Shifting Focus.

How Registered Nurses in Residential Aged Care Organise Their Work: A Grounded Theory Study

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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 nor material which to a substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements

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Almost weekly I have met with two colleagues also using grounded theory in their thesis project. Anita Wacker, Stephanie Muncaster and I formed what Dr. Lynne Giddings calls a critical group. Our meetings have been full of discussion, challenge, sometimes tears, and many times, fun as we poured through our own data and literature about grounded theory, gradually becoming clearer about the methodology and learning to live with not knowing. I thank them both deeply for their support and now their friendship.

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ABSTRACT

Registered nurses in residential aged care work with older people who have complex care needs. Besides providing direct care, these nurses have a wide range of responsibilities which include supervising staff and attending to the smooth running of the care facility. This grounded theory study using dimensional analysis was aimed at answering the question: How do registered nurses organise their work?

Indepth interviews were conducted with 10 registered nurses who worked in a range of positions in aged care facilities. Theoretical sampling and constant comparative analysis was used to guide both ongoing data collectiona and data analysis. Categories were examined for their relationships and dimensions to arrive at a substantive grounded theory which I have named 'shifting focus'.

Individual and institutional philosophies of care were core elements in the registered nurses' focus of work. There was a relationship between staffing adequacy, individual and institutional philosophies of care, and the focus of registered nurse work. These relationships created conditions where the registered nurse would focus on ensuring the delivery of individualised resident care or focus on getting through the routine of care.

The relationship between staffing adequacy, philosophies of care and the registered nurses' focus of work remained consistent when staffing adequacy changed. In instances of decreased staffing adequacy, the participants' focus shifted to either maintaining individualised care or focusing on safety. When the registered nurse aimed to change the philosophy of care, an increase in staffing adequacy enabled some aspects of cultural change to commence.

The relationships between residents, family and staff were significant contrasting elements within an individualised philosophy of care, and an institutional philosophy of care. In the former, relationships were valued and developed. In the latter, they were benevolent, functional or conflicted.

The significance of this study is that it reveals how registered nurses and management personnel in aged care facilities, can create conditions where the relationships between residents, their families and staff, are valued and developed to result in positive care outcomes. It is recommended that future research be conducted to examine the resources required to maintain an individualised approach to the nursing care of residents in aged care facilities.

CHAPTER ONE: INTRODUCTION

The Focus of the Study

The focus of this study is the work of registered nurses in residential aged care in New Zealand. It is into the residential care setting that the most frail and disabled older people are admitted when they require 24 hour care of the type that is unavailable in their own home. The number of older people living in aged care is small, approximately 5% of the total population of older people (Ministry of Health, 2002b). The care needs of this population, however, are often varied and complex. As most of the residents in this setting are admitted for long term care and, in many instances, are unable to return to their own home, the residential facility becomes their place of living. Staff working in residential aged care are required to work towards each person reaching their optimum level of health in order that they can have access to an acceptable quality of life (Minister of Health, 2001a).

In the residential aged care setting caregivers provide the majority of the direct care for residents under the supervision of the registered nurse (Featherston, 2000). Professionally, registered nurses have not been attracted to working in residential aged care and there have been reports of difficulty with recruiting and retaining registered nurses in this care setting (Schumacher, 1999). This difficulty is compounded by the current national nursing shortage in the acute care setting.

Added to this situation is a current debate about the adequacy of the mandated numbers of registered nurses required to ensure the safe care of residents. An advisory working group, instituted by the Ministry of Health, has been asked to advise the Government on minimum registered staff numbers which would be required to ensure resident safety (Brown, 2002).

These issues raise questions about resident care in aged care facilities. How is it that in some situations there is evidence of high quality care and in others poor quality care? What is it that makes the difference? How can we learn from our understanding of those differences? These questions have led me to undertake this research study in completion of a Masters in Health Science (MHSc) degree.

My thoughts were that by explicating the work processes of one group of registered nurses in one type of aged care setting, that of residential care, I could provide some insight into the conditions and contexts that impact on registered nurses' work towards ensuring that residents receive high quality care. I can't claim that my findings are pertinent to all registered nurses working in aged care. I can say that the work processes I have revealed in this study were recognized by a number of nurses from a variety of aged care settings who have listened to my presentations of these findings.

Purpose

The purpose of this study was to uncover the processes of care delivery that underpin registered nurses' work in residential aged care. I wanted to explain these processes of registered nurse work so that future decisions regarding staffing, staffing mix and the processes of care practices could be informed by these understandings. The

Ministry of Health has formed an expert advisory committee to make decisions about safe staffing levels for registered nurses working in residential aged care (Brown, 2002). It seemed reasonable that the discussions regarding safe staffing levels for registered nurses in residential aged care could be informed by a study on how registered nurses in this setting organise their work.

Focus of Inquiry

This study used the interpretative qualitative approach of grounded theory to answer the question "How do registered nurses in long term aged care facilities meet the care needs of a frail dependent population?" The question was directed at registered nurses and specifically towards the field of residential aged care. In grounded theory, the study question is deliberately broad as the researcher does not know what processes underlie the actions of the participants and needs to remain open to the data provided by those participants (Glaser, 1992a). Approaching the field of study in this way enables the participants to articulate what is problematic for them in the context of the study phenomena.

Significance of the Study

The significance of this study is that it will add to the beginning conversations about care delivery processes for older people in long term institutional care in New Zealand. Central to those conversations are the notions of how staff are prepared for work in this area of care, how work is organised to facilitate rather than constrain care practices, and how those working in aged care facilities can best meet the Government's current direction of working in partnership with residents and their families (Minister of Health, 2001a).

The Structure of the Thesis

The thesis comprises seven chapters. In this first chapter I introduce the general area of inquiry and describe the thesis structure. Chapter Two contains a background to residential aged care in New Zealand. In Chapter Three I extend that background from the New Zealand context to the international context by presenting a literature review of those subject areas which have an impact on residential aged care and therefore on registered nurse work in that area. In Chapter Four I focus on the research methodology and describe the process of research undertaken in this study. Chapter Five and Chapter Six contain the research findings and Chapter Seven, a discussion of those findings, synthesized with the literature presented in Chapter Four. Also, in Chapter Seven I outline the conclusions that I have reached as a result of this research study. The chapter also includes suggestions for further research.

Organisation of material

All of the participants who took part in this project were females of European origin. I have used the term she/her when referring to these participants. Within the literature review and my discussion however, I have endeavoured to use inclusive language when referring to gender.

The spoken word is full of hesitations, pauses, repeats and different voice tones. The richness of an individual's speech cannot be fully captured in words. Some participants felt uncomfortable when they saw their words translated exactly as they had spoken. The spoken word, directly transcribed can also be difficult to read. I have therefore removed some of the repeated words, and made the sentences complete both

to assist the participants when reading their own conversations and for general ease of reading.

I have used some words which are Maori. A translation of these words is in the glossary. Different countries have a variety of terms which they use for aged care facilities and their staff. Where I have been aware of those differences, I have provided an explanatory note in the glossary.

CHAPTER TWO: BACKGROUND TO THE STUDY

Introduction

New Zealand's population is ageing. With the increase in life expectancy for Maori and Pacific Islanders as well as increased immigration, New Zealanders can look forward to a richly diverse ageing population with women outnumbering men (Ministry of Health, 2002b). Current New Zealand Government strategies and action plans are directed towards maintaining the health of all New Zealanders. New Government policies focus on forging partnerships between those receiving health care, those delivering health care and those funding health care (Minister of Health, 2000; Ministry of Health, 2002b). This research study focuses on registered nurses who work with older people who reside in residential aged care. Both the registered nurses and the older people they serve, represent different aspects of the partnership with Government.

In this background chapter, I will describe the New Zealand context in which residential care services are provided for older people. I will broadly outline the current population trends and the health care needs of older people in New Zealand, with a particular focus on those older people who live in residential aged care. I will then describe current residential care services for older people and the future directions that have been outlined in New Zealand Government policy and legislative documents.

The New Zealand Context: Demographic Trends

New Zealand is undergoing major demographic shifts. The increase in the proportion of New Zealanders over 65 years of age will move from the current 12 % to 26 % of the New Zealand population by the year 2051 (Ministry of Health, 2002b). The life expectancy of the Maori population in New Zealand is currently lower than the

remainder of the population and their health status is significantly lower, with requirements for specialised care commencing at an earlier time in their life (National Health Committee, 2000). The life expectancy for Maori, however, is also changing. By the year 2011 the Maori population over 65 years is expected to have doubled (Minister of Health, 1997). The Pacific Island and Asian populations are also ageing and overall women have a longer life expectancy than men (Ministry of Health, 2002b). The increase in life expectancy of older New Zealanders has resulted in an increase in the need for residential care services as demonstrated by the statistics presented in the following paragraph.

Barker, Caughey and Guthrie (1982), in their report to the World Assembly on Ageing stated that in 1966 there were 5,691 residents in residential homes. In 1971 this number rose to 6,966. In 1976 a further increase of residents in residential homes brought the number to 8,478. By 1981, the number of residents was 9,703 (Ministry of Health, 2002b). Statistics New Zealand (2001) estimates the number of disabled adults living in residential care at 27,300 in 2001 and notes that this figure comprises 4 % of the adult disabled population in New Zealand.

In New Zealand one third of adults over 85 years of age enter residential care at some time. Between 1999 and 2000, people entering aged care were on average, 82.5 years of age. The average length of stay was two years with 20 % surviving less than three months and 40 % surviving less than 12 months (Ministry of Health, 2002b). Disability increases with age leading to an increased need for the provision of health care services either in the community or in residential aged care.

Health Care Needs of Older People Living in Residential Aged Care in New Zealand

A description of the levels of disability experienced by older people in residential care, is reported in the statistical reference for the health of older people in New Zealand (Ministry of Health, 2002b). As well as the higher level of disability already noted, this population has increased levels of multiple disability when compared with older people who live in the community. Older people in residential care are reported to have increased difficulties with self care activities, decreased mobility, impaired vision and hearing, difficulty with speaking and difficulty with cognition. The New Zealand Disability Survey (Statistics New Zealand, 2001) reports that 83 % of those living in residential care were severely limited by their disability. While the majority of people with dementia are cared for at home (70 %), the incidence of dementia for people living in residential aged care is considered to be high and expected to increase, which in turn could increase the demand for residential care services.

The Balance between Community and Residential Aged Care

There is a funding tension for the New Zealand Government while they work to achieve cost effective, quality health care services for older people along a continuum of care which aims for appropriateness of service at each level of health care need. The majority of older people have indicated a preference for remaining in their own homes and health care funding has been directed towards meeting that preference (Age Concern New Zealand, 1999; Richmond, Baskett, Bonita, & Melding, 1995). The National Health Committee (2000), while advocating for policies to enable older people to remain at home, suggests that there is also a continuing need to provide adequate funding for a high quality of care for older frail and ill people residing in long term care

facilities: "In 2000/01, public expenditure on rest home and continuing hospital care subsidies was $426 million" (Ministry of Health, 2002b, p. 95). According to the Ministry of Health (2002b) in the five years between 1996 and 1997 as well as 1999 to 2000, there was an "overall average increase in residential care expenditure of 5.5 % per year up to 1999/00 and a 1% increase after that date "(p. 95). The increase is reported to be due to increased patterns of utilization which may be related to older people entering residential care at a later stage with "higher levels of disability or frailty" (p. 94).

The dependency threshold at which a person becomes eligible for residential services has increased (Ashton, 2000). The net result of a focus towards community care and an increase in the dependency threshold means that people are entering residential care at a later age and with increased dependency levels. The increasing numbers and dependency levels of older people in residential aged care has implications for the provision of effective care delivery services. Austin (2000) states that:

> Many providers of aged care have been operating under considerable financial constraints in recent times. Managing tensions between addressing need, maintaining quality services, workforce training, retention and skills development, within limited resources have all been major challenges within the age care sector and the health sector as a whole, over the last ten years (p .2).

In New Zealand, the majority of funding for health care services for older people comes from Government. Now in its second term in parliament, the current Labour led New Zealand Government has introduced wide-ranging changes in the health care sector. These changes will have an impact on residential care services.

Government Changes in the Aged Care Sector

The current changes in the aged care sector in New Zealand reflect the need for Government and health care organisations to recognise the health care needs brought about by population ageing. The New Zealand Health Strategy sets the future direction for health services in the New Zealand context. The strategic direction outlined in the New Zealand Health Strategy (Minister of Health, 2000, 2002b), outlines a vision of shared responsibility for health. At the same time, there is recognition that societal inequities can impact on the level of shared responsibility and lead to ill health. The health strategy has given rise to the positive ageing strategy (Minister of Senior Citizens, 2001), the positive ageing action plan (Ministry of Social Policy, 2001) the health of older people strategy (Minister of Health, 2001a), and the palliative care strategy (Minister of Health, 2001b).

Legislative changes will impact on residential aged care services. These changes include legislation which changes the licensing process for all health care facilities in New Zealand ("Health & Disability Services (Safety) Act," 2001). The Health Practitioners' Competence Assurance Bill 2002 (Ministry of Health, 2000), currently in process, will form the legislative basis for New Zealand health practitioners' registration and ongoing competence. Lastly, there will be an impact from changes to the Health and Safety Employment Act (Minister of Labour, 2002) which aims to place an emphasis on health and safety in the workplace. I have made every endeavour, in the next section, to provide up-to-date information regarding health care service delivery in residential care in New Zealand. There may, however, be errors due to changes that may have occurred as a result of a variety of ongoing consultation processes.

Health Care Service Delivery in Residential Aged Care

There are a variety of residential care facilities in New Zealand ranging from stand alone rest homes and private hospitals, to large co-located facilities comprising independent living apartments, serviced apartments, community care services, rest homes, dementia care services and hospital wings. Entrance to residential care in New Zealand is by way of a national assessment of support needs known as the support needs assessment profile (SNAP). Residential care is both means and asset tested. People are subsidised depending on whether they have assets above the limit set for their particular context, either married with a partner remaining at home, married with a partner already resident in institutional care, or single. There are some facilities which are solely funded by residents' fees and do not receive Government funding (non-subsidised). Other facilities may have residents who are both subsidised and non subsidised.

People requiring residential care can be admitted to a rest home (low band care), private hospital (high band care), or specialised dementia unit. Government subsidies for residents and the level of facility they enter are related to the level of care that is required, with low band care facilities providing for some personal care needs, and high band care facilities providing for those people who require skilled nursing care. Government requirements for licensing and the maintenance of standards are articulated through the recently legislated Health and Disability Services (Safety) Act , (2001). Added to this, providers of residential care who receive Government subsidies are required to sign a national contract which sets the boundaries for care (Ministry of Health, 2002a, 2002b; New Zealand Nurses Organisation, 2002).

New Zealand is a bicultural country. Te Tiriti o Waitangi (The Treaty of Waitangi) is the document of partnership between Maori and other cultures. The current Labour Government has a commitment to honouring Te Tiriti o Waitangi. The commitment to Maori has a flow on effect which leads to improved cultural services for a diverse range of groups from other countries, particularly those from Pacific and Asian countries who live in New Zealand (Minister of Health, 1997, 2000, 2001a, 2002a; Minister of Social Development, 2001). The needs of older Maori and those from other cultures are clearly addressed in the Government contract with residential aged care providers. To develop care plans for Maori, providers are to initate and maintain a connection with the appropriate local Iwi. A service plan to meet the needs of Maori is to be available in each facility and staff are to be educated to meet the cultural needs of all residents (Minister of Health, 2001a; Ministry of Health, 2002c).

Education and training is also seen as an issue for those staff working in specialised dementia care units or facilities. Recommendations from the recent report into the quality of care for people with dementia in residential care, state the need for an improvement in care delivery (Lewis, 2002). As Lewis states:

> Facilities also face tensions between providing a custodial 'institutional' model of care with a focus on risk minimisation versus a 'person-centred' model that allows expression of normal risk taking behaviour. It is essential for providers to continually be aware of the needs of people with dementia, how these change over time, and what strategies can be implemented to achieve them. Involving whanau, families and carers in safe and acceptable practices of care will to some extent help with finding solutions to sometimes complex needs (p. 5).

The Ministry of Health has accepted the recommendations from this report and there is now a requirement that all staff working with people with dementia undergo specified national training courses. Auditing specific to the standards for restraint minimization will occur (Standards New Zealand, 2000). Finally, the Ministry's expert advisory panel has been requested to "develop a formula that specifies the number of registered and enrolled nurse hours that should be provided to each client" (Ministry of Health, 2002a, p. 2). The standards and requirements for the licensing of aged care facilities are also changing.

The newly legislated Health and Disability Services Safety Act (2001), outlines the processes for meeting the required minimum standards of care in all New Zealand health care facilities. This Act replaces the previous process of health provider licencing. New standards to accompany the legislation are being developed; previous standards are in the process of continuous update and auditing processes have been outlined (Standards New Zealand, 1999, 2000, 2001). Funding for residential aged care is currently centralised through the Health and Disability section of the Ministry of Health. The development of guidelines for a national needs assessment for older people is due for draft comment in 2003 (Ministry of Health, 2002d). The proposed comprehensive, multidisciplinary assessment tool is to be implemented across a variety of health care settings including residential care. This tool will be used to decide the level of health care services for older people (Minister of Health, 2001a). The changes outlined above have implications for the workforce in residential aged care. What is this workforce?

Residential Aged Care Workforce Composition

Residential care in New Zealand is provided by a workforce comprising registered nurses, enrolled nurses and unregistered caregivers. As at 2001, 3,207 registered nurses and 1,207 enrolled nurses were working in the continuing care (elderly) sector (New Zealand Health Information Service, 2002). No official data has been collected on the unregistered caregiver workforce. Brown and Duncan (2001) estimate the number of caregivers working in residential aged care to be approximately 25,000. Registered nurses, enrolled nurses and unregistered caregivers work together in various configuations depending on whether the facility they work in is a rest home or private hospital. It is the registered nurse workforce, however, that is responsible for the supervision of the enrolled and unregistered staff.

Registered nurses in residential aged care

New Zealand is experiencing a shortage of registered nurses throughout the acute, community, and residential care sectors. This shortage is felt keenly in the residential care sector which is seen as lacking in status and unattractive to registered nurses. Registered nurses frequently work as the sole registered staff member in a facility and are usually responsible for a large number of residents and staff during the time they are on duty. Because there are few registered nurses on each shift, they often report a sense of professional isolation. Their rates of pay are lower than those of their colleagues working in the acute care sector (Lauder, 2002). There are, however, groups of committed gerontological nurses who have offered a great deal to the specialty over recent years. The New Zealand Nurses Organisation National Gerontology section developed the New Zealand Nurses Organisation gerontology standards (2000) followed by the development of Gerontology nursing competencies (2002) which have

been endorsed by the New Zealand Nursing Council. The New Zealand Nursing Council accepts aged care as a defined area of practice and quotes the draft statement developed by the Ministry of Health expert working group on aged care:

> These nurses demonstrate the application of specialty knowledge in the provision of clinical assessment, therapeutic interventions, treatment modalities and referral to other health professionals, for those aged 65 and over or younger people with like interest conditions. These nurses work with individuals and population aggregates across the care continuum in a variety of community and institutional settings. They utilise nursing knowledge, judgement and assessment to plan and provide competent care, advice, advocacy, and treatment and ongoing monitoring for older people. This is provided in the areas of health promotion, health maintenance, restoration of health, continuation or encouragement of independence, rehabilitation, minimisation of disability, and death with dignity (Nursing Council of New Zealand, 1999b, p. 1).

Adequate staffing numbers impact the ability of registered nurses to carry out their role as defined above.

Staffing and skill mix in residential aged care

Currently the national contract between the Government and aged care providers sets the registered nurse input according to type of facility rather than size of facility and complexity of client needs (Ministry of Health, 2002c). For example, a rest home of 10 beds is required to have one caregiver on duty during a 24 hour period. The staff ratio for caregivers increases with resident numbers. Registered nurse input is described by way of responsibilities for assessment, careplanning and skilled nursing input rather than staffing numbers. All rest homes must have at least one registered nurse to carry out these responsibilities. The legislation which guides staffing in rest homes does not stipulate any registered nurse numbers, but does state a ratio of staff hours to resident numbers on a sliding scale. For example, for 11-15 residents the

legislative requirement is for 160 hours of staff ("Old People's Homes Regulations," 1987). The opposite situation exists for private hospitals where the legislation addresses registered staff and enrolled staff numbers but not caregiver numbers.

The national contract between the Government and providers of services for private hospitals does not stipulate staffing ratios in terms of resident numbers. The stipulation in the contract is that private hospitals are required to have at least one registered nurse on duty continuously over a 24 hour period as well as a minimum of two care staff on duty during the same time period (Ministry of Health, 2002c). Legislatively, the registered nurse staffing numbers for private hospitals are mandated according to the Hospitals Regulations 1993 Schedule 2. Schedule 2 is a sliding scale of registered staff or registered and state enrolled nurses which is set according to resident numbers. For example, a 36 to 40 bed private hospital is required to have seven registered nurses or part time equivalent hours based on a 40 hour week which would equate to 280 hours of registered nurse input per week ("Hospitals Regulations," 1993).

These legislative requirements will be phased out as facilities gain certification according to the Health and Disability Services (Safety) Act (2001). From the time of certification facilities will be expected to comply with the approved standards ("Health & Disability Services (Safety) Act," 2001). All facilities will be expected to have gained certificaton by October 2004. The approved standards which accompany the Health and Disability Services (Safety) Act does not set registered or unregistered staffing numbers. The standards leave the onus on the care provider to ensure that there are adequate numbers of suitably qualified staff (Brown, 2002). It is not surprising that the situation of staffing hours is problematic when there is little guidance for facilities regarding skill mix.

Some facilities have experienced difficulty recruiting registered staff and are able to continue to operate if they have notified the Ministry of Health of their situation. They are expected to continue to do all that they can to appoint staff as well as provide evidence that they are minimising the risk to patient safety during their time of staffing shortage (Manchester, 2000). Manchester, however, also reports that there are facilities that are operating without sufficient staff and states a concern that there is no mechanism for the ongoing monitoring of these facilities. Adequate staffing in residential care facilities is a concern for Government.

An expert advisory committee to the Ministry of Health is currently working on recommendations for minimum safe staffing levels in aged care with a planned review of the recruitment and retention issues facing residential care (Brown, 2002). Staffing numbers alone do not necessarily ensure high quality care. The skill mix of registered nurses, state enrolled nurses and caregivers, related to the levels of resident care need, is an important factor to consider. Enrolled nurses make up one aspect of that skill mix.

Enrolled nurses

State enrolled nurse training has recently been re-established in New Zealand. Enrolled nurses undergo a 12 month training at a technical institute. The training level is set at Level 4 of the New Zealand Qualifications Authority framework for education (Manchester, 2002). Enrolled nurses are second level nurses who work under the supervision of a registered nurse. In some rest home settings, a registered nurse will be on call with the enrolled nurse supervising unregistered caregivers during particular shifts.

Unregistered care givers

Unregistered staff, otherwise known as nurse aids or caregivers, provide the majority of direct care in residential aged care facilities in New Zealand. As Featherston states, "The caregiver is the person who interacts more closely with the patient than any other staff member, and who provides close personal care in all aspects of daily living" (p.7). Until recently, there was no requirement for unregistered staff to have any training in the field of aged care (Featherston, 2000). The National Contract between Government and care providers sets out the requirements for orientation and ongoing staff education for unregistered staff. For those staff working in dementia specific units, there is now a mandatory requirement to pass particular nationally recognised courses in dementia care (Ministry of Health, 2002c). The unregistered staff who work in aged care receive low rates of pay at around $10 per hour (Brown & Duncan, 2001). The difficulty in staff recruitment into aged care, the relatively low wages and the lack of required training, are proving to be health workforce issues.

Healthcare Workforce Issues in Residential Aged Care

The Positive Ageing Strategy (Minister of Social Development, 2001) outlines future plans for a workforce comprising health care professionals and health care workers. The vision is for knowledgeable and competent members of the workforce caring for older people across a variety of settings. There is a recognition in this report, that the older population have specific needs which are best met by those who have specialised in the health care of older people. All levels of staff require knowledge and skills in gerontology to meet the current needs of this population. The need for specialist gerontological nurses may begin to be met by the current changes taking place in New Zealand in the scope of practice for registered nurses.

Provisions have been made by the Nursing Council of New Zealand to expand the scope of registered nurse practice with the introduction of Nurse Practitioners ™ . The ability to prescribe is an added pathway within the Nurse Practitioner role. Prescribing rights for Nurse Practitioners™ in New Zealand are currently confined to aged care and paediatric care (Nursing Council of New Zealand, 2001b). The introduction of this specialised role into aged care may work to increase the level of support for other staff working in this area. The introduction of the role of Nurse Practitioner™ however is insufficient to address the range of problems facing staff in this area. As Brown and Duncan (2001) state, "the fundamental problems facing the aged care sector are inadequate training, staffing levels, skill mix and conditions of employment" (p. 6). The Health Workforce Advisory Committee (HWAC) reports a need to increase the level of resources applied to this workforce and is currently working to suggest a direction which could increase knowledge and skills, as well as create working conditions to attract new recruits and retain existing staff in institutional settings (Health Workforce Advisory Committee, 2001).

Conclusion

The context for residential aged care in New Zealand is that those who enter residential care are older, more frail than in previous years, and experiencing for the most part, major impairments to their health. Those providing care for these older New Zealanders are working towards meeting current changes in Government requirements which are aimed at ensuring that quality services are provided across a continuum of care where older people, service providers, and Government agents are the negotiating partners.

The goal for the future in New Zealand is that health care delivery will be accessible, timely and appropriate, for those receiving the care, while at the same time making the most effective use of the available resources: "Funding for residential care has increased over the past few decades, but has not kept up with demand" (Minister of Social Development, 2001, p. 38). There is a need for additional resourcing to support the current changes in the residential aged care sector. The Ministry of Health "intends to increase funding to the sector [Residential aged care] by approximately \$11.4m annually from 1 December 2001" (Disability Issues Directorate Ministry of Health, 2001, p. 29).

The staffing in residential aged care is made up of registered nurses, enrolled nurses, and unregistered health care workers. The pay and conditions for these staff are not equitable when compared with colleagues working in the acute care sector. In a context of international nursing shortages, recruitment and retention are major issues facing the health care sector in New Zealand. The perception that residential aged care is not an attractive place to work compounds the staffing problems for this sector. This background sets the context for residential aged care in New Zealand. The international nursing literature confirms that New Zealand's experiences are part of a worldwide trend. Both national and international literature will be reviewed in Chapter Three.

CHAPTER THREE: LITERATURE REVIEW

Introduction

This research study explored the work processes used by registered nurses in residential aged care. Registered nurses in residential aged care are working with an increasingly frail and vulnerable population. This change in resident population is due, in part, to the demographic shifts associated with an ageing population and in part due to shifts in Government policies consequent to the changing demographics. Many people who currently reside in residential care experience multi systems disorders that are exacerbated by the ageing process. As Stevens and Onley (2000) state, "The major issues facing older people in need of care in residential settings clearly reveal that they require skilled nursing and medical care" (p.129). Registered nurse work is central to the provision of that skilled nursing care.

