). There are ten goals arising from this strategy which address income, access to health services, housing, transport, work and culturally appropriate services. Of particular significance to this study are the goals 5 and 10;

- Goal 5: Older people feel safe and secure and can "age in place" (p. 21).
- Goal 10: Increasing opportunities for personal growth and community participation (p. 23).

The strategy clearly promotes the opportunity for older people to be able to live in a physical and social environment which supports their ability to stay at home. This study looks to uncover some of the strategies that older adults are actually using to enable this to happen. Additionally, the notion of promoting healthy lifestyles through health promotion and education is raised in the Primary Health Care Strategy, Objective 3 (Ministry of Health, 2001), which states that primary health care services will 'offer access to comprehensive services to improve, maintain and restore people's health' (p. 13). The Primary Health Care Strategy goes on to say that many health problems can and should be managed by the individuals with the right supports. This adds further weight to the need to find out what useful strategies older people are using or have developed for themselves.

There is a need to keep New Zealand's population healthy as it ages. If improvements in health are not managed within our society, then we are going to be facing some very serious problems relating to the provision of health care services in the coming years with the increasing age of the population. One of the ways which has been demonstrated to support health and well-being is participation in occupations (McIntyre & Howie, 2002). This study is potentially important in uncovering ways that people manage, by opening the possibility of sharing effective strategies or participation in daily life with others.

Context of the study

The world's population is ageing. A report by the World Health Organization (1998) indicated that the population over the age of 65 years was likely to grow by 88% over the next 25 years. Maintaining health and quality of life will be needed, not only for the older adults, but also from an economic perspective, as the productive working age sector of the population will need to service far greater numbers. New Zealand reflects the trend across the world, with growth in the older population expected to rise over the next few decades. Older adults in New Zealand are increasingly going to be living at home and needing to manage to participate in occupations. For the purposes of this study 'older persons' has been defined as those over 65, in keeping with the use of that term in New Zealand policies on the matter, such as the Positive Aging Strategy (Minister for Senior Citizens, 2001) and the Health of Older People Strategy (Minister of Health, 2002).

In 2001 approximately 1% of people in the 65-74 age group were receiving subsidised residential care, increasing to about 5% of those in the 75-84 age group and up to 27% of those people over 85 years (Ministry of Health, 2002). The population of older New Zealanders is growing and is expected to reach 25% of the total population by the year 2051 (Ministry of Health, 2002). The current expected life span is 80 to 85 years of age (Statistics New Zealand, 2001). The increasing life span and the limitations on institutional care mean that greater numbers of older New Zealanders are already spending longer in their own homes. Currently, some persons at 65 years of age may be entitled to subsidised rest home care, but the majority of people are remaining in their

homes for as long as possible. The reasons for remaining at home may be varied. People want to stay in their own homes; I have often heard people say they will "leave in a box", meaning that they will not leave their home until they die. The policies set by government are also encouraging people to remain at home, with the increase in the aging population creating a shortfall in beds available in aged care. The New Zealand government has demonstrated through various policy documents (such as the Positive Ageing Strategy and the Primary Health Care Strategy) that it is determined to support the aging population to live in the community and reduce the cost of health care with ongoing opportunities for participation, adequate support systems and knowledge of the issues for this group (NZ Disability Strategy, 2001; Minister of Health, 2001; Minister for Senior Citizens, 2001). In 2002, the annual cost of subsidies by the government for care for persons residing in institutions was $426 million (Ministry of Health, 2002).

It is difficult to locate comparable data for those needing care at home either with or without informal supports: however, one might reasonably expect the cost to be less per capita than subsidising care in an institution. From a cost perspective alone, the desire by the government to support people to continue in their own homes for as long as possible is understandable. Not only is the drive to have people reside in their own homes for longer, there is also a drive to ensure that they are in good health. My own experience of working within a large hospital is to observe the increasing pressure on bed availability in hospital and a drive to constantly reduce the length of stay of people. Alongside this, research supports the knowledge that persons who are able to be engaged in meaningful occupations have better health outcomes, feelings of well-being and quality of life (Ball, Corr, Knight, & Lowis, 2007; Green, Sixsmith, Ivanoff, & Sixsmith, 2005; Häggblom-Kronlöf & Sonn, 2005). Again the World Health Organization supports active ageing, based on the rights of older people and the United Nation's principles of independence, participation, care, self-fulfillment and dignity (United Nations, 2000). Active ageing is the process of optimizing opportunities for health, participation and security to enhance the quality of life of the older adult (World Health Organization, 2002). This study looks to contribute to the body of knowledge about participation of older adults, in particular in relation to the strategies that older adults use to participate in day-to-day occupations.

Myself as the researcher

In research, particularly in studies employing qualitative methodologies, the researcher is an integral part of the process. It is therefore important that I provide an introduction to myself in relation to this research, since my experiences, both professional and personal, have no doubt influenced the manner in which this research has been approached. I carried out this research as partial fulfillment of a Master of Health Science degree. I am an occupational therapist and have had an interest in older people, working predominantly in this area since I graduated. I have worked in a variety of areas with this age group, including mental health, working with older adults in the community and working in a multidisciplinary rehabilitation service, which has provided a wide range of experiences of the problems that older people face. In particular my roles were about helping people to put strategies in place that would enable them to safely do the things that they identified as being essential to remaining at home, and doing what they considered important to them. I have always felt that helping people to do things safely was a fine balance; what one person considers safe, another does not. Certainly the desire to remove all risk from the person in question is something that has changed significantly in my own practice. I have gained more experience and more trust in the client's perception of what is safe and effective for them, and their ability to determine their own capabilities and priorities.

I also have a special interest in occupation and its influence on health and well-being, and have always preferred to use the wide-ranging occupations of individuals in their therapy. My interest in occupation led me to focus on this throughout my postgraduate studies. Occupational science is a knowledge area that has undergone an immense period of development, research and academic discussion over the last two decades (Clark, Parham, Carlson, Frank, Jackson, Pierce, Wolfe, & Zemke, 1991; Hocking, 2000). Whilst occupational science has come to fruition long after the development of occupational therapy, I believe that occupational science is unique in its ability to add to the body of knowledge about occupation. This knowledge can be used to benefit occupational therapy practice, although it is not restricted to informing this profession only. An occupational

view of health considers a person's ability to participate in their usual occupations in their own environments (Hocking, 2008; Yerxa, 1998).

When I contemplate the older people I have worked with, they frequently have some form of health condition which is impacting on their body, physiologically or psychologically, or structurally (through bones or joints). While some continue to manage their day-to-day occupations, others struggle to maintain this ability. Occupational therapists have long believed that participation in meaningful occupations influence our health (Reilly, 1962; Wilcock, 1993). As an occupational therapist I have had an active interest in promoting participation in meaningful occupation with people who have faced challenges due to their health and environment. When working with older people, the types of strategies an occupational therapist might suggest to older people with occupational challenges are quite varied; however they often tend to focus on the main areas of self-care and home maintenance. Strategies will relate to the matters that have been identified by the client, or through assessment, as ones which are causing problems or need to be addressed. These might be to do with the individual, for example addressing cognitive or physical changes of the person, or to do with the environment, making adaptations to enhance the performance of the individual. It is important to acknowledge that in this study, in my role as a researcher I am taking a different role to that which I do when I engage with older people as an occupational therapist. By reflecting on the types of concerns I usually have foremost in my mind when I am a therapist, I am able to set these to one side, in order to minimise the effect of my preconceptions in relation to data gathering and analysis for this study.

I have a strong belief that the client-centered approach to health care is integral in achieving positive outcomes for the individual receiving services, as well as the health practitioner. It has been demonstrated that client-centered practice improves client participation and self-efficacy in rehabilitation (Henriksson, 2002), improves health-related outcomes, including goal-attainment (Neistadt, 1995), and increases client satisfaction with the service (King, Rosenbaum & King, cited in Law, 1998). In keeping with this, health care is about partnership between the older person and the health

professional. This study, in recognising the importance of what older people have found through discovery and learning, and what works for them, makes sense to me in the context of client-centered practice. Supporting the possibility of being able to share this information with older people, to help them in their own adaptation to changes in their health and functioning as they grow older, is a logical fit.

My confidence that older New Zealanders are indeed developing some strategies that assist them with participation comes in part from having observed my own grandparents and their different ways of coping with the things they needed to do at home. Despite increasing age-related illness and some significant functional challenges, they turned their back on the suggestion that they should consider rest home care, apparently defying odds and managing their day-to-day activities in their own home in their own way. Whilst my admiration for my own grandparents is great, I was sure that they were not the only older New Zealanders who had adapted to the challenges of aging. If they were developing strategies and modifying how they had previously carried out day-to-day tasks to maintain participation in life, others were also likely to be doing this. These experiences, along with my personal and professional philosophies, have shaped the way in which I go about my own daily life and how I came to select the question for this research. Thus my interest in finding out what sorts of strategies older New Zealanders were using began and continues.

Overview of thesis

In this chapter, I have outlined the focus of this study, strategies that older people use to manage their lives. I have provided the background to why this particular study was of interest to me and salient in the current context, through describing some of the most relevant policies and statistics relating to ageing populations and places of residence in New Zealand. I will now go on to describe how the rest of the thesis is presented.

A review of the literature relevant to the research question is outlined in Chapter 2. This begins with a discussion of occupation and health and the older person, and self

managing health and lives. An account of what is known already in the literature about the strategies that older people are using to maintain participation and remain at home are also reviewed, setting the context for this study.

In Chapter 3, I describe the methodological approach chosen for this study, the qualitative descriptive approach, and why this was appropriate for this study. I then provide the details of how I conducted the study; recruitment and selection of the participants, ethical considerations, the process of analysing the data and what strategies were used to ensure rigour.

Chapters 4 and 5 are dedicated to the presentation of the major categories of strategies identified in the data. Chapter 4 presents two categories; 'strategies for keeping me safe' and 'strategies for recruiting and accepting help'. Chapter 5 presents the final two categories; 'strategies for meeting biological and social needs' and 'strategies for conserving resources'.

In the final chapter, Chapter 6, I present a synopsis of the findings, and situate the study in relation to previous knowledge, before discussing the implications in three key areas; policy, practice and education.

Chapter Two: Review of the Literature

Introduction

In order for older people with chronic health conditions or increasing frailty to remain successfully at home, there is recognition that adequate supports need to be in place. How individuals manage these supports and the practical strategies they devise or adopt in order to participate in occupations they need or want to do have not been well explored. The specific focus of this study is the strategies individuals use to participate in day-to-day occupations at home and in the community. An example of a strategy might include using pliers to open medication packaging (Bytheway, 2001).

As outlined in Chapter 1, this review will first examine the relationship between health and occupation for older people, to establish the case that finding ways to manage occupations and remain active has benefits for health. I then examine the literature to find any evidence that older people have practical strategies that they use to manage day-to-day occupational challenges. I also outline common strategies occupational therapists use when working with older adults. As it is proposed that the knowledge of strategies being used might be useful for older people, I have also examined literature about self-management (i.e. individuals managing their own health condition) to establish the case that there is evidence of people successfully taking charge of at least this aspect of their day-to-day life. Since little was found about self-management by older people, I examined the literature that exists in the area of chronic illness, with the assumption that some of the principles might be useful. I then discuss the use of this information in managing health, and consequently, managing lives.

My search of the literature for the types of strategies older people might be using began with the health professional literature. Using the database OVID (which accesses AMED, MEDLINE and CINAHL) key words to elicit relevant literature included occupation, daily living, older person, older adult, elderly, strategies, and participation. I limited my

search to literature published after 1990. I also did some manual searching of occupational therapy and ageing journals.

Health and Occupation

Health is a complex phenomenon which, along with other factors, shapes the subjective experience of well-being that individuals experience at any point in their life. Well-being can exist despite the presence of disability or illness, and can exist even when the environment (physical or social) is not favourable to the individual (Kendall, 1996). Health has been defined as a "state of being well in body or mind; person's mental or physical condition" (Burchfield, 1984, p. 351).

Occupational therapists have long assumed a link between a sense of well-being and occupation, such that through participation in domestic and community occupations, individuals can influence their health and well-being (Reilly, 1962; Wilcock, 1993). As stated earlier, 'occupation' refers to the ordinary and familiar things that people do, which provide meaning and structure, through the organisation of time, social interactions, and opportunities to make choices and exert oneself in the environment (Dickie, 2008). Occupation is highly individual; what has great meaning and importance for one person will not for another. Personal characteristics impact on the importance of occupations, and on how they are performed, both physically and in what quality is expected (Hocking, 2008).

Occupation allows humans to meet basic needs, to exercise their capacities and to experience meaning and satisfaction in their lives (Wilcock, 1993). Individuals' health may support or reduce their capacity for occupation, whereas engagement in occupation can maintain health. Occupation also has the ability to undermine health depending on the occupational choices made and the environment in which it is performed (Hocking, 2003). For example spending large amounts of time watching television, or looking at the internet will often mean long periods of sitting. Associated with these occupations might be the consumption of unhealthy foods that are high in salt, saturated fats or sugar. Other

occupations expose people to excess sunlight, or dampness. People engaging in occupations with demands that exceed their skills, or that underuse their skills may become anxious, stressed, bored or depressed. In contrast, occupations can provide meaning to people's lives and help them to express who they are. Participation in and accomplishing occupations that provide a challenge further enhance the well-being experienced (Csikszentmihalyi, 1993).

Research from a range of disciplines supports the claims of a relationship between occupation and health. For example, engaging in physical activity, through sport or walking, has been shown to have a positive influence on length and quality of life (Loland, 2004). Participants in a study by Scanlon-Mogel and Roberto (2004) examining older adults' beliefs about physical exercise found that exercise improved their physical capacity and had a positive impact on other aspects of their lives, such as feeling better about themselves, being more alert and being better able to carry out their daily chores. The Well Elderly Study examined a group of well older adults who participated in a preventative occupational therapy programme. It demonstrated a connection between occupation and health, where those who participated in the programme had better outcomes than their peers in the control groups who had not (Clark, Azen, Zemke, Jackson, Carlson, Mandel, Hay, & Josephson, 1997). In particular, participation in personally selected and satisfying occupations was positive to one's health (Jackson, Carlson, Mendal, Zemke, & Clark, 1998).

The World Health Organization has promoted the importance of what people do through its classification system, the International Classification of Functioning, Disability and Health which promotes a view of health in relation to functioning and participation (World Health Organization, 2001). In order to participate in day-to-day life, people with a health condition may need to adapt to or compensate for impairments, which are losses or abnormalities to a body structure or physiological functions like pain, fatigue, or the lack of motivation. Although impairments are more common in older age, the effect of age on health varies. Illnesses, disease, injury and changes to sensorimotor and cognitive functions have the potential to affect the health and the occupational capacity of older

adults. Yet adapting to these changes, through compensation, changes to the environment, enlisting assistance, and selecting activities that enable participation in occupation, can in turn have a positive effect on the individual's physical and mental health. It is important to note, that while ageing does happen, health changes do not necessarily, and those that do can be contained through occupations that promote well-being (Glasgow, 2005; Wilcock, 2007).

Alternatively, participation might require people to overcome barriers, which act as impediments or deterrents to participation. Barriers are factors in a person's environment which through their absence or presence limit functioning. This might include the lack of availability of products and technology, obstacles in the natural environment or human-made changes to the environment; difficulties with support and relationships (for example, family, friends, acquaintances, neighbours, personal assistants and care providers, or strangers); disabling attitudes of people and society; or limitations of services, systems and policies (World Health Organization, 2001). It is worth noting that many of the barriers are outside an individual's influence, for example the availability of the right health service, the societal attitudes, or the geography of the land where an individual lives and may be real or imagined (Easom, 2003, p.7). The barriers identified in the literature that might impede participation include lack of time, lack of family support, and financial or environmental restrictions. Impairments that might impede were physiological stress such as fear, pain, fatigue and lack of motivation (Easom, 2003). Easom suggested that altering an older person's view of these barriers or looking for ways to reduce them should be a goal of nursing interventions. My belief is that it would be a suitable goal for many health professionals, not just nursing. Drawing on all these perspectives, strategies to participate in occupations might be about overcoming a range of impairments or barriers. The assumption underlying this study is that older people may be able to devise strategies that moderate the impact of those barriers in order to regain participation, despite any impairment.

Occupation and the older person

In the previous section I discussed the link between occupation and health. The notion that health is influenced by participation in occupations is of course applicable right across the life span. It is of interest that traditionally, older adulthood has been seen as time to wind down and relax. Although these notions are being frequently challenged, the current health, societal and political systems also put in place a range of safety nets for older adults, reducing all types of risks that they might be exposed to (Wilcock, 2007).

Successful ageing is seen as the ability to take care of oneself and find one's own way, despite advancing age (Steverink & Lindenberg, 2005). What might assist people to age successfully is a topic that has been investigated in a number of different fields, including medicine, social policy, occupational therapy and occupational science. I have focused on occupational therapy and occupational science in this literature review. The notions of well-being, being functional both physically and cognitively, and maintaining independence have all been raised in previous literature (Stanley & Cheek, 2003). Wilcock (2007) challenged traditional Western views of ageing, suggesting that chronic diseases that might be associated with ageing can be mitigated by on-going active engagement in activities that promote physical, mental and cognitive well-being. Supported by the World Health Organization's views (2002), Wilcock argued that active ageing is possible despite impairments, but that older adults are often faced with other barriers, such as societal, attitudinal and political barriers. The perspective taken in this study is that engagement in occupation can contribute to both active ageing and a sense of satisfaction or success in the process (Green, Sixsmith, Ivanoff & Sixsmith, 2005; McKenna, Broome & Liddle, 2007).

In discussing older people's engagement in occupation, it is useful to consider evidence about what they do. An Australian study (McKenna, Broome & Liddle, 2007) examining occupations of older adults found that older adults are a diverse group who spend varying amounts of time in a range of occupations from sleep, to leisure (social and solitary), to activities of daily living, both self-care and around the home. What is particularly interesting about this study is that the amount of time spent on any particular occupation

did not necessarily reflect the importance of the occupation to the individual concerned. So, while socialising might have involved the least amount of time, it may have been the single most important occupation to the individual. Leisure itself has been categorised in a variety of ways as active or passive hobbies and interests (Ball, Corr, Knight & Lowis, 2007); as media, individual, collective, social or relaxing interests (Häggblom-Kronlöf & Sonn, 2005); and as culture-entertainment, productive-personal growth, outdoor-physical, recreation-expressive, friendship or formal group (Silverstein & Parker, 2002). Common to all these categorisations is the great variety of different leisure occupations that people participate in, from ones done by themselves to those with other people, within the home or external, active or quiet. Diversity is also reflected in the literature about leisure pursuits of older people, although gardening and walking were commonly identified as active interests that people engage in (Ball, Corr, Knight & Lowis, 2007; Häggblom-Kronlöf & Sonn, 2005; Silverstein & Parker, 2002). Participation in productivity occupations, meaning those that contribute to the 'maintenance or advancement of society as well as the individual's own survival or development' (Creek, 1997) are also varied, with participants engaged in occupations that fulfill housework, home maintenance, voluntary work, caring (for a spouse or grandchildren), paid employment or learning (Knight, Ball, Corr, Turner, Lowis & Ekberg, 2007).

Common also was the involvement in occupations related to health. Some older adults reported being more able to participate in activities because they had the capacity to do so from a health perspective, yet many also reported that being engaged in occupation was beneficial to their health and sense of well-being (Ball, Corr, Knight & Lowis, 2007; Green, Sixsmith, Ivanoff, Sixsmith, 2005; Häggblom-Kronlöf & Sonn, 2005; McKenna, Broome & Liddle, 2007; Silverstein & Parker, 2002). Adding further weight to the relationship between occupation and health for older people is the effect that engagement in regular physical activity has on a person's health, through improving cognition (Hillman et al., 2006), preventing functional decline (Graf, 2006), and increasing aerobic capacity, muscular strength and endurance (Fahlman, Topp, McNevin, Morgan, & Boardley, 2007).

This brief review of the literature paints a picture of a multifaceted relationship between occupation and health. Participation in occupations can have a positive impact on health. Health can also be viewed through occupation, where the ability to participate despite impairments can affect health and well-being. In addition, there is evidence that supports the assumption that older people engage in a broad range of occupations, that these occupations support their health and that older people themselves recognise the health benefits of participating in occupation.

Strategies in the literature

As discussed earlier, the literature search included database, as well as some manual searches. While some literature was found, there was not as much as I might have expected and each article tended to focus on one particular aspect of occupation such as medication management (Bytheway, 2001), telephone use (Nygård & Starkhammer, 2003) or managing without a car (Davey, 2007). I broadened my search to also include what might be more readily available to the general public. I searched the internet through an internet-based search engine, anticipating that I might find a range of information about strategies people were using on websites or support organisations in the community, or posted by older people themselves. I also examined what sort of information might be available through libraries or other community avenues. While I was not successful in finding a great deal of information that older adults were sharing through this means, it may be that I was not using the right words to trigger the kinds of information I was seeking. I also considered the possibility that older people are not yet using the internet as a forum for sharing this kind of information. Community agencies that support people with certain conditions like arthritis have brochures which provide some examples of how to maintain independence, suggesting the types of equipment that might help or how to adjust the way in which activities are carried out (Arthritis Care, 2007). Typing words like ‘arthritis’ or ‘stroke’ into a Google search does supply a variety of information about specific conditions and some strategies people can use or adapt, although this is not necessarily targeted at a specific age group.

Because relatively little information about strategies older people use to support ongoing participation in occupation was located, and what was identified pertained to specific occupations, that information is reported in some detail. Nygård and Starkhammer (2003), for example, looked at the use of the telephone of person with dementia living at home and found that there were particular methods in responding to problems. Individuals either accommodated or adapted to their circumstances. When adapting, they responded to the problem either without any strategies (effectively taking a chance) or with environmentally-based or cognitively-based strategies. The types of environmental strategies used were visual strategies such as a phone list or highlighting important names; habitual strategies were things such as keeping the phone in the same place, and using verbal strategies, such as saying names or numbers out loud. Adjusting to the environment such as moving to the light was also used. Cognitive strategies included repeating actions or sequences, and stopping and reflecting or thinking about names. Allowing participants time to carry out these strategies appeared important. Although this study examined the strategies in a specific area, telephone use by people with dementia, the findings support the idea that older adults do have strategies which help them to participate in day-to-day life. To further support this, Bytheway (2001) found that while people varied in the specific ways they managed their medicines depending on their individual requirements, there were some common types of strategies. These included establishing routines and specific reminder strategies, and having relatively easy access to medications, which might mean that they were stored in more than one place or carried in a handbag or pocket. Developing ways to get into the medicine bottles and packs, for example, the man who used pliers to open bottles with safety tops, was also reported. Weekly tablet boxes were also used by some participants, but others found the boxes were not big enough to hold the quantity of medicine they were taking.

The types of strategies for getting and preparing food used by older people include being economical with their resources, purchasing fewer items more frequently because of difficulties transporting the items home, and purchasing partially prepared or ready-to-eat items (Sidenvall, Nydahl & Fjellström, 2001). A further study by Porter (2007) about food focused primarily on the problems people have with preparation. Some of the

strategies which were developed for people participating in that study included finding ways to deal with pain or fatigue, such as making use of visitors to peel vegetables. One interesting strategy was the introduction of an item of equipment (microwave) by a daughter. This was not wanted by the older woman. However over a period of time she began to use it and valued its place in her kitchen. While the microwave ultimately proved to be a successful strategy, equipment is not always used for its intended purpose. For example, furniture might be used as supports, and a walking stick used as a door knocker, to alert a neighbour that help is needed. A shower stool might become a place to put a flower pot (Forchhammer, 2006). Another study indicated older adults are open to new strategies that might assist in maintaining independence and safety, such as using 'smart home' technologies (Demiris et al., 2004), including devices like remote controls for controlling lighting, heating, windows, doors, and locks; visual and tactile signaling devices, and reminder systems to announce upcoming appointments. The aim of smart homes is to allow older people to remain safely and independently in their own home. Indications from the study by Demiris et al. (2004) indicate that while older people are open to the new technology, not all forms of technology are acceptable to all older adults. For example, many did not want cameras to identify falls or accidents in their home. It was clear that consultation with this group is needed when planning developments in this area.

The ability to get out into the community without a car was examined by Davey (2007). Strategies for getting out included the use of taxis, public transport and family or friends. The choice of transport and willingness to use it depended strongly on the reason for going out. People were more inclined to make use of all forms of transport available to them for serious travel, such as to medical appointments, or shopping for food; however for discretionary outings, for enjoyment, recreation or church older adults were less likely to request assistance, and the use of taxis for these purposes was almost never considered (Davey, 2007). This indicates that people are selective about what strategies they use, and for what purpose.

While in part my interest in this research is to help older people to be able to stay at home through the use of a variety of strategies, it could be that living at home is actually one of the strategies older people employ to maintain participation in valued occupations. It is established in the literature that remaining at home is important for the health and well-being of older adults (Green, Sixsmith, Ivanoff & Sixsmith, 2005; Haak, Ivanoff, Fänge, Sixsmith, & Iwarsson, 2007; Hayes, 2006). Whilst not particularly strategies, other aspects of the home and local environment may support older people in their health at home, including how easy it is to alter the property, such as by installing a wet area bathroom, or wider doorways for access (Goodacre, McCreadie, Flanagan, & Lansley, 2007), and an environment which facilitates physical exercise, is peaceful, clean, and supports social interaction (Day, 2007). These may not be areas that individuals can change, but it does highlight the impact the social and political environment has, supporting or restricting an individuals' ability to remain in their homes.

The types of strategies reported in the literature range from use of technology, to individuals demonstrating adaptability and ingenuity in finding ways to do things. The use of technology varied from low-tech options, like a list of phone numbers on the wall, to quite high-tech with the 'smart home' concepts, using automatic and remote controls for a variety of functions such as lighting, heating, and appointment reminders. The use of environmental modifications also included the use of equipment, although not always in the intended way. Some strategies were initially resisted, becoming more acceptable over time. Further strategies point to the use of other people to provide assistance. This review of the literature has demonstrated that there are some strategies being used by older adults, and some of these have been reported in detail about specific occupations. Given that most of the research was qualitative in its methodology there are always caution about how it can be extrapolated to other groups. Very little could be located that originated from research within New Zealand, indicating that this is an area that could benefit from further research.

Strategies recommended by Occupational Therapists

A review of strategies would not be complete without including a review of the types of strategies employed by occupational therapists to support participation of older adults in occupation. This is important because occupational therapists are concerned with people participating in occupations, particularly as the connection between health and occupations has been at the foundation of the profession. Occupational therapists recognise that there is a dynamic interaction between the person, their occupations and the environment they work, live and play in (Townsend & Politojko, 2007). Willard and Spackman's Occupational Therapy text (Crepeau, Cohn & Boyt Schell, 2008) is a recognised and well trusted source on occupational therapy interventions. That text brings together several dozen recognised experts to provide strategies for occupational therapists to use in their interactions with older adults. Strategies recommended include compensating for impairments; this might be achieved by altering the method by which an occupation is carried out (for example washing at the sink if unable to get in and out of the bath safely); by altering the objects used to carry out the occupation (having the soap on a rope so that it is not dropped and then unable to be retrieved by someone who cannot bend down) or by modifying the environment (installing grab rails and a bath seat to enable the person to remain seated during their wash) (James, 2008; Toglia, Golisz, & Goverover, 2008). Energy conservation is a strategy occupational therapists teach older people with endurance problems. Examples of such strategies include pacing oneself; by performing energy-demanding tasks earlier in the day, breaking activities into smaller units and completing them over several days, and prioritizing; by delegating tasks to others, or deciding which are the important activities and which are the ones which can be left until later or need not be done at all (Poole, 2008). Work simplification is also a strategy used to help conserve energy, such as buying pre-cut vegetables as one way of simplifying meal preparation (Poole, 2008). Environmental modification of the home can include advising the older person about removing hazardous features in the environment (such as scatter rugs in a room), or adding features, such as a shower stool or other adaptive equipment. Environmental modifications can be quite costly and time-consuming if the strategy is to completely modify a bathroom for example. Occupational therapists take into consideration the various strategies that could be used and the choice

of strategy ultimately used can be influenced by the knowledge of the person's condition and his or her ongoing needs, and the various environmental constraints such as finance and architecture (Rigby, Start, Letts, & Ringaert, 2008).

Self-management

Self-management is defined by Clark et al. (1991) as the "day-to-day tasks an individual must undertake to control or reduce the impact of disease on physical health status" (p. 5). They note self-management also requires the ability to cope with psychosocial problems generated or exacerbated by the chronic condition. Successful self-management requires individuals to be knowledgeable about their condition and treatment options so as to make informed decisions, perform activities aimed at managing the condition and use skills to maintain adequate psychosocial functioning. This all works towards reducing the impact of the health condition on their daily life. The focus in this study represents something of a shift, addressing management of all the day-to-day tasks in which individuals participate, in the belief that all of the things people do to occupy themselves affect their health. The emphasis on coping, success and self-management remain, but are applied to the broader scope of skills and knowledge to manage life rather than a health condition.

The discussion of self-management is largely found in research topics about chronic illness rather than in literature about older persons; however, there is some relevance as I will discuss. The literature surrounding the self-management of chronic illness provides a theoretical basis for the study. It points to the impact self-management can have on improving health status and lowering health costs (Lorig, 2003; Marks, Allengrate & Lorig, 2005). Achieving increased effectiveness and efficiency in the treatment of chronic disease uses the complementary knowledge of the health professional and the individual (Holman & Lorig, 2004; Lutz & Bowers, 2005). Some of the literature describes how individuals can assist others by educating themselves and modeling management of their chronic illness. The knowledge of the individual on how to self-manage their illness includes ways they have discovered to manage occupations and

participation. Consistent with the self-management literature, it is assumed that the practical knowledge developed and used by individuals who experience some challenges or barriers in relation to everyday activities can aid the journey of others as they learn to overcome barriers themselves (Bodenheimer, Lorig, Holman, & Grumbach, 2005; Lorig, 2003).

Chronic illness requires ongoing management of symptoms to reduce or maintain the impact that it has on the life of the individual. Not only does the individual need to attend to the details of the illness, but to incorporate it into the way in which they carry out their daily activities and participate in their life. The characteristic of ageing mimics chronic illness to a certain degree. The process of change and the fact that for the most part there is no return to previous youth means the older adults need to incorporate the ageing process into their daily life.

Clark and colleagues (1991) reviewed the literature relating to self-management and older adults and found that, while there has been much reported on the self-management of chronic illness, there has been little pertaining specifically to older adults. This is significant as older adults often have more than one condition and strategies taught to younger people may not be specific enough. Their social and environmental situation is also different to younger persons. A search of more recent literature found the proposal of a new theory of self-management of well-being to help older adults age successfully (Steverink & Lindenberg, 2005). The main feature of this model was the identification of six key self-management abilities; self-efficacy beliefs, a positive frame of mind, taking the initiative, investment behaviour, multifunctionality of resources and variety in resources. On the basis of some early studies Steverink and Lindenberg (2005) proposed that the use of these key abilities could help in the design of effective strategies for successful ageing. This model supports the idea behind my study, that older people are using strategies and that these could be promoted to support successful ageing.

Managing health

Managing a chronic health condition requires an ongoing engagement in activities that support health, for example an individual with diabetes needs to engage in healthy eating practices, regular exercise and close monitoring of blood sugar levels to maintain their daily health and to protect their future. Self-management theory acknowledges the person with the condition knows the most about the consequence of the condition and its therapies particularly in relation to themselves. Initially there will be a lot of learning and health care professionals are partners, sharing complementary knowledge with the individuals concerned. Self-management acknowledges the individual's knowledge about his or her activity options and preferences, and the ongoing modifications to these as they occur over time. Whilst the health professional may be an expert about diseases/illness or functioning, the individuals concerned are the experts about their own lives (Bodenheimer, Lorig, Holman & Grumbach, 2005; Holman & Lorig, 2004). In relation to this study, individuals are similarly acknowledged to be experts in their own lives and participation preferences, but the knowledge sought is less about managing an illness than managing to sustain participation. Here, the participants are recognized as the experts from whom the health professionals will learn.

Studies have shown the usage of self-management education has a greater effect than didactic education, where information is provided by a teacher or expert. However, self-management education has been shown to be effective in improving outcomes for some groups, possibly reducing costs of health care, but not for others (Bodenheimer et al., 2005). One of the rationales for the inconsistent findings was the predominance of the medical model in society and the lack of sufficiently trained personnel in the self-management education programmes. Where improvements in self-efficacy are achieved, studies demonstrate that, given the right information, people can effectively manage their health condition (Holman & Lorig, 2004). In much the same way, it is possible that the information generated by studies such as this might be used to educate older people to more effectively manage participation in day-to-day occupations.

There already exists a vast body of information on self-management techniques and strategies, located in booklets produced by specific societies such as the Arthritis Foundation, or produced and available in healthcare facilities such as hospitals. Other avenues include the Accident Compensation Corporation, New Zealand's accident compensation scheme, where information about modifying one's home environment and lifestyle to prevent falls is readily available (Accident Compensation Corporation, 2003; Accident Compensation Corporation, 2006). The internet also provides much information. Typing in key words such as 'arthritis', 'stroke', 'self help', 'strategies', 'overcoming difficulties' can bring up a great variety of information. Much of this information focuses on the disease, the symptoms and the treatments. Whether these avenues are well used is less evident. It is possible that persons or their families may access this information. Health professionals may choose to use this information source and pass it on to clients, although my suspicion is that it occurs less frequently, as health professionals have little time to search for information, and check its authenticity. It is not known to what extent older adults are using the internet, or other agencies, as a source of information to self-manage health conditions and find strategies to promote participation.

Managing lives

There is evidence in the literature that older adults are adapting to losses occurring as they age (Lang, Rieckmann & Baltes, 2002). Alongside this, it has been noted that while some older adults reach later life in good health, for others a lack of (self-care) activities accelerates the process of ageing (Easom, 2003). To complicate this further, many older adults need to manage multiple chronic conditions, such as arthritis and a heart condition. It is suggested that successful living requires engagement in a variety of daily activities, both self-care in nature (such as eating, bathing and dressing) and self-enriching (such as leisure, work and social activities) (Horgas, Wilms & Baltes, 1998).

A study that examined what older adults in America were doing to help themselves remain more independent in the future found three main areas in which strategies were developed: promoting health, maintaining adequate social support networks and managing finances wisely (Yuen, Gibson, Yau, & Mitcham, 2007). In addition, personal attributes such as attitudes were noted to influence the use of strategies. It is thought that

self-efficacy, 'people's judgments of their capabilities to organize and execute courses of action required to attain designated types of performances' (Bandura, cited in Easom, p. 7, 2003) underpins people's actions. Self-efficacy is acquired through four means; successful achievement of performing a task, observing others performing a task, verbal persuasion (i.e. encouragement and information), and eliminating emotional arousal to subjective threats such as fear and anxiety. Recently, Easom (2003) has suggested that self-efficacy as well as perceived barriers influence how individuals perform in their lives.

Yuen et al.'s (2007) study suggests that older adults are putting in place strategies to manage their lives and continue to be able to participate in day-to-day occupations. Their report also discusses 'self-regulated dependancy'; (Baltes, cited in Yuen, p. 47, 2007) where help for certain tasks is sought, so that sufficient capacity is available for others. An example of this was getting help for certain household task so that they could remain living at home. It was proposed that this strategy might be used more as an individual's functional performance declined, and that as this occurs, perceptions of what constitutes independence also change. This notion is supported in other literature, women preparing meals being one example where, over time, they shifted from doing this completely themselves, to getting meals delivered. While meal delivery was initially disregarded as a strategy, it became more acceptable at a later stage, when it became harder getting meals organised (Porter, 2007). Such findings suggest that health professionals need to be aware that there is a time when strategies are more readily accepted by an individual and that this will vary greatly between people.

In addition to the very practical strategies focused on achieving a particular end, the literature identified some generalized approaches. Adaptation is one way to manage with satisfaction. Clark and colleagues (1996) examined the types of adaptive strategies a group of low-income well older adults were using. They found that some of the strategies reflected areas typically addressed in occupational therapy training, yet others were more unique to the individual and their environment. While categorising strategies is somewhat arbitrary, it does serve as a useful place to initiate future discussions with older adults.

The adaptive strategies were grouped into 10 life domains, some of which were outside of the areas in which occupational therapists might usually engage with clients. The areas were activities of daily living, adaptation to a multicultural environment, free time usage, grave illness and death – spirituality, health maintenance, mobility maintenance, personal finances, personal safety, psychological well-being and happiness, and relationships with others. The participants in the Clark study lived in a unique environment, were mostly female and with low incomes, which was likely to influence the types of specific strategies they developed. A different way of considering adaptation strategies includes physically, by reorganising important activities through planning and doing the activity in new ways, perhaps using aids and equipment to support that new way. Adaptations might also be made to the way people interact with caregivers, which includes influencing the caregiver, or changing one's perceptions and values (Åberg, Sidenvall, Hepworth, O'Reilly, & Lithell, 2005). A further study examining functioning and adaptation, highlights the strategies of selection, compensation and optimization (Lang, Rieckmann, & Baltes, 2002). Selection is the active reduction of activities in order to focus on those areas that are important, which relates to the notion of self-regulated dependency. Compensation is the use of a new or different way to reach a goal, and is expected to occur when a person has experienced a loss or decline in their functional ability. Optimization is the enhancement of one's resources in a particular area of functioning, and is used where there is no functional loss. The types of strategies older adults use may change over time, particularly as their view of independence may change over time, from being independent in the performance of an activity to being able to make autonomous decisions about daily life at home (Haak, Fänge, Iwarsson, & Ivanoff, 2007). Steverink and Lindenberg (2005) also suggest broad types of resources that assist older adults in self management abilities, being external resources (food, shelter and social support) and internal resources (skills and abilities). Resources should be considered for their ability to serve multiple aspects (for example physical and social well-being), such as having dinner with a friend. Maintaining a variety of resources and ways to achieve a specific aspect of well-being was also recommended.

Managing lives is complex and individual. Different strategies include self-regulated dependency, engagement in a variety of daily activities and adaptation strategies. The type and availability of resources is also influential on what strategies are used by older adults. Given these findings, it was expected that this study would find a range of strategies that might reflect individuals' resources, and situations.

Summary

The New Zealand government's strategy to support ageing in place (Ministry of Social Policy, 2001) requires some knowledge about barriers to participation in domestic and community activities and how older New Zealand men and women overcome the barriers encountered. The review of literature has shown that there is some evidence that older people generate strategies to overcome barriers they encounter, and that occupational therapists have long-standing strategies that they recommend. The literature also shows that given education, older people can manage health conditions themselves. It has also highlighted that older people are a very heterogeneous group and single solutions and strategies do not necessarily suit all. While many of the studies reviewed are qualitative in nature, only Hayes study of older Appalachian women who live alone in America (2006) employed a similar methodology to the study that I carried out, focusing on the area of formal and informal supports. The aim of this study is to uncover strategies used by older persons in New Zealand to participate in day-to-day home and community based occupations using a qualitative descriptive methodology, with the intention that the strategies identified will contribute to the later development of interventions to assist older New Zealanders to continue to manage their daily occupations.

Chapter Three: Methodology

Introduction

In this chapter I will outline the qualitative descriptive approach taken with this study and explain why this was appropriate for the question it is concerned with. To begin, the nature and underpinnings of qualitative research are explored. The study design, participant and recruitment criteria are then described, and the ethical issues that needed to be considered for the study are discussed. Following this I will describe how the analysis was conducted and the data managed. Finally, strategies to ensure rigor and trustworthiness will be presented.

As stated in Chapter One, the question the research addressed was "What strategies do older New Zealanders use to participate in day-to-day occupations that they need or want to do?" While the literature review provided support for the idea and examples of strategies that are being used by older adults, these were either very generic or quite specific about a particular occupation. As there was very little about New Zealand older adults and what strategies they were using, I selected a methodology that would allow exploration of this area. Because the study is exploratory, a qualitative research approach was selected to inform the methods of data collection and analysis for this study. In particular this study has a qualitative descriptive design, which provides a valuable way to explore human existence as it occurs in everyday life (Sandelowski, 2000). The choice of a qualitative descriptive design for this study was influenced by the fact that little is known about the specific strategies older New Zealand people are using to address activity limitations and barriers to participation in their day-to-day occupations. There is also little that is being drawn from older adults themselves, in the way that a qualitative descriptive methodology would allow. Accordingly, participants were interviewed to elicit and describe the strategies they use to manage limitations or overcome the barriers they experience to participating in day-to-day activities at home and in the community.

Research Approach

Qualitative research is a broad term used to describe research which focuses on human experiences in naturalistic settings. Research based on naturalistic inquiry takes place in real-world settings, and the phenomenon of interest unfolds naturally. This form of research has also been coined 'discovery-oriented' which seems an apt description for this study, given this is an area in which there is very little reported research available in the literature (Guba, as cited in Patton, 2002). In naturalistic inquiries, the basic assumption is that it is not possible to separate the outside world from an individual's ideas and perceptions of that world. Those who experience the phenomena are the 'knowers' and transmit their knowledge through doing and telling. In order to know about the realities the individuals have created, the research design needs to investigate phenomena in their natural context (DePoy & Gitlin, 1994).

The qualitative research paradigm, or world view, contains three important elements with which to provide justification for the choice of research methods (Crotty, 1998; Denzin & Lincoln, 2000). These are ontology, epistemology and methodology. Ontology is concerned with 'what is', what things there are in the world to know. Epistemology is the theory of what we know and 'how we know what we know' (Crotty, 1998, p. 8). Methodology is the strategy or 'plan of action which links the choice of methods to the desired outcome' of the research (Crotty, 1998, p. 3). In Table One I have provided a summary of the research approach taken for this study, with more detail about the various constructs provided later.

A constructivist epistemology underpins this study. That is, the study takes for granted the multiple realities constructed by the participants in the study and the implications of those constructions for their lives and interactions with others (Patton, 2002, p. 97). Data derived from constructivist inquiry represents another construction to be taken into account in the move towards consensus of knowledge. This seems a particularly useful approach for this study as it aims to gather and describe the phenomenon, 'the strategies older people use to participate', that could be added to over time.

Table 1: Summary of constructs and Approaches Used in the Study

Construct	Definition of Construct	Research Approach
Aim of the research	The theoretical goal of the research	To describe strategies older New Zealanders are using to participate in day-to-day occupations
Paradigm	Basic set of beliefs	Naturalistic
Ontology	What is, what things are there in the world	Relativism
Epistemology	How we know what we know	Constructionism (social)
Methodology	How knowledge can be gained about the world	Qualitative descriptive
Method	Process and strategies used to gather data	Individual semi-structured interview

What is in the world, or the ontological perspective used within this study was that of relativism. In relativism there is recognition that each of the participants creates their own reality. No worldview is necessarily the same and there can be multiple realities. From the perspective of relativist ontology, when a person describes something, he or she is reporting something that is meaningfully constructed within the community in which he or she exists (Patton, 2002). With this ontology as the framework, I expected participants might have different views and circumstances (communities, experiences) that would contribute to the strategies they would describe.

Qualitative descriptive studies

Qualitative methods are useful to better understand a phenomenon about which little is yet known (Strauss & Corbin, as cited in Hoepfl, 1997), with qualitative descriptive research described as level one exploratory research, designed to elicit descriptions about a particular topic. Other levels of research focus on the relationships between variables (level two) and the focus of different research might examine the cause and effect nature of the relationship (level 3) (Patton, 2002; Sandelowski, 2000). The purpose of

descriptive studies is to 'document and describe a phenomenon of interest' (Marshall & Rossman, 2006, p. 34). Qualitative descriptive design is particularly useful when the researcher wants to capture an event and describe it in everyday language. In qualitative descriptive research the language is a means of communication, not something that must be interpreted in itself, as with methodologies such as phenomenology (Sandelowski, 2000). It is a methodology that is more descriptive than interpretive.

The qualitative descriptive approach is not as well used or acknowledged as other qualitative methodologies, such as phenomenological or grounded theory research (Sandelowski, 2000). In discussions with other people conducting postgraduate studies, about my anticipated study, many were surprised I wasn't intending to use one of the more philosophically-driven qualitative methods. However for the purpose of this particular study the method of choice was one which allowed for the straightforward description of phenomena, the practicalities of who, what, why and how people manage their lives and the types of strategies they use to do so. My main focus was to describe what these strategies were, in order to establish a foundation of knowledge that could be built upon by others.

The value of qualitative descriptive research lies in being able to describe the issue under investigation in everyday language with low-inference interpretation. This is not to say that qualitative descriptive research is without any interpretation. Indeed the descriptions the research provides are dependant on those that are provided by the participants and then what the researcher selects to describe, thus the beginning of transforming that particular experience or event takes place (Sandelowski, 2000). In order to maintain credibility the researcher must make provision within the method and methodology to ensure that the descriptions accurately convey the events and meaning intended (Hoepfl 1997; Patton, 2002; Sandelowski, 2000).

In qualitative descriptive research the researcher serves as the human instrument of both data collection and analysis. Data analysis begins during data collection and is predominantly inductive in that critical themes emerge from the data (Hoepfl, 1997;

Sandelowski, 2000). Both descriptive validity, the accurate accounting of events and interpretive validity, the accurate account of the meanings participants attributed to the event are sought in this form of research (Maxwell, cited in Sandelowski, 2000).

As with other forms of qualitative research, the researcher aims to describe and interpret the findings maintaining empathic neutrality (Patton, 2002). It is acknowledged that the researcher is not a distant objective observer, totally distinct from the research being done, and that the way in which the interviews are carried out and the data collected can be influenced by the knowledge and personal background of the researcher. This is why describing my personal and professional background and my interest in this particular topic in Chapter One was so important, to lay open what has influenced me as I came to this research. When the questions were formulated to guide the interview process, care was taken to eliminate any personal bias or influence that might have shaped or distorted the accounts provided by participants.

Ethical approval was sought and obtained from the Auckland University of Technology Ethics Committee in November 2006 prior to commencing the study [Appendix A]. As participants were recruited outside of the health system, through local community groups and I was not offering intervention as an occupational therapist, ethical consent from a health authority was not necessary.