Registered nurses in residential care settings develop relationships with family, colleagues, the staff they supervise and management personnel. The quality of these relationships contribute to the quality of care registered nurses can deliver. The context of care delivery in residential aged care is multifaceted and complex. This work occurs within an environment where issues of increasing resident acuity, adequate skill mix, staff shortages, difficulties with recruitment and retention and inadequate funding are compounded by increased Government auditing and accountability requirements. These issues are not confined to aged care as similar issues exist in the acute and community health care settings. The situation in aged care, however, can be exacerbated as registered nurses move to the more attractive and more lucrative options in the acute and community care settings.

This literature review presents some of those issues from a national and international perspective. I have chosen studies from Australia, the United States of America (U.S.A.), Canada and the United Kingdom (U.K.), as I am most familiar with the systems of care in those countries and can understand the main similarities or differences to the system of care in New Zealand. Most research into this field, however, is international, as New Zealand research into the work of registered nurses in aged care is in the beginning stages of development.

Demographic Changes

Changes within the nursing home population in the U.S.A. and the U.K. are similar to those within New Zealand (Beattie, 1999; Kovner, Mezey, & Harrington, 2002; McBride, 2000; Merlis, 2000; Neville, 1999; Nolan, 1997). These authors note the increased acuity, shorter length of admission and high complexity of care needs for residents in aged care facilities. Closer to home in Australia, Garratt (Garratt, 1998) states that old people requiring residential aged care services, are "frail, highly dependent, often over medicated, have multiple disease processes and are in need of highly sophisticated preventative care" (p. 5).

The Residents' Context: Complexity of Care Needs, Quality of Life and Quality of Care

For some older people, residential care is the outcome of increasing disability. A number of studies have been conducted with the aim of discovering how institutional care is experienced by older people. Kahn (1999), conducted an ethnographic study over nine months in a nursing home for Jewish people in the U.S.A. These participants often used the phrase 'making the best of it' when talking about their life in the nursing

home. Kahn identified four dimensions of the phrase 'making the best of it' which demonstrate the processes of adapting to the nursing home.

> (a) recognizing the ambivalence of their living environment and situation, (b) downplaying negative aspects of it, (c) having no other options, and (d) using their will to transcend and create a home (p. 119).

Another ethnographic study was conducted by Fiveash (1998) over a six month period, in two 80 bed nursing homes in New South Wales, Australia. Fiveash identified four themes related to the participants' experience of nursing home life. The participants in this study felt they had little choice about whether or not they would move into care. After admission, they found themselves living a public life with few opportunities for privacy as well as living with people who they would not normally consider friends or acquaintances. They experienced the staff as being in control of their daily activities and they experienced nursing home residency as tedious and monotonous, constraining and dehumanising. Residents moving into and living in residential care find themselves confronted with a number of challenges as these studies demonstrate. The conclusion reached by the researchers in the two cited studies is that the staff can do much to assist people in residential care to enjoy a higher quality of life than that described. Fiveash states that "nurses need, where possible, to give further consideration to the emotional, social and psychological aspects of residents' care and, where possible, to involve residents in their care" (p. 174). Two further studies (Shiu, 2001; Stone et al., 2002) demonstrate that when the residents are involved in their own care the outcome for them can be very different and autonomy can be enhanced.

The Wellspring model of nursing home quality improvement arose out of the Wellspring Alliance, a confederation of 11 not-for-profit nursing homes in Wisconsin, U.S.A. The Wellsprings Alliance (Stone et al., 2002) was developed to achieve two ends. Firstly, to improve residents' lives in nursing homes, and secondly, to create an inclusive working environment which was supportive of staff. A recent evaluation of the Wellspring programme found among other positive outcomes "a better quality of life for residents and an improved quality of interaction between residents and staff" (p. viii).

Shiu's (2001) case study investigation included both staff and residents in a home for older people in England. Data collection was by way of semi-structured interviews, nonparticipant observations over a two week period, as well as an analysis of documents relating to the history and philosophy of the home. Shiu's findings revealed a facility where residents experienced a high level of well being, were involved in decision making, and felt they were in control of their own lives. In this study, it seemed that an organising factor in the facility was focused towards developing and maintaining those attributes which related to resident well being.

The requirement of Government, the residents and their families is that residential care is concurrently an environment which can assist a person to maintain or improve physical functioning and an environment where a resident can continue to enjoy a quality of life. Research reveals that while many providers of institutional care aim to provide a high quality of care and an enjoyable quality of life, the achievement of this goal is variable. What is understood by high qualty care can be different for different people.

The residents' voices: Life in residential care. Quality of care and quality of life

Bowers, Fibich and Jacobson's (2001) study into residents' perceptions of quality of care were part of a larger study looking into care and caregiving practices. This study using grounded dimensional analysis, was conducted over three long term facilities in the U.S.A and focused on what nursing home residents perceived to be quality of care. Twenty six participants took part in the study. The participants' definitions of quality of care included care-as-service, care-as-relationship and care-as-comfort. Depending on their context and perspective, residents define quality of care differently. These definitions have an impact on their expectations for care and therefore an implication for staff assessment and careplanning if individual needs are to be met. For example, those residents who perceived care-as-comfort were experiencing increasing frailty. These residents reported that they experienced difficulty in interpreting bodily cues when they also had multiple interacting conditions. The authors recount the residents' experience of the difference that minute positioning can make between "comfort and terrible discomfort" (p. 543). For these residents, quality of care was connected to the degree to which they could experience comfort. For other residents, quality of care was present when the service they were receiving was individualised and respectful (care-as-service). For the third group of residents, quality of care was perceived to be present when the relationships they had with staff were positive (care-as-relating).

Rantz et al. (1999), conducted nine focus groups over five locations in the United States to gain information about how residents and families viewed quality of care. Sixteen residents and 80 family members took part in the focus groups. The findings from this study showed that these consumers considered staff and care to be the two most important aspects relating to quality of care: "Families simply wanted the staff to take care of their family members, to do the basic care and to do it well" (p. 23). The families' descriptions of basic care included physical care, social, emotional and spiritual activities. When talking about physical care the participants cited instances where fundamental care needs were not being met, for example, continence pads not being changed when required; residents being missed out for supper; and exercise needs not being met. The consumers also reported accidents and injuries which occurred as a result of incorrect transferring techniques, rough care and ignoring call bells. Under the conditions described by these authors (Bowers, Fibich et al., 2001; Rantz et al., 1999), care can be experienced as painful, uncomfortable, invasive, undignified and at times, unsafe. Gooder (2001), using a phenomenological approach, studied patients' experiences in a rehabilitation ward in an acute hospital in New Zealand. Important in this study was the high degree to which an altered body had an impact on the participants' sense of self and how little the health care professionals seemed to be aware of this altered sense of self, and to take this into consideration during care activities.

Research findings reveal that environments which are characterised by routine care tasks, lack of activity, choice and control, leave residents discontented, disempowered and at times afraid of the consequences of not adhering to the facility rules. Lorimer (1984) suggests that these are the conditions which lead to learned

helplessness and can lead to a cycle of increasing dependency. Koch, Webb and Williams (1995) conducted an existential-phenomenological study over 70 months in two wards in a district hospital in the United Kingdom. Koch et al. named four themes which arose out of the participants' descriptions of their experiences. These themes were geriatric routine, depersonalization, care deprivation, and geriatric segregation. Participants reported a sense of powerlessness. They felt they had no influence on their own care needs and the public nature of the wards and care led them to experience a loss of dignity and privacy. The residents reported concern at the quality of the care in terms of "lack of attention in matters dealing with food, safety, comfort and hygiene" (p. 88).

In all these studies, residents state a need to be treated as individuals, to be involved in their care decisions, receive good fundamental care, remain connected with family and have effective communication with staff in an environment which is pleasant, comfortable and socially stimulating. Relationships are complex and interactions between residents and staff can on the surface appear to be aimed to meeting the resident's goals, but in reality may be subtly maintaining staff control. Shawler, Rowles and High's (2001) case study was part of a three year ethnographic study conducted across four nursing facilities in the U.S.A. The aim of this study was to explore how increasing frailty changed the dynamic of decision making for institutionalised older people. Their findings revealed that decision making with the resident decreased as frailty increased. These authors state the case graphically:

> All too often, Edna was informed about what was to happen to her in circumstances where she was clearly able to express a preference. All too rarely was she consulted and provided with the opportunity to have meaningful input into decisions affecting her life. Gradually, invidiously, and

> inexorably, she was rendered powerless and alienated as the ambiance of a pervesely beneficient decision-making environment in which she found herself moved along the path of progressive surrogacy at a rate more rapid than was warranted by her increasing frailty (Shawler et al., 2001, p. 621).

There is a challenge for staff working in residential care facilities to become aware of the nature of the gap between a belief in the importance of resident autonomy and the actual provision of circumstances which could lead to autonomous actions. This challenge extends to those residents who have cognitive impairment. A review of the literature related to this care speciality, reveals that many staff may incorrectly consider that the person with cognitive impairment is unable to communicate their preferences for care.

People in residential care who are cognitively impaired

There is now a considerable body of literature which demonstrates that people with dementing illnesses can usually communicate their requirements in terms of care needs. While, for many, the manner of this communication may be impaired, the ability to understand an individual resident's context lies in the skill that nurses have to listen, to make sense of metaphor and to observe people's response to care approaches (Kitwood, 1998; Kitwood & Benson, 1997). Williams and Tappen (1999) set out to discover whether it was possible to create a therapeutic relationship with people in the late stages of Alzheimer's disease. As part of a larger study into Alzheimer's disease, these researchers recorded interactions between 42 residents and four advanced practice nurses. The advanced practice nurses met with the participants three times a week for 16 weeks and interactions were recorded three times over the space of the 16 weeks. An analysis of the transcripts demonstrated that 83% of the residents had begun to move through the stages of a therapeutic relationship with the nurses. Acton, Mayhew,

Hopkins and Yauk (1999) explored whether meaningful communication was present in the conversations of people with dementia. They clustered 18 themes of meaningful communication from 20 interviews with community living people with dementia thus demonstrating the communication ability of people with this condition. Kayser-Jones and Schell (1997b) report a study which was part of a larger anthropological study into meal times in nursing homes. The report in the cited article was based on extensive observations of 100 residents during meal times. Kayser-Jones and Schell could identify those communications or care strategies which facilitated residents' nutritional intake.

These studies, summarised above, demonstrate that people with dementing illnesses communicate their needs in ways that can be observed and understood. Staff ability and knowledge, however, often determine how and when residents with cognitive impairment are heard. The complexity of this subject is revealed by the findings of Kaasalainen et al. (1998). This study primarily set out to discover the relationship between assessed pain and the administration of pain medication. The secondary aim of the study, which was part of a larger study comprising 283 residents in one long term care facility in the U.S.A., was to question whether there were differences in pain medication administration between those residents who were cognitively intact and those who were cognitively impaired. Kassalainen et al. found that while registered nurses were assessing the presence of pain by use of a visual analogue scale, they were not necessrily administering pain relief for those clients. These researchers also found that those with cognitive impairment were receiving significantly less pain medication than those residents who were cognitively intact.

An awareness of the impact of care can make a difference to staff care practices. Wylie, Madjar and Walton (2002), set out to "gather systematic and detailed data on how the residents lived and experienced care, hour-by-hour and day-by-day" (p.7). This research study, was conducted in Queensland, Australia, over a 20 month period in a 22 bed ward for people with dementia. Wylie et al. used dementia care mapping (DCM) developed by the Bradford Group attached to Stirling University, in the United Kingdom to document the residents' responses to daily life events. DCM involves observations of five to seven people over extended periods of time by trained observers. Every five minutes during that period, actions and interactions are classified and recorded. The initial mapping results for the group of residents in this study, demonstrated that on the whole they experienced a passive life with little interaction with each other or with the staff. The residents' time was spent either walking the corridors or watching staff. There were long periods of time when the residents were left alone. During the second phase of DCM, care staff became involved in the mapping process, which gave them an opportunity to observe the impact of staff, the environment and other residents on the people they were observing. As a result of the staff involvement in DCM, there was a raised awareness of the contexts which increased resident agitation. Wylie et al. give examples of changes in care practices which included environmental adjustment, increased resident staff interaction and increased presence where the DCM had highlighted particular residents' needs for increased assistance. Changes in care practices during meal times led to an increase in weight gain for some residents. There were observations that indicated the residents had an increased enjoyment of their mealtime experiences. While Wylie et al. report a satisfactory change in care practices as a result of this study, they also note that the presence of a registered nurse and support from management were vital aspects of

maintaining the changed practices. The quality of registered nurse support, however, may also be variable.

Michel (2000), in her discourse analysis focusing on the practices of restraining confused elderly people in New Zealand, cites examples where the required knowledge and skill is not present in some nurses who work in this specialty. Michel states:

> It is not uncommon for practitioners to argue that restraint is the only way to manage the 'difficult behaviours' they associate with dementia. By labeling the behaviours 'difficult', it gives a rightness to the action of physically restraining the old person (p. 104).

The studies reviewed in this section suggest to me that there is knowledge available about how to communicate with the person with dementia. There is knowledge available about how to assess a range of experiences such as nutritional intake, pain and mobility. In the experiences of some residents, however, it would appear that that knowledge is not always enacted in practice. Wylie et al.(2002) note that increased awareness led to a change in care practices but that the maintenance of that change was dependent on leadership and organisation from management. During the study there were times when this leadership was not available and the care practices which had been developed were not maintained. Michel (2000) laments the silence of the nursing profession in forums which might lead to reducing or stopping the practice of restraining patients in this country. Some explanation regarding this silence is provided by Stevens and Herbert (1997).

Stevens and Herbert (1997) prepared a discussion paper for the Royal College of Nursing, Australia. They suggest that ageism in the wider society influences the nursing profession. These authors state: "That nurses as a group, a very large and powerful coalition, are not making a significant impact on issues relevant to aged care

may also be considered as ageist" (p. 12). The outcomes of ageism are described in the

discussion paper as:

> … diminished quality of life; reduced equity and access to health care and reduced access to opportunities that are available to younger people in the community. Older people have reported being made to feel marginalised, disempowered and the objects of disdain. These experiences have been shown to become self fulfilling prophecies, resulting in many older people applying the definitions and expected difficulties to themselves (p. 1).

Stevens and Herbert (1997) construct a compelling argument which links

language (demeaning ways of talking about older people) and stereotyping (grouping

older people into particular negative behaviours) with organisational actions

(inadequate funding) and individual practices (avoiding older people). As a result of

these interacting factors, older people can experience abuse and either active or passive

neglect by the staff caring for them. Age Concern New Zealand (2002) define elder

abuse as:

> occurring when a person aged 65 years or more experiences harmful physical, psychological, sexual, material/financial or social effects caused by the behaviour of another person with whom they have a relationship implying trust (p. 1).

and elder neglect as including the harmful effect described above but occurring

> … as a result of another person failing to perform behaviours which are a reasonable obligation of their relationship to the older person and are warranted by the older person's unmet needs (p. 2).

Age Concern (2002) further divides elder neglect into active neglect when the

neglect is intentional and passive neglect which occurs as a result of lack of awareness

or knowledge. Institutional abuse, as defined in the cited report occurs when "the

policies or practices of the institution and not just the behaviour of an employee of that

institution, result in abuse or neglect" (p. 5). An example of institutional abuse was

cited in this report as "imposing unreasonable routines to facilitate efficient management at the expense of humane treatment of residents" (p. 2). Age Concern New Zealand reported 127 cases of institutional abuse during the period 1998 to 2001. Of those 127 cases 96 involved individual clients, and 31 represented groups of clients for example a group of clients in a rest home. Age Concern is one of a number of organisations who receive complaints of abuse and neglect of older people. The figures quoted here are therefore not "representative of the overall incidence of elder abuse and neglect in New Zealand" (p. 1). The issues of abuse and neglect of older people are complex and a full examination of these issues is not attempted in this literature review. The observations and discussions by the cited authors (Age Concern New Zealand, 2002; Michel, 2000; Stevens & Herbert, 1997), however, point to the need for professional and family advocates for older people. Families will often adopt the role of advocate for their relative in residential care. Research reports demonstrate that the families experiences of institutional care are varied.

The Family Context: Family Perceptions of Care and Need for Inclusion

There are research studies which demonstrate that negotiations for appropriate care are of importance to many families as they continue to support their relative through changed living arrangements and changing health care needs. Families differ in the type and amount of their involvement in residential care. The degree of family involvement, once the resident has been admitted, reflects the historical relationships which existed within individual families (Bowers, 1988a; Keefe & Fancey, 2000; Opie, 1992). While I am talking about residents, families and relatives in this context, I would like to take these terms to include significant people who are involved in residents' lives who may not be relatives.

Family experiences of a relative's transition to residential care

In the process of decision making about admission to an aged care facility, residents and families require more information and support than would seem to be available. These comments come from the responses to an interviewer administered questionaire surveying 48 carers in the U.K. and 54 carers in the U.S.A. (Nolan & Dellasega, 2000). In another study, Penrod and Dellasega (1998) identified four themes in their grounded theory study of 10 caregivers' experiences during the admission of their relative to an aged care facility in the U.S.A. These caregivers reported uncertainty about the health of their relative, had questions about the permanence of the admission to a nursing home, and wondered what to look for that indicated quality of care in a nursing home. While the caregiver needed to have input into finding a facility for their relative, the hospital system was active in making the decision that this was the time that they needed to consider long term care. As their relatives were in an acute care setting, the hospital system's need for beds created an urgency which made it difficult for relatives to make a well informed decision about the most appropriate care facility for their family member. This situation often led them to make a temporary decision and move their relative again as a bed became available in a facility they considered more suitable. Caregivers who were in the process of admitting their relative to long term care consistently looked to professionals, friends and other family members, for validation that they were making the most appropriate decision at that time and that the facility they had chosen was at least suitable in the short term. These findings were similar to those of Kellett (1999) who identified five shared meanings related to family experiences of placement decisions. The five shared meanings included a sense of loss of control, simultaneous feelings of failure, guilt, loss and

relief, and disempowerment. Other researchers (Cheek & Ballantyne, 2001; Sandberg, Lundh, & Nolan, 2002) report similar themes which further demonstrate the toll that this process takes on family members. These studies demonstrate that families perceive that they have caregiving responsibilities after their relative moves to residential care.

Families may take the position of care managers of their relative's care. Family involvement can range from providing some direct physical care to being involved in decision making with and advocating for their relative's care (Keefe & Fancey, 2000) or just 'keeping an eye' on the care their relative is receiving (Sandberg, Lundh et al., 2002). Bower's (1988a) grounded theory study into family caregiving in a nursing home revealed that:

> Families held themselves responsible for monitoring and evaluating the effectiveness and quality of caring tasks. This included teaching the staff how to deliver high quality care, picking up where the staff failed (filling gaps) and providing direct care to their relatives (p. 363).

Bowers (1988a) outlined four types of preservative caregiving which families considered important in maintaining their relative's sense of self. These were maintaining family connectedness, as well as their relative's hope, dignity and control over their environment. Families could independently maintain their connection with their family member but required collaboration and co-operation with staff to maintain the remaining three preservative care tasks. Families can find that their inclusion in the care activities related to their relative assists their own and their family member's adjustment to the changed circumstances.

Families can, however, experience barriers to their participation in the care decisions and care processes concerning their relative. Such barriers to family involvement in care can inhibit the development of relationships with staff in the

facility and important information regarding the resident's care needs and preferences could be lost (Friedemann, Montgomery, Mailberger, & Smith, 1997; Hertzberg, Ekman, & Axelsson, 2001; Kellett, 1998, 2000; Specht et al., 2000).

The message to care staff in this body of research is about the importance of communicating with families who have made the difficult decision for their relative to go into care and are now adjusting to that decision. The researchers also emphasise the importance of involving residents' families as part of the multidisciplinary care team, providing information for families as their relative's health care needs change, and being flexible to the families' needs to socialise with their relative (Gladstone & Wexler, 2000; Janzen, 2001; Sandberg, Nolan, & Lundh, 2002; Walker, 2001).

Person Centered Care, Individualised Care and Knowing the Resident

The current literature regarding residents' and families' experiences of care, reveals that residents want and need to be treated as individuals with unique needs. Families want and need to be treated as partners with the resident in care. Person centered care is congruent with these wants and needs. The efforts to clarify what we mean by person centered care are just beginning, and several authors are working towards articulating how person centered care can be implemented and what health care resources are required to ensure that person centered care is achievable (Kitwood, 1998; Lauver et al., 2002; Lutz & Bowers, 2000; Nolan, 2001; Pincombe, O'Brien, Cheek, & Ballantyne, 1996). Person centered care is described as care that is tailored towards an individual person's needs and preferences (Lauver et al., 2002).

A national research study into perceptions of client centered care was carried out by Manukau Institute of Technology in partnership with the New Zealand Nurses Organisation Gerontology section (Rummel, Manukau Institute of Technology, & NZNO Gerontology Section, 2003). This study spanned residential and community care, was conducted throughout New Zealand, and was bicultural in that Maori and Pakeha worked in partnership throughout the project. The Maori and Pakeha participants, included those receiving care, as well as informal and formal caregivers (34 in total). The research explored the perceptions of person centred care of older people and the related satisfaction of their caregivers within the New Zealand context and was based on the Davies, Nolan, Brown and Wilson's (2001) framework of the six senses.

According to Davies et al. (2001), having the six senses of security, belonging, continuity, purpose, significance and achievement can assist older people to maintain wellbeing. These authors found that staff retain satisfaction in their caring role when the six senses are available to them as well. Nolan (cited in Manchester, 2003b) suggests that person centered care may be better named relationship centered care as "relationships lie at the heart of good care. We need to promote positive interactions between a range of groups, including older people, their carers and health professionals" (p. 14). It is this relationship which featured in the findings of the New Zealand project as well.

The New Zealand findings showed that "continuity in caring, personal relationships with carers, the sense of love and belonging and finding meaning in their lives were important to both Maori and non-Maori recipients of care" (Manchester, 2003b p. 14). For Maori recipients of care their connection to their family, tribe and

marae were of vital importance. These participants stated that "it was actually more important to be at the marae when they were unwell than when they were well" (p. 14). These findings are important if health care providers are to move towards working in partnership with residents and their families. Knowledge of a person's needs, preferences, experiences and characteristics arise out of a carefully developed partnership between the health professional and the person and give rise to person centered interventions (PCI) (Bowers, Fibich et al., 2001; Mead & Bower, 2000).

Lauver et al. (2002) note four types of PCI. Individualised care is the PCI which is congruent with the type of person centered approach that best meets the residents' requests for individuality and autonomy: "An individualised intervention is one that is highly customized to a particular individual and that person's situation" (p. 251). How to put person centered care into practice was the focus of a study by Wright and McCormack (2001), who undertook a change project to develop care practice towards individualised care in a rehabilitation ward for older people. The authors gradually moved care practices to include permanent assignment to a team, choice about meals, hygiene care, timing, and inclusion in decision making. An evaluation at the conclusion of this project demonstrated that ritualised and routine care had been replaced by individual choice and involvement of the patient whereever possible. The patients knew their nurse and were well informed about their care progress and goals because they had been involved in the development and maintenance of their care plan. Nurses reported increased job satisfaction. Coker (1998) also reports individualised care as an outcome of knowing the person while at the same time noting that time, education and reflection are needed to develop this indepth knowing.

The importance of knowing

Bowers, Esmond and Jacobson (2000), when exploring the views of nurse aids, demonstrated that these staff perceived that knowing the patient was central to quality of care. A New Zealand study into the nursing care of people with dementia receiving respite care emphasised the connection between getting to know the person and the ability to provide satisfactory care (Gilmour, 2001). O'Sullivan (2002) explored gerontology nurses' responses to meeting the psychosocial needs of patients in the rehabilitation setting in New Zealand. From her findings, she emphasised that the patients' psychosocial needs cannot be met unless the nurse knows the patient. Schirm, Albanese, Garland, Gipson and Blackmon's (2000) findings showed that, for registered and unregistered staff, caring involved being able to build relationships with residents and doing more than just the job. The need to know the resident in order to be able to assess, negotiate and plan for meeting a resident's care needs are confirmed by many of the cited studies. There is no doubt that knowing the patient in depth works towards enabling the nurse to provide effective individualised care. Gooder (2001) states:

> The process of knowing the patient needs to be a deliberately organised happening. Health professionals need to do whatever it takes to create a climate in which patients can feel sufficiently valued and to trust the relationship enough to share who they are (p. 136).

Leadership and Organisation of Residential Aged Care

How do organisations deliberately plan for staff to engage in the process of getting to know the resident and their needs? So far the literature reviewed has demonstrated that residents and their families prefer an approach to care which is inclusive and which focuses on individual needs. Nzarko (1998/9) suggests that:

> The most important aspect of quality care is the nurse manager. Homes where the manager displays passion, vision and commitment provide higher quality care than better resourced homes that lack committed leadership (p. 18).

Managers in residential care are faced with many challenges in how they organise their care facility. Nolan (cited in Manchester, 2003a) describes care facilities as either controlled and hierarchical, cosmetic or complete. In a controlled facility, the staff is in charge with the resident at the bottom of the hierarchy. A cosmetic community looks good but provides indifferent care. A complete community according to Nolan is one where "everyone is equal and valued and older people are at the centre" (p. 12). Youngson (2002) suggests that health care organisations where clients are not included in their care planning will not achieve the effective care outcomes that they desire. He suggests that hospitals need to create learning environments where leader-servants attend to creating shared understandings between health care professionals in an effort to create an emphasis on building effective relationships between the hospital, clients, families and the community. A focus on learning relationships, flexible organisations and inclusive systems, takes both time and courage with leadership activities taking place throughout all levels of the organisation. Youngson notes the challenge for manager leaders who wish to change the emphasis of their organisation towards a philosophy of valuing and learning when he states that one barrier may be:

> The level of fear among senior managers and board members; who may be unable to meet political demands for budgetary control in the face of an ever increasing demand for health care. Economic survival may become the main motivator for some providers, thus preventing them from learning from creative experimentation and from their mistakes (p. 12).

At the same time, Youngson (2002) insists that a change in focus is crucial if health care organisations are to meet the needs of the consumers of health care. He suggests that one way that could begin to move organisations towards this goal is to invest in staff development while at the same time acknowledging that the results of this investment may not be apparent for some time. Developing staff may lead to the results that Magnet hospitals have reported in terms of staff retention (Havens, 2001). As previously discussed in this review staff shortages, recruitment and retention are issues facing the nursing profession as a whole.

Staffing of residential aged care

The Gerontological nurse specialty is not perceived as having high value or status (Nay, 1998b; Nay & Closs, 1999; Nolan & Tolson, 2000; Reed & Clarke, 1999; Stevens & Herbert, 1997). Employers in this field of nursing, have difficulty attracting and retaining registered nurses. On the other hand, some registered nurse leaders have chosen this specialty to be the focus of their career (Manchester, 1999; Roeters, 2000; Schumacher, 1999). Staffing is a central issue in the aged care setting.