Selection criteria for participants in this study

This study is about the strategies older New Zealanders use to participate in everyday activities. I selected 65 as the minimum age to participate in the study as 65 is the age used in New Zealand policies relating to older age, such as the Health of Older People Strategy (Minister of Health, 2001). As there has been very little in the literature about the strategies used by older people, I did not want to exclude either gender from being included in the study. I also did not anticipate that gender would affect the information gathered.

To be included in the study, participants needed to be community dwelling and receiving some form of support or assistance. For the purposes of this research I defined community dwelling as persons living in the community, and not living in residential care facilities. They might be living with a spouse, family or any other persons. The type of assistance they receive might vary in level and source, such as private or government agencies. As mentioned earlier, in this study needing support is taken to be an indication that older adults experience some limitation in, or barrier to their everyday activities, in response to which they might have discovered or developed coping strategies. The rationale for receiving support being part of the inclusion criteria was thus that participants would be in a position of needing, using and being able to discuss the strategies they had developed or adopted.

Participants needed to be articulate in English as this is the language in which I am fluent, and the nature of the methodology being used meant that the participant and I needed to be able to have a conversation. Using an interpreter and obtaining translations of the interviews would have been outside the scope of the budget for this thesis. As a result participants were excluded from the study if they were not able to articulate their stories in English. Participants also needed to be cognitively able to provide informed consent. Persons with cognitive difficulties that might have impeded their ability to provide informed consent and recall how day-to-day activities are carried out were excluded from the study. Persons with acute health conditions that may be affected by participation in the study were also excluded, as participation may have added an additional burden.

Selection of participants

Determining sample size is an ambiguous area in qualitative studies (Patton, 2002). The number of participants recruited to qualitative studies varies; however some of the key considerations in determining when sufficient participants and data have been collected are the clarity of the topic, and the quality of the data collected. When the nature of the topic is clear and information is easily obtained, fewer participants are needed. Data collected can vary between participants. Some are better able to reflect on the topic and

express themselves more articulately than others (Morse, 2000). In this study, the topic was straightforward, and following discussion with my supervisors it was agreed that data from 8-12 participants would generate enough data for analysis and form the basis of a meaningful discussion for the study. Purposive sampling was used to recruit participants who met the inclusion criteria (Patton, 2002). In the event, eight participants were recruited. They appeared able to provide different examples of strategies they were using in the course of the interview. Once eight interviews had been completed and transcribed the volume of useable data was adequate. There were several different types of strategies evident, yet it was also apparent that the participants had some similar strategies.

Recruitment

A Wellington church was approached through a contact I had at the church. He provided me with an initial opportunity to explain the purpose of my study to some of the church's older members through a presentation at one of their weekly 'Friendship' groups. Several church staff were also present. The presentation included an introduction of the researcher, the aim and purpose of the study and the time involved for participants, with an opportunity for questions. The presentation was approximately 15 minutes in duration. Information sheets [Appendix B] and a contact/demographics form [Appendix C] that prospective participants could send to me were available at the presentation to give to potential participants.

Two of the potential participants chose to contact me by phone in the week or so following the presentation. I was able to check they 1) understood what was involved with participation in the study, 2) were willing to be involved and 3) to arrange a suitable time and place for the interview. I obtained the demographic data at this time, which assisted in providing details for future contact and to ensure that participants met the eligibility criteria for the study. It became evident that one of the participants did not fit the criteria because she was experiencing cognitive difficulties and was not able to reliably provide informed consent or recall her day-to-day activities. The other participant was recruited.

In addition to the presentation, members of the church staff were left with information sheets about the study [Appendix B] and contact forms to disseminate to any other people they knew that fell within the inclusion criteria. The intention was that if any of the church members consented to have me make contact, that information would be forwarded to me and I would phone as above, one week after the individual received the information. The delay between the participant receiving the information and my phoning was to give them opportunity to properly consider participation, without perceived influence from me. Prospective participants identified by church staff were also able to post the contact/demographics form to me. To assist them, prepaid envelopes were provided with the information sheets. Two further prospective participants were identified this way. One was recruited. The other did not fit the original criteria as she was the spouse of someone who was unable to participate.

Recruiting participants took longer than anticipated. However, as explained above, some of those willing to participate didn't fit the inclusion criteria themselves, but were the spouse of someone who did fit the criteria but was unable to participate because of communication difficulties. After consultation with my supervisors, the inclusion criteria were altered to allow such individuals to participate as it was anticipated that they had valid and useful information to add to the study about strategies that benefited their partner. The revised criteria were taken back to the ethics committee for approval which was duly given [Appendix D] before these volunteers were recruited, including the spouse mentioned previously. This enabled me to go back to recruit the woman described above.

An additional, unplanned recruitment strategy was that my contact at the church had informed people outside the church about the study. As a result two women consented to me contacting them. I phoned them for their contact details and briefly explained the purpose of the study. I then posted out information sheets and followed up as with the earlier participants in the following week. Both were recruited.

Snowball recruitment

Snowball methods involve asking (potential) participants themselves to provide the names of others who may meet the study criteria, which can be a good way to access a population that might be difficult to find (Patton, 2002). Snowballing was introduced in to this study because I was finding that, while a few people were happy to put themselves forward from the community presentation, no further participants were forthcoming, yet some of those who had volunteered spoke of friends they had that would be suitable and were happy to refer. This also enabled people who had heard me describe my study to put forward names of people they were in contact with who were interested in participating in this research. One was through a preschool music group I attended with my children. The group facilitator knew of some older people who might be suitable and passed on some information sheets for me. Three potential participants responded. Two did not fit the criteria as they were not receiving any support and were not included in the study; the third was recruited. The final participants were recruited through an older woman I had met in my local community, who chose not to participate but who knew of a friend who met the study criteria. She passed on an information sheet to her friend who became a participant. That participant also introduced me to a friend of hers who became a participant. A summary of how each participant was recruited is provided in Table 2.

Participant location and support services

There were eight participants in the study. Most participants were recruited from Wellington, the capital of New Zealand. It is a city set on the edge of a harbour and surrounded by hills, on the southern coast of the North Island. It has a population of just under 500,000 (www.wellingtonnz.com). One participant lived in a nearby town. Initially it was intended that the non-Wellington participant would be interviewed in order to pilot the question guide and as a practice for qualitative interviewing, but the data collected from that participant was thought to be similar in content to the other participants so has been included as a part of the study. The town, while not a city like Wellington, is not too dissimilar in terms of physical environment, with a population of 45,000.

Table 2: Summary of how Participants were Recruited

Participant	Recruitment Strategy
1	Volunteer from community contact
2	Volunteer from Church presentation
3	Volunteer from Church presentation after criteria broadened
4	Volunteer via contact person from the church
5	Volunteer via contact person from the church
6	Snowball recruitment via community contact
7	Snowball recruitment via community contact
8	Snowball recruitment via participant

Participants were receiving support for a number of reasons including frailty, poor vision, difficulty mobilizing after a CVA, and lung disease causing decreasing stamina and exertion. Support was in the form of formal assistance from home help organisations organised by the local hospital and informal assistance with family members and neighbours aiding in some areas such as grocery shopping or regular phone calls to check that all was well.

Data collection and interview process

Demographic data had been gathered from those who indicated willingness to participate in the research [Appendix C] prior to the actual interview occurring. The demographic data requested included age, ethnicity, gender, living situation, challenges experienced in day-to-day living and current support services. I tried to gather as much of this as I was able to over the telephone. This was to enable the sample to be diverse should there be an influx of prospective participants who fulfilled the criteria, and I was in the position of selecting from a greater number than required. This data is reported in the findings chapter.

Before each interview started the interview process was explained to the participant. He or she was invited to ask any questions they might have had and written informed consent was then obtained [Appendix E]. The participants had the opportunity to have someone present with them during the interview. Two chose to have someone there, specifically as support during the interview. In addition to this two had husbands present for part of the interview, although one slept throughout. The remaining four were interviewed on their own. The interviews were conducted in the participant's home. It was important that the participants felt comfortable with the surroundings to enhance the quality of the interview itself. Being in their own surroundings also allowed them to show me any features in their home that helped illustrate the strategies they were discussing. In a number of interviews participants showed me the various pieces of equipment that supported the strategy they used, such as the rails at the step or the particular container they used to gather the washing in. Having someone else present at the interview did not appear to affect the interview. This may be because the participants chose to have a particular person there, and appeared to welcome the contributions that person made during the interview.

To warm-up the participants to the topic I started by introducing myself and asking about their activities that day. The warm-up was used at the start of the interview to engage the participant, and demographic data previously gathered was also clarified and recorded. The interviews were recorded on a digital audio recorder; this was discussed with the participants prior to recording beginning. This helped provide clear and accurate recording for transcription.

The data comprised eight semi-structured interviews of 45 to 90 minutes. A semi-structured interview format was chosen to guide the interview discussion with the participants. In semi-structured interviews a question guide is developed around the topic of interest to the study being undertaken. The questions were to act as prompts in the interview, and asked about how participants were affected by their impairment, about an activity that needed to change and what they might do differently now, compared to previous times in their life [Appendix F]. The intention was to gather descriptions about

how impairments affected their activities, how they had changed the way things were done, and how they came to that particular method. The questions were derived from literature indicating the types of barriers older people experience and from my own observations as an occupational therapist who has worked extensively with older adults residing in the community. If a participant needed some prompting as to what kind of information I was seeking I used categories such as looking after themselves or what they did for leisure to open up a new strand of conversation. The questions did not have a fixed wording or sequence. Some examples of the types of questions are listed below:

- Tell me how your impairment affects your ability to do….
- What is different about how (activity) is done now?
- Do you use another person to assist in any tasks?

The possibility of a follow-up interview time of approximately 20 minutes had been indicated on the information sheet and in presentations about the study. This option was not needed as all the interviews were captured clearly on the audiotape and were able to be easily and accurately transcribed. No questions arose about what the participants had meant in their accounts of the strategies they use. Recruitment was discontinued after the eighth interview as sufficient richness of data was available for analysis.

Transcribing the data

Each interview was recorded on a digital recorder. Following the interview each was downloaded onto the computer and then transcribed verbatim. Access to the computer is protected by a password. For the most efficient use of my own time, the interviews were transcribed by a typist. She completed a confidentiality agreement [Appendix G]. I listened to each of the interviews a number of times, checking them against the transcribed data in the process. Prior to printing of the transcribed interviews, names were changed and a pseudonym allocated. Printed transcripts were kept in a secure folder in my office at home. The digital recordings will be kept until the completion of the study, before being deleted.

Ethical considerations

Ethical procedures exist to protect the integrity and safety of all those involved in research. As a registered occupational therapist, I am bound by certain requirements which relate to ethical behaviour, in particular the Health Practitioners Competence Assurance Act (Ministry of Health, 2003) and the Code of Ethics for Occupational Therapists (Occupational Therapy Board of New Zealand, 2004). Tolich and Davidson (1999) outline five principles to guide ethical conduct of research. These are: voluntary participation, informed consent, maintaining confidentiality and anonymity, doing no harm, and avoidance of deceit. Using these principles the key concerns for this particular study will be described below.

Voluntary participation and informed consent

Participation in this study was voluntary. When recruiting the participants, strategies were put in place so that the voluntary nature of recruitment was clear, versus some sort of coercion or pressure to participate. An example of this was the cool-off time between the participant receiving information about the study and the follow-up phone call from me. Informed consent means participants have adequate information about the research, are capable of comprehending that information and that they make the decision to participate without undue influence or coercion (Green & Thorogood, 2004). All participants were fully informed through an information sheet [Appendix B] prior to being selected to the study. The rights of participants, particularly in relation to being able to withdraw from the study at any time until data analysis had occurred were discussed prior to participants being asked to sign the consent form [Appendix E]. The consent forms were signed prior to the interview being carried out.

Confidentiality and anonymity

These concepts mean maintaining the participants' privacy in all areas, both separate to and including the research setting and by preserving their anonymity in the published report (Green & Thorogood, 2004). Raw data was kept in a locked file during the data collection and analysis. The taped interviews were transcribed by a typist who had signed a confidentiality agreement [Appendix G]. Once the transcriptions had been checked for accuracy and the recordings had been listened to again through the analysis process, the

audio recordings were then deleted at the conclusion of the study. A copy of each transcript will remain at the Postgraduate Office of the Faculty of Health and Environmental Sciences at Auckland University of Technology for a minimum of six years in locked storage. The completed participant consent forms were stored separately to the transcripts and have now been transferred to AUT, where they will also remain for a minimum of six years.

The identity of the participants was protected at all stages of the project. The participant had the option of determining where the interview would be held, and all of them chose to be interviewed in the privacy of their own home. Each participant was provided with a pseudonym prior to sending the audio recording away for transcribing and the typist used the pseudonym to title the transcript. I eliminated any identifying details such as family, street or building names that might have identified the participant to others when I checked the transcript.

Do no harm and avoidance of deceit

Research ought to be designed in such a way that no physical or psychological harm is done to participants. This is not only during the recruitment and interview process but also in how the data is dealt with and discussed in the final report (Tolich & Davidson, 1999). Efforts were made to alleviate any discomfort participants might have felt by letting them have the option of choosing the venue for the interview and having a support person present. Being in their own familiar environment also assisted in creating a partnership in the interview process. I was striving for the relationship to be that of equality rather than the power being with the interviewer.

It was not anticipated that any discomfort or risks would be experienced as a result of participating in the study. However I had provisions to help identify suitable support for the participant should this have arisen, and this was clearly stated in the Information Sheet [Appendix B]. None of the participants called on my offer to assist them in locating support.

Separate to doing no harm, I envisage that the research might prove beneficial to the participants and to a wider group of older New Zealanders and health professionals. While there was no direct benefit to the participants of the study, it may be that from an altruistic sense they feel positive about sharing strategies that have potential to help other older New Zealanders in the future and to contribute to a postgraduate student's effort to learn more. All participants of the study received a summary of the types of strategies that had been described by the participants, and those who have indicated they would like to will receive a summary report of the study at its completion.

Finally there was no deceit of the participants or recruiters about the purpose of the study or the methods I was using throughout. The findings were reported in a truthful manner and the participants were informed of the findings as they were formed.

The Treaty of Waitangi

In New Zealand the Treaty of Waitangi provides an agreement between the Crown and Maori. The Royal Commission on Social Policy (1988) identified three principles of the Treaty. Within the design of this study I have sought to uphold those three principles of partnership, participation and protection. Participants were not sought or excluded on a cultural or ethnic basis. The availability of resources to ensure Maori participants had the appropriate cultural supports had they chosen to participate had been considered. A Maori minister was consulted about the aim of the study and was available to provide guidance and connection with more local support. While there were no participants who identified as Maori in the study, my methods were sufficiently flexible to provide any changes that might have been required. For example, built in the study design was the ability for the location of the interview to be determined by the participant, and for the participants to have support people present.

Analysing the data

There is no prescriptive way in which to approach analysing qualitative data. Approaches to analysis are varied and often reflect the particular methodology chosen (Green & Thorogood, 2004). The method of analysis selected for this study is that of a general

inductive approach which seeks to find the core meanings evident in the text that are relevant to the research objectives, and to outline and describe the categories which are most relevant (Thomas, 2006). While it is consistent with other methods of qualitative data analysis, qualitative descriptive studies tend not to involve the degree of theory building that characterises a grounded theory approach. Rather a general inductive approach focuses on the presentation of the findings as a description of the most important categories. This differs from a discourse analysis where the researcher is conducting the analysis in a way that a descriptive account of multiple meanings within the text might be presented and from phenomenology, where a narrative about the lived experience is prominent in the presentation of the findings (Green & Thorogood, 2004; Thomas, 2006).

Miles and Huberman (1994) described three main tasks of analysis. These are data reduction, data display and conclusion drawing. These three tasks are also the main tasks involved in the general inductive approach for analysing data. The principles underlying the general inductive approach are described by Thomas (2006) and include; multiple readings and interpretations of the raw data, development of categories from the raw data, findings resultant from multiple interpretations made from the raw data (they are inevitably shaped by the assumptions and experiences of the person conducting the study), that different evaluators may not produce identical findings, and the trustworthiness of the findings to be assessed using the same methods as with other types of qualitative analysis. Data analysis is a messy and time-consuming process that is not necessarily carried out in true linear fashion (Marshall & Rossman, 2006), although for ease of reading I shall lay out the process followed in a linear manner.

In carrying out the analysis I needed to consider what the core meanings evident in the text that were relevant to the research objective. Categories most relevant to the research objective were identified and then a description of the most important categories and sub-categories were developed. I followed Thomas's (2006) procedure of inductive coding, which I have described below.

1. Preparation: Raw data was formatted to the same style, and a copy was made of each interview. Each interview was printed on a different coloured paper.

2. Close reading of the text: I began with listening to the audio recordings and reading the transcripts several times. This allowed me to become familiar with the data. I began this process after the first two interviews had been completed and transcribed. As with much qualitative research, ongoing data collection and data analysis occurred simultaneously.

3. Creation of categories: Categories were identified and described. In inductive coding, categories are often created from actual phrases or meanings in the text. The categories developed from the strategies that the participants were describing in the interviews. When creating the categories I began by literally cutting up the colour coded text and placing it in piles on the floor under the headings of the categories that were forming. Initially many of these were separated out into categories such as self-care, productivity or leisure occupations, such as with the Canadian Model of Occupational Performance (CMOP) (Townsend, 2002). Initially I thought that using the CMOP might provide a suitable framework, in recognition of how people's strategies for occupations could be categorised. Before making a decision to proceed with this, I discussed this idea with my thesis supervisors. I also found some recent literature relating to categorization of occupations by Jonsson (2008). Jonsson proposed that moving from categorizing occupations in traditional arenas, such as self care, productivity and leisure, to an experience-based conceptualization of occupation would more ably support the individualized meaning of occupation. Jonsson illustrated how the same occupation of working at a computer was experienced very differently by two different people: one very bored, the other enjoying the challenge in front of them. Reading this led to my own reflection on how occupations can be classified. I have often struggled in practice with placing an occupation for a client under productivity or leisure as the meaning of occupations often seem to change for people, depending on things such as their life stage or the environment they live in. During this process it became clear that using categories such as self-care and productivity were not going to be properly reflective of the data that was being recorded in the interviews. These three things, discussion with my supervisors,

the timely article and my own reflections were influential in making the decision not to use the CMOP for this data. For example getting bathed or showered would be a self-care occupation, yet two different examples of this from participants had illuminated different ways of achieving this, with one participant describing a strategy of recruiting help, and another describing setting up the physical environment. Categorising these as self-care would not have allowed for the differing strategies to be reflected.

My process of creating categories continued to evolve as I progressed through the interviews and transcripts. I then placed these on an excel spreadsheet so that I would be better able to manage the data when it came time to place excerpts in the findings chapter. As I interviewed each further participant and had their interview transcribed I was able to start to add their data to the framework that was developing. This process included the creation of new categories where participants identified strategies that were different to those previously mentioned, and re-organising data as new sense was made of data placed in existing categories. For example I initially grouped all the money strategies together, in a category for financial strategies, however these strategies are ultimately found threaded throughout various categories and subcategories such as meeting biological needs for food and conserving resources. At the end of the process, some categories had very little text associated with them and on further reflection fit better as a subcategory of one of the more general categories. It also became quite clear that many of the categories did not exist in isolation; there were relationships with other categories. For example the strategies used to conserve resources had impacts on the strategies used for getting food or opportunities for social contact.

4. Overlapping coding and uncoded text: This refers to text that might be coded into more than one category and text that remains unassigned at the end of this process. At the end of developing the categories and having gone through each interview several times, I did have some text that was not assigned to any category. In general these pieces of text were not relevant to the objectives of my research. I also came across several segments of text that could have been assigned into more than one category. In these instances I chose to place them in the category that the text displayed the strongest association with.

5. Continuing revision and refinement of category system: Once I had categories that I thought were representative of the data I needed to label them and provide a short description of the meaning of the category [See Appendix H]. This allowed me to test the data against the description and examine the links between the categories. Appropriate quotations to convey the essence of the category were selected. Each category also needed to include, where possible, alternative or contradictory points of view. For example in 'keeping safe' many of the quotations illustrated specific strategies that participants employed to maintain their physical and personal safety. However one participant also described taking some risks instead of her usual safety practices.

There had been about twenty categories initially developed. During this part of the analysis many of those 'original' sets of categories were combined, reducing the total number of categories and developing sub-categories where appropriate. The final result was that five main categories are described in the findings; Strategies that keep me safe, strategies for recruiting and accepting help, strategies for meeting needs, strategies for conserving resources and strategies for making choices. There are sub-categories which shall be described in the following chapter, where links between the categories that were developed are also described.

The anticipated outcome was that a comprehensive summary of the data collected would be developed, that describes the strategies older New Zealanders use in managing their occupations. This was accomplished, in a form that can be added to and refined through future research.

Strategies to ensure rigor

Accounting for rigour is important in all research. It is this which lays out the trustworthiness of the research and the findings presented (Curtin & Fossey, 2007). Guba and Lincoln (1994) described four tests of rigour which are the equivalent of internal and external validity and reliability within the positivist paradigm, where a great deal of

quantitative research is carried out (Hoepfl, 1997; Koch & Harrington, 1998). Guba and Lincoln's four criteria; credibility, transferability, dependability and confirmability are cited by others in the literature (Koch & Harrington, 1998; Marshall & Rossman, 2006; Patton, 2002) and will be discussed further in this section.

Credibility

Credibility or the truth value refers to the confidence readers can have in the study identifying and describing what it sought to do and what the participants were trying to convey (Hoepfl, 1997; Krefting, 1991; Marshall & Rossman, 2006). Credibility is said to occur when the study presents accurate descriptions of the phenomena, so that people who might also share that experience can recognise the descriptions (Sandelowski, 1986). There appear to be two main areas of credibility, of the information and of the researcher (Patton, 2002). Ways of strengthening credibility don't necessarily separate these areas.

In relation to credibility of the information, using the audiotape and then checking the transcripts myself ensured accurate capture of the data. A thick description of the research process also adds to the credibility (Curtin & Fossey, 2007). In addition, through the interview process I repeated and reframed questions to seek the descriptions from the participant. My experience in interviewing older people in my role as an occupational therapist has provided skills in neutrality during an interview. This assisted in the participants being able to convey the strategies they use, rather than imposing my own assumptions upon them. At the end of each interview I went over the discussion and checked if there was anything further the participant wanted to add, correct or challenge (Thomas, 2006).

Regular discussion about the research process and findings with the research supervisors challenged any findings or interpretations I was making, which constituted a type of peer examination throughout the research process and strengthened the credibility of this study (Krefting, 1991). Along with this regular debriefing, frequent research supervision contributed to establishing rigour. Using the participants' words alongside my interpretations allows the reader to see for themselves the type of text that was being coded into a category (Krefting, 1991; Thomas, 2006). In addition, I regularly kept notes

on my involvement with the study, and categories as they were developing, forming an audit trail of my processes and thoughts (Krefting, 1991). An extract is presented in Appendix I.

Furthermore all participants had been given the option to receive feedback about the study's findings. This was indicated on their consent form. Of the eight participants, six wanted to receive a copy of the report of the research. Accordingly, a summary was posted to the participants with a prepaid and addressed envelope with a request for them to provide any additional comments about the categories and strategies that had been created from their interviews [Appendix J]. One of the participants had passed away. Of the remaining seven, five responded to the summary sent. All the participants who responded reported positively on the categories outlined. Some added additional strategies, provided comments on what they had found hardest to accept, or specific comments about a strategy used by another participant. Adding to the credibility of this study was the recognition from the participants that these categories were ones that made sense to them and reflected the strategies they had told me during the interviews. The additional strategies people discussed fell mostly into the keeping safe category.

Transferability

Transferability refers to the applicability of the research to people in other places. In order to determine the transferability of the study adequate information about the participants, settings and processes used in the study need to be provided so that readers are able to judge for themselves whether or not the findings reported and interpreted have relevance for their own settings (Curtin & Fossey, 2007; Koch, 2006; Krefting, 1991; Patton, 2002). The findings of the study were not intended to be generalised to the whole population, as might be planned in a piece of quantitative research. However I have described the settings and participants as fully as possible, so that the reader might be able to judge whether the findings are able to be transferred to their own settings.

Dependability

Dependability refers to the consistency of the findings. Dense description of the data gathering, analysis and interpretation are needed to satisfy this rigour criterion (Krefting,

1991; Sandelowski, 2000). The process ought to be auditable. To create a process that is completely open to audit, I have, throughout this study, sought to provide rich and accurate descriptions of the methodology, the way in which data was gathered, the process for analysis and the interpretation. These descriptions are found particularly in this chapter and the following, but are evident throughout. Any decisions relating to the study have been documented in supervision notes and in applications to the Ethics Committee.

Confirmability

Confirmability refers to the objectivity of the study. The intention is to consider whether the findings of the study could be confirmed by another (Marshall & Rossman, 2006). In particular this rigour strategy is seeking to ensure the confirmability of the data objectivity, not the researcher's objectivity (Krefting, 1991). It is said to have been satisfied when credibility, transferability and dependability issues are addressed (Koch & Harrington, 1998). Discussing the data with my research supervisors is one of the ways in which confirmability of the data was addressed. Since I have sought to ensure rigour in each of these areas, the objectivity or confirmability of this data has been addressed.

Summary

In this chapter I have described the research approach that I have taken to this study, being a qualitative descriptive approach. Qualitative descriptive design is a useful approach when the researcher wants to capture an event and describe it in everyday language. Situating this approach in the ontology of relativism allows for the expectation that participants might have different views and circumstances that would contribute to the strategies they would describe. Having described the approach within this chapter, I have concluded that it is a suitable approach to my question; what strategies do older New Zealanders use to participate in day-to-day occupations that they need or want to do? I have discussed the selection criteria and recruitment process for the participants and how the data was collected and analysed. The ethical considerations were described and finally the strategies to ensure rigour of the study were discussed. In the following two

chapters I shall describe the findings of the data, and provide the categories that were developed in the analysis and the descriptions and examples that support those findings.

Chapter Four: Findings

Introduction

The findings from the participant interviews are presented in the following two chapters. I start this chapter by introducing the participants themselves in order to help the reader understand them, and their context. I will then begin the presentation of strategies that came through the participant interviews, with two of the four categories into which findings have been organised. I elected to present 'strategies for keeping me safe' and 'strategies for recruiting and accepting help' first because these strategies appear to set up the participants. Also, the strategies participants are using have some similarities, whereas the strategies discussed in Chapter 5 are more particular to the individual's circumstances. Chapter 5 will present the remaining two categories: 'strategies for meeting biological and social needs', and 'strategies for conserving resources'. In both findings chapters presenting findings, some of the categories have been broken down, so subheadings will help the reader to follow through the chapter. Data from participants who were caring for a spouse, following changes to the inclusion criteria, have been included. As predicted, they were able to provide useful information about strategies that benefited their partner and themselves.

Participants

Gillian is the primary caregiver for her husband. She immigrated to New Zealand as a young woman and met her husband here. They moved from a large home on a hill to a flat easy care-section following her husband's cerebro-vascular accident (CVA). He has since had a second CVA and needs the support of both Gillian's and the care providers to remain at home.

Like Gillian, Albert is also the primary caregiver for his wife who has early onset dementia. They reside in a large town near Wellington, having moved there when Albert

retired. Albert's son and daughter-in-law live nearby. Albert's physical activity and vision are affected by emphysema and cataracts.

Connie lives with her husband, who has dementia, in a council flat close to a shopping centre. Her husband attends a day care programme most days. Like Albert, Connie has a condition which affects her physical activity. Both Albert and Connie use walking aids particularly for the outdoors. Unlike Gillian, Albert and Connie were interviewed about the strategies they had developed for themselves rather than their role as care-giver for their spouses.

Denise has a different arrangement, where she and her daughter share the same home. Denise has lived in this house for the past 60 years. Her daughter is her main support and although blind, Denise is able to mobilise independently with a walking frame within her home environment.

Rita has also lived in her home for over forty years. Her husband, no longer able to live at home, moved into a residential care unit in a neighbouring suburb nine months ago. Rita does not drive, but visits her husband most days in his residential care home.

Like Rita, the remaining participants live alone. Beatrice was widowed many years ago and lives in her own home of several years. She remains very active in the community groups and the church of which she is a member.

Gretchen lives in a flat, part of a low level complex of housing owned by the local government, commonly referred to as council flats. She is nearby a shopping and medical centre and has a daughter who lives a short drive away who helps from time to time. Gretchen is frail, and mobilises with a walking frame when outdoors.

Millicent moved from a large sloping section a few years ago to a small apartment close to a medical centre and bus stop. She has had a number of ailments in the past year and has regular district nursing input.

Of the eight participants, one was male. Four lived on their own, three with a spouse and one with a daughter. Although the selection criterion was people over the age of 65, those who participated in the study were over 70, ranging from 73 to 92. All of the participants were of European descent. One immigrated here when she was in her 20s; the others were all born in New Zealand. A summary of the participants' demographic data is provided in Table 3.

All of the participants were keen to be involved in the study and to talk about the strategies they had developed or were of assistance to them in residing at home.

Table 3: Summary of Demographic Data on the Participants of this Study

Name	Age	Gender	Living situation
Albert	80-84	Male	With spouse, in unit, spouse with dementia
Millicent	75-79	Female	Alone, in unit
Gretchen	80-84	Female	Alone, in unit
Rita	80-84	Female	Alone, in house for 40 years, spouse in rest home
Gillian	70-74	Female	With spouse, in town house, spouse requires hospital-level care
Denise	98	Female	With daughter, in house for 60 years
Connie	70-74	Female	With spouse, in unit, spouse with dementia
Beatrice	85+	Female	Alone, in house several years

What kinds of strategies are being used?

There are a large number of strategies being used by the participants. I was surprised that some participants were not very aware of and willing to show off the specific strategies that they had developed. I found that I needed to probe during the interviews to discover these strategies, as some participants put what they did down to common sense or

'getting on with it'. Others were very aware of the specific strategies they were using and welcomed the opportunity to discuss them in some detail. Trial and error appeared to be the most common way of coming to the strategies, although most participants were not able to clearly discuss how they came to a particular method.

One of the things that struck me was that although some very specific strategies came out of the interviews, in line with some of my expectations; there were also strategies in areas I wasn't necessarily contemplating. I expected some practical examples around showering and other personal self-care occupations, and, while there were some, this was not an area that provided many detailed examples. In contrast, areas relating to safety, shopping, and getting around provided more examples from participants and were areas where many conversations led to. Perhaps the participants were less willing to discuss more personal self-care issues with someone they didn't know well – although my experience from working within the health system would indicate that this is not usually so.

As discussed in the previous chapter, the categories in which the findings are presented are derived from the ideas that came through in the interviews and have been named to reflect the data contained therein. The areas discussed are not necessarily completely separate from each other, as I found when I was working through the process of categorizing the data from the transcripts. As mentioned, both categories presented in this chapter have a number of subcategories that I will discuss and illustrate with quotes taken from the interview transcripts.

Strategies for keeping me safe

This category captures the things that people put in place to give a sense of physical and psychological safety for themselves and their resources. Safety is defined as "freedom from danger" in the online Oxford English Dictionary (2000). There are a variety of strategies that the participants used to illustrate how they are being safe. These range from environments to people. Safety underlines many of the other categories and for this

reason I am presenting it first. As it is a large domain, two sub-categories became apparent, which are presented in the following order; safe environment and personal safety.

Safe environment

These were strategies which overcame environmental barriers to participation such as the physical and social living environment. Strategies that provided an environment that participants perceived as safe could be quite dramatic, such as moving home. This might involve moving to a different geographical area that presented fewer barriers, or to a smaller home which became more manageable. Generally those who moved appeared to consider the distance to local amenities such as shops, medical centres, and transport.

Gillian and her husband moved homes to a place they thought would be easier and safer to manage with her husband's condition. They moved from their house on a hill, where they had been managing despite the husband having had a CVA, to a home on a flat easy-care section as it would be safer for them to move around it. In hindsight it would appear to have been a sound decision when the husband had a second CVA affecting the opposite side of his body to the first CVA. This move has enabled Gillian and her husband to remain living together despite his current condition.

> *We had to move from [a seaside suburb] because we were living up the hill…which was pretty hard because we lived there for 28 years.... we were half way up our road [on a hill], a beautiful view. This house is actually a very, very suitable home you know [on the flat, near shops]. Everything is sort of easy to get to. [We chose the current place because of the level surroundings] and where the bathroom is and the wide passage because he was already in a wheelchair then. [Our previous house] was very difficult actually. We had 13 steps in the front and it was the only way we could get him in. We had other doors but you know they were impossible to get in. And a long drive down. Although at that time he [husband] was actually [mobile], with help walking up the stairs, he had [only] one stroke which incapacitated his left side. And then we were only here for about six months, and then he got the other stroke which affected the other side.*
> *Gillian*

Here we see Gillian and her husband had strong ties to their previous home, yet they are satisfied with the change they made as they have been able to stay together at home.

Connie also talked of moving homes to continue to be safe. Her initial reasons for moving were to do with personal safety from neighbours who she felt threatened her and her husband's personal safety and that of their home. Connie's health condition of chronic obstructive pulmonary disease (COPD) has meant that they chose an environment which enabled ease of access to the hospital and other medical facilities. Connie's need for reasonable access to the hospital is one which she has considered for many years, as living too far away poses a big barrier in terms of timely access to medical treatment if required. Moving homes to a different environment can mean safer access within the home and to facilities out of the home.

> *Where we lived, we were in a house, which we were lucky because my husband was working for the Housing Corporation, and that was good but we had a gang one section away that used to have parties all night and it got to the stage where I just said to my husband, 'Well I've got to do something, because I'm either going to do something I'm sure I'll regret, or move out'. If I had of known, that they were going to get a court order put on them [neighbours] and things would change then, I wouldn't have gone…. It was [a] good [house] and it was right near a bus stop and everything which was [good], closer than this [current unit] is, you know. So it was good in that respect and, we were very lucky because it was a new house because they [housing corporation] gave us the option of, have, having a place in P [a suburb 30 minutes from the city centre] and I said to the boss when he came and saw us, I said 'Well' I said, 'the point is, my health is not good, so being in P is not going to be very good for me because' I said 'sometimes I have to go to the hospital from the doctors. So therefore, to come from P could, you know be quite a hassle'. At that time he [husband] didn't have memory problems but if he had you know, as time has gone by it would have made it really, really difficult you know. And so they said 'Oh well you can have the option of having this house'. Well we did and then, I mean the gang got so bad and, they used to have fires that went 35 feet up in the air. And I was always worried about the trees. And the house that we lived in, the black lining paper that the builders put in hadn't been trimmed off under the, under the eaves. So of course, I was always worried that this would catch fire. Consequently when they had a fire, I would never go to bed, I wouldn't sleep. You know because I'm terrified of fire because I've been close to quite a few big ones and um, and lived,*

next door but one from a man who got burned to death in a house. So it makes you a little bit more, touchy. So when my girlfriend, [who was looking for a new flat] said 'I'm going down to the council to see if I can get a council flat'. So I said, 'Oh I'll tell you what, I'll come with you'. Well while she was there I put in for, at the same time. So that's how we got this. I mean it took over a year and a half. But the point was, if I had sort of thought about it, but I didn't, I don't know. She did it there and that just made me think well I'll take the bull by the horn and do the same thing.
Connie

The strategy of not moving should also be considered. Denise and Rita are both living in the family homes that they have resided in for a significant number of years. In Denise's case, her loss of sight meant that being in an environment so familiar to her could be a strategy that enabled her to continue to get around within her home in a safe way, which she might not have been able to do in an unfamiliar place. Additionally, moving home does not always work out as anticipated. Albert appears to regret moving to what he had considered a safe choice, to the town where his son lived. Albert described how he and his wife have struggled to connect socially in the new town. This provides an indication that the social environment may be as important as the safe physical environment.

No we don't go out actually it's, it's one of the things we made a mistake. We shifted, in one way we shifted from P [large town] to here [another large town] too late. I, I was in the post office, and before we retired you get a book of what to do, what not to do you know. In the book they suggested you want to live in a place ten years before you retire, decide where you're going to retire, ten years before and go to live in that place. And I'm afraid it was right.
Albert

Other strategies to improve safety were altering the physical environment by introducing things intended to reduce the risk of falls. Interestingly most of the participants had some form of equipment at home, ranging from a walking stick they had purchased themselves at the pharmacy, to more complex setups of hoists and shower chairs. The most common modification was putting in rails to hold while descending steps to their home, or to get in and out of a shower safely. A number of participants showed me through their homes to see the rails that had been placed in bathrooms, toilets and steps into their home to assist how they managed in these areas. The use of this environmental adaptation overcame

barriers to getting in and out of their homes and, in some instances, specific occupations such as toileting and showering or washing.

While the rails that participants had initiated were readily accepted, other available strategies were not. For example, Gretchen has equipment to assist her with safe washing and personal cares, but will not consider using it until she feels her safety is really at risk.

> *Well I couldn't shower, I'm frightened, [and] I'm getting to the stage now where I'm frightened of slipping. I've got a seat there, [because] I've been getting right down [in the bath] and I have a job to get up. That's why I've got the seat, the hospital seat. But I'll have to start using the seat now. Some nurse came and she put it there. But I haven't been using it; I'll have to start using the seat now because I can't get up out of the bath you know. So I'll just have to alter my ways…. Oh yes I can sit on the seat and I've got a shower but it's a hand shower. Before I liked to get down in the water if I can you know. It [the shower] is on the taps and I've just got to do it, you know. Yeah well I'll have to stop getting right down the bath now but I like to get properly clean and you feel better getting right in the water don't you.*
> *Gretchen*

Gretchen's dilemma has been reducing the risk associated with an activity or doing the activity the way she prefers. So far she has chosen sitting in the water in the bottom of the bath over the reduced risk of sitting on a seat in the bath, but it appears from this conversation that this may be in the process of change. Something about the performance of this activity is influencing when she implements her new strategy – of using the bath board. Perhaps Gretchen is waiting until she is no longer able to get out of the bath? This reluctance is echoed by Connie, who has also been given a piece of equipment to adapt how she goes about washing or showering herself.

> *They've [health professional] given me a seat to use to sit but, I haven't actually used it yet which is very naughty. But, I'm a bit, nervous about sitting down in case I can't get up. You know. When you've got bad legs and you think well if I'm, if I'm up, I'm lucky to be up and if I'm down and I can't get up, like just now, see he [husband] might have been here but then he might have gone walking down to the letterbox and*

sometimes I've been in there calling him to come and help me and I don't know where he is!
Connie

As seen with Gretchen, the equipment may be in the home for a long time before its use is actually contemplated. It is interesting to note that environmental changes like moving home were more positively reflected on when they were determined by the individual. Changes that were determined by others were not necessarily taken up immediately if at all, as with the bath-board or shower-stool that sits in a bathroom unused for months. People have a certain way they like doing things, like Gretchen's soak in the bath. Fear of the equipment not working for them also appeared a hindrance to the uptake of new strategies. Equipment provided, intended to provide a safe environment, potentially cluttered the home, possibly making the environment less safe.

Personal safety

This is about strategies that protect body structures and functions. This might be motivated by fear of injury or illness through falls or exacerbating symptoms of diseases. Strategies for being safe include being particularly careful with your body to protect it from harm. This might be the older person modifying the way in which they approach tasks or reassessing the occupational choices they make to reduce risk.

Denise is conscious of her body in all the occupations she engages in during the day as she has had a couple of falls now.

I'm very careful in case I slip because of my knee…so you know I take my time with everything I do.
Denise

Participants had also established a strategy for accessing help when they need it, or when they weren't feeling safe. These plans used formal agencies such as personal alarm companies and informal networks such as neighbours. Denise and Gretchen both describe using alarms for assistance in the event of a fall. The knowledge that assistance is

available and on its way, should they choose it, helps eliminate the fear in some situations and appeared to ensure the participants had a feeling of safety.

> *Yes I got a pendant…it goes to Freedom Alarms…it's been used several times when there's been a fall at night.*
> *Denise*

> *I've got a thing around me neck [personal alarm pendant]. When I had a fall, bad fall too, it was late at night I don't know why. Must have been pretty late, perhaps I'd sat up for a long time or something or other you know, and then [fell] down and it's quite frightening when you're on your own but luckily I've got that around me neck. It goes to the hospital.*
> *Gretchen*

Connie takes being safe very seriously, but is also motivated by the fact that her husband needs her. He would be unable to manage at home on his own if Connie were unavailable to assist, and may need to go into care. Connie uses a strategy of not putting herself at risk, and therefore does not participate in some activities such as gardening that she might otherwise.

> *You see, the point is with people with CORD, if you have a fall, late in life like our age, you may not be able to be operated on, depending on how your chest is so you may have to stay in hospital. Well I don't really want to do that if I can help it. So I don't do a lot, where I put myself at risk of falling. I mean, I would be out doing the gardening but I, I can't now because my balance is not good. A couple of times I've thought 'Oh I'll go out there and straighten that up myself,' and I've nearly had a couple of falls. So I've thought, well it's not worth the risk. Because I sort of have to be okay for my husband as well….I just think you've got to. Put it this way, you've either got no sense, or commonsense! And that's what it comes down to I think. If I'm going to be sensible, I won't do things where there's a chance of me, maybe ending up in a wheelchair or in a hospital for five or six weeks you see. Because I now have to think, I've got to think of him [husband with dementia]. Because if I go in to hospital or anything, or have an accident, he has to go in to respite care.*
> *Connie*

Good neighbour networks did not feature as much as I thought they might in keeping people safe. Traditionally the neighbours and community may have consisted of family members and neighbours who have know each other for a long period of time and ensured safety for the older person. In this study there did not appear to be much evidence of this, although Rita had established a strong network with her neighbours and local community. Rita talks of being able to call on her neighbours if she felt reason to or her physical or personal safety demanded so.

> *Well the man [neighbour] said to P [son] and me if I wanted anything to just give them a call. Well you know I thought the couple on the other side I would have called on first and then one night there was a knock on the door and he [neighbour] came over and said, 'Rita, I want you to know, if your frightened T [neighbour's wife] or I will be over'. And I thought well he's taken the trouble, he's genuine.*
> *Rita*

In contrast, Gretchen had developed a variety of ways to maintain her safety and protect her privacy from her neighbour, by being assertive, and by eliminating a resource that he came into the house to access.

> *My neighbour, he rings her [his wife in Malaysia] everyday and uses my phone. He paid the bills you know but it just about drove me mad because he's got a loud voice, and I have no privacy you know. And I'd have to sit here and 'Oh my dearest darling', that went on everyday. Yeah so at the end he, he wanted to come in yesterday and I just said no. I got my daughter to ring up and cut the toll calls.*
> *Gretchen*

Interestingly for some, risk wasn't always to be avoided. Aspects of personal safety needed to be weighed against other considerations and that with the greater need considered. For instance, Gretchen described when she was walking home from a short walk one day and ran out of stamina. She regularly took rests against a fence and on this day made the decision to take a risk.

> *Oh yeah I suppose I would [run get short of breath] if I was going fast you know but I just take my time. And [one day] I was hanging on to fences and that, and cars were stopping for me and that. So I was a bit*

cheeky to one man, he turned around and he said to me 'Can I give you a hand' he said 'I see you're hanging on the fence', I couldn't get back any further [walking to my unit]. And I looked and I thought 'Oh gee you've got to be careful you know'. I said 'Ooh as long as you behave yourself it's alright!' Anyway he laughed. Anyway I went, took the risk of going with him but he was quite, quite a gentleman. So he bought me and dropped me in the gate and then he said 'Oh I only live around the corner.'
Gretchen

Where Gretchen's assessment of risk involved judgments about others' motives, Albert's related more to features of the physical environment. He had been provided with a walking frame and he also had a walking stick to use. The walking frame he mostly used for outdoor walks, and this greatly reduced his risk of falling. However Albert didn't take either of these aids with him when he went to the supermarket, instead relying on the supermarket trolley for balance.

No, no I don't, I don't bother. Because you've got the carts to push, the trolley, so I can lean on that. I have a stick, I used to take that but I've given that up now because it's more of a nuisance with the trolley than without it. So once I get to Woolworths, I get the trolley and I'm alright, you know.
Albert

Gretchen also demonstrated that, while willing to take risks, these are calculated on her experience also. Choosing to use an aid to support her balance because of the risk she associated with not using it, outweighs her preference to walk without an aid.

I was quite worried because I was frightened to get up in case I [fell over], I've had a few falls you know. I'm more careful [now] I think really. On the odd occasion I [would] come out without the walking stick, that's the thing I don't do [now]. No, always bring it whether I want it or not because it just stops me from falling and that.
Gretchen

The element of choosing what presents a risk to one's safety and what is worth the risk or other considerations appears to vary between participants, yet most weigh up at some

point what strategy they will use and for which safety situation. Evidence of occupational choices is apparent, in choosing to give away gardening, walking that bit further, or taking a ride with others.

Strategies for keeping themselves safe included moving homes to a place that they thought would be easier and safer, altering the physical environment by introducing things intended to reduce risk of falls, such as rails stools and other pieces of equipment, or doing an activity the way a person preferred, despite the associated risk. Other strategies for personal safety included being conscious of one's body and what one intends to do with it, accessing help when it is needed, preventing others from using your resources, calling on neighbours, not putting yourself at risk (and therefore choosing not to do some things), using objects for a purpose different to that intended by the designer (like a supermarket trolley for balance). In participants' accounts of safety concerns and the risks they face, there was a notable absence of any sort of problem-solving about what might cause falls or present as a particular risk to them in their environments. This is perhaps the type of problem-solving that a health professional might engage in or direct older adults to consider. Rather than trying to change things to reduce the risk of falling, the participants acknowledged the risk, relating it to particular occupations, such as washing themselves, and had very generalized strategies such as 'being careful' or not engaging in occupations such as the gardening.

Strategies for recruiting and accepting help

This category of strategies is about how the participants recruit and accept the help or assistance they need from various sources to participate in their day-to-day life. Help was sought or provided from different sources; formal help from agencies or institutions such as hospitals or home care agencies, informal help from family and friends or neighbours. Help was either structured, in that it is a regular and organised part of the person's routine of daily or weekly occupations, or it was on a more casual basis. An example of structured help is a daughter coming to help each week with the grocery shopping.