"The bottom line from consumers is that without good staff nothing else is possible" (Rantz et al., 1999 p. 31). In the U.S.A., U.K., and Australia, staffing mix, staffing ratios and quality of care are continuing research agendas (Bowers et al., 2000; S. Davies, 2001; Dellefield, 2000; Nay & Closs, 1999; A. M. Williams, 1998; Wykle, 2001). Research studies suggest that there is a positive relationship between increased

quality of care and higher ratios of registered nursing staff in care facilities (Bowers et al., 2000; Harrington & Carrillo, 1999; Harrington, Kovner et al., 2000; Harrington, Zimmerman, Karon, Robinson, & Beutel, 2000; Johnson-Pawlson & Infeld, 1996). Koch et al. (1995) make the following statement in relation to the setting that was the focus of their research:

> Limitations posed by past management deficiencies, under-staffing and poor physical environment contributed to the situation reported. Trained nurses felt they worked hard to give the best care they could but, with a high ratio of untrained staff and lack of continuing education, they were aware that their levels of achievement were far from ideal (p. 186).

Nay (1998a) begins to unravel the contradictions found in nursing home care where seemingly good intentions still lead to a poor quality of care in which residents feel trapped and powerless. Nay refers us to the layers underpinning many care practices and suggests that many nurses in aged care have not had the benefits of higher education to assist them to deconstruct ageism both within the society and within the health care system. Within this context, Nay suggests that though the nurses genuinely experience a motivation to caring, their perception of caring can lead them to "unwittingly devalue and dehumanize" (p. 404) the people in their care. Certainly the studies which I have previously cited, would suggest that receiving care in an institutional setting can be both devaluing and dehumanizing and respectful and inclusive. How then do registered nurses talk about their work?

How registered nurses experience their work

Bowers, Lauring and Jacobson (2001) used grounded dimensional analysis to study the work of licensed nurses in long term care. Registered nurses in this setting experienced time to be a major constraint in their ability to build relationships with residents. To effectively use the time available to them to deliver care, the nurses employed strategies which included working as efficiently as possible, establishing a routine, working with the same residents consistently, organising work by task or by resident, prioritising and re-prioritising. When time was even further constrained they would do what must be done, prioritising to leave some tasks until the next day and would non-verbally communicate unavailability to the residents. Coming to work early, missing breaks and leaving work late were strategies the nurses used to create more time in their work shift. The outcomes for both the residents and the staff under these conditions were negative. Time also emerged as an issue for nurses working in an acute care setting.

Williams and Irurita conducted concurrent grounded theory studies in the acute care setting in Western Australia to discover both the patients' and nurses' perceptions of quality care (Irurita, 1996; Irurita & Williams, 2001; A. M. Williams, 1998; A. M. Williams & Irurita, 1998). The four articles cited, explain different aspects of these two concurrent studies that were then combined into a grounded theory called balancing and compromising. Balancing and compromising activities were related to preserving integrity for both the nurses and the patients. The ability to preserve integrity was dependent on the nurses' ability to meet patients' needs. Williams found that the threat to integrity for nurses was related to the degree to which they could provide quality of care to the patients and named the nurses' responses to contextual conditions as

selective focusing. The nurses' focus was conditional on the time available to meet the patients' needs. These nurses perceived therapeutic effectiveness when the conditions were available for them to be able to attend to the whole person and not just particular aspects of the person's health care. To be able to be therapeutically effective led to more job satisfaction and the opposite conditions impacted unfavorably on job satisfaction.

Jones, Cheek and Ballantyne (2002) conducted 30 individual interviews with registered nurses and 11 focus groups with people working with or involved with the registered nurses. The registered nurse participants and the focus group participants were from 12 South Australian residential aged care facilities. Focus groups were also held with five nominal groups of industry and professional stakeholders. The purpose of this study was to map the issues for registered nurses working in residential aged care and was phase one of a three phase study. An analysis of the collected data led to the naming of five broad themes which were considered issues for the registered nurses. The participants in this study noted that registered nurse work in residential care is expanding and becoming increasingly complex as a result of the increase in resident dependency, as well as the increase in Government requirements for accreditation and documentation. They were aware of the way in which they were negatively perceived by their nursing colleagues in that the nursing profession does not necessarily recognise the changing environment of residential aged care and the skill required of nurses working in this area. The last of three themes articulated by participants in this study was that in the midst of an increasingly complex role, the registered nurses needed strategies to work with others such as unregistered staff, as well as requiring strategies to cope with the everyday demands of their work within an environment where they felt

increasingly powerless. Central to the concerns of the registered nurses was the expansion of their role without the corresponding organisational administration, support and education to enable them to better meet the changing role requirements. Registered nurses reported the tensions inherent in an increase in documenting requirements (on which funding is based) that took them away from direct care, while at the same time, an increase in resident frailty required more rather than less of their presence in the direct care area. The presence of the registered nurse in the clinical area has implications for the quality of care.

Registered nurses, by virtue of their registration, are accountable for the care that is provided during the time they are present either on duty or on call. The Nursing Council of New Zealand (1999a) states that:

> Where health service assistants are employed, or the client's family are assisting with the care of the client/patient/resident/woman, and the registered nurse or midwife accepts responsibility for the supervision/and or delegation of that care, criteria for direction and supervision apply and accountability for nursing processes and outcomes remains (p. 1).

The Nursing Council of New Zealand (1999a) recognises that supervision may vary from setting to setting and also acknowledges that the current legislation is not clear with regard to unregistered health care workers. The current legislation does state, however, that the enrolled nurse works under the supervision of a registered nurse. According to the Nursing Council, supervision includes:

> the active process of directing, guiding, monitoring and influencing the outcome of an individual's performance of an activity related to assigned apsects of nursing practice or a delegated activity and providing support in ways which enhance performance (p. 2).

The Nursing Council of New Zealand (1999a) distinguishes between direct and indirect supervision. The cited Nursing Council document, notes that while the registered nurse does not need to be constantly observing the work of the enrolled nurse, she or he does need to be aware of those instances which require the input of a registered nurse and the registered nurse needs be reasonably available in case there is a need for that input.

There is an increased use of unregistered health care workers across all health care settings in New Zealand. Consequently, there has been an ongoing professional conversation about the role of the registered nurse in the settings where there are also unregistered staff, referred to as health service assistants, nurse aids, caregivers or unregistered health care workers. A discussion paper jointly released by the Nurse Educators in the Tertiary Sector (N.E.T.S), the College of Nursing Aotearoa and the Nurse Executives of New Zealand (1999), explores the role boundaries between registered and unregistered nurse work and considers some issues related to supervision and delegation. The authors of this paper note that the relationship between registered nurses (RN) and health service assistants (HSA) needs to be such that each is aware of the responsibilities and boundaries related to their work roles and the accountabilities attached to such roles. They outline the guidelines for the delegation of tasks to the health service assistant. In doing so, these organisations reiterate that: "The HSA is an assistant to the RN, in the provision of patient/client care and related activities as delegated by and under the supervision of the registered nurse" (p. 10). Later in the same report, these authors state that the purpose of using the HSA is to free the registered nurse to spend more and not less time developing quality of care for the resident or patient depending on the setting. When these issues are considered in the

light of the research conducted by Cheek et al. (2002), the tension for registered nurses working in institutional settings is highlighted.

Issues for registered nurses working in institutional settings are also reported in the literature from the U.S.A. Schirm et al. (2000) report registered nurses' discomfort in their supervisory role. The registered nurses in this study on quality care, reported that they were ill prepared for the supervision of unregistered staff, were not knowledgeable about what to expect and experienced tension between attending to their own work and working alongside the unregistered staff. Other registered nurses in this study, described the need to build relationships and develop caregiver knowledge so that the work environment could be pleasurable for staff, as well as providing an environment of quality care for the resident. In response to perceiving the changing complexity in nursing, Davies and Fox-Young (2002), developed a scope of practice decision-making framework which is now in use by the nurse regulatory authority of Queensland, Australia. The tool comprises a number of principles which the registered nurse can follow in a variety of contexts from the expansion of registered nurse practice to the delegation of nursing tasks to unregulated care providers. Consistently across all levels of staffing, time constraints and inadequate staffing numbers prove problematic (Bowers, Lauring et al., 2001; Kayser-Jones & Schell, 1997a).

> Interviews with NAs [nursing assistants] suggested that the detrimental impact of short staffing falls most heavily on relationships and by eroding them, erodes both quality of life and quality of care (Bowers et al., 2000, p. 58).

Unregistered staff, otherwise known as nurse aids or caregivers, provide the major part of direct care in residential aged care facilities both in New Zealand and internationally (Bowers & Becker, 1992; Michel, 2000). It is the unregistered caregiver who, by providing the majority of direct personal care, is in an ideal position to alert the

registered staff about subtle changes in residents' conditions (Brannon & Smyer, 1994; Crogan & Shultz, 2000). Indeed, the New Zealand Nursing Council (1999) would require that the communication of a client's change in condition occur as a matter of patient safety. Nursing assistants, however, have reported dissatisfaction with the responses of registered nurses who do not act on the information the assistant provides about particular residents or who do not return to the nursing assistant to explain the outcome of particular interventions for individual residents (Bowers, Esmond, & Jacobson, 2003; Crogan, Shultz, Adams, & Massey, 2001).

Bowers and Becker (1992) note that "between 80 and 100% of the direct care provided to nursing home residents is provided by nurse's aides" (p. 360). They also note that approximately 12 minutes of skilled nursing work is provided for each resident each day. These are interesting figures in the light of the previous paragraphs regarding the supervision of unregistered staff. Kayser-Jones and Schell's (1997) study into the mealtime experiences of residents, found that "an inadequate number of knowledgeable staff and an insufficient number of professional nurses to supervise care at mealtime contributed to a poor quality of care for nursing home residents" (p. 70).

The position of unregistered staff in aged care is a difficult one. Brannon and Smyer (1994) refers to these staff as representing:

> … the underclass of the health services delivery system. At the bottom of the service heirarchy, they are continually grappling with the conflicting institutional goals of providing healthcare and providing a home for residents (p. 34).

Nursing assistants receive low rates of pay. They often experience a heavy workload and have little input into decision making. In consequence many nursing assistants report feeling devalued (Bowers et al., 2003). These staff can experience increased job stress and decreased job satisfaction (Chappell, 1994; Close & Carroll, 1994; Cohen-Mansfield, 1997; Stone, 2001). It is not surprising then that the turnover rate for nursing assistants has been reported to be between 85 and 110% per year (Bowers et al., 2003).

Job satisfaction

Caregiver job satisfaction in care facilities in Auckland was investigated by Featherston (2000). Caregivers in this study however reported overall satisfaction with their work. The main area of dissatisfaction which was reported was with the levels of salary and the difficulty of work advancement. Factors that were cited as leading to job satisfaction included being valued, having responsibility, feeling secure and feeling good about themselves. Elsewhere, being involved in careplanning was found to decrease staff turnover especially if the level of involvement increased the nurse aid's level of responsibility and authority in resident care and provided nurse aids with a communication link into care delivery (Banaszak-Holl & Hines, 1996; Brannon & Smyer, 1994; Stone, 2001).

Effective leadership can lead to the development of management systems that are valuing of staff contributions, supportive of the development of staffs' clinical skills, and involve staff in the decision making processes (Bond & Fiedler, 1999; Stone et al., 2002). Anderson and McDaniel (1998; 1999) demonstrated that including registered and unregistered staff in decision making led to improvements in resident outcomes and enhanced job satisfaction. Yeatts and Seward (2000), found that self

managed work teams which included shared decision making for both registered and unregistered staff enhanced job satisfaction and led to reduced turnover. Nzarko (1998/9) likened nursing homes which employed these types of inclusive strategies to the Magnet hospital concept where a commitment to valuing, respect, autonomy and inclusion occurs for both staff and patients. Research has demonstrated that the positive outcomes for Magnet hospitals include improved quality of care and increased job satisfaction leading to increased staff retention (Havens, 2001; Havens & Aiken, 1999).

Education

Initial and ongoing staff education has been shown to be an important factor in working towards delivering a high quality of care (Lindell & Olsson, 1989), noticing resident changes, responding to resident communications and providing adequate nutrition (Burgio, 1996; Crogan & Shultz, 2000; Sloane et al., 1997). Orientation programmes need to be sufficient to support the appropriate development of work practices (Bowers & Becker, 1992). Effective education can be both formal and 'on the job' as experience is developed (Burgio et al., 2000; Schirm et al., 2000). Education, however, without associated changes in work organisation and working conditions is unlikely to be effective.

An examination of the literature demonstrates that staff want and need in their working life, much the same as residents and families want and need in their residential life. To be able to provide care in an environment that is respectful and supportive, provides them with decision-making abilities, and enables them to further develop their knowledge, skills and practice.

Conclusion

It may seem that I have spent many words describing the experiences of residents and their families in this literature review, when the focus of my research study has been on registered nurses' work. This literature serves as data in this sense. The accounts of the residents and their families when compared and contrasted with the accounts of the participants in this study serve to confirm some examples the registered nurses have given to depict their work and their work environments.

Quality of care issues and satisfaction with care have been explored from the perception of managers and nurse aids with identification of a number of recurring themes related to adequacy of staffing, relationships between staff of different skill levels, caring practices and processes of delivering care (Beattie, 1999; Bowers et al., 2000; Rantz et al., 1999; Schirm et al., 2000).

While research in New Zealand has revealed some aspects of registered nurse work with older people in the rehabilitation setting, I have not found any New Zealand studies that articulate the work of registered nurses in residential aged care facilities from the perspective of the registered nurse. This research study will begin to contribute to the debate surrounding adequate staffing numbers, and organisational systems that inhibit or enhance resident care and staff recruitment, retention and job satisfaction.

In the next chapter, I discuss the research methodology, research methods and research process in order to provide a platform for the presentation of the research findings related to this study.

CHAPTER FOUR: METHODOLOGY AND METHOD

> Action always occurs within a context. Social life consists of processes. Everyday actions, negotiations, interpretations create stable social structures, they do not merely exist. Actions give rise to reconstructing meaning; in turn, meaning and symbol inform action (Charmaz, 2001, p. S172).

As a novice researcher, I have used this project to learn the dimensional analysis method of grounded theory as articulated by Bowers (1988b), Kools and McCarthy (1996), Robrecht (1995), and Schatzman (1991). Grounded theory was first developed by Glaser and Strauss (1967), in order that social theory which explained human processes of interaction could be accessible to both professionals and non professionals. Grounded theory is aptly named. In grounded theory, the theory that arises out of a research project is firmly grounded in data collected directly from the area of the study. Strauss (1987) suggests that when theory which explains social processes does not arise directly out of data, it will be "speculative and hence ineffective" (p. 1). The theoretical perspective of symbolic interactionism informs the grounded theory methodology (Schatzman, 1991).

In this chapter I will present the main ideas related to symbolic interactionism, the grounded theory methodology, and the grounded theory method, by explaining the processes I used in this research project. Issues related to rigour, confirmability and fit will be considered. Finally, I will outline how I initiated and maintained an appropriate ethical stance throughout the research process to ensure safety for the research participants. It is difficult to know whether an explanation of this nature begins first with detail or with overall concepts. I have chosen to begin with the theoretical underpinnings of symbolic interactionism and work through to the detail of the research project.

Symbolic Interactionism

"Grounded theory method, as it is used in qualitative social science research, has its roots in the symbolic interactionist tradition that grew out of the Chicago school of sociology between 1920 and 1950" (Robrecht, 1995, p. 175). Symbolic interactionism is the theoretical underpinning which assisted me to understand more fully the perspectives and contexts that propelled the actions taken by the participants in the study, to ensure delivery of resident care. Symbolic interactionism forms the basis of a sociological approach which proposes that actions within a society are the result of interactional processes between individuals and objects. According to Blumer (1969), who first coined the term symbolic interactionism, people act towards things according to the meaning that things have for them. The meaning which people have for things is derived from their interactions both with the external environment and within their '*self*'. Thus, the process of making meaning is both internal and external to each individual. In order to make meaning or ascribe meaning to objects, individuals use an interpretative process. The end result of this interpretative process is action.

From a symbolic interactionist perspective, objects do not have meaning outside the meaning attributed to them as a result of interaction. Objects are either physical, as in people, social, as in institutions, or abstract, as in values. Objects become any thing that a person indicates to themselves (Blumer, 1969). The process of interpretation and action does not happen without firstly an indication that something requires noting. Blumer suggests that there are some non-symbolic interactions which are reactive, however, most interactions are the result of a reflective process. The reflective process begins with an indication of noteworthiness which leads to a consideration of action

and response from the perspective of the role of the other, and concludes with an interpretation and a subsequent action by the individual.

Taking the role of the other and considering what the other's actions might be in response to the action an individual is contemplating, is a central notion within symbolic interactionism. As the events, contexts and conditions within which interactions occur are constantly in a process of change, people adjust their actions according to the meaning they interpret within a variety of contexts. Action then, arises out of an individual's interpretation of particular events within a particular context. Differing contexts will give rise to differing interpretations and thus differing actions (Blumer, 1969).

During the data collection phase of my study, an interesting illustration of this process occurred. One participant in my study described how the caregivers, who were immigrants from a Pacific Island culture, insisted on providing the residents with milk and sugar in their tea or coffee regardless of the number of times that they had been told that certain residents did not take milk and sugar with their drink. The participant was puzzled by this behaviour and wondered whether it was as a result of the caregivers just not listening to the residents. Within her context, the residents' preferences were important for the delivery of a high quality of care. In this instance, she perceived that the residents' preferences were not being met and redoubled her efforts to insist that the caregivers be aware of and attend to those preferences.

Not long after I had interviewed this participant, I was at dinner with another person who had recently returned from living for some years within that Pacific Island culture. She was not aware of my research project and we were talking about her experiences when she was overseas. During our conversation, she mentioned that she

had given up having black coffee when she was overseas. When I asked what that was about, her reply was that milk and sugar were precious commodities in that country. When a guest visited a person's house, it was considered an honour to that guest to provide milk and sugar in their drink. Regardless of her preference for a drink without these additions, she always received milk and sugar and began to see that she was being honoured from the perspective of the people she was visiting (Personal communication Heather Kelly, March 2002).

Two people within different contexts having different experiences came to different conclusions about the same actions. How then do we come to patterned ways of behaving? Blumer (1969) suggests that we still proceed through our own internal interaction with external events but that when we and another person act in the same way, we are acting in alignment. It is this alignment which gives rise to shared patterns of action.

Symbolic interactionists have the perspective that the personal is shaped by the social and political context within which the person operates. Shared ways of acting arise out of our childhood experiences and are refined and changed throughout our life. People are constructed by their environments and their actions arise out of those constructions. Thus we can be seen as co-constructors within society. From our earliest sensory experiences, we interpret our world from others' responses to our actions. "There can be no distinction between the individual and the social self since they are " 'twin born' " (Bowers, 1988b, p. 37).

The self in symbolic interactionism comprises both a '*me* ' and an '*I*'. It is the '*me*' aspect of self which is the interactor between the self and society. The concept of the '*I*' relates to the thinking part of us which takes in information and makes a decision about how the interaction will proceed. It is the '*I*' which interprets and contributes meaning to an event, and it is '*me*' which subsequently acts (Bowers, 1988b). In this way, change occurs as people interpret according to a variety of conditions and contexts and either maintain previous ways of acting or adopt new ways of acting.

Symbolic interactionism formed the theoretical perspective underpinning grounded theory as developed by Glaser and Strauss (1967). Schatzman articulated the connection between grounded theory and symbolic interactionism more directly (Bowers, 1988b; Kools & McCarthy, 1996; Robrecht, 1995; Schatzman, 1991). As in the previously mentioned example about the cup of tea, what becomes central to the researcher's understanding of a social process, is the perspective taken by a person in relation to a context. "People interact over a period of time; out of that interaction they come to share a perspective; what they see will be interpreted through that perspective; often each perspective tells us something very important about what is really true" (Charon, 1998, p. 1). It is from a perspective and within a context, that a nurse working in residential aged care will adjust care activities. The outcome of these adjustments will impact on client care.

Grounded Theory Methodology and Method

The guiding principles, contained within the grounded theory methodology are that the collected data be clearly grounded in the field of study; that the derived theory is a conceptual abstraction which arises out of that data; and that the process of research comprises concurrent data collection, constant comparative analysis, theoretical

sampling and memoing (Bowers, 1988b; Charmaz, 1994; Kools & McCarthy, 1996; Robrecht, 1995; Schatzman, 1991). Strauss (1987) states that grounded theory is:

> a style of doing qualitative analysis that includes a number of distinct features, such as theoretical sampling, and certain methodological guidelines, such as the making of constant comparisons and the use of a coding paradigm, to ensure conceptual development and density (p. 5).

Grounded theory is both an inductive and a deductive method of research. It is inductive in that the theory that emerges is grounded in the collected data. It is deductive in that the data analysis moves through increasing levels of abstraction into theory (Glaser, 1999). Glaser (1992b) reinforces the importance of an emergent design when he states that "Grounded theory allows the relevant social organisation and social psychological organisation of the people studied to be discovered, to emerge – in their perspective!" (p. 5).

As Strauss (1987) has suggested, the grounded theory researcher uses particular analytic processes to discover the theory inherent in the participants' accounts. The constant comparative method of analysis occurs when the researcher continually compares data in order to find similarities and differences, which enable understanding of different aspects of the participants' experiences. Comparisons are considered within individual interviews and across all participants' experiences. Comparisons are also considered in relation to literature connected to the field of study. Finally the researcher may compare concepts that are contained within a variety of contexts. For example, the constant comparative analytic process that I used during the research process, led me to ask questions related to leadership. I was interested that some participants experienced distance from the management in their place of work, while other participants experienced connection with the management. Yet other participants were themselves

the manager. Additionally, participants described different experiences in their efforts to effect positive change in the quality of resident care. I began to ask questions about the relationships between the registered nurse and the management team. My questioning then led me to consider a variety of dimensions about the role of leadership within residential aged care and the range of conditions which could impact on the scope of registered nurses' authority within the context of their work.

The constant comparative method of analysis moved to theoretical sampling as mentioned by Strauss (1987). Theoretical sampling can be described as the process by which the researcher decides what data needs to be collected next in order to further explain or compare the dimensions or concepts which have been discovered in the existing data (Bowers, 1988b; Glaser, 1978). Guided by the emerging dimensions of management, leadership and authority, I began to look for participants who had different roles within residential aged care. I also began to ask questions of the participants which were related to those dimensions. Initially I had interviewed a registered nurse who worked as a staff nurse, a registered nurse owner manager, and a registered nurse who was a team leader in a unit which was a part of a larger complex. I then interviewed two more owner managers, another team leader, and a staff nurse. My questions turned to how different it might be for registered nurses who had different positions in aged care, and I interviewed two registered nurses who worked in indirect care positions. One of these was responsible for quality improvement and the other for education. I then had theoretical sampling across almost all the registered nurse positions within residential aged care. Constant comparative analysis and theoretical sampling processes are described more fully as I outline these principles as they were applied to my research process .

Grounded theory builds. With the focus of grounded theory being towards an emergent theory, data interpretation needs to be precise in order to demonstrate the connection of the theory to the participants' perspectives. The grounded theory data analysis begins with a line by line, paragraph by paragraph, and incident by incident coding of the interview data. At the same time, the researcher will use written memos to record her responses to the data, her thoughts about the meaning of the coding and the questions she raises during the coding process (Strauss & Corbin, 1998).

As the data build, repeating codes will become conceptual categories. Eventually, categories can be linked in terms of their properties, dimensions, causal contexts, stages, and outcomes. Saturation of the data is reached when new interviews do not generate further categories (Glaser, 1992a). Towards the end of the process of analysis, coding and categorising, a core category may emerge as the central process to which all other categories can be related and linked, thus demonstrating a theory which has been grounded in the data (Corbin, 1986).

Grounded theory analysis occurs simultaneously with data collection. The ongoing direction of data collection is informed by the analysis. The experience of doing grounded theory is that it is a messy process as the researcher moves back and forth between data collection, analysis, theoretical sampling, and theory development. I have presented above an overview of the theoretical perspective informing the grounded theory methodology. I have also broadly described grounded theory methodology and method. I now turn to a more in depth discussion of how I used the principles of grounded theory throughout the research process. Writing up a grounded theory research process needs to occur in some sort of linear fashion which does not fully demonstrate the weaving and constructing process as it occurs in reality. The

writing of the next part of this chapter may resemble in some way, the 'to and fro' nature of the methodology itself. I have described the principles of grounded theory which guided the method that I used, and used examples from my documentation of the research process to explain the method in action. As I have constructed the rest of this chapter according to the aspect of the research process which was salient at particular junction points, I have repeated the broad concepts which were foundational to my research actions. I feel like telling the reader to put on their safety belt now and come on a journey! However, I do actually begin at the beginning.

Grounded theory as a discovery process

The grounded theorist is working towards discovering and explaining common social processes which occur repeatedly in the life of the participants (Chenitz, 1986). The belief here is that individuals may be conscious of their actions, however, they may not be aware of the underlying social processes that impact on their actions. A grounded theorist will aim to explain these processes with one important purpose being to offer understanding to the participants. Understanding can lead to enablement and to change if the discovered processes are problematic (Glaser, 1999).

In this grounded theory study, my aim was to explore the processes registered nurses used when working with older people in residential aged care. In order to ensure that the data emerge out of the field of study, the researcher endeavours to enter the field aware of any preconceived ideas about what they might find. As Glaser (1992a) suggests, the grounded theory researcher "moves into an area of interest with no problem. He moves in with the abstract wonderment of what is going on that is an issue and how it is handled" (p. 22).

The researcher's position in a grounded theory study

Within the qualitative interpretative paradigm, researchers are considered to bring themselves into the field of study (Tolich, 1999). The researcher and the researched operate together. The grounded theory researcher needs to demonstrate that theory has emerged directly from the data. As the sole researcher, it is important to acknowledge my experience of working within this field of study (Cutcliffe, 2000; Hutchinson, 1993; Strauss & Corbin, 1998). Having experience within the field can sensitize me to particular processes that the participants may describe. On the other hand, having experience within the field may also blind me to some processes the participants are describing.

A challenge for the grounded theory researcher is to be able to maintain a connected yet distant relationship within the field of study. The connection is towards the field of study as the researcher moves into the participants' world in order to understand that world from their perspective, and the distance enables the researcher to achieve two aims. Firstly, maintaining some distance from the data can assist the researcher to more effectively conceptualise from the research data. Secondly, some distance is effective for being able to deal with the researcher's own preconceived notions (Bowers, 1988b). Prior to commencing my research and as a result of the advice of one of my supervisors, Associate Professor Lynne Giddings, I asked a colleague to interview me in order to make explicit my preconceived ideas regarding the field of study I was entering.

I knew that I had some passions relating to working with older people and some strong notions of how care 'should' be delivered. I also discovered during this taped session, that I wondered why nursing care in residential aged care lacked status and reputation as a preferred nursing specialty. My previous and current experience in the field of gerontological nursing spanned education, community nursing, and residential aged care. I wanted to articulate how registered nurses worked in this care specialty. One of the reasons for embarking on this research stemmed from the questions that I myself wanted to answer. In this sense, I was very open to hearing the stories of the participants and allowing the data to speak for themselves. Because of my background, however, I used journalling and memoing extensively to track my attitudes and responses to the data which did emerge. I also returned to the data on many occassions to satisfy myself that the interpretations I had made, were firmly grounded in the participants' words.