Recruiting help

Recruiting help involves directly requesting assistance, or modifying the assistance already being offered. It can also involve making others aware of the difficulties that the older adult is encountering, either by talking about a problem, or by being seen to be experiencing difficulty. Directly requesting assistance is perhaps most easily accomplished when there is someone living in the same household who is able and willing to assist. Connie was able to recruit help from within her own household as she and her husband both live at home. Connie has organised her husband to do the parts of the laundry that she is now unable to do without undue difficulty, recognising that the task is no longer one she can adequately carry out.

> *Well I try and do it [get the washing done in the machine] now because with my leg I can't. Like I took a basket out the other day and, and I, and I thought I'm going to drop this stuff before I even get to the clothes line but luckily enough I didn't. But ah I thought to myself I've got to be a bit sensible here. So what I try to do is get it done, so when he's [husband] here he can hang it out [and] he will bring it in, he's very, very good [and] he will fold it. He's a very good folder. Better than me actually.*
> *Connie*

Connie recognises here that she is no longer able to carry the washing and peg it on the line and so makes use of a resource that she has – a very physically fit and able husband. Connie's approach to recruiting help from her husband is quite directive, and she feels satisfied with the resulting outcome.

> *My husband has to help me get in the shower because it's in the bath, you know. And, and I just say to him, 'Will you stand close just in case I [fall]'. My balance is not good and I might need him you know. And so that's something, you know I manage quite well, at present.*
> *Connie*

Recruiting help does depend on knowing where the 'helper' is when you need them. For example, Connie needs to know her husband is around the house when she takes a shower, and not wandering down to the letterbox.

Denise has also recruited family to assist her in some areas. Her daughter, who lives with her, assists with things that she struggles with due to her loss of vision and level of frailty. Whereas Connie's recruitment of help is directed towards help she might need, just in case she loses her balance or is unable to get up, Denise's daughter is indispensable. In the following excerpt Denise's daughter talks about the development of their showering strategy.

> *Yes unfortunately we haven't got good facilities, and I looked at getting something, more suitable. The man from Park and Clark [bathroom hardware shop] came and said we'd have difficulties because of our concrete walls. And anyway time's gone on, we've found a way. The hospital leant us a chair, a bath chair, ah that swivels around. And so you sit in it to have [shower over the bath], but we haven't got a shower to bath [in] so that was a bit awkward, we actually had to use a dipper to shower with it. But then that got [to be] a problem because, of the arthritic leg, getting over the bath. And we couldn't use the little shower, tiny shower in the ensuite because; ah it was too far to walk to it, through narrow doorways and, cluttered furniture in my part of the house and a step over in to the shower. All of that was too difficult. So what we've done is, we've used the, bath chair, I use um, a big, bucket to wash the feet and legs first, then we do the rest of the body sitting on the chair over the bath. So the legs are on the outside of the bath so that they don't have to go in.*
> *Denise's daughter*

Despite having sought help from different avenues, Denise and her daughter didn't appear to find a strategy that provided an adequate solution for their requirements. Accordingly, they have modified the use of the equipment they have to find a solution that is acceptable to them. This is not a solution that they ever appeared to have imagined they might be using, but they appeared particularly proud of the fact that they had come up with something that worked and was acceptable to themselves. Thus, in this instance, Denise recruited her daughter's assistance in solving the problem of how to bath, and her ongoing assistance in accomplishing the task.

Participants also recruited help from others outside of their home, particularly as many participants lived alone. Notifying agencies when circumstances change is one instance of recruiting help from outside, which is used to modify the help that is already in place.

This may also indicate that the participant has a sense of control over the help being recruited.

> *But the laundry we used to send it to the laundry here [run by the IHC] every Tuesday morning. They were very good but they've finished, they've closed. So they've [health care agency] allowed the, lady that does the cleaning here, [an extra] 20 minutes, once a week.*
> *Albert*

Another way of recruiting help is to discuss concerns with someone, and getting that person to action the solutions they identify. For instance, Gretchen readily accepted her daughter's offer to get a toll bar on her phone.

> *I got my daughter to ring up and cut the toll calls. I didn't know you could do that you see but [daughter] did it. And then he wanted to come in yesterday but I wouldn't have him. He wants to come in here all the time. I need time to myself if you understand.*
> *Gretchen*

Being seen to require help is another method of recruiting help. When participants are unable to control who sees their need, however, there is caution in accepting help – as with Gretchen leaning on a fence to gather her energy to get home, and accepting a ride.

When Connie and her husband found their home, they used existing contacts to get the help they needed. Others use information technology to recruit help, like Denise's daughter when she searched the internet looking for an appropriate wheelchair for her mother. Picking up on other people's initiatives is another strategy Connie uses. For example when she decided to go and find out about council flats because her friend was doing so. Recruiting help appears complex. Some participants appear quite skilled at recruiting help in a variety of ways, and others appeared to be very selective about how they recruited help. Some participants recruited friends and family positively, others because they needed to.

Recruiting help can at times be complex. For example, one participant and her family recruited networks of people to take her on daily visits to her husband in a nearby rest

home. These visits also included stopping off to get various items she might require at the chemist or supermarket. As none of Rita's children live in Wellington, they used a variety of willing friends. The way in which this was organised meant that the load on any one person was minimal, yet Rita was able to fulfill her roles as a wife and home-maker by her frequent visits to her husband and basic organisation of her home and herself that may require her to be out in the community.

> *I've got people organised to take me to visit D [husband in a resthome] and the supermarket or doctors. Today I've got to pick up a prescription from the chemist. Things like that…about six or seven times a week. P [son] would know. He pays!*
> *Rita*

Here again we see, as with Gretchen earlier, getting someone else to action things as a strategy, as Rita's son is arranged to oversee the transport details. Part of recruiting help might also be accepting that someone needs to pay, as in this example.

Rita uses different ways of recruiting help. She has a well-established network of family and community friends who are set up to enable her to continue many of her roles. One method she has established is that of exchanging one service for another to obtain help. Rita lives down a steep path, which because of its incline and her frailty would pose safety risks for her to navigate each day on her own. To reduce those risks, Rita has set up a strategy that enables her to get her mail each day.

> *…another couple who have their car in our garage, bring the mail and paper down.*
> *Rita*

Rita also uses her family to help get tasks done. When they come to stay, they wash the sheets and make the beds for the next person coming. Although, by preference, the family completes the tasks for her before they leave, Rita also spoke of how tasks were completed if the family were unable to get the washing done and beds made before they left. The use of time as a strategy is important to Rita in that circumstance.

If they [family] can't [do their washing before they leave after staying], I just hang the washing in the laundry if it's blowing or wet and, you know, there's no great hurry because they're not coming back, for a few weeks and, then gradually get the beds made and sometimes A [home help] does it but often R [daughter] does it. And that's um, I'm very lucky because, lifting beds, to put the sheets under, that is quite hard. And I've heard a lot of people say that they find bed making is tiring. But um, you know, everything, can be done if you just take time.
Rita

When Rita takes time to complete a task, it is not only about doing the task slowly; it is also about how the completion of the tasks is spread over time. The use of time is also evident in other strategies presented by other participants which will be presented in Chapter 5. Gillian also asks her family for help if needed when her husband is in hospital.

Well, I try to ring some of my family to sort of um, help me ah getting backwards and forward to the hospital and so on.
Gillian

The use of familiar and repeating strategies is also evident here. Rita and her family use the same routines that have worked on previous occasions, as does Gillian each time her husband is admitted to hospital. These are strategies that the participants and the others involved are familiar with and cooperate with.

Another of the participants recruited church friends to get to evening groups. A mutual friend described how Beatrice maintained her independence and control over the ride home by refusing to be escorted into her home. Beatrice acknowledged the concern of her helpers, however, and they arranged a 'signal' so the helper would know that Beatrice had got inside safely.

During one of the interviews, a friend of Gretchen's from the same council units offered her help whenever it is needed to which Gretchen replied *"Well yes but you're not well yourself F[friend]"*. Here Gretchen illustrates there are complexities in choosing how and who may assist you in getting things done. People that you may prefer to spend very little time with may nonetheless be preferable to asking for help from a friend who you

perceive to be unwell, and perhaps needing some help themselves. This is an example of recruiting help by expressing a need, but rejecting help that is not acceptable because it is perceived as asking too much of the helper.

While the majority of the participants' accounts of recruiting assistance were positive, requesting assistance can be problematic. For instance Gretchen has a complex relationship with her neighbour. She has set up strategies to protect herself and her home from his constant invasion to use the phone. Yet she also needs her neighbour, as she uses him to help her by hanging out her washing if he is available.

> *I've got the washing machine but I can't, hang out the sheets and things on the line. So I have to get R [neighbour] to help with that. I had to get him to hang out my sheets and that last time. I can't reach up the line, it's just too much for me.*
> *Gretchen*

Satisfaction with the arrangements participants had made was more evident when the participant conveyed a sense of control of the recruitment of the help they required. While many of the participants do not have a problem with requesting help, others such as Millicent spoke of being dependant on help. There appear to be friends who are willing to assist, however Millicent is reluctant to accept help this way. The implication that this is undesirable was very distinct in her tone.

> *Um, up 'til now I've had to **depend** on a friend to take prescriptions to the chemist. And when I first got sick some friends from [my old neighbourhood] used to come over and do my shopping.*
> *Millicent*

The fact that Millicent was in a position where she needed help, when it wasn't her preference, took away the sense of control she had over the process. Certainly the attitude she demonstrated around recruitment of assistance from others was different to that of Beatrice and Albert.

Accepting help

Accepting help is about the strategies people have developed to go about accepting and managing the help they need. In accepting help, participants frequently remained involved in the activities they required the assistance with. Accepting help means that some tasks are completed that may not otherwise.

> *Our lady who does the showering, she ah takes our [prescription in and] pays for them for us, but ah, they [pharmacy] actually deliver them. We've had her [home help], since Christmas I suppose, all this year? [6 months]… she helps with both [of us]. She's a big Maori woman. And you wouldn't argue with her! …By the time I've had a shower and got dressed again, I've absolutely had it. It sort of knocks the hell out of me. But it does help you know I feel far better for it. It's good. I wouldn't have a shower if she wasn't coming… And she's one of these people, she cooks us a dinner, very good, she's good, you know good plain cook but she gives us too much. And I said to her, 'Oh don't give us as much as this G' [home help], I said 'I can't eat much' and she just said to me, an old Maori saying, 'no kai, no tutai, you die. Eat!' And that was that! No messing with her! We're very fond of her. No she's very, very good. She's really good. [More hours] would make a lot of difference yes. See through [the home help agency] the lady does the floor and all that business, she's very, very good. She does the vacuuming, changes the bed.*
> *Albert*

> *Well that's not enough, I think they should, give her, well twice a week at least, washing you know, we wash more than once a week. But we have been managing. Ah what we do now that the laundry's closed.*
> *Albert*

Albert uses the formal help that is available to him to assist with a variety of tasks, but is concerned about the amount of jobs that home helpers are expected to do within a limited timeframe. He accepts the help by doing what the helper directs, having a friendly relationship with her, and by positively evaluating the work she does. He is also considerate of the amount of jobs she needs to get through in her allotted time, and whether that is fair.

> *This lady puts the washing on, takes it out, gets it on the line, I've bought one of those pull out lines so it's low you know. And we use, I use the, wheeler thing [walking frame] with the basket on top of it and I just pull the pegs and it drops down so we do manage you know. And she*

> *comes round to bring it in if it's a big load. [Home help does this as an extra act of kindness]. But most times I say well we, we can do that.*
> *Albert*

Albert's strategy towards accepting help is to actively work with the helper, doing as much as he can and accepting help for the rest. For some, help is organised on their terms as with Rita. She is not bossed about by those who assist her and she has the help aligned to her own method of doing the household work. The help is accepted, but on her own terms.

> *Well I do have help once a week with the cleaning….they're supposed to encourage you to do little things, as you get better. And Anne said to me, 'Rita have you been doing the dusting?' And I said 'No Anne, I'm not in to dusting!' And she thought, 'Hopeless!'*
> *Rita*

In accepting help on her own terms, there is also a strong element of choice about what housekeeping will be done and when. Previous habits and household routines such as what is to be cleaned, and how often, appear to have been passed on to the home helper.

> *Well no every now and again I, I, I do [dust] and polish and you know, make a good job of it and then, that's before visitors! Yes I choose what I do now! Whereas when I was very young, I did dusting and polishing every day. The furniture was in very good condition. But you know, if you keep the kitchen, toilet, bathroom clean, that's the main thing. I did that when I was working. I found out I couldn't do, housework, and you know, and I'd, do that at the weekends but um, as long as the kitchen, toilet and those are clean. She washes the kitchen floor and bathroom and does the toilets and vacuums. Downstairs one week, upstairs the next.*
> *Rita*

In addition to remaining involved to some degree, and exerting more or less control over when and how help is given, participants varied in the extent to which accepting help becomes part of everyday life. For instance some, like Albert, have integrated the help into their day.

> *Well put it this way, I'm the breakfast cook, I do all that, and the lady [home help] does the showering. Um, cleans the shower, we've got one of those wet wall showers you know. She does all that. She does the lunches. Then I do the evening meal.*
> *Albert*

Gillian has also integrated the help she receives into her daily round of activities. As you will recall, Gillian does not require the assistance for herself directly but in order for her husband to remain living in their home with her. They have a very structured routine of carers coming into their home to enable personal care occupations to be carried out with Gillian's husband. This means that the husband is able to be washed every day and to be transferred from his room to the lounge for the day. Without this involvement it is unlikely that Gillian would be able to manage by herself.

> *Well at 8 o'clock in the morning two carers come in to shower him, so I get up about 6 and ah, have a shower and get dressed and then ah, I'll get breakfast ready and of course I'll have to feed him. And give him his drinks and everything. And then I shave him and ah, by that time it's not far off 8 o'clock and then the carers come and they shower him and ah, he's got the, sort of reclining shower chair and we have a hoist. And, they're here between 8 and 9 and then we put him here in the chair, and then he's usually exhausted, then he could sleep 'til 1, 2 o'clock. Then, well I'll try and give him some lunch. Usually [a] cup of soup and maybe a bit of pureed fruit. And then about 3 o'clock another carer comes, and then we lay him back on the bed again to change his pads. And, then back in to his chair, and then, he stays in there 'til about 7.30[pm] and then, the carer comes again and helps me putting him in to bed. They come three times a day. Two in the morning. One at 3 o'clock, and one at 7.30. And I assist them when there's only one. [And] on Friday I have a half day off and I've got another person that comes and sits with him from about 10 to 2 o'clock.*
> *Gillian*

While both Albert and Gillian demonstrate how they work the home help into their daily routine, both also rely on the home help provided to them to achieve some of the things that need to be done in their day. This may have influenced the way in which they have gone about accepting the help. In contrast, some of the participants see the formal assistance they receive as useful but keep it very distinct from the rest of what occurs during the day or week.

Well we get some assistance from Presbyterian Support which is very good. They do the vacuuming, that's the main job… she does a little bit of dusting and I do the rest of it.
Denise's daughter

[Do you have anyone to assist with other tasks?] Yes, the guy comes this afternoon to hoover and, and, and do the floors and that sort of thing yeah.
Connie

While Albert thought that the time given to those helping him was too short, others like Denise and her daughter are less keen for the involvement to be too intrusive in their routine and have minimised how much it intrudes by decreasing the jobs.

Well they would come once a week if I wanted them to but they come once a fortnight. We were given a very generous allowance but because I have to be here quite a bit to do other things for my mother, it, it's better for me not to have somebody coming too often. I'd just be in their way and they'd be in mine.
Denise's daughter

Another approach to accepting help was to assess its veracity or motivation. Earlier we heard how Rita's neighbours offered their help to her should she be frightened or worried. They had informed her son, but it wasn't until they 'took the trouble' to talk to her that she considered accepting that offer if it were required. There is a checking out process here, about whether an offer is genuine. It is not just 'any' offer that is accepted. Rita's choice to use this strategy if required was confirmed only after the neighbours did something that indicated the offer was genuine. Part of this reticence or care in choosing who to call on for support might arise from concern that neighbours might become intrusive, or that she might be imposing on their kindness.

One way of accepting help was by the terms and for the reasons it was offered, for example because the doctor said. However this acceptance did not carry over in all situations as Millicent describes, in dispensing with the help when the timing doesn't work out.

> *[I get home help] Everyday since June [4 months]…. Well they have to be here before I climb in the shower which is over the bath. In case I fall over. And, to start with they pull off these elastic stockings. And when I've had a shower they rub lemons fatty cream all over my skin…because the doctors from the hospital said this cream had to be rubbed on me everyday. I do my arms I can reach those easily, and then they pull on the stockings, they make the bed, do the, vacuum cleaning, wash the kitchen and bathroom floors. And they do a dust around. Sometimes I'm not here, if I have to be at the hospital at 9 o'clock well, there's obviously no time to be showering before I get there. So I go dirty.*
> *Millicent*

The difference between Albert and Gillian and the other participants who use formal help might be the frequency with which it occurs. Albert and Gillian both have daily assistance, with the carers coming in more than once a day in Gillian's instance, which may lead to a different relationship developing between the people providing the help and those using it. When the help is less frequent it is perhaps easier for the person using the help to make it a distinct and separate part of their life. The help provided to Albert and Gillian may also be more essential to not only their participation in daily life, but also the management of essential activities, such as food and personal hygiene.

Albert, who has integrated the home help into his day, had also taken back a task they had previously delegated out to family: getting the groceries. This strategy of doing the groceries themselves provided Albert and his wife with an outing and some social interaction in their community. This also resonates with the earlier notion of retaining control over the assistance recruited.

> *The son and daughter-in-law, they used to get them [the groceries] once a week. But then, I decided, we don't get out anywhere. I said to them 'We'll do our own, grocery shopping' and we've done that for the last, what, month or so. And we go down to Woolworths here and it's quite enjoyable. You, you have a look around, just take our time. And it's ah, quite good. Anything else like, now we don't buy meat in the, Woolworths, we buy it from the Mad Butcher or we get the son and daughter–in-law to take us for that. That's how we get around it.*
> *Albert*

Part of accepting help appears to be recognising and sometimes rejecting the consequences of being helped. For instance, although Millicent has been reliant on friends and more recently home help to assist in overcoming the barriers to doing some aspects of running her home (some cleaning and groceries) she does not anticipate this being long term strategy, planning instead to get out to do some of these things herself.

> *I haven't had this help since February. It's only started in June. So um, I hope that in the future I'll be able to, go down myself [to get medicines]. I haven't been able to go and buy any new shoes or any clothes or anything.*
> *Millicent*

Framing the help she receives as short-term seems to make it more acceptable to Millicent. Another cognitive strategy that appeared to make receiving assistance more acceptable relates to the activities it is for, as illustrated by the comments by Albert and Millicent. Food shopping and medical matters were areas in which people were more likely to ask for or accept assistance because they are seen as essential.

In recruiting and accepting help, the type of help varies. In the New Zealand context, the use of help from formal agencies is predominantly for ensuring the home is clean, floors are vacuumed or mopped, that washing is hung out to dry, groceries bought in and personal self-cares are able to be done. The recruitment for this type of help tended to be for activities around the home, which is not surprising given that the current manner in which these services are funded relates to essential physical needs and safety. It is very hard to access formal structured help through government funded healthcare agencies that goes beyond showering, house cleaning and groceries. The paradigm that the funding works within doesn't consider activities that fall within the social and leisure environment as essential, leaving the support for those areas to other agencies such as churches. Recruitment of more informal help by family, neighbours or friends was better able to address issues regarding access to the community through transport and social outings.

Strategies for recruiting help included recognising when tasks are no longer do-able, exchanging one service for another (like the use of the garage for the mail delivery), requesting help from a family member or other person and notifying agencies when circumstances change. Accepting help can be shown by doing what the helper directs, having a friendly and personal relationship with the helper, actively working with the helper and integrating them into the day. Some participants were careful about minimising the intrusion of help into lives, others used the help when it suited them, but discarded it if the timing didn't suit.

Summary

In this chapter I have described the strategies older New Zealanders adopt to keep themselves safe, and recruit and accept help. In keeping safe, participants described having a safe environment through the location of home, to the less permanent physical structures of the use of equipment, or not. Keeping safe also included strategies for personal safety, being conscious and cautious of body movements, the use of mobility aids, choosing what presents a risk to one's safety and what occupational choices are worth that risk. In recruiting and accepting help, participants described ways in which these were achieved. The satisfaction with which these strategies were employed appeared to be related to the sense of control which they had over the recruitment of help and the context within which it was needed. In the following chapter I shall describe the other two categories that emerged during the analysis.

Chapter Five: Findings

Introduction

Having looked at strategies to address safety concerns and strategies around recruiting and accepting help in the previous chapter, I move on to present the rest of the findings. These concern the strategies for meeting needs and those for conserving resources. The strategies presented in the previous chapter were ones in which participants had developed similar strategies. In the categories discussed within this chapter the participant's strategies were more individual to their particular set of circumstances. Whilst the outcome may have been similar, participants had different ways of achieving this. I will conclude the presentation of the findings by making some overall comments about the data.

Strategies for meeting biological and social needs

These are the strategies people use in order to manage the practical demands of meeting their need to gather and prepare food, have social contact and fulfil their roles and obligations.

Food

This encompasses the strategies used in both the acquisition and preparation of food required for daily living. Acquiring food is achieved in a variety of ways, from walking to get the groceries themselves to arranging others to purchase on their behalf.

> *I take bags. I've got bags that I bought and I can sit them in there [on the seat of the walking frame] and I've got a strap around [the frame] to hold the bags on. I lift the lid on [her walking frame]. They're the shop bags; you know [the durable recycle bags]. I've got an old, old belt thing [to strap them on with]. That stops them from falling off… I can't do it all in one trip I have to go down twice and sometimes I go down just for the walk you know and company and that.*
> *Gretchen*

As this account reveals, Gretchen has developed a strategy that enables her to get the food she needs from the shop, by modifying a mobility aid so that she does not have to carry things. What she can transport home is limited by what she can physically manage within the system she has devised. This means more than one trip a week is required. Here we see that Gretchen breaks down a task, using more time to get the task done, and also makes more manageable units to transport herself. It appears that the strategy she has devised is acceptable because it is also satisfies a need to have company and social interaction.

Connie and her husband also walk to the local shops to get their groceries.

> *Well we, what we do is, we'll walk up if the weather's okay and we'll take the [shopping] trolley. But we always get a taxi home because I can't, walk you know. We did, we used to try um walk and push a trolley home but it was just too much and I thought well you've got to be sensible you know.*
> *Connie*

Connie may make modifications to the strategy according to the weather. Being able to adapt the manner in which an occupation is carried out requires some flexibility in plans, through being aware of more than one option to consider.

Beatrice has a multitude of options that she uses to achieve essential tasks such as getting food. Family, friends and neighbours all feature in her plans, but she also uses public transport and goes herself. Having several strategies for doing one task versus a single strategy was in itself a strategy that others also alluded to, but perhaps it was best seen in Beatrice. Beatrice has lived on her own for a number of years and has a very independent manner. She is also not afraid to ask for help if she needs it, as seen here with the bus driver.