Memos from a grounded theory perspective

Memoing in grounded theory serves a number of purposes. Grounded theorists use memos to guide their constant comparative analysis, track theoretical decisions, and record the researchers' thinking about the emerging theory (Bowers, 1988b; Glaser & Strauss, 1967). Another function of memos can be to assist researchers to recognise when they are operating out of preconceived assumptions and moving away from the data. Memos also record the researcher's own process during the research project. The researcher in a grounded theory study is interpreting information in the same way that the actors in the field of study are processing information on a daily basis. I have included excerpts from my memos which illustrate this process. Memos are often comprised of stream of consciousness thinking, reflective thinking, feelings, thoughts,

musings, and attitudes. They are not usually tidy and can be full of the writer's own shorthand way of thinking. These memos reflect those aspects of this researcher as well!

27.12.01 Authority and autonomy. This is interesting in that in Jan's transcript her autonomy is curtailed by a number of institutional and staff constraints and the sense of autonomy does not show through as strongly as in either Sally or Roses transcript. Jan does have authority and uses that within the way that she leads a shift i.e. writing notes. Autonomy is something more than authority and has a deeper dimension on ongoing decision making. Jan can and does make decisions however the depth of leading care is different to either Sally or Rose. Rose because she is in charge on an ongoing basis and Sally because she is the owner as well as the manager.

22.12.01 Assessing change in resident's condition. Noticing changes in client's condition differences between Rn and Caregiver knowledge? This is one of the differences between Registered Nurses and Caregivers in many instances. The Registered Nurse will notice a change and will not intervene until the person requires it - or they might take extra notice about the resident's intake when the assessment is that the client is deteriorating. They will endeavour to maintain function for as long as possible and then perhaps start small interventions like giving smaller more frequent meals, initiating the client to take food, encouraging, prompting if the client has forgotten to eat. In this way they maintain function while at the same time maintaining nutrition. Jan finds this very difficult to do under two conditions. Firstly, when she is doing medications and trying to keep an eye on the meal delivery to clients and secondly when she is really busy with the extra work load as this comment came soon after she was talking about it "not working" under certain conditions i.e. staffing. Caregivers are not educated to make the minute assessment and management decisions that the RN is responsible for . If the RN does not notice under these circumstances, the client can become malnourished - a condition which is often found in nursing homesThis is an outcome of structural decisions regarding timing of medications, work flow; and staff resident ratios including staff mix.

Theoretical questions arose from my thinking about registered nurse work in both these memos. The first memo demonstrates the thinking related to the dimensions of leadership which I have discussed earlier in this chapter. The second memo gave rise to questions related to registered nurses who might not have the knowledge, education or experience, to undertake the assessments I have described in the memo. In the three transcripts that I had analysed at this stage, the participants had articulated very clearly their assessment and management of a variety of clinical situations. Using theoretical sampling, I began to look to recruit participants who were new to aged care. I recruited one participant who had joined aged care within the previous twelve months. This participant, however, had been nursing for many years in the acute care sector and was experienced in finding out what she needed to know in new situations and was continually updating her knowledge base. I was unable to recruit into the project any other registered nurses new to aged care. This process of memoing can be seen to assist the researcher to reflect, think about and make decisions regarding the ongoing collection of data, the process of constant comparative analysis, theoretical sampling, and finally theory development. I also kept a research process journal which guided the decisions I made at the very early stage of the research, when I was deciding how I was going to carry out the research project.

Approaching the Field of Study

I struggled with how I was going to approach the field of study I had chosen. I am living in a small country undertaking a thesis project for the completion of a masters degree. A thesis at this level has the constraint of time and length. Originally I intended to carry out participant observations as well as indepth individual interviews. I considered that within a small geographical area, I would need to undertake participant

observations in at least three facilities in order to ensure anonymity and confidentiality. I decided that my planned project would be too large for a master's thesis, and I chose to focus on indepth individual interviews only.

Participant Sample

I recruited the study participants using purposive sampling (Tolich, 1999). Because of the nature of my inquiry, the participants were approached because they were considered to be directly involved in the field of study (Beanland, Schneider, LoBiondo-Wood, & Haber, 1999). I asked colleagues to approach participants, and then asked initial participants to contact other registered nurses who worked in residential aged care and whom they thought might be interested. I excluded students in courses that I co-ordinated, because of the potential for coercion between teachers and students. I did approach some participants myself where I was sure that there would be no sense of pressure or coercion. Some participants volunteered themselves when they heard about the project. If potential participants did not respond to my or others' initial approaches, I did not persist. Each participant took part in an indepth individual interview which lasted between one and two hours. I spoke further with some participants by telephone. On these occassions, I checked whether they gave their permission to include that data.

Ten registered nurses agreed to participate in the research. Three participants were owner managers. Two owner managers worked in rest homes. One owner manager worked in a private hospital. These three facilities ranged in size from thirteen to fifty beds. Three other participants had positions of authority as managers or team leaders. Two participants had indirect care positions, for example, quality improvement co-ordination. Two participants were staff nurses working shifts. Those participants

who did not own the facility worked in co-located complexes which consisted usually of a private hospital, rest home, dementia specific area and independent living apartments or cottages.

All participants were active in pursuing their own educational needs. Two had completed master's level education and a third was in the process of obtaining this degree. Two had completed a bachelors degree after their initial registered nurse training. As well as this, a number of participants had attended formal courses on leadership, management, and clinical practice. All participants both delivered and attended inservice education on a regular basis. The process of ethical approval for this project will be detailed later in this chapter.

Individual Indepth Interviews

The grounded theory researcher sets out to discover theory (Bowers, 1988b). The initial interview question in grounded theory is purposefully broad to enable the participants to talk about what they see as problematic or important from their perspective. For this research project my question on commencing the initial interviews was "Tell me about working with older people" or "Tell me about working in residential aged care". From the initial question I would then ask clarifiying questions. These clarifying questions would also be open ended. For example, in an interview with Jan, a clarifying question followed from her comments about problem solving:

J: Other times it takes a bit of thought and sort of brainstorming with other people.

R: So when you brainstorm with other people. How would you do that? Who would you do that with?

(R = researcher)

As the analysis proceeded I began to ask more theoretically directed questions of the participants.

Theoretical Sampling and Theoretical Questions

In theoretical sampling, the researcher selects both participants and interview questions which can assist to further answer questions which have arisen out of the analysis process (Bowers, 1988b). For example, I had conceptualised that there was a relationship between participants' individual philosophies of care and the philosophy of care statements within the facilities. I began asking questions about this relationship.

R: What would you do if there was some sort of separation between your personal philosophy and the facility's?

C: I'd in fact, it's interesting because I was ready to resign not so many months ago because of that. Huge conflict that I couldn't resolve. I just, I couldn't. I didn't think I could stay working with the pressure and the stress that was being generated by all the changes and it seemed that people weren't listening.

As a result of this questioning, those relationships I had conceptualised were more fully developed. At the same time, the concept of having an active philosophy of care which was placed at the centre of the organisational structure, was also developed when participants talked about the way in which care practices were or were not aligned with the facilities stated philosophy. Theoretical sampling and constant comparative analysis will be again described later in this chapter (see p. 70) as I develop the analysis processes I used within the research project.

Dimensional Analysis

Schatzman (1991) emphasised the way in which stories contain the elements of social processes. Schatzman saw that the steps of data analysis mirrored the process which individuals go through on a daily basis as they work to solve the problems they encounter. His aim was:

> finding or constructing a general theory of analysis that would include both the analysis explicit (often barely) in research and the analysis presumed necessary to effect such universal, cognitive processes as interpreting, defining, comparing, evaluating and deciding, which occur both in and outside research (Schatzman, 1991, p. 303)

Schatzman (1991) introduced a dimensional matrix to construct a framework for the ordering and conceptualising of data. Within the dimensional matrix are the elements which reflect the "complexity of a phenomenon by noting its attributes, context, processes and meaning" (Kools & McCarthy, 1996, p. 315). The researchers ask questions of the data they have collected and as in all grounded theory approaches, data collection, analysis, theoretical decisions, and theoretical sampling, are concurrent processes. To demonstrate how I used dimensional analysis, I will explain the analysis process from the commencement of coding and conceptualising.

Initial analysis process

Interview transcripts are examined line by line in order to identify the dimensions of an event or interaction. Kools and McCarthy (1996) refer to this process as the labeling of data bits. Bowers (1988b) describes the early analysis process as "discovering and describing the characteristics (dimensions) of the objects (categories)

and identifying the salient objects (core categories) in the object world" (p. 47). My research process at this early stage was at times one step forward and two steps back.

The coding process

When I commenced the process of analysis, I spent three months analysing the first three interviews. Because of time constraints and because I was anticipating a holiday period from work, I collected the first three interviews in quick succession. Ideally, data collection occurs sequentially with data analysis. Ethics approval for my project was obtained in mid November of 2001. I knew that many people might be on holiday and therefore not available for interview. As I did not wish to lose precious time, I quickly carried out three interviews. This method of data collection was not ideal. Although I analysed the data sequentially I would try to avoid this situation in any future studies. On a positive side, I had a large block of time over the Christmas period where I could concentrate on the research process.

The analysis was detailed. I wrote many analytic memos containing the questions I was asking of the data to guide my interpretations. I was constantly unsure that I was 'doing it' correctly! As well as coding line by line, I would listen to an interview playing on my walkman as I walked each day. I came to recognise the nuances of tone and emphasis as well as the words, which gave clues to the perspectives and contexts within which the participants were operating. I coded in both pencil and on the computer. An example of my initial coding and way of articulating those codes is attached as Appendix A and Appendix B. The following table represents the initial coding of data which was conceptualised as recognising residents' contexts, and demonstrates how actors in the field, in this case the registered nurses, take the role

of the other (Bowers, 1988b). There were other codes related to this data, but, for the purposes of illustration they are not included here.

Table 1. *Example of initial coding*

Raw data	Initial codes
You can see a lot of who they are, and what they've been and I enjoy talking to them. Sort of … It's quite amazed me sometimes, how, how together they are you know, and you know and living in such a difficult situation (Jan) So how can we make, find ways to connect with people that's not around that too…so that we can just …ummm. Just well put some pleasure back into people's lives. (Rose) …this is their loved mother father whatever brother sister whatever it is. They know that their placement is going to be until they die (Sally). then I ask him to do little things for me that I know he is capable of doing and he thinks that's great that he is included not just a patient which people like people to feel (Victoria)	Recognising residents' contexts

Constant Comparative Analysis and Theoretical Decisions

In grounded theory there is a constant interplay between the data and the data analysis. This method is circular and occurs within a consistent methodological perspective. Within grounded theory this process is called constant comparative analysis. The researcher moves between initial data, analysis, and subsequent data, and then extends this movement to include literature as data to check the emerging theory. During the analysis process, the researcher is continually asking comparative questions of the data.

I had discovered from two interviews, that the way in which two participants organised their work and their relationships with the residents, their families and the caregivers, meant that they effectively enrolled everybody into some aspect of the processes of care delivery. When this strategy was effective, care work within the facility was transparent, and the registered nurse worked consistently to develop caregiver knowledge and skill. I made a decision to compare interviews where the participants talked about the nature of the relationships with families, and where they talked about caregiver skill development. I also began to ask theoretical questions related to the role of the family in the facility, how caregiver roles were developed, and how caregivers were rewarded.

What emerged out of these theoretical questions was that in facilities where there was inadequate staffing and the registered nurse was very busy, the relationships between the caregivers, registered nurses and families, were more distant. For the registered nurse participants in this context, supervision of the caregivers consisted of watching, pulling up, checking up, and organising. This was a distinct contrast to those facilities where the relationships between the registered nurse, the families and the caregivers, were more connected. In these instances, as mentioned previously, the caregivers' knowledge and skill base were continually developed both informally and formally, and the caregiver was more included in planning care, for example, caregivers would attend family meetings to review the resident's care plan. Asking these theoretical questions and comparing participants' interview data, proved useful and added to the development of the theory of 'shifting focus' which is the outcome of this research project.

As in the above example, the process of constant comparative analysis leads to the researcher preparing and asking questions of later interview data. In doing this, the researcher aims to answer questions which have arisen concerning the concepts which have been discovered in earlier data analysis. A second example of constant comparative analysis follows. It illustrates the development of concepts related to staffing of residential aged care facilities.

Coding from the initial interviews suggested that there was a relationship between staffing numbers and the level of care. Two further interviews demonstrated that numbers were not the only aspect of staffing that impacted on the quality of care delivery. In the first instance, the participant, Susan, described care processes which demonstrated that the unit which she managed worked from a philosophy of individualised care. The staffing levels in this unit were slightly less than in other facilities where the participants described similar approaches towards individualising care. During the interview, Susan described how she worked with caregivers to develop their clinical practice. At the same time, she described processes which she used which ensured individualised care for the residents. Finally, she talked about the ways in which she developed the leadership skills of caregiving team members.

In the second instance, the participant, Dorothy, worked with staffing levels which would appear to be quite adequate. However, this participant articulated that she was distressed at the level of care which was provided for the residents. Dorothy described how she reported to management the many incidences where care delivery did not fit best practice approaches. She also outlined how she had tried to initiate change by talking with staff individually and collectively about the level of care the residents were receiving. The strategies that she used did not lead to effective change.

While the staffing in each of these instances was adequate, the care practices were very different. These differences led me to ask theoretical questions during later interviews, about the relationship between the registered nurse, the caregiver, and management. As a result of this constant comparative analysis and the subsequent theoretically driven questions, the initial codes relating to inadequate staffing numbers became dimensions of inadequate staffing. The dimension of inadequate staffing included inexperienced or resistant staff as well as inadequate staffing numbers.

Constant comparative analysis guides the development of theoretical questions and occurs at all stages of the analysis process. After my initial analysis when I decided I wanted to explore the dimensions of family contributions to care more fully, I thought I was probably carrying out dimensional analysis quite effectively. I decided to check that my coding was satisfactory and at this stage attended a workshop on dimensional analysis where I began to wonder if I was in fact conceptualising as effectively as I had thought.

Dimensionalising

Following the workshop, I returned to the literature on dimensional analysis and began to grapple with the idea of creating a matrix relating to each interview and building this matrix conceptually with each subsequent interview (Bowers, 1988b). I ended up becoming too engrossed in the initial coding sequence and built dimensional maps which did not reflect the conceptualising process. At one stage I was challenged that I was in fact doing a case study rather than grounded theory and much to my consternation, I discovered that I had moved in a direction which was not building towards theory. I had not moved into the abstraction process by sufficiently conceptualising the codes that I had already generated.

This realisation led me to return to the initial transcripts and check my analysis again. At this stage I moved all my data into the QSR NVivo software programme. While I still manually manipulated data, I found that I was more relaxed knowing that I could find my way back to the initial codes via the software programme. I also found the software assisted in diagramming possible relationships amongst concepts. An example of diagrams produced in this way is attached as Appendix C. As a result of this learning process, I was able to move forward, becoming more effective in my analysis. I think that after moving back and forth between data analysis and data collection, I gradually began to see the relationships between concepts in a different way.

Conceptualizing, Constant Comparative Analysis and Theoretical Saturation

Data analysis continued after each interview until concepts were saturated. Theoretical saturation in grounded theory occurs when you are beginning to hear the same comments, or concepts, repeatedly. During the process of analysis, and connected to the notion of recognising residents' contexts, concepts began to relate to each other. For example, while some participants could recognize the residents' contexts and perceive the uniqueness of each resident, they were unable to work from a philosophy of individualised care because of the context surrounding their work environment. An example would be when there were staffing constraints. Data were constantly compared both within the same interview and between interviews so that the dimensions, their properties, the context and the outcomes, could be examined for differences or similarities. The following table demonstrates the building of codes into dimensions and properties of a dimension.

Table 2. Conceptualising and categorising

Codes	Dimensions	Salient dimension
Recognising residents contexts	Creating congruent environments	Working from a philosophy of individualised care
Perceiving uniqueness		
Communicating philosophy	Creating philosophy guided practice	
Translating philosophy to practice		
Valuing		

Gradually the dimensions of registered nurse work were uncovered as the concepts were labeled and considered against each other for conceptual relationships. The actions of seeing how the concepts related to each other was facilitated by the use of a dimensional matrix which I was by now learning to use more effectively.

PERSPECTIVE

Working from a philosophy of
individualised care

CONTEXT

Authority to
direct care

STRATEGIES

PROCESS

Lead the team

Focus on the resident
&
the family

Getting to know
work

CONDITION

Establishing
supportive
systems

Adequate
staffing

CONSEQUENCE

Effective care outcomes
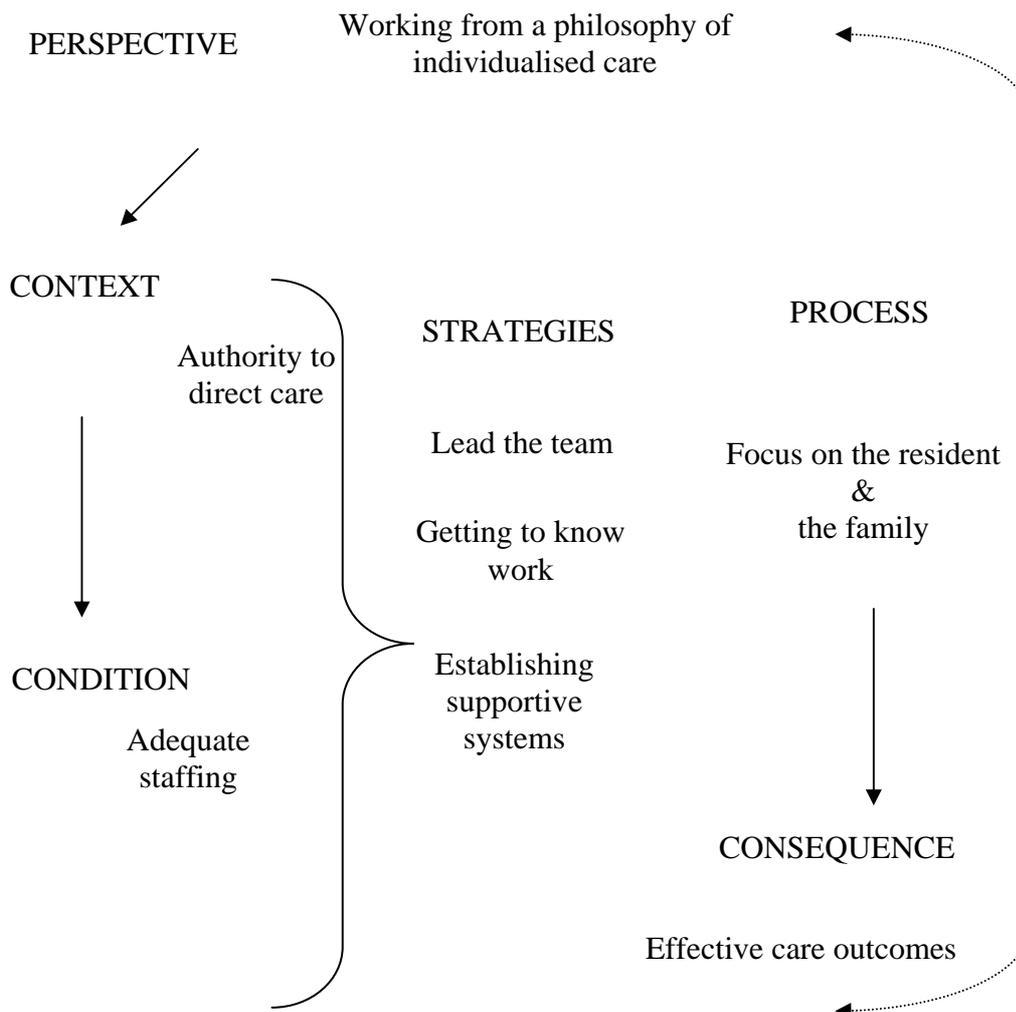
Figure 1. Dimensional matrix: Working from a philosophy of individualised care

A Dimensional Matrix

Schatzman (1991) considers that every dimension needs to be given an opportunity to act as perspective or context because if the perspective and context change, then the whole process changes. Kools and McCarthy (1996), and Robrecht (1995) echo this process. Kools and McCarthy provide a diagram of a dimensional map as a framework to assist the researcher to explore the relationships between the dimensions of a concept and to develop a matrix which best explains how the actors work to solve the problems they face in the field of study. An example of a dimensional

matrix is shown here as Figure 1. While this dimensional matrix does not follow exactly the Kools and McCarthy framework, it does contain all the elements of process. For each phase of the theory of shifting focus, a dimensional matrix was developed. These matrices showed the perspective, context or cause, conditions and outcomes related to the process the participants used to manage their work. These matrices are used in table form in Chapter Five and Chapter Six to explain the research findings.

In Figure 1, the elements of the dimensional matrix are in bold. What this matrix demonstrated was that there was a relationship between being able to put a philosophy of individualised care into action, and having the authority to do so. Some participants had a philosophy of individualised care but did not have the authority to enact this philosophy. Neither did they have adequate staffing which could enable them to consistently work from a philosophy of individualised care during the individual shifts where they did have a limited scope of authority. When I gave the concept 'authority to direct care' the opportunity of perspective, I realised that a person may have authority but a different philosophy of care. Alternatively, they may have authority for a shift but they work in a facility where the overall structure does not support an individualised approach to care. Gradually with the use of the dimensional matrix as a framework for conceptual development, I could make sense of the relationships amongst the salient dimensions which had become visible through the analysis process. In this way, the participants' data became abstracted into a substantive theory which demonstrated the actions which participants used in order to ensure that resident care was delivered. The research findings are explained in Chapters Five and Six. The next question which arises in terms of the research process regards the use of literature.

The Use of Literature

In an emergent research design such as grounded theory, the researcher works in a particular way with the literature related to the field of study. Literature is initially used to map the field of study. At later stages during the research process the literature is accessed as the researcher begins to discover emerging processes (Stern, 1994). In the traditional positivist approach to health research, the researcher enters the field to test a theoretical hypothesis already derived from literature and previous research studies. For the researcher using grounded theory, no hypothesis is made at the outset in order to encourage the discovery of theory from the data. Literature, however, plays an important part in grounded theory once the data has begun to surface an emerging theory. Literature then becomes part of the method by which the theory is compared, contrasted, sorted and expanded (Glaser, 1992b). For the grounded theorist, the literature within the field of study then becomes data (Chenitz, 1986). For example, when I commenced this study, I did not openly use the literature to guide my thinking. I think that I stayed too far away from the literature because I was aware of my breadth of knowledge about the field, was teaching within the field, and was concerned not to influence the research process. I would come across an article in the course of my work that I would think looked useful and put it aside. I ended up with a great deal of reading to do and I think I could have begun that reading earlier during the research process. Once the theory had begun to emerge out of the analysis, however, I began to read literature related to the organisational processes used within a variety of institutions. My reading of literature again expanded at a later stage into concepts related to leadership. Finally, as stated by Strauss and Corbin (1998) :"When an investigator has

finished his or her data collection and analysis and is in the writing stage, the literature can be used to confirm findings *and* just the reverse ..." (p. 51).

The literature, which is related to the findings from this research study, is included in the background to the study and in Chapter Seven where the research findings are discussed more fully. Literature does to some degree assist the researcher to demonstrate that the concepts they have developed have 'fit', that is, they easily explain the processes used within the field of study. This alone is insufficient to demonstrate that the findings of a research project can be trusted. I will examine trustworthiness from a grounded theory perspective.

Rigour in Grounded Theory Research

Glaser (1999) suggests that the process of grounded theory is rigorous, even though it does not easily fit the criteria for rigour that arises out of quantitative research. For grounded theory, questions of rigour focus on the trustworthiness of the emergent theory in terms of its fit and applicability within the field of study. Careful documentation of the research process is important if the researcher is to be able to demonstrate its rigour. An audit trail will need to show that there is consistent congruence between the theoretical perspective, methodology, and methods (Corbin, 1986).

During this research project, I met with two supervisors regularly to explain the research process. I took copies of my coding and analysis process to demonstrate my analysis and to discuss the concepts which I was uncovering from the data. As well as meetings with supervisors, I was a member of a grounded theory research group where students undertaking research projects using grounded theory, would present and

discuss individual research projects. I also met weekly with two colleagues and together we formed what Associate Professor Lynne Giddings calls a 'critical group'. During these weekly sessions, we would discuss, present, ponder, reflect, and sometimes argue, the steps we had taken in our respective research projects. Finally, I attended workshops in grounded theory which were facilitated by Professor Barbara Bowers. During these workshops there was time set aside for individual and collective consideration of the grounded theory research process. Professor Bowers also took the role of consultant on two occasions. Her guidance enabled me to deepen my ability to ask appropriate questions of the data and to understand how symbolic interactionism, dimensional analysis and grounded theory both inform and form a framework to guide the research and the research findings.

The processes of challenge, discussion and reflection, along with continued individual learning, assisted me to maintain consistency within the research process. For the grounded theorist, internal consistency is reflected when concurrent data collection, analysis, and memoing are demonstrated to have guided the theoretical decisions made by the researcher. The grounded theory that has been explicated as a result needs to reflect to the participants, the everyday processes that they use to solve the problems associated with their work.

Confirmability and Fit

Glaser and Strauss (1967) emphasize that a grounded theory needs to meet criteria of applicability within the field of study. The discovered theory must have 'grab' in that it is easily understandable by those who work in the field from which the theory was discovered. A grounded theory needs to be applicable within a number of situations that arise within the field. Finally, a grounded theory needs to provide actors

within the field with some ability to change or enhance the processes that are used to solve problems that exist within the field of study. I have taken my substantive grounded theory (Appendix G) to participants. Their response has been very positive. I have been asked by one participant "why hasn't this been done before? It is so true". The return to the participants has resulted in long sessions, usually two hours, as they become animated in their discussions about the findings. During the discussion, they talk about the facilities in which they have worked. They spontaneously position these facilities along the gradient of the shifting focus model.

The second process by which I have checked my findings is by presenting them to registered nurse educators and clinical practitioners. I have been humbled by their responses. I have been told, "this totally fits my experience". I have also had the response that "I have worked at this level of the model and at this level of the model". My findings have been confirmed as explaining how the registered nurse manages her work in the residential aged care setting. My thanks go to those who have listened to my findings.

Ethical Considerations

In all research projects, participants have the right to protection and safety. The researcher has a responsibility to ensure the project meets the principles of ethical conduct outlined in (Tolich, 1999). These principles are addressed in the following sections and include informed consent procedures, cultural and social justice features of the project, the process of ethical approval, and how autonomy was maintained for the research participants. This section concludes with a consideration of the risks to the research participants that might be associated with this study.

Informed consent procedures

The participants received an information sheet describing the research and a copy of the consent form. Examples of these forms are attached as Appendix D and Appendix E. Once the participants had indicated a willingness to take part in the research, I explained the study process and answered any questions that arose for them This process of explanation occurred sometimes by phone and at other times in person, depending on individual participant's preferences. All participants were guaranteed confidentiality. They were aware that identifying features would be removed from the interview data. They understood that anonymity couldn't be totally guaranteed within a small society. I showed two participants chapter drafts and checked that quotes that I was using would not identify them. Both participants were happy that it would not do so. Participants consented to the research findings being used for the purposes of publication and dissemination through conferences. They also consented to the data being used in future research studies that I might undertake.

All participants were aware of the security precautions that would be put in place for the interview transcripts. The principal supervisor, Jan Wilson, kept the consent forms in a locked filing cabinet at the Auckland University of Technology.

Cultural and social justice

The Treaty of Waitangi provides me with the right to live in New Zealand. The partnership within the Treaty of Waitangi is between Maori and other New Zealanders. This research study needs to benefit the needs of the nursing profession and potentially all older people who are cared for by registered nurses.

The research project was discussed with Kawa Whakaruruhau Komiti from the Auckland University of Technology, School of Nursing and Midwifery, prior to my final decisions regarding methodology and research process (Thomas, 2000). I wanted to leave room for a negotiation process, should Kawa Whakaruruhau wish to enter into a bicultural research project. The committee did not think that they could do so at this time. Kawa Whakaruruhau, however, offered a support person for any participants who were Maori. Unfortunately, I did not have any Maori participants. Regardless of this, and in view of the proposed future ageing of the Maori population, a copy of the findings will be provided to Kawa Whakaruruhau in order to inform any questions Maori may have about registered nurses' work with older Maori. Interpreters were to be offered to any participant for whom English was not the first of their languages. Again registered nurses from other cultures did not choose to enter the research study as participants.

Ethical approval

Approval for the research project was gained from the Auckland University of Technology Ethics Committee (AUTEC). The documentation from this committee was available to all participants. All participants received an information sheet that contained the phone numbers of a designated person from AUTEC. They were aware that they could have access to this person if required at any stage of the research project.

Autonomy

I have described earlier in this chapter, how I approached research participants to ensure that they did not feel coerced in any way. I reiterated the consent procedure again prior to any interview taping. The participants were given a choice of venue either at their own home or a private room at the Auckland University of Technology. From the first contact, the participants received the name and phone number of my supervisors in case they wished to discuss any issues that may have interfered with their autonomy.

Risks to the research participants

There is a tension that exists in all research projects between the risks and benefits to participants (Tolich, 1999). For this research project, participants were reflecting on the work they do with people who may be entering the final stage of living. I had offered support for any participant who was triggered into an emotional response as a result of reflecting on their nursing practice or on the contexts within which they practice. While some participants found the reflection process regarding their work disturbing, they did not request any further assistance. For one participant, the research process gave her a voice that she did not have in the facility where she worked. She told me this when I took the findings back to her, and her comment demonstrates that while there are risks within the research process there is also the potential for benefit to the participants.

Conclusion

For this research project, I used grounded theory dimensional analysis. The theoretical perspective which guides grounded theory is that of symbolic interactionism. Symbolic interactionism is a sociological perspective which arises out of the constructivist interpretivist paradigm. According to symbolic interactionists, individuals and society are co-constructed. Individual and group actions arise out of the meanings which actors give to events in their lives. Over time individuals within a society develop shared meanings and shared patterns of acting. Underlying these patterns of action are social processes or social psychological processes which can be articulated. Glaser and Strauss (1967) developed grounded theory in order to explain the processes which people use to solve problems within their daily lives. Grounded theory methodology is so named because the data which is used to develop theory is derived directly from the field of study.

Grounded theory analysis involves a concurrent process of data collection, constant comparative data analysis, and theoretical sampling, based on the emerging theory. Schatzman (1991) developed the dimensional analysis process of grounded theory as a method of analysis which was aimed at systematically analysing data according to the dimensions of social processes. These dimensions of social processes include the perspective, context, conditions, strategies, processes, and outcomes individuals use in problematic situations. Dimensional analysis involves looking for the ways in which changing contexts and perspectives alter the strategies and processes people use in order to solve daily problems.

In this grounded theory research project, I was interested in exploring the work of registered nurses working in residential aged care. The project involved ten registered nurse participants who undertook individual indepth interviews. Using the concurrent processes of data collection, constant comparative dimensional analysis and theoretical sampling, dimensional matrices were developed which explained registered nurses' work in residential aged care.

Trustworthiness of the research findings was demonstrated by my use of supervisors, documentation of analysis, and presentation of the research process development to colleagues. When the research findings were taken back to participants in order to check that the findings did fit with their experiences in residential aged care, their responses were positive.

I experienced the grounded theory research process as both exciting and exasperating. As a novice researcher, I did move off track at times as I was learning the skill of dimensional analysis, and theory development. Because of the supervisory process and challenge of colleagues, I was enabled to develop my skills and become more proficient in this method of research. The outcome of this research process is that the results are well grounded in the data; the research project has followed a safe ethical process; and has uncovered the processes which registered nurses use to manage their work in residential aged care in the New Zealand context. Chapter Five and Chapter Six contain a full description of the research findings.

CHAPTER FIVE: RESEARCH FINDINGS

Shifting Focus. How Registered Nurses Organise their Work in Residential Aged Care

> What I do can be the difference between those frail years
> being really good or those frail years being really unpleasant
> (Rose)

This chapter begins to answer the following questions. How do registered nurses conceptualise their different care approaches? What conditions influence the decisions registered nurses make when they organise their work? What is the purpose for which they are organising? I commence the chapter with a brief overview of a substantive grounded theory which I have named Shifting focus: How registered nurses organise their work in residential aged care (diagrammatically represented in Appendix G). I will then describe the first grounded theory process of 'focusing on the resident and their family'. The processes of 'focusing towards the resident', 'focusing on routines and tasks' and 'focusing on safety' will be described in Chapter Six.

Overview of Research Findings

This research study uncovered that the participants organised their work according to contexts and conditions that required them to shift their focus. The shift in focus, moved from a focus on the client and their family, to shifting focus back towards individualised client care when care routines had become a predominant focus. Some participants focused on routine care and then on safety, when conditions within a facility were such that the participants' ability to direct care was severely constrained. The participants employed different strategies for each shift in focus. They related the

change in strategies to variations in staffing levels as well as to the culture of the organisation in which they worked.

Participants perceived two main organisational approaches that set the culture of care in the facility where they worked. Firstly, they described a context where there was an active philosophy of care that aimed towards placing the resident and their family at the centre of that care. Work processes, staffing levels and the day to day running of these facilities were set up in a way that facilitated the registered nurse to focus on the residents, families, and staff needs. Secondly, participants described a context where there was an articulated philosophy of care that was focused on the residents' needs. In these contexts, however, the work processes, staffing adequacy and the day to day running of the facility was organised so that there was a predominant focus on the collective needs of residents. In these instances, the participants described the organisation of the facility as traditional and hierarchical. Some participants described traditional and hierarchical organisations that were deliberately moving towards providing more individualised care. Other participants did not perceive any movement towards changing work practices so that care could become more individualised. All participants talked about the scope of their work and responsibilities.

Registered nurses in the residential care setting supervise unregistered staff who carry out most of the direct personal care for residents. When one participant talked about her vision for care within her ward, she stated that "to get it to work I actually have to get the staff to do it because there is more of them" (Rose). Registered nurse work extends beyond the direct clinical care that they provide for residents. They may be the only registered nurse on duty or they may be on duty with one or two other

registered nurses. It is their responsibility to organise the caregivers, attend to administration and trouble shoot any issues that arise within the complex.

The range of responsibilities is dependent on the registered nurses' level of authority within the complex. For example, four registered nurses who were participants in this study, worked in complexes where, during their time on duty, they might be responsible for the hospital wards, the dementia care centre and the rest home area. They may also be responsible for responding to requests for assistance from people who live in cottages on the site. How they attended to these responsibilities was to shift their focus of how they organised their work.

When the participants worked with a focus of individualised care, they organised work so that the relationships between residents, family and staff were optimised. Their ability to work within with this focus of individualised care was influenced by their level of authority and the culture of the facility. When the participants' focus of individualised care was congruent with the facility's vision of care, their work strategies were aimed at setting up work conditions that placed the resident and the family at the centre of care delivery. There was a variation in this process that caused the participants to make deliberate decisions to re focus on the resident. When there were times of staffing variations, the participants shifted their focus to concentrate on assisting care staff to continue to provide resident centered care. Here their strategies were shifting administrative tasks or development projects to the background in order to focus on providing care for the resident.

The next process 'shifting focus towards the resident' was described both individually and collectively. When participants worked informally alongside individual staff, they facilitated a shift in focus away from tasks and routine towards the resident. Participants who worked in adjunct positions worked with staff individually and informally, in order to facilitate a shift in focus towards the resident. These staff were not responsible for a direct care area but for a function within an organisation such as quality assurance or education.

When the participants who worked within a hierarchical organisation had some authority, and had extra time they worked to shift the culture of the organisation towards becoming more resident centered and they enacted strategies towards this end. Participants in these contexts perceived that they could work in facilities with a focus on routine and task and still aim over time, to achieve their vision for individualised care.

Task and routine, however, became the focus when the participants worked within a hierarchical framework in an institutional culture and perceived staffing to be inadequate. At these times the participants added individualised care into the routine for some residents. In this context, the registered nurse did not have authority for decisions about staffing levels and care practices. These decisions were made at management level with little input from the registered nurses working individual shifts. For participants working in these environments organising work focused on the tasks of client care within a definite routine. Relationships with individual residents gave way to the process that I have named 'focusing on routines and tasks'. Staffing constraints led to the final shift in focus, that of 'focusing on safety'. The focus on safety occurred

regardless of the organisational care approach and was a result of severe staffing constraints. In some instances, this process occurred infrequently, in others, frequently.

All participants pointed to staffing, as the most salient dimension of their work that led to difficulty in providing high quality care. Within an institutional setting, difficult times however, were perceived not only in terms of staff numbers, but also in terms of staff experience and staff attitudes to the residents, their families and the participants. Some participants deliberately worked to develop the staffs' knowledge and skill in order to be more resourced when staffing was constrained. Resourcing in this context included knowing the resident and their family; knowing best practice in care delivery, and knowing what is expected in terms of how the facility was organised. Added to this staff, are resourced in knowing the organisation's expectations of how residents ought or ought not to be treated.

The remainder of this chapter focuses on a detailed description of the research findings, beginning with how the participants organised work to focus on individualised resident care. This process has been named 'focusing on the resident and their family'.

Process: Focusing on the Resident and Their Family

The following dimensional table, summarises the research findings related to focusing on the resident and their family. The various ways in which participants perceived client-centered care will be included in a description of how these perceptions influenced the way in which registered nurses organised their work. The research findings will be discussed in Chapter Seven.

Table 3. Dimensional matrix: Focusing on the resident and the family

Process: Focusing on the resident and the family		
Dimension	Category	Sub category
Perspective	Working from a philosophy of individualised care	Perceiving uniqueness Translating philosophy to practice
Cause	Authority to direct care	Having authority Managing what's going on
Conditions	Having adequate staffing	Using resources creatively Working with familiar staff
Strategies	Leading the team	Being an effective role model Building team cohesiveness
	Getting to know work	Prioritising personhood Focusing on care processes Using inclusive strategies
	Establishing supportive systems	Communicating expectations Providing frameworks for care
Consequences	Effective care outcomes	Optimizing physical and emotional health Maintaining staff job satisfaction
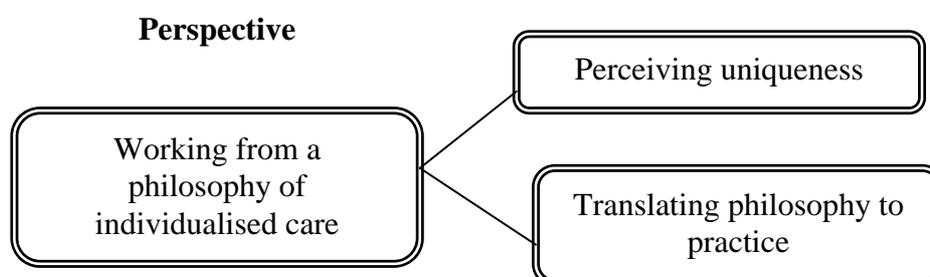
Perspective

Figure 2. Perspective: Working from a philosophy of individualised care

> The client is not just a medical problem. The client is a unique person. You tailor the care to that person. (Ros)

Perspective: Working from a Philosophy of Individualised Care

How did the participants perceive they were working from an individualised approach to care? The codes that built towards this category included the ways in which the participants thought about the uniqueness of people, and their understanding of the residents' contexts. These particular ways of thinking and talking about the residents'

uniqueness were collapsed into the sub category of 'perceiving uniqueness'. How the participants translated this philosophy into action included codes about including the resident in decision making, consulting with families when it was not possible to include the resident and planning ways to meet the needs and goals that the residents and families wanted. Codes in this dimension were collapsed into the category of 'translating philosophy into action'. Together these codes collapsed into the category of working from a philsophy of individualised care. There was then, a relationship between perceiving each person as unique, being able to articulate that perception to others, for example, families and staff, and then being able to move that perception into action. When these relationships were present, the participants perceived they were working from a philosophy of individualised care.

Sub category: Perceiving uniqueness

Individualised care for the participants was about the residents having choice, independence, comfort, and being satisfied with their lives.

> If people want their lunch at 2 o' clock they have it at 2 o' clock. It's their main meal, they can do what they like. (Victoria)

> I think I can give more choice to them like if they want breakfast in bed or if they want to go to bed for tea or they don't have to get up early. A more relaxed atmosphere. They can join in what they want or they don't have to. (Alice)

The majority of participants worked with residents who were either very frail or who had a dementing illness. When Rose talked about working with residents who have a dementing illness, it was about finding their individual meaning and working towards meeting the resident's needs in a way that is appropriate to that meaning. Implied in

these statements are the concepts of enabling people with chronic illnesses to have a

satisfaction with life, be comfortable, and to make their own choices.

> While I need to know what is happening with their brain and drugs and what's going to happen to their bodies and things. The challenge is finding their spirituality, their … what's underneath. Their psychosocial needs. Meeting their person needs is actually what makes a difference to their being. So that is incredibly challenging. (Rose)

> Yes. Sometimes someone will come in. If the family or the resident is capable of choosing . Some residents are perfectly capable of choosing or not choosing. We are quite happy for them to. Independence is very important. (Victoria)

How then do these registered nurses translate this philosophy to practice?

Sub category: Translating philosophy to practice

Participants described how they included residents in decisions about what they

wanted. The degree of rehabilitation that the resident would consider was discussed and

the subsequent goals decided together with the care team.

> And the patients talk about what they want. So we can talk about their goals with them. Some of them don't think they want to be rehabilitated but they might want to go out in the car. Well at the moment they can't even stand (Sally).

> … He was obese. Had heart problem . He came in a four category of care [Support need level four]. And we set him up in a big rocker, just started talking to him "do you want to live"…Yes he says. "Are you sure you want to live? It's going to be a hard fight for about six months". Let's see what we can do with your diet and your drugs and turning and exercising. The girls would move his arms and legs and things. That was four years ago. So he is very happy. (Victoria)

Negotiating choice within a facility was seen as a two way responsibility and not always simple. While participants recognised the importance of choice they also recognised that there is at times, a tension between their professional responsibilities and the personal choices that residents might make. The following excerpt demonstrates some of those tensions the participants encounter:

> … it depends what you see as safe. Safe practice is what is safe for the client is probably what the client wants. If the client wants to walk around and fall over, is that safe practice or is that unsafe practice? I feel that it's their choice … if its an informed choice and they choose.But is it also right to keep them cocooned in the bed with the cotsides up and buffered up with pillows just so they don't fall? So I think there's a balancing act. How far do we go in allowing a person to make their own choices? And when do we intervene and say " We need to look at different options ". (Ros)

How is choice afforded to residents who are cognitively impaired? For Rose and Susan whose specialty is working with people with dementing illness, choice is about finding out the person's preferred activities and reestablishing them where possible. It is also about listening for the message inherent in the resident's behaviour. Susan talks about how she responds and teaches staff to respond to individual resident's communication.

> And we have somebody … and they have been watching me over the weeks and now they, the staff will actually do what I do and I don't get called every time he bangs the table because actually all he is doing is calling for someone but the staff were taking it as aggressive and frightened to go in there but now they just do what I do. I walk in and start talking to him as a normal sensible human being and ask him what he would like and he is fine. He responds accordingly (Susan).

Rose spends time looking for the meaning in a person's behaviour so that she can plan appropriate activities and interventions. The following quote also demonstrates these registered nurses' ability to recognise the residents' contexts.

> I guess it's me finding … Me believing that there is meaning in that activity and that it's actually therapeutic for her and realising that she was once an incredibly busy housewife like for instance she never eats. She **never** eats breakfast sitting down and now that she needs to be fed I actually have to feed her standing up and I see myself in the mornings doing it as well when I am getting my own children off to school that I eat standing up and on the run and that's how she does it. That's how she does her life (Rose).

These particular participants, had the authority to put their philosophy into action. In the next chapter I will consider those instances where the person may have had a philosophy of individualised care but not the authority to put that vision into action.
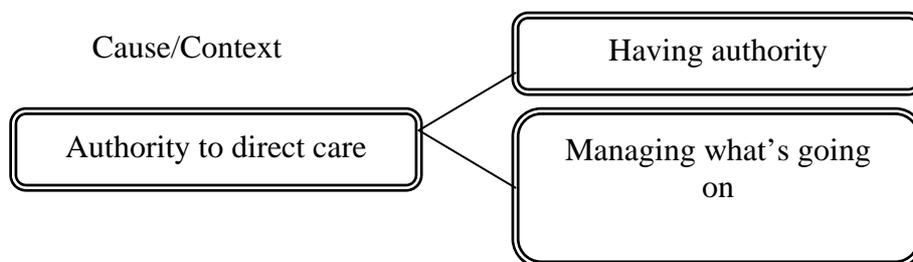
Figure 3. Cause/context: Focusing on the resident and their family

Sub category: Having authority

Seven participants were registered nurse owners, managers or charge nurses. One participant had authority for runing a unit but did not have a title which indicated her authority. The owner managers had full authority to direct the philosophy of care within their facility.

> The reason I started off with older people, I mean this kind of business is that I did find working in private hospitals or working for the public hospital where ever. There was always something. It always seemed to me to be a rush. You didn't get time or the care that you like to give and that's really why I decided to look after older people. To make it a more relaxed time for them. Yes and to give that extra little thing that I thought was missing. Plus I like my own business and having it the way I enjoy. (Alice)

The remaining nurse managers and charge nurses were part of a wider organisation.

> I have to make some of the management systems and run some of the management systems like making sure the quality assurance program's working and writing up reports for the board and doing the staffing and the rosters and all those sorts of things. (Rose)

Because of the level of authority these participants had available to them, their philosophy of care could lead to active care strategies within their area of authority. These participants did need to fit with the organisational structure for some structural processes, such as documentation.

Some participants working in an area which was part of a larger, facility expressed dissatisfaction when they perceived that the organisation did not necessarily share the same philosophy of care, or when a philosophy existed but the participants did not perceive that it was active throughout the organisation. While they retained the authority to direct care processes in their area, there was some impact which led to tensions between them and the organisational structure.

> I think where we are we have a philosophy of care but it is not strong enough.The institution that I work for is huge. It isn't entrenched enough in the institution. I think that we are working. We're working really hard at talking about what we are doing but we get constrained within our institution by

the expectations from our institution as well. While we might be talking about creating this homelike environment, they're talking about these are the careplans that we will use because this is what everybody uses but they don't necessarily fit for us and that every thing that we create has to be approved, by a quality assurance group of people. And we might be thinking. "OK what we are going to do now is, we're not going to wear uniforms and things like that, that turns us into an institution". But the institution that we are a part of doesn't like that. (Rose)

Dissatisfaction was mostly voiced in the area of philosophy, documentation and to some extent staffing. The reference to staffing occurred when caregivers came from other wards to replace absent staff. All the nurses in the situation of being co located within a wider organisation were active in working to influence change throughout the site.

I push for things that I think are actually really important for the staff and running the unit and things. (Rose)

Sub category: Managing what's going on

Registered nurses in aged care are usually responsible for directing the care as well as managing the facility. In some ways, they can be seen as a conductor working towards making sure that care is effective and appropriate and that the facility is working harmoniously. Ros describes this conducting activity:

Yeah. I think it's continuous. It's like your assessing the situation all the time. I mean you're assessing each client on every personal encounter, on every reporting encounter you get from your staff as well. There are the external things you are pulling in too. Such and such needs an Xray, such and such needs to be at this place at that time Ummm I think you're kind of gathering how the staff is on that day, how they're going to work and have I got enough staff for this shift. Do we have hot water, do we have enough medication, and do we have all that stuff will be data processed probably while you are trying to do something else. And while you're there you're looking and smelling and feeling and talking and the whole process . (Ros)

The participants talked about balancing staff with appropriate skill mix. They matched caregivers with clients towards providing positive care outcomes, and stepped to assist staff with client care.

During the initial coding of participants' data, I had thought that supervision was going to be 'the process' which guided this whole study. Supervision has remained a major part of the participants' work that was aimed at ensuring that residents' care needs were met.

> I can see everything that's really going on and with only one glance I have now got it all. I don't have to and often I don't do anything at that time. I just leave it and then I come back to it again and watch and you can get an idea of the performance of staff. (Alice)

For these participants, caregiving staff are an integral part of the care team rather than being positioned as unskilled workers that need to be under surveillance. The participants had the knowledge and experience to direct care. They also had a legal requirement, as registered nurses, to be accountable for the quality of care that is delivered. Participants were aware of the need to supervise caregivers and check that care was delivered appropriately.

> I'm always looking and always seeing and always walking around, as are the others [registered nurses]. (Sally)

How staffing was organised facilitated this process of supervising and managing what was going. Adequate staffing assisted the participants to direct staff so that care was focused on the individual resident's needs.

Conditions

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┌─────────────────────────────┐
│  Having adequate staffing   │
└─────────────────────────────┘
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┌──────────────────────────────┐
│   Using resources creatively │
└──────────────────────────────┘

┌──────────────────────────────┐
│   Working with familiar staff │
└──────────────────────────────┘
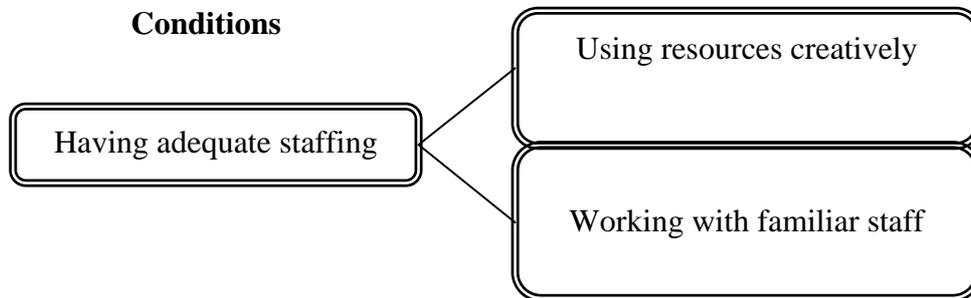
Figure 4. Condition: Focusing on the resident and their family

Condition: Having Adequate Staffing

Participants discussed staffing levels at length. They were very aware that there was a minimum level where their ability to continue to be focused on the resident would be severely reduced. How the registered nurses approached their organising work when staffing was reduced will be discussed in the processes of 'refocusing on the resident' and 'focusing towards routine and tasks**'** as well as when I describe the process of 'focusing on safety'.

Most participants had staffing levels which they perceived to be appropriate at the time of interviews. Most participants employed more staff than required by their licensing agreement with the Ministry of Health. This was a deliberate policy and was seen to be important if they were to continue to deliver the quality of care which would meet their professional and business needs.

> Because of the layout of the building and size of the building, we aren't the flashiest facility in town. We don't have the money behind us to be the flashiest facility. So from a business point of view, to be 100% full, is more viable than providing less staff and poor care and being 70% full. So we made a business decision that we would be 100%

full and we spend no money on marketing. We spend no money on advertising. In fact we are not even in the phone book through whatever and we get more referrals. I mean people come because of the care and I think that's been a good choice. (Sally)

But its got such a good reputation that it doesn't need advertising. People just come along. A most amazing thing. A lady came along today and she said "I took my mother out of [named facility]". Because she took her to another rest home which is much newer and flasher and stuff and she said "I can't stand the care my mum is getting I need her back". (Victoria)

Each facility configured their staffing differently. Resident dependency levels had an impact on staffing numbers. For the two rest homes where there were less than 20 residents, the registered nurse owner managers worked at least full time which provided coverage beyond the minimum. The following excerpts are examples of staffing levels and requirements as described by one participant:

15 [staff]. There is 4 full time and the rest are part time to varying degrees … but you have to have 24 hour care and I've got palliative patients. Come in for palliative care for two or three weeks time to die. They need special nurses for them. My nurses are care givers. The emphasis is on care.

2 RN's, 2 EN's, the rest are caregivers or qualifying to be caregivers. Each have got their own things to bring to the home. My rest home only needs 13 half hours a week of RN input. (Victoria)

The dementia care units had between fifteen and thirty beds. The residents in these units were, at the time of interview, quite mobile, with some residents maintaining quite a high level of cognitive and physical functioning. These units were co located within a wider organisation and their resident staff ratio was not as high as in the owner manager facilities. Susan had a ratio of caregiving staff of one caregiver to ten residents, while Rose had approximately one caregiver to eight residents. Added to these caregiving numbers were hours where activity assistants came to the unit for

specific times. Both participants had one day a week where they employed a registered nurse while they attended to administrative work and special development projects.

> I've employed another nurse to work on [day named] so that
> I don't have to do any clinical stuff on [day named]. (Rose)

The private hospitals also provided more than the required level of staffing. The facility with less than fifty residents had between two and three registered nurses on a morning shift. These registered nurses did not have a client load. The facility ratio of caregivers was one caregiver to five residents. This was the highest level of staffing within this participant group.

An overall staffing ratio is not provided in this description because of the range of client dependency levels, and the varying ways in which staffing was configured to meet the resident care needs. A consideration of this factor gave rise to the subcategories of using resources creatively and working with familiar staff.

Sub category: Using resources creatively

Participants used resources in a number of creative ways. Staff coverage was heavier in busy times and at times when management was not so present, for example at weekends in some facilities. In other facilities, money was prioritised for the staff budget. Advertising was minimised in order to focus the budget towards staffing. Equipment was used judiciously for the same reason. Those participants who were owner managers considered that a good professional and business decision was to ensure that their facility had a name for good care. They considered good staff to be a critical factor in achieving a reputation for the quality of resident care.

> It's actually keeping the staff focused and happy and I don't think that that happens with caregivers all the time. I think that the majority of caregivers are treated shockingly in some facilities. Aren't respected or aren't valued. The reality is that they give 90% of the care so if they're slack; care is slack. (Sally)

Sub Category: Working with familiar staff

Most participants had staff who had been working for them for a long time. During staff shortages, the existing staff would provide coverage and the participants would do caregiver shifts if required.