> *[on groceries] …now J [grand – daughter] is helping me out there. And P will next door if I want anything…[and] I go on the bus with a trundler. I've always used a trundler, pushed it, for groceries, because*

> *they're hard. Sometimes the bus drivers will help you on [and off], otherwise I say 'Please help me off'. And if I come up the path and I've brought home too much, which is typical for me, I walk up the footpath backwards, very, very slowly up the whole path [pulling the trolley behind me].*
> *Beatrice*

In this example, Beatrice combines directly requesting assistance with the strategy of taking her time to accomplish a task. In this way she gets herself safely back into her home, by being prepared to walk up the path very slowly.

Gillian also needs to take time into consideration when she sets out to acquire food. In her case, getting to the supermarket or doing the garden are things that could only be done between mealtimes and visits from caregivers to get her husband organised. When he is settled in his chair, she is able to take the time to do some of these activities.

> *As you can see when he's sitting there I can easily pop around to the supermarket and do my grocery shopping….when he's been showered in the morning, at least 'til 12 or 1 o'clock he's asleep, and in that time I can do a bit of the gardening. And whatever needs doing around the house.*
> *Gillian*

While the previous strategies address how the participants themselves are involved in going out to get the food they need, participants in the study also provided strategies that they used when getting food themselves was not possible. Rather than fetching the bulk of the groceries themselves, some participants are happy to give the home helper money to purchase the groceries.

> *I've got an Always Card [which allows a person to use a cheque rather than cash] for the New World and I give the home help a blank cheque and fill out the amount [for the groceries]. New World won't take a cheque without it [the Always Card] and as far as I know we're not allowed to give these people [home help] money. I usually write New World on it. The lady at the checkout said I didn't need to do that because the machine they use to print out the amount on it prints out the*

name [of the shop] as well. So luckily it has the [shop] name endorsed on it twice.
Millicent

Beatrice uses a more formally-arranged meal delivery service. She spoke of how her financial resources have given her choices over what type of meals she can afford and choose to purchase. Whilst Beatrice spoke about the price not being of concern, she certainly knows the exact cost to her. This may be a strategy in itself; having knowledge of what she is spending and where, enabling her to continue to live the way she wants.

Well, since I had the flu and the broken collar bone, well I had meals on wheels. I hated them. They weren't nice, they were tasteless, cabbage. So I buy a certain number [of pre-cooked meals], from the city mission. They're good. They're dearer. But money doesn't make any difference to me…. They are $6.50. $45.50 for seven meals. And they have beautiful [meals. Someone said to try the fish meals, they have three veg, generally kumara, well of course that's been plentiful lately plainly. And potato, mashed potato, and baked potato, broccoli or something. I like the roast meals because that's something I don't do. And they come from the Northern Anglican church, people come from there and deliver on a Thursday. I have to put the order in on a Monday morning. So, I don't have them all the time but it's nice, when I feel like cooking.
Beatrice

We can also see from Beatrice that participants are not indiscriminate about the choices they make. That is, they choose the most acceptable options within their means.

In addition to strategies that addressed getting groceries home, participants had devised strategies to make food preparation easier. When Albert and his wife do the groceries, they look for items that are easy to prepare. This means that Albert is able to conserve energy when cooking the evening meal.

We buy those, things from the supermarket you know, cottage pies that sort of thing. Oh and I can cook a bit. I can cook, sometimes I do cook some chops and, mash potatoes and that sort of thing. And with vegetables we don't worry with so called fresh vegetables, we use those 'Watties, in the bag'. There's no peeling, no waste you know. That's

about it….they're as fresh as you can get and there's no waste. I'm not one to go looking for work!! [laughs]
Albert

Millicent also found ways to overcome her decreasing strength and stamina.

Oh well if I've got to mix something up say like cream and butter, I'll come in here [the lounge] and sit down and do it. Or I'll leave it here for the day. And let it soften in the sun. And I go very slowly.
Millicent

This strategy, leaving a hard object to soften in a sunny spot has worked for her, but might not be one that others find acceptable in the preparation of food. This highlights the individual differences in what strategies are thought of or accepted by individuals. As we heard earlier, Millicent uses her home helper to obtain the groceries for her from the supermarket. This can result in some items being purchased in a way that isn't convenient for the user.

For a long a time I couldn't even cut a piece of pumpkin. Well [I didn't] buy pumpkin [for a while] that was the obvious answer. I asked someone to get me a piece of butternut, buttercup rather, and they bought a whole buttercup home, about so big and it was so, hard I just couldn't cut it. So I put it in a big saucepan and cooked it intact and then took it apart and made soup out of it. After scooping it out of its skin. Well there's always a solution to things. You don't have to do things, in the same way.
Millicent

We see Millicent wasn't fazed by this problem; she demonstrated resourcefulness in her thinking and prepared soup, which may not have been her original intention for the pumpkin. Here we see Millicent using strategies that demonstrate her competence and adaptability, which is quite different to the way in which she spoke of using friends to pick up her prescriptions for her.

Connie also has strategies to help during meal preparation. These relate to energy conservation and preventing symptoms of her COPD.

I find now, that I have all the pots on the stove,[i.e. permanently sitting on the stovetop] which is really, not a sensible idea. Um but it is, for me

> *because, I don't have to bend down, therefore I don't get short of breath bending down to low cupboards, and I can't have them up high because they're far too high if you see what I mean. So I thought 'Well I've got to do that. I've got to make life easier, I've got to put things where they're easy to reach'. With most people with CORD, the most important thing to do, is to have things where you're not going to make yourself short of breath to get [them].*
> *Connie*

The strategies used to acquire and prepare food are varied, and relate to the participants' resources, both physically and socially. Participants demonstrated that there was often more than one strategy that could be used, and having a range of options increased their means to continue to participate in the food-related activities. Being flexible or adaptable allowed participants to chose the most appropriate strategy on the day.

Social contact

This category includes strategies for getting out and about, some of which required considerable resourcefulness with a back-up strategy of staying in touch by phone. There were varied strategies that participants used to enable them to get out and about to social clubs or long standing social and leisure occupations. One option is to use a pick-up service, which appears to be particularly helpful in getting people to the community. Gretchen, for example, was able to get to a monthly outing because a car was sent to pick her up. Knowing her restricted resources elsewhere (financial and physical), it is unlikely that Gretchen would be able make this kind of contact without the transport being provided.

> *I do go to a club once a month …Oh it's just for elderly people, it's right down the other end [of the suburb]. They send a car up for me and they bring me home in the car.*
> *Gretchen*

Gretchen's daughter also takes her on social outings on a regular basis, which entails various options of using a borrowed wheelchair, or taking her daughter's arm and a walking stick if the chair is otherwise occupied.

She [Gretchen's daughter] takes me out for a drive once a week. And she might take us all round the bays if it's nice. And we go out for dinner. And I enjoy that because I get a lovely meal. Oh it's lovely yes. And she's good like that. She generally takes me on a Tuesday... I look forward to going out for a ride because it's a change of scenery and everything you know. And I look forward to just looking around the shops. I don't take the wheel [walking frame] when I go because J's got a wheel chair, you see, that's my brother-in-law and he can't see or do anything. So I use that but D [daughter] takes the lady next door if it helps and, she wheels the wheelchair and I hang on to D [daughter's] arm and take my walking stick. We might go out to [a shopping mall] and have a look around the shops.
Gretchen

Denise was very socially active when she had her sight and mobility. In response to increasing challenges, she has developed strategies which ensure she is still able to fulfil this need. Denise also attends a regular social group. In addition, her daughter managed to find and purchase a suitable wheelchair that they use for covering larger distances, by approaching a variety of community agencies and undertaking internet research to locate the most suitable chair for their needs.

I was looking round for a long time before I found it. I knew I had to have one that was small enough to fit in the car, unless I got a pole, gradually I found out that I could have a pole put on the bumper. And you could get a wheelchair put on to it. But I used to see mothers with their disabled children, or other people with disabled children sometimes, you know sometimes bit older children, children that were a bit older and I thought there might be a wheelchair like that big enough. My mother's not very big and, anyway I investigated that possibility. Then I rang the Disability Information Service, and I went to see somebody. They said they had a chair there that was light weight. That it was 9.5kg I think. And, I didn't know whether I could get lighter than that or not but I went, I went and had a look at it but, I didn't think it was right. So I left it and they, they gave me more information and I checked things out, looked up the internet. In the end I saw that that wheelchair was the best one of the lot, the first one I'd seen. So they got me one from Auckland, and that's the one we've got now. And it's been absolutely superb.
Denise's daughter

> *E [daughter] got a nice little wheel chair in her car, and I get in it at the place I go to [Friendship club], at the church and they wheel me in and I stay in it all the time I'm in there.*
> *Denise*

In order to enable social contact, this strategy took a lot of investigative work over a period of time. Advice was sought from diverse places including a non-government agency and the internet. At home, Denise is in charge of the telephone. She has had a bag made to fit on her walking frame and the phone is put in there each morning so that when it rings Denise is able to answer it.

While some participants had effective strategies to get out into the community, others relied on a single strategy to maintain social contacts. For example Millicent has been less active over the past year and getting out interacting with friends has not occurred as it did previously.

> *I have a visitor from St. Mary of the Angels. Sister Francis brings me communion once a week. But otherwise I don't have visitors as a rule. Occasionally someone from Strathmore comes. Most of my contacts are over the phone.*
> *Millicent*

Like Denise, the phone has become a tool for maintaining contact with others. Having regular visitors to her home, like the Sister, is another way of meeting a social need.

There was great variety in the number and kinds of strategies that participants had to meet biological and social needs. The reasons for the variability were not evident, but it was clear that some strategies, such as requiring a suitable wheelchair required concerted effort to put in place. Some successful strategies were initiated and enabled by others, and some strategies involved an element of risk, such as the home helper taking the money for the groceries. A strategy around transport was an important consideration in meeting biological and social needs.

Strategies for conserving resources

These are strategies that people have in place to conserve a variety of resources such as finances, physical capacity (such as breathing and energy), and their body (such as their senses, vision and hearing). This could be achieved by finding ways to cut back, conserving what they have or even holding something in reserve for a later time.

Ways to cut back

Albert and his wife demonstrate ways to cut back to conserve their financial resources, through choosing not to have a service they had previously enjoyed. The increasing cost of the service certainly affected their decision, as did the decreasing amount of time they were able to enjoy it, due to Albert's glaucoma (eye condition).

> *We had Sky TV [pay TV] but when we first got it, it was $40 a month, which was pretty good. But then it sort of gradually got up and up and, early this year it was, the bill was $60 a month. It's too much for us. And particularly when you're restricted, we don't watch it enough, so I did away with it. I was only really interested in the sports side of it.*
> *Albert*

Gretchen also made choices about which enjoyable occupations to participate in. As resources are stretched on a weekly basis, she has no extra for entertainment. Gretchen shows a strategy of making do with what she has.

> *By the time I get me groceries one week and then next week I'm broke then you know. So I just read books, that's why I've got papers and books, you know! I do a lot of reading. I have to, I've got a mountain of books. No [I haven't joined the library] I've got books, plenty of thick books here and that.*
> *Gretchen*

The use of taxis for transport was commonly employed by the participants, with most having devised ways to cut back the cost. Most participants had heard of or had taxi vouchers available for their use. How and why these were used varied. Some, like Connie, used them only one way, such as on their return journey from the grocery store. Efforts to cut back on expenditure shaped decisions about what to attend and transport

options. Millicent preferred to use a bus pass rather than taxis; however her current health prevented her from using the bus service very much.

> *I have been using taxis to go backwards and forwards, to the hospital. I've got a book of 25 taxi vouchers. And I've used 23 for transport to the hospital only. And friends have been taking me on occasions. And the ambulance has taken me twice. They pay, the Wellington Regional Council pay 50% and I pay the other 50% and to go to the hospital from here is just on $20 and the same, approximately to come home. So yes it is fairly costly, yes. And you can ride round Wellington all day on buses for $5, for a senior ticket.*
> *Millicent*

Another way of cutting back the cost of transport was to share it with others. One participant had complex arrangements with a friend to get to some of her monthly outings, whereby they cooperated to get an outcome that was better for them both.

> *My friend May and I…we get a taxi. She gets a taxi from her place in W St and I stand out there and get the taxi [with her]. I pay one way, I've got one of those taxi vouchers, then he drops me off on the way home. And then goes on to her place. So we manage very well. [Do you use taxi vouchers for all of your outings?] Only, if we're going in the evening, May and I will probably go to the opera or the ballet something like that. It's very expensive.*
> *Beatrice*

Millicent spoke of using friends to occasionally transport her to the hospital, yet they were not mentioned as an option in assisting to get to a social club. Her method of cutting back, was by not attending the social outings, or using a bus if she was able to travel via that method.

> *I used to belong to several clubs but it's now down to one and I haven't been to it since the 28th February because it's over in [suburb], in the community centre… It was an Eastern Suburbs Spinners and Weavers club… I haven't used the taxi vouchers for that. I'd rather go on the bus. A $5 bus ticket is better value than a taxi voucher.*
> *Millicent*

Earlier we heard how Gretchen uses her neighbour to assist in getting the washing on the line to dry. If there is no one available to help out, she resorts to another strategy, but is now finding with her limited resources that this is becoming too costly and has had to develop a further strategy for getting her clothes dry that doesn't involve using help, or increasing costs.

> *Well I used to put them on the heater but the electricity bill's getting so high I had to stop it. So I've got things in my bathroom but the pegs are all broken off but anyway. So I do that and I open the window and let the air in and they dry that way.*
> *Gretchen*

Strategies to cut back on the cost of heating their home vary according to the availability of the money that people have. Being warm enough to do things and to sleep are needed but how participants go about that varies.

> *Yes I've cut the power down. I don't have the heating going so much because I feel the cold because of my blood trouble. But I've put that away and I just sit here and I've got a blanket I throw over me if I feel the cold. Because I do feel the cold terrible you know.*
> *Gretchen*

Gretchen needed to develop strategies to reduce the amount she spends, so has reduced her power intake. Beatrice on the other hand is happy and able to use her money on the power bill.

> *I like being independent and I think it's good for you. So um, no I manage. But of course then I haven't any money worries. I'm not struggling to pay my bills, to pay my electricity you know, it wasn't too bad because I was in bed most of the time, last time. I had the heater on in the hall at night. It's one of those, you know, [oil column] ones and what I do is, I shut the doors and leave my bedroom door open. It isn't very hot, it takes the chill [off], and I think that's the main thing.*
> *Beatrice*

In finding ways to cut back participants chose to go without something they previously had enjoyed, used cheaper options, and made do with what resources they had. Sharing

transport or cutting back attendance at social outings were also used to reduce the cost involved with transport.

Conserving

This strategy refers to conserving a resource such as vision or stamina. The use of time and choices were strategies used to help conserve a limited resource. For example Albert needed to ration his time, as his glaucoma meant that he was unable to spend much time reading or watching TV.

> *I'm a keen football fan but I can only watch about two hours, then my eye starts to water you know…so I've got to be selective about what I'm going to watch and when I'm going to watch it.*
> *Albert*

Here Albert shows us when there is something important to him, such as a sporting game on TV, he had to plan ahead so that he hadn't used his 'ration' already in that portion of the day. I asked Albert how he knew to ration his TV viewing time and how long he would need between TV sessions.

> *Well quite simply I, I'd watch the, watch the football for example and, this, this eye would start to ache. And I stopped. And, I'd have the TV off for a couple of hours and I could turn it on again but I had the same thing you know. So I also like watching the girls netball too. So it's sometimes works that you can watch both you know because you've got the time between.*
> *Albert*

Overcoming fatigue was a common issue amongst those interviewed for this study. Participants had a variety of ways of getting the jobs done. One way is to conserve their own energy by utilising other resources, such as help from others, as has been previously discussed in this chapter. Another means of conserving energy was in their use of time. For example, Millicent had difficulty continuing to manage cleaning her house when she was feeling very fatigued as the result of her illness.

> *When I was vacuuming, I would do two rooms and the next day I'd do the other two. That was my routine.*
> *Millicent*

Millicent breaks the task into manageable pieces. She also demonstrates how the use of routines is useful in getting the job done. This is echoed by other participants, like Rita in her housework routine and Gillian in the daily routines with the care assistants. As discussed earlier, Rita also talks about using time (and assistance if possible) to get household work completed. Rita demonstrates how when help isn't available she modifies the task to suit the weather conditions. And she demonstrates how time is an important strategy to use when managing tasks around her home.

The choice to use energy conservation strategies may be determined by how their health is on any particular day. Connie's strategy for getting the mail involves stopping to rest a number of times. The time taken to get to the letterbox can vary depending on the number of stops made. It might be a quick trip one day and use lots of time another day due to the stops.

> *Well if you're not having a good day, it means your breathing is fairly bad. So it means that you don't do a great deal you know. But you still try to do a certain amount because it's no good for you to be completely lazy either you know what I mean?! Ah and um, some days you're, you're really short of breath, you can't sort of, walk out the door, and go to the letterbox down there, maybe three stops. Another day, you can walk down there and you wouldn't think there was anything wrong. You know it's a funny, well I think it, not funny funny, but I think it's just, funny how the one day you can be, really kaput and the next day, you can do exactly the opposite to what you did the day before. But it is, best that we know, what we're capable of, because we're all a bit like that. We do, when we're feeling good and you can get down to the letterbox you know, you think 'Oh yes well I can really go up the road now and I can do this and I can do that.' But that's really, not very wise. Better to try and pace yourself if you possibly can.*
> *Connie*

Getting to grips with using energy conservation took trial and error at times and as Connie described left her better off when she learnt to control things. Connie used the strategies she had been taught from a health professional to manage her energy and breathing.

… if you pace yourself you're far better off, and you can control your breathing and that a lot better you know. And by, going to the ah, respiratory classes ah, at the hospital, you learn, to control your breathing and you learn, not to quite panic so much, as you would if you hadn't been. Because there's nothing more frightening than being short of breath and wondering if you're going to make the next breath if you know what I mean.
Connie

Strategies to conserve and protect financial resources protected were also reflected by Gretchen's daughter getting a toll bar on her phone, as described earlier.

Conserving strategies to protect limited resources included strategies that related to finances, such as the toll bar, to conserving energy through rationing a resource, using help, and using time.

Holding something in reserve

In contrast to the strategies around conserving a resource, Gretchen had gathered stocks to last into older age because she had realised ahead of time that resources were going to be tight. Accordingly, she had planned ahead and had purchased extra clothing while she was younger so that she would have sufficient.

I've got to do a lot of tidying up in my room because of me clothes because I saved up for when I got old so they wouldn't have to spend money on clothes all the time. And because I'm old but then I get a bit tired with trying to hang the hangers and put them in the wardrobe to tell you the truth, so I'm not ready to do it.
Gretchen

Millicent preferred not to use an expensive resource for attendance at a social outing, such as the club she had been a member of, holding the taxi vouchers for hospital visits if needed. Similarly Albert also likes to keep the taxi vouchers available for use to get to hospital if needed.

If I use a chit both ways [to supermarket] I haven't got any in reserve if we have to go you know, say to the hospital or downtown, where it's

going to about $12 or something like that. So I use the taxi chit one way and I just pay the full price the second way.
Albert

Keeping taxi chits in reserve for use relating to health was not unusual for the participants, perhaps providing a sense of security, and linking back to their personal safety.

The strategies for conserving resources were in three main areas, finding ways to cut back, conserving a specific resource such as vision or stamina and holding something in reserve. Strategies for conserving resources varied, with the strategies being specific to the participant's situation. However many of the participants employed similar strategies to conserve resources around transport.

Overarching strategies

A common theme that was evident with the majority of the participants was that of "getting on with it". There appeared to be an attitude amongst those participating that one just had to make do. They didn't perceive themselves as doing anything special, rather that they were using an element of commonsense for managing their lives.

There are always solutions to every problem, just exercise your lateral thinking.
Millicent

What are you to do… you get on with it.
Beatrice

Well there's always a solution to things. You don't have to do things, in the same way.
Millicent

….so we manage you know.
Albert

I lived on a sloping section with a large garden. And I found I was running out of steam. Especially in the cold months.....I always knew I'd have to move, so there was really no impact……It's just a case of you

know, it's time to go. Some people insist on staying and I don't know why. A lot of them complain they can't manage.
Millicent

Being sensible was also reflected in the strategies developed, being sensible because of other responsibilities, such as a spouse to care for or look out for.

Having a sense of humour was not articulated by many of the participants yet it was clearly a strategy to overcome otherwise overwhelming situations.

I think with aging, you have so many things that you want to do and you could do, when you were younger. And it's very annoying when you do them, and you're, just exhausted and, and you can't do things as well as you want to do. And, but, unless you laugh at yourself… when Bill was at home he was having so many falls and one morning he was on the floor at 5 o'clock. And I said well I'm not going to ring Dave from next door, it's only 5 o'clock but we had a Freedom Alarm, and so the ambulance man came out. But when [Bill had to wait], I said well I'm going to put the eiderdown on you and give you a pillow, just stay there. And we both started laughing because I said well I can't get you up! And another day I'd showered him and, when I went to put his shoes and socks on, bending over, I was getting giddy, so I said 'Oh, sit down for a minute' and then I got down on my hands and knees and I couldn't get up! And we were, he was trying to help me and I was saying 'No, no' because I knew I could pull him over and we were both laughing so much. And suddenly I was up! And, you know it was because we, we started, to make a joke of it.
Rita

Making choices was also something most participants needed to do. Many of those interviewed had made choices about moving homes. The reasoning behind those choices was fairly varied. Some moved home to enable better occupational performance, as with Gillian moving from a hillside to the flat easy home and section, and Millicent, to reduce the large garden. Others' moves didn't go quite as planned, as with Albert, who found that moving to a new town after retirement was not conducive to a socially active retirement. And others, such as Connie, made choices about moving house because of the need to feel safe, as discussed earlier.

What was missing?

There are strategies that, as a health professional, I noticed were absent in the ways the participants had found to manage their lives. When stamina was a barrier to getting a task done, participants did not mention that working on their strength or fitness was a way to look at overcoming this. When falls had occurred at home, participants hadn't mentioned that looking at the existing environment and removing rugs or other common hazards had been considered. The strategies mentioned related more to avoiding risks they had recognised, choosing to do different occupations or having people there to assist.

Summary

In this chapter I have discussed the strategies for meeting biological and social needs and for conserving resources. Meeting biological and social needs primarily focused on gathering and preparing food and social participation. Participants described unique and ingenious ways of overcoming potential and actual barriers. Of particular note, were that these were not ones that might be recommended or endorsed by a health professional; however they were satisfactory to the participant using the strategy. Meeting social needs was not prioritised as much as meeting biological needs and participants were more reliant on the use of others to get out of their home to meet social needs. The telephone was one way of maintaining social contact. Strategies for conserving resources include finding ways to cut back, like stopping pay TV, conserving the resources they had, such as energy, and holding something in reserve for a later time, like the taxi chits for hospital emergency trips. Overarching themes of managing and getting on with it, sprinkled with a sense of humour by some participants was present in the attitudes of many participants. In the following chapter I shall discuss the findings, and the implications they have for policy, practice and education.