> When staff, caregiver, a valued caregiver if something happens, usually the other staff because I have got so many. Because they are just so bonded will ring up and say Oh [name] rang and said she is sick and got a headache. I can do that shift and have my day off later in the week if that's all right. On it goes. It's a good thing that you put so much effort into people that you get something back.(Victoria)

Two owner managers did not use nursing agency staff at all. Those who did use nursing agency staff had a process of asking for effective staff to return when next required. At the same time they asked that staff who were not effective did not return.

> The agency nurses. I keep an eye on what they are doing especially if they have never worked there before. I also get feedback from my staff because they are very concerned about the residents and they don't want anybody who isn't going to give the best care. (Susan)

Staff recruitment was selective. While participants were concerned that staff were not attracted to aged care and staff recruitment was becoming more difficult, they also worked to ensure that the registered staff they did have were suitable. All participants felt that they would be willing to use scarce resources on assisting staff to settle and develop within the facility, if the staff member was going to be able to work

within the philosophy of the facility. This was more definite for some participants than for others.

Sally describes her approach in the following quote:

> Getting all staff in the last two years is really difficult. And that's really stressful. Registered nurses …always had our quota of registered nurses. Really committed staff and good staff. Probably six months ago we were two registered nurses short. … and staff that actually came and applied to the ad I wouldn't employ. So we were short for probably for four or five four months anyway. I just wouldn't employ them. They had the NZ registration. They just wouldn't have fitted in as part of the team.
>
> **What would need to be different for them to have fitted in?**
>
> I think one is their skill level yeah … so their skill level and I think their communication. Their English was poor. And when I asked them what their philosophy was in caring for older people they couldn't even answer me. When I asked them what was important for them caring for older people, they couldn't answer me. So I couldn't see the point in paying. (Sally)

The participants' actions with staff in maintaining the quality of resident care forms part of the sub category of 'leading the team' which is described in the category of 'getting to know' work.

When the participants had the authority to direct care and adequate staffing, care centered on the client. Given these conditions what strategies did the participants put in place which led to the process of focusing on the resident and the family?

Strategies

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┌─────────────────────┐        ┌─────────────────────┐
│  Leading the team    │────────│ Being an effective role │
│                     │    ╲   │        model         │
└─────────────────────┘     ╲  └─────────────────────┘
                             ╲ ┌─────────────────────┐
                              ╲│  Building team       │
                               │   cohesiveness       │
                               └─────────────────────┘
┌─────────────────────┐        ┌─────────────────────┐
│                     │────────│ Prioritizing personhood │
│  Getting to know work│    ╲   └─────────────────────┘
│                     │     ╲  ┌─────────────────────┐
└─────────────────────┘     ╱──│ Using inclusive strategies │
                           ╱    └─────────────────────┘
                          ╱     ┌─────────────────────┐
                         ╱      │ Focusing on care processes │
                                └─────────────────────┘
┌─────────────────────┐        ┌─────────────────────┐
│ Establishing supportive │─────│   Communicating      │
│      systems         │    ╲   │   expectations       │
└─────────────────────┘     ╲  └─────────────────────┘
                             ╲ ┌─────────────────────┐
                              ╲│ Providing frameworks for │
                               │        care          │
                               └─────────────────────┘
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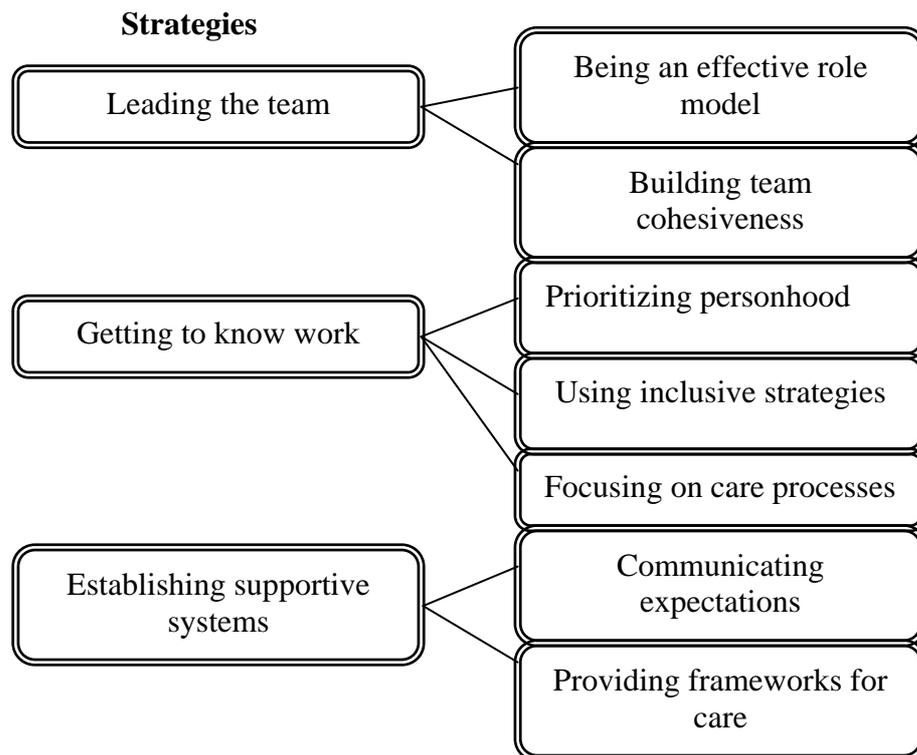
Figure 5. Strategies: Focusing on the resident and their family

Strategy: Leading the Team

The participants perceived that one of their major responsibilities was to lead the care team. They talked about the importance of the caregivers' contributions towards maintaining quality of care. They also recognised that to facilitate the caregivers' contributions towards quality of care they needed to consider the caregivers' needs as well as the development of caregiver practice. There were two aims for this strategy. The first aim was towards a high quality of resident care, and the second was to provide job satisfaction for caregivers so that they would remain working with them.

Including the caregivers in care decisions, valuing their input and rewarding them for work, were leadership strategies aimed at maintaining a quality of care not only for residents but for staff. Caregiver practice was developed through formal and informal education. Valuing caregiver work included strategies such as providing support, recognising good care work, celebrating events, assisting with personal needs and understanding the caregiver context. The participants talked about how they role modelled leadership and worked deliberately to build the team. When I was analysing the participants' data I considered that a registered nurse can get to know caregivers without necessarily using that knowledge to further resident care. Taking a leadership position was a strategy that facilitated the participants to develop a cohesive care team.

> I work as a team leader. I don't see myself as a charge nurse, a manager or a big title. I see myself as leading them and sometimes having to pick up the pieces if they need someone to help clean up, I go and do that. So I'm doing any job that really comes up and I help anyone. But as I am doing that I am teaching and I think as a charge nurse you've got to teach your staff. Especially in a specialised area like dementia. (Susan)

Taking time to get to know the caregivers is an organising strategy aimed at maintaining and developing caregivers to become part of a team. Participants wanted to keep their skilled staff and recognised that a relationship existed between the morale of the staff and the maintenance of quality care.

> I think it's at our level, at my level it's a constant battle to keep the morale of the hospital high enough to ensure that the quality is provided. (Sally)

Participants employed a number of strategies to let staff know that they were valued. On a personal level, birthdays were celebrated along with seasonal celebrations; time was given when a staff member's family needed to take priority; money was saved for staff to have extra celebrations, and dinners were held at various times to mark the contributions of staff. All these rewards demonstrate a valuing of caregiving work.

> Staff meetings. Informal parties. Everybody who has a birthday gets spoilt for the day. Oh we put banners up for the staff. Put money in for presents. Figure out what they would like particularly that's nice. A cake. With the residents too, … sing them happy birthday. The same as the residents get. It makes you feel good for the day I hope. I hope. (Victoria)

In the same vein Sally takes time to reward caregivers.

> You know just giving them support. Like they might want time off to take their family here there or anywhere. They might be stuck financially for a week. Lend them money and they pay it back in next week's wages. (Sally)

Leading the team included developing the caregivers' knowledge and skill. Continuing knowledge development about gerontological nursing featured in all participants' data to a greater or lesser degree. Two participants had a Masters degree, and one participant was working towards this degree. Two participants had completed their degree in nursing since becoming registered and the remainder was involved with education in some form.

Education can be seen as both a strategy to develop quality of care and a strategy to value caregivers.

> I've got both men and women working for me. They like the input. They like to know they are getting somewhere. Being validated and are part of the team, part of the working structure, and every bit of information they get goes towards

their CV. You know, every bit of knowledge they get is helpful. (Victoria)

Including the caregivers in discussions regarding the resident they are caring for is an aspect of getting to know work (discussed within the next strategy).

And I mean we have taken patients who have been severely dehydrated from other facilities and haemoglobin's sky high and within a week or two weeks, haemoglobin is normal and their sodium, potassium is normal. And the staff see that. So we actually share that with the staff. And the doctors do too. So the doctors know all the caregivers' first names. And if we do a doctor's round and they go to a ward, the doctor will say "Hey [name], how's Mrs [name] today". So they may not ask us. So they do feel part of … And they all come to the family reviews. (Sally)

Participants deliberately employed strategies of role modeling and showing by example as they worked alongside caregivers.

Yeah building teams. And to be part of the team you actually need to be working with the team. You can't be "I am the team leader but I'm going to tell you what to do but I am not prepared to do it myself" I don't think. And that's also to do with assessment. But if I am not prepared to clean up faeces and vomit, hey, what respect am I going to get from caregivers working in the team with me? Working alongside the caregivers that's when you get the opportunity to say, "Oh look at that ", or "this is how should you do it" or "do you know that" or "do you know why this has happened"? Or even just listening to how the registered nurse interacts with the client may change attitude, may change care delivery. (Ros)

In order to build the team, new staff had approximately two weeks orientation. The orientation would be extended if the new staff member wasn't quite ready to work alone. Alice describes part of the process as follows:

I bring them in for the mornings because I feel you get to know your residents at that time of the day. I really feel that they are more alert, the residents. They get to know the staff. Their needs are more at that time because you have showering, activities, and all the people who are already

> coming in and out of the home are coming at that time. So they can see how the home is run. They might do that for four or five mornings. They'll come in for the afternoon. Work with the other afternoon person or usually I work with them for a few afternoons. (Alice)

Caregivers had input into careplanning, attended resident care review meetings and were representatives on facility committees. Some participants had developed a pathway for caregivers that led to the caregivers having seniority and becoming team leaders.

> So I did things like. Who is going to first lunch and asked the senior staff member so that she would start making decisions and what I found out is they would automatically make decisions but that's how I started them making their own decisions. I had one of my junior staff in charge the other night and I said to her "It's your staff. It's up to you what you do. If it was me I would ... but it's up to you. It's your shift" and I walked out and I noticed she followed my advice. But I didn't want to take it away from her. (Susan)

There is a relationship between leading a team and the strategies participants used to develop a high quality of care. Getting to know the resident was a strategy which was built into the structure of work and was aimed at making sure staff knew the resident.

Strategy: Getting To Know

Participants organised time so that they and the staff could get to know the residents and their families. 'Getting to know work' has three subcategories, 'prioritising personhood', 'focusing on care processes', and 'using inclusive strategies'.

Getting to know work is focused work that takes time. This type of work is episodic and contextual, for example, getting to know might be about getting to know a new resident and his or her family or about developing a relationship with the resident

over time. 'Getting to know work' is about building relationships, which in effect gives a voice to residents and their families. Participants aimed for an environment where input into care was encouraged from the resident, the family and the staff.

> I think after that it's just once they are on the ward, they get to know the families themselves and these are very involved. (Sally)

During my initial coding I had named this category 'knowing'. As I generated more codes related to the various types of knowing and began to understand the relationship between getting to know work and other types of work, I realised that knowing is a developing activity. 'Getting to know work' then is work that is ongoing and dynamic and which takes time.

> The most benefit that most people get is actually from one on one stuff and that it's finding what that one to one thing is, and actually doing it. And the other thing that is part of all that component, is that the caregivers are really unique and individual. And that's the other thing that I really need to recognise. That somebody actually might not seem to be like ummm doing very much for want of a better word. But the fact that she actually takes a resident with her that finds ummm housework meaningful and that's part of it. The fact that she takes that person with her, and they make beds together …all be it that it takes forever, is actually just as meaningful as someone that will ummm go for a walk in the garden, with someone else who that is important for. (Rose)

Participants either talked about getting to know, knowing, or needing to know. Included in 'getting to know work' is reflection, discussion, and thinking about how to best meet the needs of residents' families and staff, or, how to approach changes in care delivery. A major dimension of getting to know work is getting to know the resident.

Sub Category: Prioritising personhood

The registered nurses described how they get to know what is happening for the residents.

> Like trying to be really intuitive about what actually might be happening for people and then it's always changing so that it's…. Yeah I guess it's about getting to know people really really really well and then looking for the person who is there underneath their disease because…Even though people can be incredibly diseased … the essence of that person still remains. And it's still trying to find the essence and work with that. (Rose)

All participants talked about getting to know the person they were caring for in order to be able to meet their needs.

> I ask first and do our best to cater for what they want…cause I am lucky. We are a small rest home and we have got plenty of time to do that. Oh not plenty of time, but are able to do that. (Victoria)
>
> I think good care for me is about being able to assess and meet the patient's needs so that their essential functions their activities for daily living if you like will be met but also that psychologically we will actually care. (Sally)

For the participants, getting to know work was about building a relationship with the resident.

> He is coming to terms with it and then I ask him to do little things for me that I know he is capable of doing and he thinks that's great that he is included. (Victoria)

When the resident and the registered nurse work together within this relationship, it could be said that the resident is 'given a voice' about what is happening for them. This strategy then, fits with the participants' notions of choice and negotiating choice. Residents were also invited, where they were able, to have input into their care plan, and to be a part of the family meetings.

> Well residents have input and residents are asked and family are asked when they come into the home to be part of the care plan. We do like their input. (Alice)

When the resident was admitted, the participants described a mutual getting to know process, in order that the facility continued to operate harmoniously. Admission, in these instances, was a negotiated process with both sides needing to be comfortable however; this appeared to be more important for those facilities with a smaller resident population.

> Usually I get them or their relative saying "Oh yes this will be fine, Mum will love it" and I am not having any of that because it's only a small home. I have to like them. They have to like us. Let them come, stay a few days or not whatever, or just afternoon teas, and see how we get on. And then they, you can see that they get to like you and are thinking, oh well she's all right. So things are not stuck in concrete. (Victoria)

Participants took the time to get to know the resident in order to deliver individualised care. Within each facility where the participants worked, there was a level of routine. The routine was flexible towards the residents' needs. The process of care rather than the tasks or the routine of care was emphasised.

How to solve particular care or organisational issues such as a reduction in resident falls also fits into this category of work. Participants talked about times when care practices were not working effectively. Their interviews contained what I coded as conversations of possibilities, in which they noticed a care process was not working as well as they would want, and began to do something about improving that care process. In contrast, those participants who worked in the institutionalised settings talked about not being able to do much about certain aspects of care. For those participants who could work from a philosophy of individualised care, getting to know the resident helped them to plan the resident's care.

Sub category: Focusing on care processes

> We will show that we want them here. That we will meet
> their needs. That we will communicate with them and that
> we will be available. And the continuity is going to
> continue. That it might not just happen for eight hours. It
> will happen for, you know, 24 hours a day, 7 days a week.
> (Sally)

When participants described their care processes, their language was about assessing care needs with the resident and the family if the resident was unable to do so. They talked in terms of resident choice, and resident preferences. Added to this, there was an emphasis on moving pace with the resident rather than expecting the resident to move to the nurse's pace. For example, Alice talks about how she encourages the caregivers to work with the resident:

> You walk with them. You walk slowly. You don't make it
> "Oh come on. There are 101 things I want to get done"
> Some people can manage the 101 things as well as walk to
> that pace and it's not particularly here. I am only talking
> about my own home really. You have time. (Alice)

Care assessments were individualised and consultative and took place over time

> I guess families and what they say about people are really
> important. So finding out what's gone on before hand is
> really important but sometimes by the time that people come
> to you, the families have actually forgotten…a lot of that
> stuff because they have been existing with this other person.
> And they have almost forgotten the important things as well.
> So that it's … it takes a really long time. So sometimes it's
> just sitting and watching and looking at events that happen
> and then trying to ummm trying to explain why they might
> have happened or … Ummm … trying to find some
> meaning and trying to find some meaning for the person . I
> mean they can't tell you what the meaning is…and then
> talking to families again. And then talking to, trying to get
> staff to write down what they think is happening as well
> (Rose).

Participants expected that residents would have care explained to them regardless of their cognitive state, that time would be taken to ensure sufficient fluids and nutrition would be offered, and that the staff would be available when the resident required assistance.

> I mean older people actually like to drink. The ones who are mentally alert who worry about going to the toilet, if they know the nurse will be there when they want to go, they'll drink. And so it's just a circle really. (Sally)

Care processes extended beyond usual activities of daily living towards meeting social and emotional needs as well:

> … if it was a nice day to put them in the wheelchair take them outside in the garden for a walk...you know, sit down with them, read to them, do their nails, do a hand massage. (Claire)

> Saying that I also have a resident who gets up when she wants to get up … has a shower when she wants a shower and we don't push her in any direction. She does what she wants and we work within that and we do that with the majority of our residents though. (Susan)

The third sub category in 'getting to know work', focused on strategies which included the family in the care process.

Sub category: Using inclusive strategies

Families figured significantly in 'getting to know work'. Time was taken with families at the initial meeting when the family came to look at a facility, and continued after the resident was admitted. This time involved getting to know the families and educating the families about what to expect of a facility. Participants talked about advising the family to look at a number of facilities. They also pointed out what to look

for in good facilities. Most participants were aware of the distress that families feel during this time of decision-making and worked to minimise that stress where possible.

> Certainly for the first couple of weeks I'm dealing very much with family and I see that, as a big part of my role is to ensure that the families understand our philosophy and where we are but also that we will actually care. That it's not just a placement. (Sally)

Getting to know the families was deliberate and progressive for these participants. In a sense they enrolled the family as a guide to care. Families were invited to family meetings for input into the care plan. They were invited to special occasions as well as to become a part of what was going on within the facility in the moment.

> They will come in if I am in the kitchen. They come in and stand there if I am doing something and they'll say "Oh I'll do that while we are talking". It's just my nature. It's just like home. You know if you go to someone's home you often go into the person and they are doing something you say "Oh well we can chat while we are doing this." And they seem to accept that. Often they will come up and they'll say "Can I see you" and then I know it's something they want to talk about privately so we make time. We go into the office and we sit down for that. (Alice)

It was felt by most participants that when the resident and the family was involved in the care and the relationship between them and the facility was one of openness, then any difficulties could be dealt with more easily.

Participants demonstrated an empathic understanding of the difficulties families face when they are making decisions with or for the person who needs to go into care. 'Getting to know work' includes demonstrating an understanding of how life might be for both the family and the resident.

> Most of them are making a permanent move and usually after a life event and so most of the clients are in shock when they arrive as are their families. (Ros)

> I think for me it's actually about reassurance. It's actually about explaining who we are and what we do and it's about telling them. Many of them don't know the questions to ask. Like they don't know what good care means. They have an understanding of what they want cause they may have cared for them at home … where ever. Or they may never have cared for them. They may be in hospital. They actually love that person and they want that person to have the best care that they think that they deserve. So it's about saying that we can do that. And it's about talking about what we will do and how we will care for them. (Sally)

At the same time participants were aware that families also had other commitments. Susan adjusted celebration times so that families who worked could be part of the celebration.

> And a lot of the families that we don't see very often. Mainly because they work. We had the [event] on a Saturday so that everybody could come and they did. (Susan)

'Getting to know work' then is also about involving families in the care team, getting to know their particular contexts, and coming up with strategies that might meet the needs of both the care team, and the family. Getting to know work is enhanced when time is organised to enable the staff to spend time on this type of work. The next set of strategies, demonstrate that the participants working in this way also paid attention to establishing systems which supported rather than constrained the staff's ability to provide individualised care.

Strategy: Establishing Supportive Systems

This strategy underpins the other strategies in that it provides structure which facilitates a perspective of individualised care. The coding which demonstrates this category relates to a sub category of 'communicating expectations'. 'Communicating expectations' included the way participants made sure that the caregiver knew the systems of care as well the boundaries within those systems.

> We have permanent staff. That we have staff that have been here for about 10 or 12 years that actually hopefully the majority, not everybody, has the same philosophy of care and our philosophy says that it will be a home away from home. That we will actually care for the person like we would our mother. (Sally)

For example, there were codes related to disciplinary actions which would take place if the care guidelines were not followed. The participants worked to make the systems of care transparent to families. Families knew what was expected of staff, and knew that they could approach management at any time, and that they would be invited to attend care review meetings along with the resident, if the resident agreed.

The second category, relating to establishing supportive systems, was named 'providing frameworks for care'. The coding within this category related to the way in which staff were assigned; how the caregiver role developed; how standards were set, and how the participants organised to be available or to provide backup when they were not available.

Sub category: Communicating expectations

Participants saw the need to create a structure where expectations, and responses to expectations not being met, was clear and unambiguous. This structure extended to ongoing day to day communication which commenced at orientation.

Communicating expectations for care occurred in a variety of ways and gave rise to a code of 'documenting strategically'. Care plans are interesting in this respect. Where participants reported that careplans were not read by caregivers, they developed a system of making sure that information was communicated between shifts. Rose described careplans as "wasted space" because the caregivers did not read them and because they were corporate careplans, which did not lend themselves to ease of use within the unit she administered. In order then to organise for care activities to be carried out, Rose devised her own system of documentation. Resident care needs were documented and placed strategically in the place where the care would most likely be carried out, for example, in the residents' wardrobes, in the bathroom with their toiletries, and in the progress notes.

> They usually get them [talking about the progress notes] and I watch them reading back to see what's happened the last few days. I stick a piece of paper in there written on it."This has to happen today". (Rose)

In contrast, where the management had simplified the documentation, extra notes did not feature in discussions about documentation.

> I think we have a really very good documentation system. We don't write in progress notes every day. We decided several years ago that that was pretty pointless to write "Slept well. Bowels open." "Slept well. Bowels open." So we have a daily care review sheet which the caregivers fill in every day and it's just a little thing. It's a one page is a month and each day, each shift, they write whether they've

> bathed, showers. And we have a system that says like fluids and it might be, very good, good, poor and inadequate or whatever and so we've got more than 1000, less than 500, more than 750, less than 500, less than 200. So they are responsible for filling that in and we audit that. Not everyday, but we can see if someone is dehydrated and the nurse has put that they have had a good fluid intake then we will go back to that nurse and say "Hey this is actually not quite what has happened to them because you know". And they know. They fill those in fairly accurately. (Sally)

Discussions about resident care occurred verbally at handover.This time was seen as an opportunity to discuss particular resident needs and to problem solve different care approaches. Discussions about expectation for care also occurred in the moment as the registered nurse was working with caregivers.

Sub category: Providing frameworks for care

Participants had a system of assigning staff to particular residents. Most of the facilities had a system of permanent assignment while others moved caregivers after approximately two weeks. For those who worked in facilities where there was permanent assignment, the advantage was in getting to know the resident.

> She has the same area each time. One of her residents is [age] and she's to go away for a few weeks but she just taught everybody how to look after her residents. She has been telling us what she does and I think I could step in and still give that detailed care that she does because she just wants it to carry on so much and I think that's important. They really take pride in their work. (Susan)

An added advantage for the registered nurse was that of accountability. If they knew who was caring for the resident, they could correct care if it was not to the required standard. Conversely, they would also let staff know when they had done a great job.

> We have eight patients for example. We have two nurses who work in that wing permanently on a morning shift. Now there's 7 days in a week and they can only work 5 but at least one of those days, three or four whatever there's another nurse who works there who might work in two areas. So they know those patients intimately. And so they know if there is anything untoward. Whether it's extra confusion because ... maybe a urinary tract infection. They know to report those things. They know to report if someone's got any bruising ummm and the other thing is because there's a good I mean this morning there's three registered nurses on the floor for [approximately 40] patients with not a patient load. (Sally)

Deciding assignments in those facilities without permanent assignments, was aimed at providing the best possible staff resident pairing so that the quality of care could be maintained. When there were new or agency staff, the registered nurses talked about working alongside the new staff, buddying them with another caregiver, or setting aside their own work and spending time with the residents, so that the caregivers could take the time to get themselves organised. The aim of this strategy was that the residents would be more settled when the registered nurse left for the evening. Because these participants had got to know the caregivers, they were aware of their skill level and their ability. They organised the staff assignments according to their knowledge of both the resident and the caregiver.

> I try to marry the caregiver skills and the client's needs because not all clients and caregivers can marry together with a successful outcome. So I think you do need take into account personalities. (Ros)

> There's always ummm caregivers that are more capable than other caregivers and also caregivers that more capable with particular residents than other ones so it not only checking the ones that are very good with someone you know what's happening so that you kind of know the optimum, but it's also checking with the ones that are struggling with a particular person. (Rose)

Policies and procedures formed an organising framework for care. The participants were clear that the caregivers were aware that disciplinary action would be instituted if the care procedures were not followed. The use of policies and procedures was less clear in the facilities where the registered nurse's authority extended to the ward area only. These participants were more reliant on the organisation's management to ensure that infringements ended in disciplinary procedures.

Complaints processes were clear for both staff and family, and complaints were actioned quickly. I have not used direct quotes in this section in order to maintain anonymity as far as possible. A number of participants talked about times when there were complaints about particular aspects of the care or the care environment. For example, one relative complained that an area of a facility had developed a smell. Another incident involved a caregiver taking advantage of a resident financially. In another facility, there was complaint about a caregiver's attitude towards a resident. In all of these instances, the complaints received immediate attention which ranged from calling in the police, to sitting down with the resident, the family and the staff member and talking through a situation that had occurred.

There were systems for family feedback and participants talked about the ways in which families' feedback was acted on towards improving care. All the participants were aware of the possibility of care not reaching the standard they had set, and thus organised to be available to both family and staff so that any difficulties could be clarified and the appropriate action taken. At the same time that participants talked about complaints, they also talked about the need to protect vulnerable residents. Participants talked about being present in the facility and maintaining an attitude of watchfulness, as a strategy to make sure that residents were well treated.

The participants described how they enacted this watchfulness. They talked about taking on direct care on a regular basis to check that appropriate care was given and to build a relationship with the residents so that the residents would feel safe to complain. Building relationships with families and including families as often as possible, assisted the participants in making sure that any poor care was noticed and corrective action put into place.

> Our families have a really open relationship. I have a front door policy that's open. Even if I am having a meeting they know they can just walk in. If I want to have a meeting in private then I go to [named] office. And we do make muck ups in relation to maybe care or in relation to washing, laundry. You know, we do make mistakes. And all the families. … I always ring them and say what I've done. I'm sorry or if something…anything from it might be the odd theft or anything I just ring and say "Look this is what's happened. I am really sorry." I have to take responsibility even if I am not even there. If I am away on holiday. They are all very understanding. And they all make good suggestions. So the communication is open and so they're happy. They know where they are. They love the family reviews. (Sally)

There was a relationship between the strategies participants employed to deliver care, and effective care outcomes.
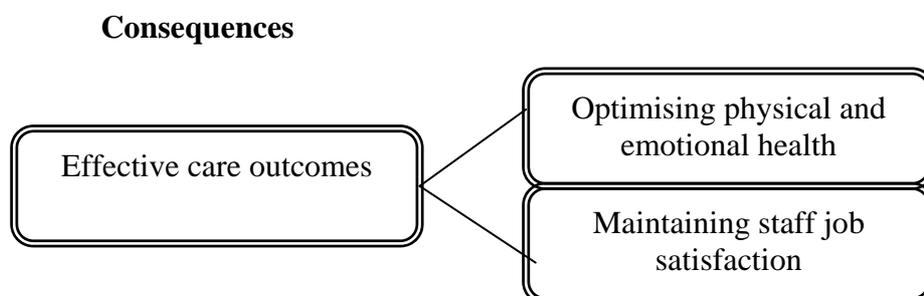
Consequences

Figure 6. Consequences: Focusing on residents and their family

Consequence: Effective Outcomes

The strategies which participants used to deliver individualised care, were aimed at two connecting outcomes. The first aim was to ensure quality of resident care. Participants recognised that to achieve the first aim, they needed to maintain a staff who were well trained, knowlegable about the care and the residents, and, who were happy in their job. There are two sub categories relating to this outcome, 'optimising physical and emotional health' and ' maintaining staff job satisfaction'.

Sub category: Optimising physical and emotional health

Codes relating to this sub category were achieving residents' goals, ensuring resident comfort, and improving physical and emotional well being. These outcomes demonstrated that quality of care had been achieved. They also validated the care processes which were used to achieve these outcomes. For those participants working with residents who were cognitively impaired, resident comfort needed to be assessed and discussed with the family and caregiving staff, to determine whether the resident's needs had been met. Participants described care outcomes related to their ability to prevent the development of physical complications. Examples of care outcomes included the absence of pressure areas, minimal urinary tract infections, decreased pain levels, improved nutrition, increased mobility, and improved cognition.

> We took one person from another hospital three weeks ago. The family told us she was terminally ill. She was dying. She had spinal secondaries. She was on morphine and she couldn't move. So she came to us and today she is actually standing at the rail. She is off her morphine. And she is mentally alert. They can not believe that they have their mother back. In three weeks she is talking, …we have got her now standing so that we can pull her pants up. We can't stand her, yet, to transfer her, so we need to use the hoist, but I would say that within two weeks. She has got some

> muscle tone. She has some leg strength back, so obviously her pains are going because she is actually using her body. She can move up the bed independently now. (Sally)

> One day you will take them out. They've been with you three or four months and you just take them them out and they say "God when am I going home" and you think, "Oh no" and they mean back to your home, back to the rest home. And then they're right. They're happy then. (Victoria)

Seeing these care outcomes in action are what the participants aimed for. This gave them job satisfaction. Participants were aware that without adequate staffing and without caregivers who could follow their vision of individualised care, these care outcomes would be placed in jeopardy. The sub category of ensuring job satisfaction for caregivers then was a related outcome.

Sub category: Maintaining job satisfaction

Maintaining job satisfaction was achieved when staff remained working at the facility, and showed, in a number of ways, that they were proud of what they did. Included in this coding were outcomes related to team harmony, increased caregiver skills and knowledge. Participants talked about how the caregivers described job satisfaction, and they tried to meet those requirements.

> And the staff say "that's really important for staff satisfaction". Even though I can't, I don't pay. I can't compete with other public hospitals or whatever, the staff, when they leave at the end of their eight hours, have done the best they can, and know that they couldn't do any more in their shift. (Sally)

All participants were clear about the strategies they needed to put into place in order to deliver individualised care. Central to their optimum levels of operating were the requirements for adequate staffing which they worked consistently to maintain. At times staffing levels changed, either due to staff sick leave, or staff moving on. How

did the participants work to manage this and still maintain the quality of care they desired? The following dimensional table comprises the codes which led to this variation. I have named this process 'refocusing on the resident'.

Table 4. Dimensional matrix: Refocusing on the resident

Perspective	Need to maintain resident care	
Cause	Staffing level changes	
Conditions	Decreased time	
Process	Refocusing	
Strategies	Shifting administration tasks	Doing the necessary
		Taking work home
		Staying late
	Sharing direct care	Doing shift for absent staff
		Helping out Managing crises situations Attending to safety
		Enabling caregivers to get on top of it
	Valuing staff responses	Rewarding extra effort
Consequences	Maintaining effective care practices	

Shifting Focus: Refocusing on the Resident

When staffing conditions changed, the participants put aside administrative tasks, and assisted in care delivery. At times they would take a full client load and do a caregiver shift. They would spend time with residents so that caregivers could get organised. This strategy maintained resident comfort, and in the dementia care unit, decreased the level of agitation which resulted when residents were feeling unsafe.

> When I know it's going to be like that then I'll just basically clear and won't do anything all afternoon and I will sit and just run kind of activities keeping groups of people busy all afternoon while the people that are going to be the caregivers kinda of get themselves together and get themselves organised for the night and then I know that if …

> I know that if I do that, then it will get them over the hump.
> (Rose)

The participants all noted that their ideal could not be met if staffing levels became too low. At these points in time, they went into what Rose described as a 'holding pattern'. Holding patterns could be sustained for short periods of time.

> I am really lucky in that the staff are, generally, it's not too bad, but that, that is what happens, and I guess that's the hardest thing. It's managing with the staff, and feeling that there's not ... so you put your own stuff away and you manage … the hardest challenge is when you end up managing the day to day, and you see the projects that you've got planned slipping further and further and further away, and you look there, and you think, I've actually made no progress. I'm just kind of, in this holding pattern.(Rose)

> I just think that it's going to get harder and harder. I think that, unless we get a funding increase, that I mean, I can't … I don't know. I love the patients. I love the care and I love to touch the patients like that, that part of my job. I don't know that I am actually going to be in it in five years time, with things like recruitment and retention. I don't want to be involved in it if I have to cut staff and not provide the care that I think the patients deserve. I do think they deserve, or the support for the staff. I might as well go and do something else. (Sally)

The impact of short staffing will be considered more fully when discussing the findings in Chapter Seven.

Conclusion

When the participants perceived they were working from a philosophy of individualised care, and they had the authority to direct care within adequate staffing levels, their work strategies were aimed at putting in place systems which provided frameworks for care, within which, care processes could be emphasised and clarity of boundaries and expectations could be communicated. In order to be able to deliver high quality care, participants became team leaders who were intent on developing caregiver

knowledge and skill. Developing caregivers in this way added to their ability to contribute to the care team. Knowing the resident, and tailoring care towards that resident, rested on a foundation of individual assessment, which included the family and the caregiving staff.

When staffing levels changed, these participants refocused their work towards the resident and assisted as and where required. In order to do this, they left administrative tasks until later, or completed them at another time, either at home, or at work. These strategies enabled the participants to maintain their care approach.

When there were new staff, or staff were moving into patterns of rushing care, the participants would individually shift the focus of the staff towards the resident. Their strategies in doing this are described in the process 'shifting focus towards the resident'. When staffing levels moved further downwards, the participants recognised that there was great difficulty in achieving quality care because of the time that needed to be devoted to maintaining the team, and getting to know the residents. The process described under these conditions, is named 'focusing on routines and tasks'. Under these conditions, the participants said they would question whether they would continue working within aged care. These remaining processes together with the final process 'focusing on safety' are described in Chapter Six.

CHAPTER SIX: RESEARCH FINDINGS

Shifting Focus: How Registered Nurses Organise their Work in Residential Aged Care

This chapter describes the organising processes of 'shifting focus towards the resident', 'focusing on routines and tasks' and 'focusing on safety'. These processes indicate that the participants organised their work differently under changing conditions. I will describe the context and conditions which led to a change in perspective of the participants and consequently an adjustment in how they organised their work.

Process: Shifting Focus Towards the Resident

When the participants' aim was to shift the focus of staff, from the routines and tasks of resident care, to a focus on meeting individual resident's needs, and there was time to do this, they organised work towards this end. I have named this process 'shifting focus towards the resident'. The process of 'shifting focus towards the resident' occurred both collectively and individually and within two different care approaches. I have named the two care approaches 'an active philosophy of individualised care' and 'an institutionalised structure of care'. Whether the overall organisational approach was that of working from an individualised philosophy of care, or whether it was working within an institutionalised structure of care, the process of shifting focus towards the resident was evident at different times, and for a variety of reasons.

For those participants who worked in an organisational approach which was focused on an individualised philosophy of care, there was an ongoing process to shift staff focus towards the resident. When staff became focused on routine or getting the tasks done, the participants worked to shift the focus back to the client as the centre of the care. When orientating new staff, they worked to ensure that these new staff were aware of the approach of the organisation. Within an institutional framework of care, the participants worked to shift the focus away from task and routine, towards the resident when they had extra time, or had a role which was more indirectly related to care work, for example, coordinating the quality assurance programme. Finally, when participants were aiming towards an individualised philosophy of care, within a current institutionalised structure of care, they used extra time to begin a culture change by shifting the organisation's structures, and the staff focus, towards the resident. One participant described the organisation where she was instituting change by shifting the focus towards the resident, as the centre of care:

> ... so the old school. The ethos has changed. Aged care is no longer custodial care. We are actually trying to maintain functional ability. We are trying to maintain people in their new home. I think some of that, for some nurses, is a difficult shift. (Ros)

The following dimensional map demonstrates the building of this process.

Table 5. Dimensional matrix: Shifting focus towards the resident

Dimension	Category	Subcategory
Perspective	Seeing possibilities for resident care	Knowing what Knowing how
Context/cause	Adequate staffing	Adequate staffing ratios Regular and willing staff
Conditions	Having some time	Using time Spending time
Strategies	Creating opportunities for connection	Moving towards residents and staff Taking opportunities for teaching
	Having input into institutional life	Contributing towards organisational matters Trouble shooting
Consequences	Changes in care delivery	Noticing practice changes Noticing organisational changes
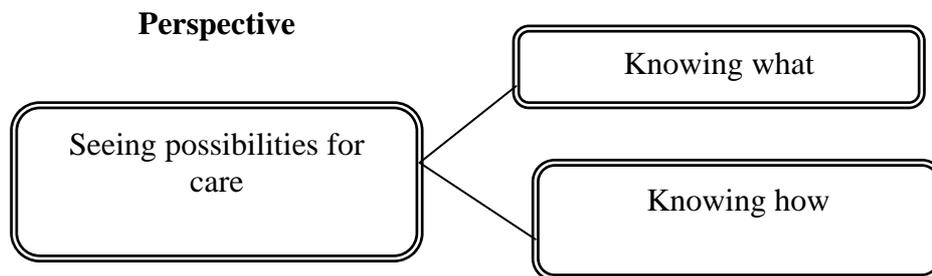
Perspective

Figure 7. Perspective: Shifting focus towards the resident

Category: Seeing Possibilities for Care

The codes in this category related to the ways in which participants could conceptualise possibilities for resident care. There were two sub categories. The first subcategory of 'knowing what', contained codes which indicated knowledge about care, knowing how to care for older people, and the methods participants used for maintaining their knowledge base. The second category of 'knowing how', was related

to the strategies which participants described that could assist to shift the focus towards individualised care.

Sub category: Knowing what

All except one participant had worked in aged care for between five years and thirty years. One participant had been working within nursing for over twenty years and had, for the past year, been working in aged care. All participants talked about attending to their educational needs on a formal and informal basis. Participants described how they maintained and developed both their theoretical and clinical knowledge base.

> I used to work there once or twice a week.There was stuff I needed to know. I was doing a paper on palliative care and I needed to know the things, in order to write about the things. It was great. I loved it.(Victoria)

> Doing that drug research was fascinating. All the interactions and that … the doctor came to me and said "You must have really done a good job of that. All the nurses are questioning my prescriptions and things and telling me the side effects of drugs". (laughing) It was good. (Jan)

As well as formal education, the participants searched the internet for new information, maintained journal subscriptions, attended regular inservice education (as well as conducting inservice sessions), canvassed the visiting professionals, such as the pharmacist, and discussed issues with valued colleagues in the field. As Alice said, "They get to know what you're interested in and every month I will see him because he brings up our medications and we can sit and talk".

The second set of codes were named 'having knowledge' and contained data where the participants' conversation included their knowledge about working with this population, and what skills they perceived to be needed by nurses who were working with unregistered staff.

> I think that every registered nurse has to be an educator because they've got caregivers there and so they need to be able to educate the caregivers. They also need to have really good assessment skills because they are working with very frail elderly with their multiple pathophysiology and things. So I think that they do need to have good assessment skills umm and a reasonable knowledge base if they are going to be working in gerontology - Then they should have had some education and experience before they come in. (Claire)

> I get new clients all the time. Then I will do an education on that illness ... so that everybody knows what it is and their careplan builds on that illness, like Parkinson's disease. What they need, what their diet is …why they have to have their drugs at that time. (Victoria)

Having knowledge was also about knowing how to maintain or restore physical health:

> Our patients are coming to us now three weeks after having a stroke, with a PEG in because they can't swallow, and we have got them swallowing, and we take the PEGs out. I mean, that's actually a huge challenge when you are working with mostly untrained staff. (Sally)

Included in 'knowing what' was data which included the resident's quality of life and the relationships staff built with residents:

> And a really good thing is seeing the client's face light up when a certain caregiver comes in, and you see the joy, and that's a really good thing. (Victoria)

> I think you can learn a lot more by watching people and what they are doing and how they are having meaningful talks and their actions and reactions to the people they are looking after. (Heidi)

The participants knew the current approaches to care in many areas, for example, falls reduction. They were concerned about nutrition and were aware of the importance of good nutrition in maintaining health. They were aware of the need for maintaining health in order that the residents could enjoy a quality of life.

> Quite often once they get into care they come up. They become more active, socially active, physically active and start eating and having a life being responsive and when come in they … oh , not all. Some tend to come in withdrawn, and tend to be isolated and they have haven't had people to talk to and they have got used to it to. Poor food, poor care, over medicated usually. (Victoria)

Within the speciality of gerontological nursing, those specialising in caring for people who had a dementing illness knew about observing and assessing in order to maintain function, and a quality of life for the residents with this condition.

> When I walk in I can just tell that just by looking at someone. Looking at their eyes. For instance…they are just not as there as they usually are. Not as present … or someone will walk down the corridor towards me and I'll think, that's different. You don't normally walk like that, or, they will be talking less, or talking more, or they'll just seem slightly scratchy, or edgy, or, they'll seem sleepier than normal. (Rose)

The participants talked about an awareness of the need for developing their knowledge to work with an increasingly dependent resident population. All participants recognized the complex care needs of the residents who were entering aged care facilities.

> The level of dependency of the clients is a lot higher than it was five years ago and you don't have to look very far back to say that… and tracheostomies and peg feeds is a norm not anything unusual. They've complex care needs and they would not have been kept in public hospitals or not given those procedures to keep them alive a couple of years ago. And I think there is a pattern of high acuity and complex care needs. (Ros)

> You have rest home clients on continuous oxygen ,on PEG feeding, having dialysis. (Claire)

> I think that because the patient dependency is higher, then, we've had to look at staff education, because we are getting clients in recently. If you've had staff that only ever have worked in a rest home and so they have been educated to that level of client. We are now getting clients who are so much sicker. So we need to ensure that our caregivers are educated to be able to look after these much sicker people. People who are immobile are needing really specialist care. So that's been a big thing. We've had to look at making sure the caregivers are educated to a higher standard. (Claire)

Knowing how to put their knowledge into practice was evident when participants talked about strategies they used or could use to move the emphasis for care towards individual residents.

Sub category: Knowing how

Within this sub category, some participants talked about what they would want to do if their work environment was different. Other data coded in this sub category demonstrated that some participants had the opportunity and authority to put their knowledge into action, to shift the focus towards resident care. Participants used strategies of leadership to apply their knowledge, and facilitate the development of caregiver practice.

> I think very strongly that the caregivers won't do anything if the charge nurse isn't there involved and I think that in aged care we have got all those things that we need to do but we also need to show that we will be there hands on working alongside the caregivers because that's the only way they are going to learn. (Claire)

There was an understanding that role modeling and giving the caregivers permission to move outside the routine of resident care, were important, if care practices were to change.

> It was OK to do a hand massage or even read the newspaper or even just sit and watch TV because that is what I'd said. If you are here, if everything is done, it is really important now that we spend some time with the clients because that's what we are here to do and it really is...Have the staff been given permission to actually spend some time or are they so focused on all the tasks to get them done. And we still got everything done but we also made time .(Claire)

The participants talked about strategies designed to connect with residents. Their strategies included initiating quality improvement projects which led to improved resident care, and in some cases influencing their organisation towards a client centered approach to care. Seeing possibilities for care alone did not necessarily lead towards making changes in current care practices. There was a direct relationship between adequate staffing and the participants perceiving that they had the time to encourage a change in focus.

Cause/context

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┌─────────────────────┐       ┌──────────────────────────┐
│                     │       │  Adequate staffing ratios │
│  Adequate staffing  │───────┤──────────────────────────┤
│                     │       │  Regular and willing staff │
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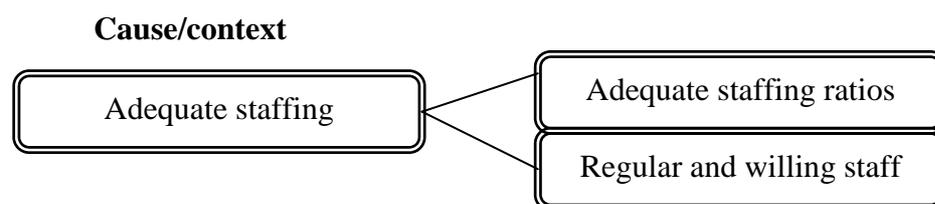
Figure 8. Cause/context: Shifting focus towards the resident

Context/Cause: Adequate Staffing

Conceptualisations about adequate staffing arose out of staffing ratios, skill mix, and the staff's openness to developing their practice. Adequate staffing is about numbers and about attitudes.

Sub category: Adequate staffing ratios

The participants who worked in an organisation which focused on an individualised philosophy of care had, what they perceived to be, adequate staffing ratios as was described in the first process of 'focusing on the resident and the family'. These participants already perceived that they had the time to shift the focus of staff who had become routine in their work. In contrast, the participants who worked within an institutionalised structure of care did not perceive that they always had adequate staffing. They perceived they could work to shift the focus of staff towards the resident when staffing numbers were increased.

> That's why I like having that little bit extra time is to have
> think about these things. What can you do that would help
> that patient more. Sometimes it comes through quickly.
> Other times it takes a bit of thought and sort of …
> brainstorming with other people. (Jan)

*Sub category: Regular and willing staff*

For those whose aim was to either, develop individual caregiver's practice, or change organisational approaches, adequate staffing meant they could begin to work towards developing more individualised care. One strategy was to begin to develop a more inclusive approach:

> I think I am going pretty slowly so that I think that you can gain acceptance on the way. I haven't gone in with big boots on kicking …That's set up to fail. Any change has to be slowly … getting the team on board … be involved in the decision making processes. Involved in the change strategies. That might be changing systems of how we nurse but also on a client level. "This is why we should change. What do you think? Lets do this, or this," and … leading client care as well. (Ros)

Sometimes the participants struggled with how to shift the focus by educating staff who seemed resistant to developing their practice:

> I think that trying to get the people that I know that are not motivated that I set up specific education programmes targeted towards them and then they don't bother attending and there is always the one group and they are the group that you know needs to be there and how do you get those people from there to actually be wanting to learn and I am not sure how you do that. If you've got these people that are so set in their ways and their practices are not always modern in their thinking. That, that's my biggest thing really is how do you motivate those people who are not motivated who are there because they talk about .. "if this happens I am going to leave" and you think "if only you would". (Claire)

In this process of shifting focus towards the residents, some participants demonstrated that they had the knowledge of gerontological nursing, and had the ability to assist staff to shift their focus towards resident care as a central focus. In some instances, there were staff who were not willing to change their practice. In other instances, the ability to shift the focus of work towards the residents was dependent on the time available to the participants.

Conditions

Having some time

Using time

Spending time
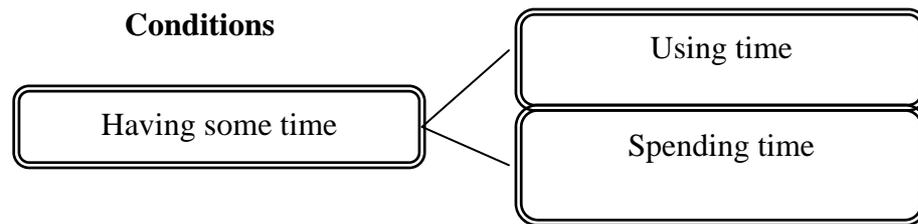
Figure 9. Condition: Shifting focus towards the resident

Condition: Having Some Time

There were two ways in which participants had time to refocus their care, and the unregistered staff's care, towards the client. Firstly, time was freed up when there was adequate staffing. Secondly, participants created time or spent time in particular ways throughout the day. In these ways, they made a conscious decision to fill space in a way that was focused on the care of the client, or on educating staff towards improving the care for the client.

Rose talked about how she worked to shift the staff focus towards the resident, and how this was an ongoing activity which she needed to engage in as staff moved back towards a focus on routine and tasks. Susan described how she had begun to factor mini care reviews and education sessions into handover time between shifts.

> … and that being really meaningful activity for that particular person. I find that's the hardest thing though, getting everybody on board with what those things mean and then getting them to stay on board. Like you can talk about it and everybody says yeah and then a month later you think … Do we need to have this pep talk again? (Rose)

> So when I have handover, we usually discuss a resident and I'll talk about how we actually deal with certain situations and I'm finding that … I've worked there a year now, and its taken that long for the staff to start to realised they can cope with people with behaviour difficulties and we can redirect some of the behaviour and we don't need medication to do it. We just need our own approach. (Susan)

Having some time then, is about having adequate staffing which provides extra time. It is also about how time is used effectively to create or maintain a shift of focus towards resident care and, in doing so, create opportunities for connection with residents.
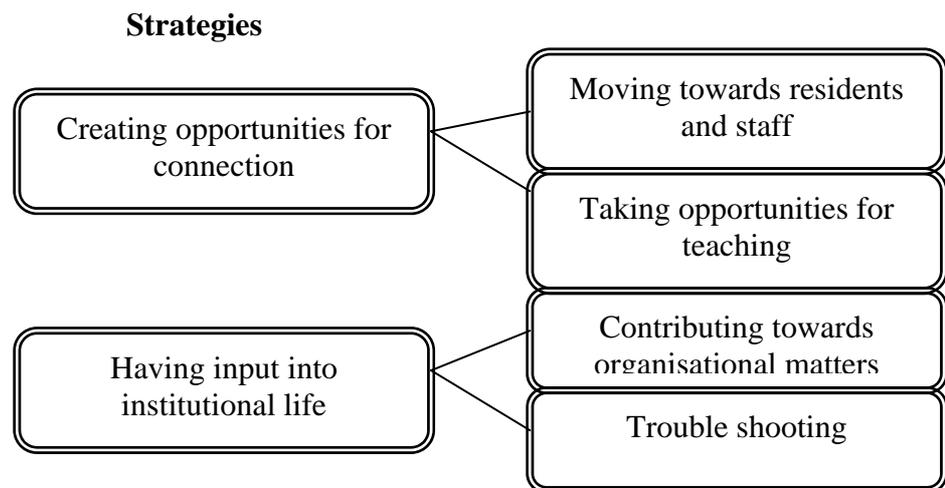
Strategies

Figure 10. Strategies: Shifting focus towards the resident

Strategy: Creating Opportunities for Connection

Having a perspective of possibilities for care meant that, when there was adequate staffing, more time was either available, or created, for the registered nurse participants to take opportunities for connection, both with the residents, and the staff. In this way, relationships could be developed which could enhance resident care.

Sub category: Moving towards residents and staff

These activities of connection were coded as 'building relationships with clients'. Connecting with the residents occurred in a number of ways.

> So yesterday I spent a lot of time talking to a particular lady and she just found that she is able to go home again. She thought she was in there for good and couldn't sleep and things. And she will be actually able to go home so that's good. (Jan)

Shifting focus towards the resident sometimes occurred during individual moments of care. These moments could occur when the caregivers were seeming to rush care, when quiet times came to talk about future directions, and when the RN was working alongside caregivers providing direct care.

> So basically I think that ninety % of the time, we're very good. But I think ten % of the time, we're, some incidences are preventable. I think perhaps staff trying to think that they have to get everything finished. So even though we want everybody to have a bath or a shower every day if that's what they want, sometimes some staff think "Well it's got to be done by such and such a time". And so sometimes I think a lot of accidents and skin tears happen if you rush. And so it's a constant battle because some of them are just very task orientated. And so I think that part of my job is to say "look that's not that important. Why don't we just slow down and just take our time and just listen to what the patients say". (Sally)

For those participants who worked within an institutionalised structure of care, relationships with caregivers were developed when the registered nurse was able to spend time instituting change within the organisation. There was a recognition that the process of moving the organisational focus from routines and tasks towards individualised care would take time. Strategies were used which began to develop the skills of the staff.

> It's got a very hierarchical structure you know that this is how it's always been done and we are very regimented and the world is not like that all the time. So the valuing of people and their skills and developing their skills to their potential is part of my role. I am not sure that it's been done before in this environment. And I know the caregivers haven't been given permission to speak before. They've been unheard. (Ros)

The development of caregiver practice, in these contexts, was a strategy which the participants used to direct the staff attention towards the resident.

Sub category: Taking opportunities for teaching

For some participants, a strategy was to revisit earlier teaching, and to bring their vision to the forefront of practice, by bringing details to the attention of staff, and by working alongside staff. Participants created the opportunity to initiate strategies for ongoing development of caregiver practice. These strategies included developing manuals to guide care, discussions at report time between shifts, and employing other staff to lead activities, thus freeing themselves to develop caregiver practice. An example of another strategy for developing caregiver practice occurred when a participant decided to assist the caregiver to understand more about the medications they were administering to residents:

> Instead of putting hypertension, I put high blood pressure. Instead of tachycardia, I put high pulse to make it easier for everyone to use. I put adverse effects. I put rashes instead of all the dermatological terms they put in [named document] that caregivers wouldn't necessarily know. And that is being well used which I am very pleased about. (Heidi)

These strategies were designed to maintain a connection towards the resident by developing the knowledge and skills of caregivers.

> Being hands on and 'this is how we do it because of' and because we are working with people who are unskilled, registered nurses have to give them a certain level of skill to allow them to do their job safely. We're all here for one person and that's the resident that we are looking after or the people we are looking after and I think that being a registered nurse gives you some more knowledge but it's not one that you can force down caregiver's throats because they're the ones doing all the basic care. (Heidi)

As well as concentrating their efforts on creating opportunities for connection with the residents and staff, participants worked to shift the focus of the facility or organisation in which they were working.

Strategy: Having Input Into Institutional Life

This strategy of 'having input into institutional life' was used to shift the organisational focus because more time was available as a result of adequate staffing. Some participants took part in institutional life as a matter of course, and time was built into their day for this purpose. For the smaller stand alone facilities, these strategies occurred more informally. Two sub categories built towards this strategy. These were contributing towards organisational matters and trouble shooting.