Chapter Six: Discussion

Introduction

What strategies do older New Zealanders use to participate in the day-to-day occupations that they need or want to do? This was the question I have sought to answer throughout this study, with a particular focus on the strategies they devise themselves. In previous chapters I have discussed why this research is important, and is of interest to me. I have searched existing literature for information on this topic and provided a review of this in Chapter Two. I then outlined the methodology and philosophy behind this research, and in the previous two chapters I described the findings, supporting these with quotations from the participants. In this chapter I shall discuss the findings, relating them back to the literature, identifying where my findings align with previous literature and what is new in my piece of work. I will begin this chapter with a synopsis of the findings. I will then discuss each of the main categories in more detail, and address the limitations of this particular research. Finally I will look at what the implications are for practice and further research in this area.

Synopsis of findings

When I began this study I had a reasonable idea that older people in New Zealand use a number of different strategies to participate in day-to-day occupations and this was supported by the findings. The older people interviewed are a resourceful group of people. They are managing their lives and using a range of strategies in order to participate in occupations at home and in the community. There are some clear motivations, such as being able to care for their spouse, which drive them to create or adopt practical strategies that enable participation in day-to-day tasks. Through the analysis process I arrived at four main categories: those for ‘keeping me safe’, for ‘recruiting and accepting help’, for ‘meeting needs’ and for ‘conserving resources’. Within each of these categories, strategies involved overcoming barriers in the

environment, physical or social, such as steps or assistance with transport; and overcoming activity limitations that diminish performance capacity, such as breathlessness or declining vision. Further to this there were some overarching characteristics that were also apparent.

Strategies for keeping safe related to both personal safety and having a safe environment. Moving homes, altering the physical environment, being careful with your body, not putting yourself at risk, being assertive and accessing help are examples of the strategies used in this category. Despite their concern for their personal safety, participants did not always choose the 'safest' option to get things done, as we can see when Gretchen accepted a ride from a stranger, or when the use of a bath board is rejected in preference to doing things the way one prefers. This highlights that the use of strategies available can be a matter of choice. It is interesting that during the interviews none of the participants spoke about increasing their endurance or finding ways to get stronger and fitter as a means of increasing their performance capacity and therefore overcoming a barrier. Given the large amount of literature published on the elderly and strengthening programmes, and the push Play 30 minutes a day campaign (Fahlman, Topp, McNevin, Morgan, & Boardley, 2007; Hillman et al., 2006; SPARC, 2008), it might have been more prevalent in this group of people than it was. Participants never spoke of improving their strength, just as they did not mention removing hazards within their environments to increase their safety.

Strategies for recruiting and accepting help are about how the participants recruit and accept the help they need. It was clear from the findings that there were a range of ways of recruiting help and a range of things for which help was accepted. Help involved the use of a variety of people, neighbours, family, friends and agencies. Help was recruited for a wide variety of day-to-day tasks, including obtaining medicines, dressing, getting to the shops, and doing household tasks.

Recruiting help often required the participant to recognise when a task is no longer do-able. Expressing a need for help was also one of the strategies observed. This was done

in a variety of ways; by talking to others about a problem they were experiencing, by directly requesting help, or, as in Gretchen's case, resting on the fence and thus being observed to need help. However, recruiting help does not necessarily lead on to accepting help. The help often will be accepted in particular circumstances; this might be on their terms, or only if they perceive the helper as making a genuine offer of help and being able to help. Checking out the reliability of possible help was something that was more likely to occur with offers made by strangers, it doesn't appear to happen with offers of help from family. Getting someone else to do things that the participant didn't really know about, like the toll bar on a phone, was also used. Accepting help was demonstrated in different ways; by doing what the helper directs, having a friendly and personal relationship with the helper, actively working with the helper, and integrating them into the day. Others were careful about minimizing the intrusion of help into their lives, or using the help when it suited them, but discarding it if the timing didn't suit.

Strategies for meeting biological and social needs were those that participants used to gather and prepare food, and to engage in social contact. Strategies varied from modifying equipment intended for one purpose for a different purpose, for example, a mobility aid becomes a shopping carrier with the addition of a belt to hang shopping bags from, or a supermarket trolley becomes a walking aid. Finding different ways to prepare food included making things easier by purchasing partially-prepared meals, such as frozen vegetables, leaving the butter to soften in the sun, boiling hard-to-cut items without cutting or peeling to make soup, using a home helper to prepare the meal or arranging for meal delivery. Other strategies focused on transport to get out of the home to get the groceries or make to social connections. Transport was a problem that most of the participants had needed to consider, as only one continued to drive her own vehicle. Strategies included overcoming the lack of transport by using the home helper to purchase the groceries, and using taxis to get to and from the supermarket, doctors, and so on. The use of taxis to get to social activities was avoided, with participants choosing to prioritise biological needs over social leisure occupations with their limited resources such as money and taxi vouchers. The results of this study indicate that the participants have been able to remain at home using a variety of different strategies to enable

transport out of their homes. None of the participants used online shopping; in future this may change as the use of the internet and technology become a more prevalent part of older adults' lives. The use of the phone as a tool to engage in social interactions was a strategy used by some participants. Participants who attended social clubs, did so where transport was provided for them by the club.

Strategies for conserving resources included finding ways to cut back, rationing their use of resources or holding something in reserve for a later time. Finding ways to cut back to conserve financial resources was varied. Participants chose to go without something they had previously enjoyed, such as pay television, or they used a cheaper option, for example the bus rather than a taxi where they were able to, even sharing transport to cut back the cost. While cutting back was a commonly deployed strategy, some participants chose not to cut back as they were aware of what they could afford. Cutting back on electrical heating to conserve money was a strategy chosen by some but not others. Resources were limited for some participants and their use needed to be conserved so they were available when needed or wanted.

Rationing the use of personal capacities, such as Albert's vision, required prior planning about what is important. Taking time and breaking tasks down into manageable pieces were strategies used in overcoming fatigue. Needing to be flexible to the resources available on the day was also apparent. Energy levels that were up or down affected how long it might take to get something done, and determined how many rests might be required before the activity was completed. Conserving financial resources by walking to the shops, in Gretchen's example, also had another effect. She needed to go more often as the load she could carry was less than if she had been using a taxi, but this increased the social interactions she had at the local shops. Examples of holding something in reserve are gathering stocks to last into older age, for example clothing or keeping taxi vouchers for specific use, such as ensuring there are some available for hospital trips. This strategy might also mean finding other ways to do things, such as using family and friends, or home help to get the groceries. There are also other complications with

gathering stocks - lack of adequate storage space might mean the living environment becomes overcrowded.

Some of the participants are strategy-rich. They have and were able to communicate a broad range of strategies they were using within their daily routines in order to manage the challenges associated with shortness of breath, fatigue, and so on. For example, Connie had strategies to manage a range of activities that she needed to perform every day around the home. She made use of her husband as a helper, to stand by when she was taking a shower; she also enlisted his assistance in aspects of the household work, folding the washing for example. She used taxi vouchers to get home from the doctors or the supermarket, but did not use them for trips she was able to walk to. She had taken on strategies to reduce the impact of her shortness of breath by keeping the pots on the stove, thus eliminating the need to bend down. Similarly Beatrice was able to draw on different strategies to achieve the same outcome of getting her groceries, by using either a family member for transport, or getting a neighbour to get items she needs, or taking the bus with her trundler to transport the purchased items. Other participants had developed fewer strategies, meaning they didn't necessarily have a range of strategies to overcome challenges. It is difficult to determine if the strategies were few because this is all they required, or they simply did not have the capacity personally or otherwise to develop strategies. In some cases it did appear that they chose not to use or develop strategies for some activities, which could be a strategy itself.

Some of the participants seemed to have developed strategies by trial and error. Connie and Albert, for example, needed to work out how much of a particular capacity was available, such as stamina or vision, that they were able to use before they exhausted their capacity to do the occupations they wanted or needed to do. In some cases education by health professionals had influenced the strategy being used. The extent to which this was taken up in everyday life varied. As discussed earlier, just because equipment was placed in the home and recommended by a health professional did not mean that it was used in daily living. Remaining in control of the choices they had and made was also a strategy that was seen. The need to change, because of falls or the

thought that there may not be another breath was also a motivating factor for developing or taking up a strategy suggested by others. Many of the participants were using long-held strategies that they continued to use and had adapted at times to fit their circumstances.

As might be expected, the strategies the participants were using varied depending on the participant and his or her particular environment or situation. There were, however, some overarching strategies. These included the attitude of the participants. This attitude flavoured the manner in which participants approached life, and may well be a long standing personal characteristic. It might also be shaped by the way in which 'life' has happened, and the choices they have needed to make as they have aged. The attitude that the participants had towards their own ageing, and towards asking for or accepting help is likely to have played a role in the strategies chosen. The depth of the participants' available resources influenced the types of strategies developed, referred to in some literature as being resource-rich (Lang, Rieckmann, & Baltes, 2002). This concept does not refer to financial resources, although that is an aspect of it.

During the initial stages of analysis I thought there would be significant differences between those participants who were resource rich; those who had a wealth of resources available to them, good community and family networks, supportive environment and sufficient financial resources, and those who were resource-poor; lack of financial resources, poor community and/or familial relationships. I thought that these differences would be positive, in that those who had a wealth of resources would be leading more active, fulfilling and easier lives. I am not sure that this is true, however. Differences did exist between those who had strong community and familial links and those who didn't. Even when the family did not live locally those who had a strong links were able to draw upon this resource. Clearly Rita also had depth in her financial resources, which she was willing to use to support the strategies she had developed with her family. This meant that Rita's ongoing participation in life went beyond the confines of the four walls of her home and out in the community to visit her husband, to do her groceries and so on. The community also came to her, as with the neighbours bringing down the mail, keeping her

opportunities for social interaction relatively high. Yet Gretchen, who appeared to be struggling the most from a financial perspective, also had strategies to get out several times a week. Often this was to fulfill a need, such as getting groceries, yet she also described those outings as an opportunity to interact with the community. Nonetheless her limited finances affected the choices she had available to her. For instance unlike Beatrice, who could choose where to access her frozen meals, Gretchen needed to be careful with how her grocery money was spent.

Situating the findings

The participants tended to focus on the practical result of the strategies they employed. I was also interested in looking at these through the lens of the International Classification of Functioning (World Health Organization, 2001). Initially I had thought I would be looking at strategies that overcame barriers to participation; however it became apparent through the analysis process that the barriers were not only external to the individual, there were also many internal influences. Some strategies developed did relate to barriers in the person's environment which align with the ICF. Examples of these are; the need to move home, adapting the home environment, and using products or technology, such as a cordless phone. Other strategies involved engaging with the environment and using it to promote participation, for example using support and relationships to counteract limitations in a body structure or function, by using family, neighbours or care providers to assist in getting things done. An area that the ICF has not classified but acknowledges can have an impact on a person's functioning is that of personal factors. Examples of personal factors include fitness, lifestyle, and coping styles. Evidence of personal factors influencing participation of the participants in this study was apparent, with attitudes like 'getting on with it', or using past experiences to shape how a support worker should carry out a task in the home. While the ICF does not indicate that these can act as facilitators or barriers to participation in life, it is apparent from this study that they do.

Being safe and meeting needs

The findings of this study indicate that being safe is an important background consideration to participation. Locating literature that goes beyond the benefits of preventing falls in being safe, and examining the impact of safety in being able to participate in other activities was difficult. Nyman and Ballinger (2000) have suggested that shared discussions with older adults about fall prevention might empower the older adult to self-manage their health, leading to better outcomes for fall prevention programmes. The older adults participating in this study had developed a number of strategies for being safe, that do not necessarily reflect the content of some falls programmes. Examples include sitting in the bath to wash, rather than using adaptive equipment to reduce the risk of falling while getting in and out of the bath, no mention of moving possible fall hazards was made by participants. Given that, I would suggest that this is a necessary dialogue.

Examination of housing is an area that appears to be increasingly addressed in the literature, as ageing populations across the world have prompted many countries to examine how ageing in place might occur safely (Haak, Fänge, Horstmann, & Iwarsson, 2008; Iwarsson, 2005). The proximity of older adults' housing to services and amenities, and the ease with which they can access these, impacts on the types of strategies that they develop. The participants in this study had used a variety of strategies to maintain participation, from moving home, or aspects of their home, to altering how they went about performing occupations within their home. Naturally many people did not consider their future functional limitations and their current homes may not be the easiest environment. What this study demonstrated is that people have different ways of managing barriers related to housing. While it was perfectly acceptable for one participant to move from her large home to a flat in a high-rise building, for another participant, moving from her home was not a strategy she intended on using. This shows that a 'one size fits all' strategy does not work; strategies need to be in the context of the person, their occupations and their environment.

The types of strategies that participants had developed in response to needing to meet biological and social needs were similar to other reported findings; using different forms of transport, purchasing less more frequently, using a tool like a shopping trolley as a walking aid (Davey, 2007; Forchhammer, 2006; Porter, 2007). Consistency with Davey's (2007) study of people without driver's licenses was apparent. In that study, pleasure outings were the least frequent as older people feel the use of a taxi is extravagant and they are unwilling to ask relatives or friends for transport. Discussion within the literature on driving about the impact of cost and availability of public transport (Talbot et al, 2005; Tuokko, Rhodes & Dean, 2007) supports this study in suggesting that older people value and need to be getting out into the community. Little commentary was found on the effects that transport had on older adults being able to remain in their own home, although it is acknowledged elsewhere that social interaction out of the home and access to local venues are valued (Green et al., 2005). There is also little acknowledgement that more strategies involving vehicles are required when local amenities were not conveniently located, which this study seems to suggest.

Managing time and oneself

The use of time is highlighted in the literature, which often points to time management as a strategy for fatigue, especially in self-help information on differing conditions characterized by fatigue (Arthritis Care, 2007). People with dementia have also been identified as needing time, in order to recall names and numbers to be able to effectively use the phone (Nygård & Starkhammer, 2003). Using time to conserve a resource such as energy was one of the strategies in this study, which aligns with previous literature and energy conservation strategies familiar to occupational therapists.

The notion of self-regulated dependency, coined by Baltes (1996), explores the idea that people seek assistance for certain tasks so that they have sufficient capacity to carry out others. Many of the strategies raised by the participants in this study support this notion. When Albert decided to use his son and daughter-in-law to help with the hard-to-get-to shops, like the butcher, he makes provision for his own capacity to manage the supermarket, yet appears clear he wouldn't be able to manage both. Changes in what is acceptable, alter with the person's circumstances and environment. Similarities with

other studies were also evident. Porter's (2007) study on food preparation by frail older women followed changes in their capacity to prepare meals over time, and for some the move to accept a meal delivery service. In a similar shift in what is acceptable, one of the participants of this study had several carers coming into her home each day to support her husband in the performance of self-care. Although she does not welcome having so many people coming into her home, she prefers this to the alternative, which is for her husband to move into a residential institution. The way in which people managed to get themselves washed was another example, washing less frequently than they had when they were younger, finding unusual ways to get clean, or sitting in a bath (rather than taking a shower) because that is how you wash, even though it is difficult to get out.

According to Steverink and Lindenberg (2005), self management abilities include having multifunctional resources. These are resources or strategies that serve more than one purpose. Gretchen's frequent shopping trips are an example of this, fulfilling both her need for food and for social interaction. In addition to having multifunctional resources, Steverink and Lindenberg proposed that people need to maintain a variety of resources to achieve one aspect of wellbeing. This study found examples of people having several strategies for achieving the same outcome. One participant had several different strategies for getting her groceries, taking different forms of transport, going with someone, asking her neighbour to purchase items for her, even getting meals delivered.

Strategies reported in other studies

I didn't find the level of description about a particular problem that has been reported in some studies, such as Bytheway's (2001) study of the ways older people manage their medication, where there were multiple practical strategies including how to open medicine bottles. In New Zealand the use of the blister pack system is reasonably common for those managing multiple medications, eliminating the need for bottles requiring strength to open them, which might account for very few details about medications in this study. Bytheway's findings were published in 2001, so it may be that the management of medications has become more user-friendly in the intervening years, or perhaps the New Zealand attitude which came through in the participants of 'getting on with it', influenced their perceptions. However I also sought participants' accounts of

how they were managing various aspects of their lives and the types of strategies they were using, which may have steered participants away from in-depth descriptions about one topic only. Conversely, Bytheway and some of the other authors purposely looked at one specific area of daily occupations, so naturally the depth of description about that topic is greater. The findings of this study support those in other studies reported in the literature. There is acknowledgment in all of the studies that older people are not a heterogeneous group and that any strategies developed for or by this group need to be diverse. Nonetheless, some strategies are being reported in other parts of the Western world that are similar to the strategies that were elicited through this study. For example taking several trips a week to shop for food and bringing back smaller amounts, allowing a participant to physically manage the groceries, and providing regular social interactions, was reported in this study and also in a study carried out in Sweden (Sidenvall, Nydahl, & Fjellström, 2001). Discovering that some of the strategies used in other parts of the world were very similar to those uncovered in this study was unexpected. This suggests that it might be worthwhile gathering together international literature to identify similarities in strategies that have been identified.

The solutions to problems that participants discussed are embedded in real life. Different solutions were found to the various challenges that the participants faced. While there were some similarities between some of the solutions, they were also individualised. The participants developed local views about what is acceptable in their home and to them. The strategies are not perfect solutions; they are individualised and work for the people using them, and may not be acceptable to others, which has great importance in practice. The strategies participants described are not necessarily ones that a health professional might or could prescribe and promote, such as leaving the butter in the sun all day to soften. Rather, health professionals looking to assist older people in finding a strategy that will work for them will need to listen to their preferences, circumstances and resources, yet this is an acceptable solution for some in order for them to overcome decreased strength and engage in the occupation of baking in their home.

Reflections about rigour and limitations

In this study I set out to find the strategies that older adults use to participate in their daily lives. I have been able to describe a number of strategies that fall within four different categories. There was a risk of identifying a predominance of home-based strategies because the participants were interviewed at home and it would appear that there are more strategies described by the participants about activities done at home, particularly around essential biological needs, such as getting and preparing food. Perhaps the environment in which the participants were interviewed influenced the strategies they chose to tell me about. Selecting participants from a club or an active community group and carrying out an interview or focus group in that setting might have provided some extra and differing strategies that were more community than home-based. It is possible that, because some of the participants were attending a church activity, an activity out of the home, that they were more resource-rich than other older adults, who were not recruited to the study because of the place I recruited participants from. However the predominance of home-based strategies in this study does align itself with activity preferences of older persons in other literature (Åberg, Sidenvall, Hepworth, O'Reilly, & Lithell, 2005). Åberg et al.'s study examined life satisfaction of older adults following rehabilitation. Personal cares, keeping in touch and activities carried out at home were all further up the hierarchy than personal interests and activities out of the home.

To maintain the credibility of the study I checked each of the transcripts against the recordings made. During the analysis I worked with the data to ensure that the findings accurately reflected what participants meant. I regularly discussed the analysis with my research supervisors, providing further opportunity for reflection about the data. Importantly, following the analysis, I summarised the categories and sent this to the participants for their reflection and feedback. The response from the participants was very positive. The majority of participants provided feedback and they agreed with the types of strategies they saw in the four categories. They were also able to add some additional strategies to some of the categories, further indicating that the categories were meaningful to them.

Most of participants in this study were women. Previous research has found that there are some gender differences in the occupations older people engage in (Knight et al., 2007). Had more men been interviewed as a part of this study there may have been more strategies around gardening and home maintenance, both productivity occupations that men were reported to engage in more frequently than women. Each participant's circumstances were quite different, and the strategies they developed were contextualized to their personal situation, yet there were some overlaps in strategies with just eight participants. I would expect, however, that other older people in Wellington would have other strategies that I did not uncover through this study.

In keeping with qualitative studies, the methods chosen for this study have meant that a small number of participants, living in similar physical locations were interviewed. This provides limits on how far one is able to say the findings can be generalised. While the study has demonstrated that some strategies are local and specific to the individuals that participated, there were some common strategies identified, which might point to these being more wide spread throughout the community.

Implications

So what is the point of this research? How might it be useful? And to whom? These are the questions I began asking myself as I read and re-read my findings and started writing about them in more depth. There are a range of different areas where this study can be used to reflect on what current practices are. These are in policy, in practice, in education and further research.

Policy

I began my research by looking at policy. I examined the policies that promote 'ageing in place', the support of the government to promote older people to continue to live in the community, the keenness to keep the length of hospital stays to a minimum, underwritten by a drive to maximise the health dollar. It seems logical, then, that in looking at the practical lives and strategies of older people at home, that this might link impact back to the policies in place. The participants do have a number of strategies, some of which

involve schemes currently set up and funded by the government. This includes the use of home help and personal care support where it is available. The participants I interviewed did not all rely on this, nor were they necessarily eligible for support provided through this means. It was not uncommon for family members to be the providers of much of the support, or for personal finances to fund aspects of support needed, such as transport. However older people in this study valued the help they received, and from a policy perspective did not want to see the help provided through social service agencies, largely funded through the government, disappear.

There are some consequences to policies that promote ageing in place, which focus on balancing the everyday risk of living at home and the way in which an older person may choose to perform an activity with 'overprotection', by striving to eliminate all risk. This is something many health professionals attempt to do in their roles, encouraged in part by the social and political environments which appear to want all risks eliminated. Policies that support ageing in place need to acknowledge that people have many different ways of living and differences in how they choose to carry out activities. For instance, it is possible that supermarkets across the nation may grow to notice and be concerned about their trolleys being used as walking frames around the supermarket and they will seek to reduce their liability should a frail older person fall while doing so. In New Zealand ACC gathers levies from businesses, and then provides compensation to injured people. The levies can be reduced where health and safety systems are in place (Accident Compensation Corporation, 2008). Rather than observing older people using the supermarket trolley a supermarket chain might consider how they can support this part of their shopping population and commission the design of a trolley that might be more suitable for this group of people, or engage in a redesign of stores to allow for parking of walking frames while older adults use the supermarket trolley. This example serves to highlight the balance between risk in participating in life, overprotection and policies relating to ageing in place.

Local amenities, like supermarkets, are being replaced by larger, centralised shopping precincts. These are harder to access and require a much greater walking distance when

out shopping. Greater consideration of these amenities needs to take priority in the ongoing development of cities. Supermarkets in local communities are generally easier to access and smaller in size making them far more accessible to older adults. Similarly, pharmacies, post offices and libraries should be readily available in local communities. While this is so for many communities, a number of them have been steadily centralising. One of the participants in this study had to deal with the closure of her local doctor, within a few minutes walk from her unit, and consequently the pharmacy beside it.

Another policy implication is that, traditionally, help provided by agencies has focused on providing support for self-care and home cleanliness (i.e. cleaning the kitchen and bathroom, vacuuming floors), or necessary occupations such as getting the food (through groceries, or meals on wheels). These are predominantly the way in which help was used by the participants in this study. However, the literature highlights that social interactions are vital for people living at home, particularly those who live alone. Accordingly, the policies that govern the provision of support for older people could usefully recognise that helpers going into the home have the potential to provide more than physical support.

Similarly, access to social and leisure activities outside of the home are limited by older people's ability to access affordable and safe transport. The introduction of the taxi supplement is one which appears appreciated and well-used by the participants, but it is set aside more for emergencies or one-off occasions; to use it to regularly attend a local club appears frivolous. In Wellington the use of buses is not unusual; however, there are not always suitable bus routes or accessible buses. Strategies by communities that look to support older adults to have choices about accessing the community more easily would be beneficial and have been shown to be both practical and financially viable in Australia (Broome, 2008). The recent New Zealand government initiative to make public transport free to seniors at off-peak times is a strategy that will be beneficial to many older adults (Edwards, 2008), however accessibility and location of bus services are also important in supporting participation of older adults in using this form of transport. Buses are not always a suitable option; it is not possible for bus routes to cover all the possible roads, or, currently, for every bus to be easily accessible. All new buses purchased ought to be

accessible. The social and leisure occupations are being neglected by many older adults because accessible, financially viable, transport options are missing. Ensuring older adults are able to get to and participate in occupations that meet their social needs, as well as biological needs (getting food, attending health appointments) is vital to the older adults' health and well-being.

From a policy perspective, houses that are more accessible, with the appropriate types of environmental supports, close to suitable amenities and affordable and accessible transport would also mean fewer barriers for older adults to overcome for those who choose to live there. Policies in New Zealand will need to consider these issues and how older adults will be practically supported and enabled to participate in a range of day-to-day occupations.

Practice

This study also has implications for practice. The findings highlight that older people do have a variety of strategies that they use – although some are not necessarily aware that they are doing so. They take for granted what they do and how they manage, and can be very unassuming about the things they put in place to ensure that they get by. As Beatrice said, '*What are you to do… you get on with it'*. As a health professional, I think it is important that we look for the strategies that are being used, and highlight these, which impacts on the self-efficacy the individual experiences (Easom, 2003). Of particular interest to me was the fact that while the older people do develop strategies, these do not necessarily overlap with strategies that might be provided by experts on certain topics. A particular example of this was that, although strategies had been developed to manage risks around falls when showering or getting dressed, the strategies related more to going slowly and taking care, rather than in increasing muscle strength or removing hazardous objects from the floor such as a mat one might trip over - strategies which are common in any falls prevention programme (Campbell et al., 2005; Clemson et al., 2004; Gillespie et al., 2003). This does point perhaps to the value of combining the strategies that older people have developed and expert knowledge in particular areas.

As an occupational therapist, I was interested to note that several of the participants had been prescribed various pieces of equipment to assist them in participating in their self-care occupations. I was even more interested to find that the use of these pieces of equipment did not feature among the various strategies some of the participants used to achieve day-to-day activities. I highlight again the importance of listening to the older person, to ascertain what strategies are acceptable to them, and to work out different alternatives with the person. A shower stool cluttering up the bathroom is potentially more of a risk for falls than the person not using it in the shower, because they prefer a different way of bathing.

Health professionals need to be increasingly aware that solutions that work for one individual may not work for another, or may not be an acceptable solution for another. However given that some of the findings of this study were similar to others from countries around the world, it could be beneficial to find out more about different strategies people develop, increasing the knowledge available to share with older adults.

In this regard, it is important to appreciate that older adults do not necessarily think they are using strategies to assist themselves with participation. Health professionals might choose to use the categories developed through this study to make inquiries about the strategies individual clients are using. Support for this suggestion comes from the feedback from the participants of this study, who were positive about the categories. They were able to recognise for themselves strategies that they used in each category and were able to provide further strategies to certain categories that they had thought about.

Health professionals face challenges in balancing potential risks they observe, solutions that may be perceived as ‘unprofessional’, and older adults’ right to choose strategies for themselves. Recognition that the older adult is the expert in his or her own life, that self-management improves health and that the health practitioner’s role should focus on partnership may assist in clarifying what is acceptable ‘risk’. This approach would have recognised Gretchen’s preference for taking a soak in the bath as opposed to using a bath board, despite the risk that she may not be able to get herself safely out, and would not

result in providing a bath board at this point. Instead the health professional might have supported Gretchen in identifying what she might do if she were unable to get out of the bath one day, thus developing a strategy for dealing with potential situations.

To some extent, the findings also raise questions about the focus occupational therapists have in their efforts to assist older people to manage their lives in the community. As mentioned previously, I had anticipated that the interviews would focus largely on self-care related occupations and was surprised that this formed only a small aspect of the interviews. The topics tended to relate more to the areas of household management and the many strategies employed to access suitable and affordable transport to get out to do things or access necessary resources in the community. I was also surprised that there were not more outings to social and identifiable leisure occupations, although getting out to the grocery store provided opportunities to interact with others. Occupational therapists could be more involved in addressing the reasons older people are not as likely to be involved in these occupations. There could be an increased focus on transport problems that affect older people. Identifying solutions that incorporate social possibilities for older adults is an area that could be a priority for occupational therapists to address. Importantly, raising political awareness of social and transport needs of the older adults is a method in which occupational therapists can help in the development of strategies for older adults (Broome, 2008).

Education

Finally, what are the implications for education? What might health care professionals and people providing support, including carers and family members, learn from this study? What education might be needed for groups that promote the concerns of older people, such as Age Concern, and older people themselves?

During the study, evidence that older people do take on and adapt strategies they see or hear of was apparent. One concrete example arising from this study was the participant who experienced breathlessness on exertion, who changed the use of her phone after I had told her of another participant who had a cordless phone she could carry around with her. The literature about self-management informs us that people can manage their

illness, with the right knowledge and support, role models and mentoring. Existing literature about older adults and self-management points to its use in successful ageing. As well as incorporating perspectives from this literature into educational programmes, I suggest that education about managing lives and developing practical strategies to participate in day-to-day occupations ought to involve the very population it seeks to address. This means that older people should be involved in education of their peers, whether that is through education programmes that already exist, such as some of the programmes through the hospitals (for example cardio education groups), or through other avenues, such as community groups. Principles of self management could be used to inform how these groups could use older adults as educators and mentors for their peers. As the population becomes more computer-literate the use of the internet for education needs to become more prevalent also. Groups aiming to educate older people and those who care for them should start to develop resources that suit this type of information sharing.

Education of health professionals, carers and community agencies needs to highlight that older adults are a resourceful, diverse group of people. Educators could focus on developing their students' skills to help older adults see for themselves the strategies they may already be using, and assist in developing a variety of strategies and multifunctioning strategies, to ensure better outcomes for the person.

Further research

Aligning with Lang et al's (2002) suggestions of resource-rich and resource-poor older people, this study revealed that some older people are strategy rich and others appeared to have few strategies to address the barriers and limitations they experience. What is not apparent is whether the participants who appeared rich in strategies had been developing these over a longer period of time than the others, and if this was related to needing to overcome challenges to occupational performance for greater periods of time. This is an area in which further research could be carried out to look at how strategies are developed, and whether there are measurable advantages to being strategy-rich.

Another line of research arises from the fact that the majority of participants in this study were city dwellers, female and of European/Pakeha heritage. It is not known if the types of strategies would have varied greatly if the participants had been mostly male, or Maori or Asian, or living in a rural area. Further studies, focusing on a more diverse group of participants, or on specific groups within the New Zealand population, such as those mentioned above, would build on the knowledge begun in this study.

Given that the strategies arising from research in other parts of the world had some similarities with those that the participants demonstrated in this study it could be useful to identify the various international strategies that have and are being researched, and create an international body or resource that would bring such knowledge together in one place. This would enable policy writers, health professionals and educators to more easily communicate and use the research that has occurred and is occurring in this field.

Finally, further research could focus on the applicability of the idea behind this study, that if older adults have strategies they use to participate in day-to-day occupations, and help them age successfully in their homes, can these strategies benefit others, through some form of self-management education?

Conclusion

This study set out to identify strategies older adults living in an urban environment in New Zealand use to overcome barriers and limitations in occupation. It uncovered four categories of strategies; strategies for keeping me safe, strategies for recruiting and accepting help, strategies for meeting biological and social needs, and strategies for conserving resources. Considered together, these strategies reveal that older people can and do use strategies to enable occupation in their everyday lives, suggesting that health professionals, policy makers and educators have much to learn from older people. Strategies resulted in overcoming or reducing environmental barriers, and also performance deficits which resulted in difficulties with doing day-to-day tasks without some change in strategy. The older people who

participated in this study are a resourceful group of people. They are managing their lives and using a range of strategies in order to participate in occupations at home and in the community. The future should consist of developing a resource for and with older adults to share ideas and teach each other about how to manage ongoing participation in occupations.

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Appendix A: Ethics approval 141206

AUT UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

M E M O R A N D U M

To:	Clare Hocking
From:	**Madeline Banda** Executive Secretary, AUTEC
Date:	14 December 2006
Subject:	Ethics Application Number 06/201 **Strategies older New Zealanders use to overcome barriers to participation: Managing lives: a descriptive study.**

Dear Clare

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 13 November 2006 and that as the Executive Secretary of AUTEC I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 22 January 2007.

Your ethics application is approved for a period of three years until 14 December 2009.

I advise that as part of the ethics approval process, you are required to submit to AUTEC the following:

- A brief annual progress report indicating compliance with the ethical approval given using form EA2, which is available online through *http://www.aut.ac.nz/research/ethics*, including when necessary a request for extension of the approval one month prior to its expiry on 14 December 2009;
- A brief report on the status of the project using form EA3, which is available online through *http://www.aut.ac.nz/research/ethics*. This report is to be submitted either when the approval expires on 14 December 2009 or on completion of the project, whichever comes sooner;

It is also a condition of approval that AUTEC is notified of any adverse events or if the research does not commence and that AUTEC approval is sought for any alteration to the research, including any alteration of or addition to the participant documents involved.

You are reminded that, as applicant, you are responsible for ensuring that any research undertaken under this approval is carried out within the parameters approved for your application. Any change to the research outside the parameters of this approval must be submitted to AUTEC for approval before that change is implemented.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at charles.grinter@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of the Committee and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Madeline Banda
Executive Secretary
Auckland University of Technology Ethics Committee
Cc: Juanita Murphy ian.juanita@xtra.co.nz

Appendix B: Information sheet

Participant Information Sheet

Date Information Sheet Produced: 28 November 2006

Project Title: Strategies older New Zealanders use to overcome barriers to participation: Managing lives: A descriptive study.

An Invitation

You are invited to take part in a study that explores strategies older community dwelling New Zealanders use to manage their day-to-day occupations.

Who am I?

My name is Juanita Murphy and I am an occupational therapist. I have worked predominantly as a clinician with older adults. I am also a mother and have three preschool children. I am currently enrolled in the Masters of Health Science program at Auckland University of Technology, Akoranga Campus. As part of the requirements of this course, I am conducting research for my thesis. The focus is the strategies that older people use to participate in their daily lives.

What is the purpose of this research?

The purpose of this study is to investigate the strategies that some older New Zealanders are using to manage their day-to-day occupations. This may range from how they manage to take their medications to how the groceries are done to how they manage to attend church. It is envisaged that identifying these strategies will in turn enable the development of assistance programmes for other aging New Zealanders.

The final research report will be available as a master's thesis in the Auckland University of Technology library. Any articles relating to the research will be published in relevant journals. The research findings are also expected to be presented at seminars.

What will happen in this research?

We will arrange an interview, which will be approximately 1 to 1 ½ hours, at a time convenient to you. It is possible that I may wish to interview some of you a second time or have a telephone discussion with you to gather further information. The interviews will be at a place you suggest, that is convenient for both of us. You may wish to have someone else with you during the interview, such as a family member or friend. You will be asked to tell me stories of your experience that relate to the research topic. For instance I will be asking for you to tell me about how you manage a task that can be difficult to do.

The interviews will be audio-taped and then typed up. Themes from the information will be collated. Your participation in the study is entirely voluntary and you can withdraw from it at any time prior to completion of data collection, without being disadvantaged in any way.

What are the discomforts and risks?

I don't anticipate any risks to you from participating in this study. However if you find the interview upsetting for some reason, I will assist you to make an appointment to talk to a counsellor, at no cost to you, at the Presbyterian Support Services in Wanganui or the Hutt Valley.

How is my privacy protected?

Interviews will be in a place of your choice. The tapes and transcripts will be confidential to me and the typist who will sign a confidentiality agreement. A pseudonym will be used to protect your identity on all material such as the tapes and transcripts. Audiotapes of interviews and the typed transcripts will be kept in a locked cabinet which only the researcher and supervisor will be able to access. They will be destroyed 6 years after the study's

completion. Every attempt will be made to avoid identification of any person in reports prepared from this study.

What are the costs of participating?

The cost for you will consist of your time. This includes time for the interview (about 90 minutes) and a potential follow up discussion time to clarify any queries that arise (about 20 minutes). If interviews are held away from your place of residence this would add time for travel.

What opportunity do I have to consider this invitation?

I appreciate you taking the time to read this information sheet and for considering being a participant in my study. If you would like to participate it would be really good to hear from you. Please contact me within 2 weeks of receiving the participant information sheet.

How do I agree to participate in this research?

If you have any questions about the study you are welcome to contact me by phone or email. If you leave a message giving your contact details I can ring you back. You may decide not to go ahead, or I may find that you do not meet inclusion criteria. Once you have agreed to participate a meeting time and place will be arranged that suits both of us. At that first meeting we will go through the Consent Form which will be signed prior to the interview. If you would like me to meet with your family/whanau or iwi prior to making a choice about whether to participate, I am very happy to do so.

Will I receive feedback on the results of this research?

At the end of the study a report about the research will be available. We can discuss how this would occur at our initial meeting.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, see details below.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, *madeline.banda@aut.ac.nz* , phone: 09 921 9999 ext 8044.

Whom do I contact for further information about this research?

Researcher Contact Details:
Juanita Murphy
Student of the Master of Health Science Programme
Auckland University of Technology
Akoranga Campus
Auckland
Mobile: 021 1107678
Email: ian.juanita@xtra.co.nz

Project Supervisor Contact Details:
Clare Hocking
Associate Professor
Auckland University of Technology
Akoranga Campus
Auckland
Phone: 09 921 9999 extn 7120
Email: clare.hocking@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 14th December 2006 AUTEC Reference number 06/201.

Appendix C: Demographics data form

Demographic Data Form

This form is to be completed by the researcher. A form should be completed for each potential participant and will be held in a secure location as per the AUT Ethics Application

Name: _____

Contact Details: _____
_____

Gender: Male Female (circle answer)

Ethnicity: _____

Age: 65-69 70-74 75-79 80-84 85 and over (circle answer)

Transport: Own car Taxi Scooter Walking
Public transport Other_____ (circle answer)

Living arrangements: Alone With spouse With family
Other_____ (circle answer)

How long have you lived at current address?_____

Activities in the community:_____

Activities requiring strength or fitness:_____

Forms and amount of support currently received:
Hours per week_____

For: Housework Personal cares Garden

Shopping Medicine Meals Transport to places

House maintenance Other _____

Impairments: Eyesight Hearing Mobility Other_____

Exclusion factors: (circle if applicable)

Cognitive impairment

Acute condition receiving treatment

Appendix D: Ethics approval 021007

M E M O R A N D U M

Auckland University of Technology Ethics Committee (AUTEC)

To: Clare Hocking
From: **Madeline Banda** Executive Secretary, AUTEC
Date: 2 October 2007
Subject: Ethics Application Number 06/201 **Strategies older New Zealanders use to overcome barriers to participation: Managing lives: a descriptive study.**

Dear Clare
I am pleased to advise that on 2 October 2007, I as the Executive Secretary of the Auckland University of Technology Ethics Committee (AUTEC) have approved the amendments to your ethics application. This delegated approval is made in accordance with section 5.3.2 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 12 November 2007.
I remind you that as part of the ethics approval process, you are required to submit to AUTEC the following:

- A brief annual progress report indicating compliance with the ethical approval given using form EA2, which is available online through http://www.aut.ac.nz/about/ethics, including when necessary a request for extension of the approval one month prior to its expiry on 14 December 2009;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/about/ethics. This report is to be submitted either when the approval expires on 14 December 2009 or on completion of the project, whichever comes sooner;

It is also a condition of approval that AUTEC is notified of any adverse events or if the research does not commence and that AUTEC approval is sought for any alteration to the research, including any alteration of or addition to the participant documents involved.
You are also reminded that, as applicant, you are responsible for ensuring that any research undertaken under this approval is carried out within the parameters approved for your application. Any change to the research outside the parameters of this approval must be submitted to AUTEC for approval before that change is implemented.
Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this. Also, should your research be undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply within that jurisdiction.
To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at charles.grinter@aut.ac.nz or by telephone on 921 9999 at extension 8860.
On behalf of the Committee and myself, I wish you success with your research and look forward to reading about it in your reports.
Yours sincerely

Madeline Banda
Executive Secretary
Auckland University of Technology Ethics Committee
Cc: Juanita Murphy ian.juanita@xtra.co.nz

Appendix E: Consent form

Consent Form

Project title: Strategies older New Zealanders use to overcome barriers to participation: Managing lives: A descriptive study.
Project Supervisor: *Clare Hocking*

Researcher: *Juanita Murphy*

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 28 November 2006.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that the interviews will be audio-taped and transcribed, and that I will have an opportunity to read the transcript and request alterations.
- ○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ○ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ○ I agree to take part in this research.
- ○ I wish to receive a copy of the report from the research (please tick one): Yes ☐ No ☐

Participant's signature:
.....

Participant's name:
.....

Participant's Contact Details (if appropriate):

……
……..

Date:

Approved by the Auckland University of Technology Ethics Committee on 14th December 2006 AUTEC Reference number 06/201

Note: The Participant should retain a copy of this form.

Appendix F: Interview Question format

Interview Question Format

Warm up
Introduction and ask how they are managing today with their activities.
Tell me about the things that you do each day or week to take care of yourself/your home/community/hobbies…

Agenda of topics

Tell me how your impairment affects your ability to do….
Can you tell me about an activity that you have needed to change due to the impairment (….vision/mobility etc)?
Tell me about a time you needed to change how you did….
What is different about how …. (this activity) is done now?
How did you come to do things this way?
When did you need to change the method of doing the occupation?
Does this new method always work, are there times you need to modify it….?

Do you use more equipment around the home/community now… (what/for what/how did you get the equipment)

Do you use another person to assist in any tasks?

Sample prompts
Can you show me how you do…..? Why do you do things this way?

Use Self care/Home management/Community activities/Leisure and hobbies as categories for prompts for occupations that may have been affected by condition and therefore changed.

Closing
Check if any other areas participant would like to comment on.
Thank for participation.

Appendix G: Confidentiality Agreement

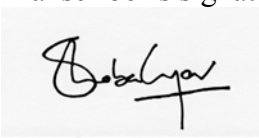
Confidentiality Agreement

Project title: Strategies older New Zealanders use to overcome barriers to participation: Managing lives: A descriptive study.
Project Supervisor: *Clare Hocking*

Researcher: *Juanita Murphy*

√○ I understand that all the material I will be asked to transcribe is confidential.
√○ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
√○ I will not keep any copies of the transcripts nor allow third parties access to them while the work is in progress.

Transcriber's signature: .....



.....……

Transcriber's name: .....Shoba Nayar.....……

Transcriber's Contact Details (if appropriate):
5/28 Evelyn Place, Northcote, Auckland……..
Ph: 09 419 4677 or 021 520 465……..
……..

Date: 27th June 2006

Project Supervisor's Contact Details (if appropriate):
……..
……..
……..
……..

Approved by the Auckland University of Technology Ethics Committee on 14th December 2006 AUTEC Reference number 06/201

Note: The Transcriber should retain a copy of this form.

Appendix H: Category description example

Description of category: An example

Being safe

The things that people put in place to give themselves and their resources a sense of physical and psychological safety.

For example; freedom alarm, writing a cheque, choosing level access house, toll bar, careful incase I slip, neighbours, not putting myself at risk, equipment (there were lots of examples of equipment, also where it is there in the home but participant chooses not to use it).

This has two subcategories:

Safe environment

These were strategies which overcome environmental barriers to participation such as the physical and social living environment.

Personal safety

This is about strategies that protect body structures and functions. This might be motivated by fear of injury or illness through falls, or exacerbating symptoms of diseases.

Appendix I: Category development

Category development

Appendix J: Letter and summary for participants

Letter and category summary for the participants

Juanita Murphy
Master of Health Science student
61 Strathavon Road
Miramar
Wellington

Name
Street
Suburb
Wellington

30 July 2008

Dear …,

I would like to thank you again for your participation in my study about Strategies Older New Zealanders use to participate in their day-to-day occupations. I have been steadily working on collating the information and preparing my final draft for comment by my supervisors at the Auckland University of Technology.

I have enclosed a summary here for you of the general strategies that were drawn from the various interviews I carried out with yourself and other participants.

I welcome any comments that you might have to make about the list of strategies I have compiled from these interviews. Perhaps you recognise the types of strategies you use within this list. Perhaps there are some that you feel are missing and would like to make comments about.

I have included a stamped self-addressed envelope and would really welcome any comments you might have about the strategies.

Kind regards

Juanita Murphy

Through the interviews lots of different strategies were described by the participants. These were collated into a few main areas. Some examples of each of these will be provided.

Strategies for meeting needs:
These are the strategies people use in order to manage the practical demands of meeting their need to gather and prepare food, have social contact and fulfill their roles and obligations.
For example:

- Modifying a walker to be a trolley for carrying food home from supermarket or to carry the telephone around the house
- Using a trolley as a mobility aid at the supermarket
- Break shopping into smaller manageable units
- Taking time to do the job
- Using a meal delivery service
- Being very aware of the cost of items
- Choosing acceptable options to yourself
- Looking for items that are easy to prepare
- Keeping pots etc in an easy reach place to conserve energy
- Using a pick up service for transport
- Borrowing or purchasing a wheel chair for outings
- Using drivers to get places
- Flexibility in plans
- Having more than one way to get something done (use family or friends or bus or taxi to get to supermarket/pharmacy or meal delivery).

Strategies for conserving resources:
These are the things people have in place to conserve resources such as finances and energy.
For example:

- Finding ways to cut back, on outings or SKY TV
- Making do
- Building up resources in advance i.e. of clothing, books
- Conserving resources – deciding when/what to use taxi chits on, energy, eyesight, putting a toll bar on the phone
- Holding something in reserve – such as taxi chits for hospital visits

Strategies for keeping me safe:
This is about the things that people put in place to give a sense of physical and psychological safety for themselves and their resources.
For example:

- Moving homes to a place were they thought it would be easier and safer or moving homes to continue to be safe
- Altering the physical environment by introducing things intended to reduce the risk of falls such as a walking frame or shower stool.
- Some people carried on doing the activity they way they preferred (despite any risk to falling etc).
- People were conscious of their body in all the things they did
- Accessing help when it was needed
- Calling on neighbours
- Relying on a supermarket trolley for balance
- Protecting personal space

Strategies for recruiting and accepting help:
These are the strategies people use to recruit and accept the help or assistance they need to participate in day-to-day tasks at home and in the community.
For example:

- Recognising when you can no longer do a certain task
- Exchanging one service for another
- Paying for help
- Accepting that you may need to pay for help
- Notifying a help agency when circumstances change if you need more or less assistance
- Recruiting family by asking or demonstrating a need for assistance
- Having a friendly personal relationship with the helper
- Minimising how much the help intrudes
- Actively working with the helper
- Using the help on your own terms and dispensing with help when the timing doesn't work
- Reorganizing how things are done
- Using previous routines and methods