Sub category: Contributing towards organisational matters

The codes generated within these instances included preparing and developing inservice education, belonging to committees, and researching best practice approaches. Taking part in staff and team meetings was a further code which was collapsed into this sub category. In the following excerpt, a participant recounts how a client talked during a family meeting about the difference that education has made to the quality of care provided by the staff.

> That when in a public forum, I mean we all like to know that what we are doing has been worth while … So when that client can say because of what they [the staff] are learning, client quality of care has improved then, that's what I figure I am here for anyway. (Claire)

Sub category: Trouble shooting

Troubleshooting was a strategy which also facilitated a shift in focus towards the resident. For those participants who were employed in adjunct roles this strategy was significant. In times of difficulty, these participants were approached by both staff and management to resolve conflicts, relay messages of discontent and suggest changes in either the care processes or the organisation of the facility. Examples of this occurred when staffing was to be cut due to budgetary constraints, when change processes were seen as problematic, when equipment was not adequate or available, and when interpersonal conflict was occurring.

> In fact I then became the spokesperson for the staff to the …
> because they saw that I was not in their area of work any
> more and they felt that I could go and independently speak
> for them. (Claire)

There were codes which moved into this sub category which were originally named go-betweens as this process of being the middle person also occurred when management wanted to check what was happening for staff. So, for those who were not in direct authority, the strategy of trouble shooting was to act on behalf of both caregivers and, at times, managers. At times, the interventions of these participants were effective. At other times they did not achieve their intended goals, however, their aim in becoming an intermediary was to develop the quality of care.

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│  Changes in care delivery │───┐   │  Noticing practice changes │
└─────────────────────────┘   │   └─────────────────────────┘
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                               └───│  Noticing organisational │
                                   │  changes                │
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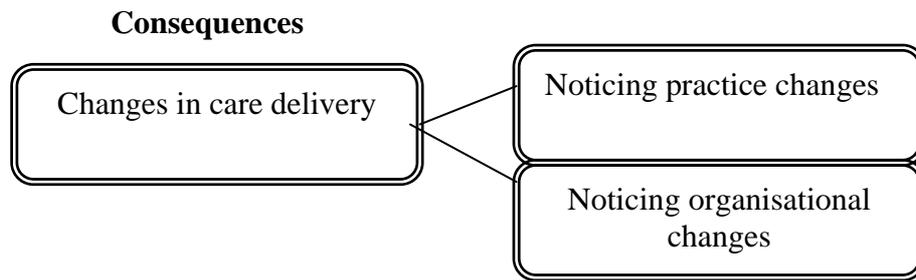
Figure 11. Consequences: Shifting focus towards the resident

Consequences: Changes in Care Delivery

For the participants, this process was effective when they could see a change in care delivery which was towards individual resident care. Codes generated in this category were collapsed into two sub categories, noticing practice changes and noticing organisational changes.

Sub category: Noticing practice changes

The changes that were noticed, were that staff would take more time with residents and individual care practices would be brought back to a primary focus. For some participants seeing small incremental changes, for example, caregivers beginning to work differently for care, were signs that the shift in care approach had begun .

> She'd come to me and say "I've been talking to Mr [name]"
> which was really good.. And she started being very good
> with patients. That was one of the successes. (Jan)

Sub category: Noticing organisational changes

The participants noticed that management would interact at times more effectively with staff, and some care decisions were reversed within the organisation.

> The outcome for the staff was that they got listened to and that there were a lot more discussions. (Claire)

Change was noticed as a result of educational programmes.

> I think the courses I've been running I've raised the standard of the education of the caregivers so that's been huge and when you run a session and at the next the next client care review , the charge nurse on one of the wards says, "After the session, that [name] ran, there had been a huge improvement in this gentleman". (Claire)

Staff were more willing to speak up:

> Well you want their opinion because they're the ones that know their residents very very well and once they've sort of got used to you I find that I am the one that they will come to first for anything. (Heidi)

> I think people, caregivers for example are a lot more open and willing to come and talk to me about issues and you know that they've raised subject, raised topics that have probably been festering for years is what the caregivers have been thinking for a long time and that these things need to be addressed and nobody's done it and we've reported it 20 times and that by actually allowing or facilitating that is probably a better word (laughing). So changing that response in that open forum. There is a willingness to share ideas and information. (Ros)

Conclusion

This process of 'shifting focus towards the resident' was employed by participants who worked in two different frameworks of care and involved shifting practice towards the resident. The coding within this category was generated out of data which indicated those incidences where the staff focus had moved away from the

resident. For the participants who worked within an individualised philosophy of care this process occurred when the participants were shifting the practice of staff, who had moved into a routine practice, were less experienced or were relatively new to the caregiving role. For those participants who worked within an institutionalised structure of care, the strategies contained within this process indicated that this was a time of development or of higher staffing levels.

For all participants, regardless of the care approach used within the facility, the strategies employed within this process were similar. The process of shifting focus towards the resident is fluid and is woven within the routine of the facility in both opportunistic and planned ways. In Chapter Five I described the care approaches the participants used when there was a framework of care which focused on the individual. In this second process, I described strategies which occur within and around the usual approach to care regardless of the organisational focus to care.

The third process, that of 'focusing on routine and tasks', describes the way in which registered nurses organised care when they perceived time to be limited and when staffing was inadequate. The strategies used by these participants were most evident in those facilities where there was an institutionalised structure of care. The following dimensional map serves as a guide to the description of this process.

Table 6. Dimensional matrix: Focusing on routine and tasks

Dimension	Category	Sub category
Context	Institutionalised structure of care	Living in someone else's home One of many
	Being organised from above	Inconsistent organisational systems Systems not working
Condition	Inadequate staffing	Resistant staff High resident staffing ratios
Perspective	Not enough time	Being very busy Being pulled between priorities
Strategies	Structuring by time and task	Trying to ensure good care Building into the routine Filling in gaps
	Pulling in management	Reporting up/ Reporting down Speaking up
	Increased supervision of caregivers	Watching Instructing to do
Consequences	Escalating distress	Conflicted relationships Families resisting
	Doing to the resident	Inadequate care

In order to understand how an institutionalised structure of care was perceived by the participants, this section commences with a discussion of how the registered nurses talked about older people, followed by how they perceived the institutional culture. Of the ten participants, five participants worked within what I have named an institutionalised culture. Two of these participants were in the process of moving the culture of their organisations towards an individualised philosophy of care. The remaining participants referred to an institutionalised culture when talking about either previous experiences or about other facilities of which they had knowledge. The participants who worked within an institutionalised structure of care had similar

perceptions of older people to those who worked from a philosophy of individualised care.

Perceptions of Older People

Codes which were generated out of these perceptions included recognition of the individual responses to ageing, and individual personalities and unique histories, which were of interest and enjoyment to the participants.

> I really really enjoy working with older people where you really get to know them even if you have got a person who has got dementia you can still get to know them in many many ways and you get to know the families really well and that to me is is really important because you can treat the older person as a real individual and they have such interesting histories and I like the opportunity to take the time to find out little by little about the history. And to get to find out what their needs are and seek to try and meet those needs. (Dorothy)

In contrast to these perceptions of older people, the participants' perception of the environment within which they worked, was that of a structural hierarchy where individual needs could be met on some occassions.
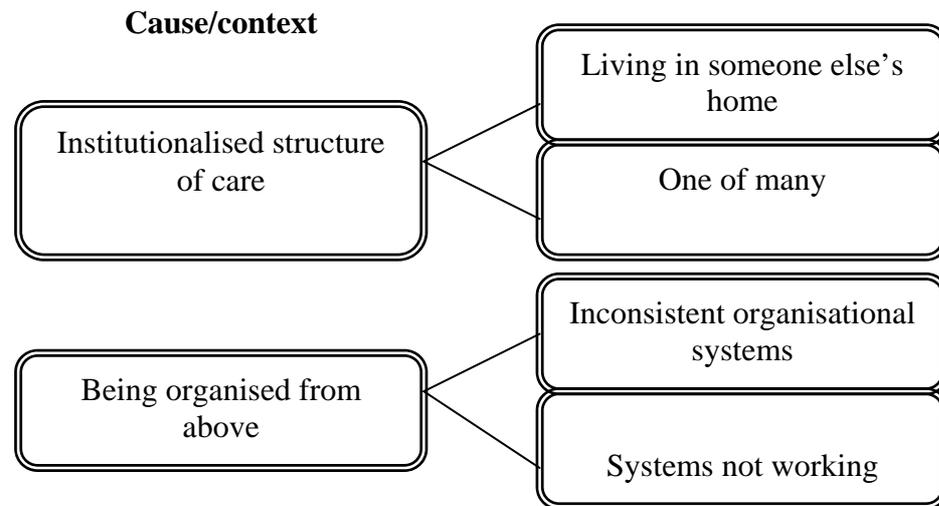
Cause/context

Figure 12. Cause/context: Focusing on routine and tasks

Context/Cause: An Institutionalised Structure of Care

The category of 'an institutionalised structure of care' was developed out of two sub categories related to the residents' context. I named these sub categories 'living in someone else's house' and 'one of many'. The third sub category comprised codes generated from the participants' perceptions of the hierarchical organisation in the facilities where they worked.

> Unfortunately in an old people's home that works against their personality to some extent because it's an institute. There is a certain amount of institutionalisation. (Jan)

Subcategory: Living in someone else's house

The codes that were related to 'living in someone else's house' described the residents' context from the perspective of the registered nurses. They included notions of powerlessness, lack of choice, lack of stimulation, lack of relationship, and few opportunities for choice.

You wake up in the morning and think "What have I got to look forward to?" And so you've got people asking you "Is anything happening today?" And usually there is very little. There's a bit of occupational therapy but it's pretty limited. It lasts for an hour or so. And that's their day … not much going for them. There is nothing to challenge them. There's no bills to pay, there's no cat to worry about, there's nothing. There's absolutely nothing they've got control of. Which is a very, very, difficult situation to cope with, cause really, there's no stimulation. They're reliant on visitors which really … They can't even make them a cup of tea you know. (Jan)

Sub category: One of many

'Living in some one else's house' had a direct relationship to the next sub category, 'one of many', in that the codes generated suggested that the residents had needs which were met, but those needs were prioritised in terms of a group of people, rather than in relation to individuals. For example, residents in one facility at rest home level had a change of routine which a participant noticed had made a difference to the residents' enjoyment of the day. The improvement in resident comfort which was noticed by the participant, was serendipitous.

R: something led you to say … breakfast will be in bed...and your comment was "they love that" so what is it that led you to make the decision?

Ummmm mainly because you could watch them trooping in at 8 o' clock in the morning just as you came on duty and they … they're all sort of dragging their chains like … kids going off to school … you can see that they're not ready to be dragged out of bed … washed and dressed by 8 in the morning … and I don't blame them.

R: and so you looked at that and you thought this is not OK?

No, that wasn't the reason … or why it happened. It was I think, … I think it became a staffing thing. They got rid of one staff that was on in the mornings, and it was actually easier once again, to do a round with porridge and their toast and teas and that around all the rooms. (Heidi)

R: How do you know they love staying in bed?

You can see … it's written all over their faces … (laughing)
and they are not being bum's rushed in some sort of way …
not being rushed into being dressed. (Heidi)

Residents were described by one participant as having to have a measure of hardness to withstand living within an institution. Her notion was that the sensitive people became traumatised and passive within this setting. Descriptions of residents' responses to the environment were coded as either succumbing and becoming passive or becoming aggressive. Together these codes were collapsed into being one of many.

On the other hand, there were codes which suggested that there were times when staff and resident's requests were met. One participant described how a relative might ask for something different to happen for their family member. Their requests would be followed for a couple of weeks until another resident took priority. In another description of institutional life, the residents complained because the corporate body of the organisation had decided against the current policy of permanent assignment of residents and caregivers. The caregivers also complained, and the decision was reversed.

Category: Being Organised From Above

'Being organised from above' was the third category which led to the context of working in an institutionalised structure of care. The codes generated here were edicts from above, communicating between departments, supervising, and being supervised, and systems not working. The management within these facilities was either distant to the geographical location of the facility or co located on the same site.

> Some of the decision making is dictatorial....the owners are in [name] and the general manager will come up and an edict is made...based on the [name]. This is the only hospital part, the rest are all rest home. An edict will be made and it happens for no good reason … I usually try to help. I help undermine them if I don't think if they are to be … they are not there for the benefit of anyone but just a thought from the head office and that downward trickle is more like a big block of wood is dropped on your head from above … you will do this and because we say you will do it. (Heidi)

There were routines within shifts which seemed uniform and consisted of particular events happening at particular times. In one facility for example, the kitchen closed at a certain time and if the resident wanted food after that time, it was difficult to find something to give to them. Having the tasks from one shift being completed before the next shift was important. Organisational communication between staff and management was usually by way of meetings, committee minutes, memos, and at times, individual interviews.

Sub category: Inconsistent organisational systems

Some participants perceived that the systems within the facilties where they worked did not have a focus of enhancing care. While there were, in some facilities, strict processes for disciplinary action for staff who were not providing the required level of care, in other facilities these processes were perceived to be ineffective. Some participants perceived that the organisation had many systems which were operating effectively and some which were inconsistant.

> Except that they don't, they won't face a challenge head on if there is a staff member that could perhaps be "OK three months from now you will perform". (Claire)

Another facility had a strict policy regarding actions in the case of inappropriate resident care, however, it was unclear as to which inappropriate care was reportable, and which was not.

> In fact I even find they … they make jokes at times against the patients … you know just to keep their spirits up [referring to the caregivers] I don't know what it is. I often pull them up on that. (Jan)

> In fact for many, when that happens, we take them immediately away from the patient even if we are not sure whether it has happened or not. We find that some of the girls who verbally abuse patients. Not that it's a big thing that happens every day. It's something we pick up occasionally, will take it out on the patient as well. "Why did you tell on me?" And they'll give them a hard time so that has to be taken to the top right away and they have to be taken away from the patient. (Jan)

Sub category: Systems not working

Care organisation within these facilities was structured from above with documentation, care guidelines, policies and procedures arising out of organisational processes. Participant interviews demonstrated that the organisational process for ensuring that the care guidelines are followed were variable within and between organisations.

> I've seen fine assessment tools and careplans but not well used. (Dorothy)

Most authority came from institutional decisions with the registered nurse responsible for aspects of care within the shift. There were differences though, in that, some participants worked in facilities which could be described as an institutional hierarchy and did include some processes which were individualised, for example, family meetings. Those participants who worked in an institutionalised structure of care where the staffing was adequate and more supportive systems were in place, did not

report disrespect to residents. They described the care staff as kind and caring. All participants did, however, mention other facilities where they had worked in the past or had admitted clients from. They described institutional patterns which were similar to those described in this section.

> They will still have the same patients but all they do is come in shower them, dress them, leave them. They don't get the one to ones. They don't get the walking and the exercising and the cycles and the walking to the shops just to make them feel a million bucks. (Victoria)

> Huge in as much that those who are accountable to … you know … those people who want a dividend and to share profit making …you notice there were staffing and cuts in facilities and you know the pressure is always on the dollar.

> Whereas working for [facility name] and now for [facility name] that the emphasis is far more on the very best for the client, not the very best for the profit and I find that to be a huge difference in aged care. (Claire)

Conditions

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┌─────────────────────┐        ┌─────────────────────┐
│ Inadequate staffing │────────│   Resistant staff   │
└─────────────────────┘    \   └─────────────────────┘
                            \   ┌─────────────────────┐
                             \──│ High resident to staff
                                │       ratios        │
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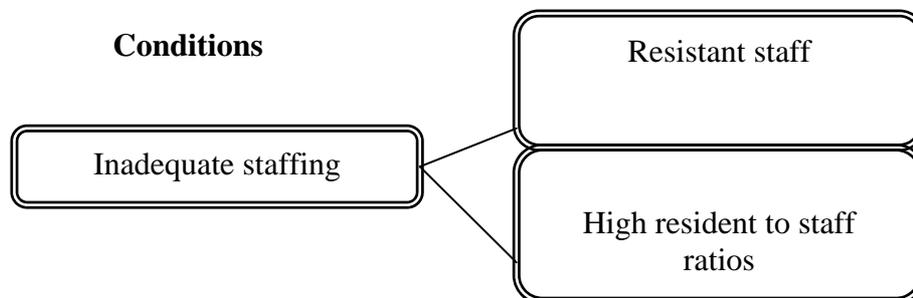
Figure 13. Conditions: Focusing on routine and tasks

Condition: Inadequate Staffing

Being organised from above led to centralised decision making about staffing levels and staff training. Inadequate staffing was a condition which led to care becoming routinised. Inadequate staffing, as a category, arose not only out of codes relating to staffing levels, but also, out of codes relating to staffing attitudes.

Sub Category: High resident to staff ratios

Staff resident ratios were approximately one staff member to five residents. There was usually one registered nurse to a ward of approximately twenty four to twenty six residents on a morning shift. This ratio was maintained for caregivers on afternoon shifts in some facilities, however, the participants usually had a responsibility for the facility site in co located facilities, and their availability to staff changed at these times. Night time staffing was usually light within these facilities.

> I think you can't cut costs to and put residents at risk especially when there is only one caregiver looking after forty residents at night. That's a lot of people for one person to be responsible for. And having to do the linen and all other bits and pieces as well. (Heidi)

Staffing ratios were not consistent across the facilities. In one high level care facility on an afternoon shift, there were two registered nurses and four caregivers to approximately thirty five residents. This resident staff ratio would seem to be adequate, however, it was the culture of the organisation which gave rise to the process of focusing on routine and tasks. Prior to commencing this study, I had assumed that poor quality of care was mostly related to inadequate staffing numbers, however, staff resident ratios in some facilities led me to recognise that there were other factors to be considered. Participants' data demonstrated that attitudes and patterns of care delivery are as important as staffing numbers in affecting the type and quality of resident care.

Sub category: Resistant staff

Almost all participants, regardless of their care approach, talked about having to constantly refocus staff towards the resident. For those participants, staff were open to the participants' guidance. This was not the case, however, in this sub category where there was a definite resistance to changing care practices. This subcategory consists of actions which were coded as refusing care instructions, ignoring care guidelines, and reacting negatively to care advice. Staff had their way of doing care and were reluctant to change their way when the registered nurse requested that they do so.

> It gets quite difficult because some nurses get very stroppy and won't take that and go to the administration and then it's a great big hoo haa you know. I had to go and give one girl a verbal warning because the supervisor had seen that … the woman was there without…the window was open and things and no privacy. It was terrible. So I went in and I gave her a verbal warning and OH. We had you know, terrible problems with it. She said that we had no right to come in. Some people can take it on board and other people just fight or resist you. (Jan)

In another example, one caregiver was asked to attend to a care task. She refused to do so. Later that evening, the registered nurse found that the resident, who was very dependent and frail, had faeces caked onto her skin suggesting that the faecal matter had been there for a considerable length of time. If the caregiver had attended to the original request, she would have had more opportunity to discover the client's need for hygiene attention. In this particular instance, the caregivers also spent time sitting and talking for a major part of their shift.

> It happens all the time that after 11 o clock in the morning all caregivers are seated in various … and in the evening their goal is to start putting clients or residents to bed and they must be finished at eight o clock or half past eight and then they go and sit, till eleven. They will do a round at … it

just is quite impossible to try and get things done better.
(Dorothy)

When there is an institutionalised structure of care which focuses on routines and tasks of care, and when there is inadequate staffing, the registered nurse perceived that there was limited time to provide adequate care. This situation arose out of a circular set of circumstances. For example, there would be either not enough staff or resistant staff. Because of these factors, the participants' strategy was to supervise caregivers more closely. They also filled in gaps of care, or did things themselves, rather than go looking for caregivers. These strategies took time and they perceived there was insufficient time to provide adequate care. The strategies are described more fully later in the chapter, but are mentioned here because in one sense, having limited time could be seen as an outcome of the situation described above. The outcome, however, for the participants was about the level of resident care and the various responses to that outcome.

Perspective

Not enough time — Being very busy / Being pulled between priorities
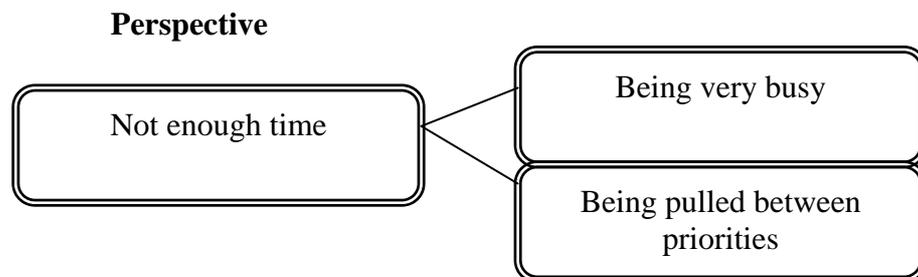
Figure 14. Perspective: Focusing on routine and tasks

Perspective: Not Enough Time

Within the context of an institutionalised structure of care, comments about limitations of time were constant. There were codes relating to using time, spending time, not having enough time, and trying to fit in time. Participants stated that they were constantly busy, and there was a consistent pull on their time. There was a relationship between being very busy and being pulled between priorities. I recognised

that one of the actions which led the participants to being pulled between priorities, was an expectation that care tasks and administration tasks be completed before they went off duty. The participants perceived that they did not have enough time to deliver appropriate care, work more closely to supervise caregivers, connect effectively with residents, and their families, and finish the tasks expected of them.

Sub category: Being very busy

> I have a very busy day from the minute I get on the ward
> organising the five nurses and their work. (Jan)

The range of activities the registered nurse needs to complete means that there is little time within the shift for what they called the 'extras'. As well as on the spot problem solving of clients' health problems, the activities required of these participants included direct client care, problem solving any changes in health status, routine appointments and doctor's rounds, administration tasks, and maintenance tasks such as re ordering stock. Responding to family concerns and admitting new residents occured in between these activities.

Sub category: Being pulled between priorities

The participants found that they needed to meet expectations from caregivers, the organisation, other registered nurses, residents, and families. During initial coding, I had grouped these incidents within a sub category related to what I had called 'at the same time work'. When coding subsequent interviews, I realised that being pulled between priorities in this instance, was related to time rather than the usual work that registered nurses do which does require them to prioritise, adjust, be flexible and still meet the usual care needs of the residents. In these instances where staffing was inadequate, the participants perceived that there was not the time to meet expectations.

> We start wound care till about midday. Midday I give out the drugs and try and supervise meals but that's quite hard to do because I've got to concentrate on the drugs. I can't see what they are actually getting and whether the patient actually likes it or not. It's quite difficult that. (Jan)

> I tend to notice emotional things.. And it always worries me that I don't have enough time for that. (Jan)

Within a context of an institutionalised structure of care where there is inadequate staffing and the registered nurse perceives that time is limited, there are a number of strategies which they use to make sure that care work is accomplished within a framework of routines and tasks. I named these strategies 'structuring the day by tasks and time', 'increasing supervision of caregivers' and 'pulling in management'.
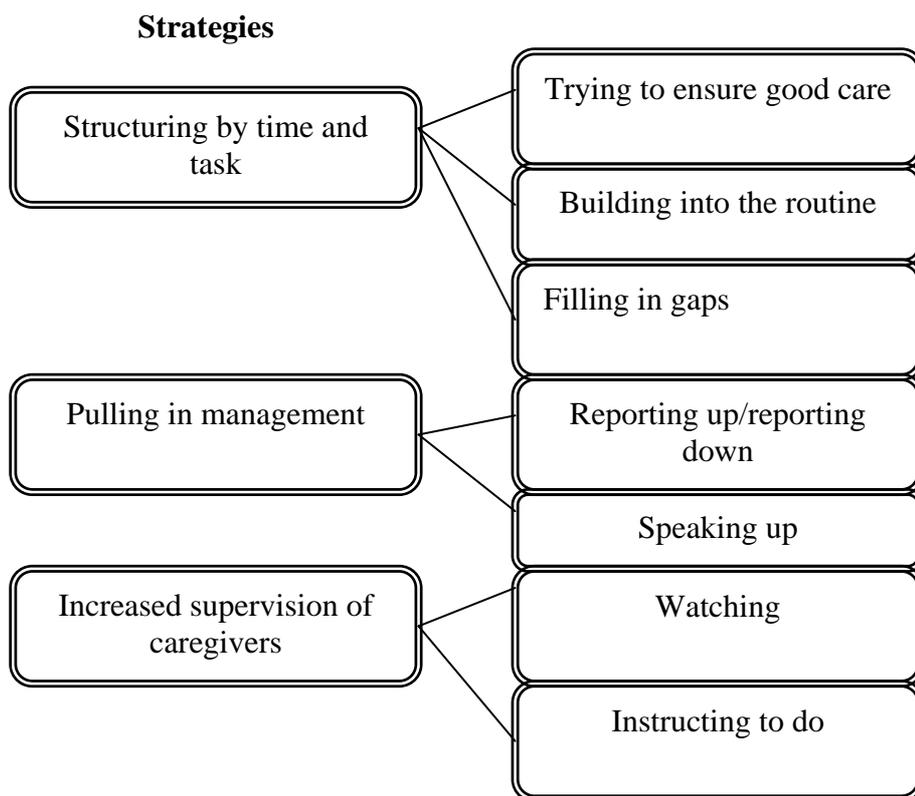
Strategies

Figure 15. Strategies: Focusing on routine and tasks

Strategy: Structuring the Day by Tasks and Time

Participants could outline in detail how the care tasks and care routines were enacted on a daily basis. There was a pattern about what needed to happen by when. This pattern of care delivery was outside the registered nurse's authority to change within the context of an institutionalised structure, and any other pattern was difficult to initiate under the conditions of inadequate staffing.

> The caregivers have got 5 patients which is a pretty heavy… sometimes they've got 6 … heavy load to get through. All the showering and hoist and things required to get their really quite dependent Level 5 [Support need level 5] patients dressed and washed and all their grooming and stuff. So they become pretty you know "hurry up get on with it" type you know, sort of, they don't spend a lot of time talking to them basically. (Jan)

The registered nurses employed some interesting strategies to make sure that care delivery was attended to.

Sub category: Trying to ensure good care

Those residents who required care outside of the routine, were of concern to the registered nurses. They began to include those care needs within the routine. Detailed lists were written for each caregiver by one participant who describes this strategy as follows:

> …Then I am giving out the list of what they have got to do with a particular patient who is dehydrated I put PLUS PLUS fluids and or extra loving care. If you don't tell them or spell it out, it doesn't happen. And it's no good saying "give everybody extra loving care" because that…. You won't get it. …. You have actually got to specify patients and say "this person is a fragile patient who needs extra care at this stage". I actually write everything down because … like I would give a report and I would say " What did I say" and they couldn't tell me. So I actually write it down. (Jan)

In a similar vein, extra forms would be commenced for the same reasons. Sometimes these strategies were effective, sometimes they were not.

> Well you would have had me the day before saying we need two hourly turns for this person. We have pressure area a sacral ulcer coming on this person - we have two hourly turns. This person has been left from nine o'clock. Like they are all left from nine'o clock in the morning till six thirty at night so some of them could be toileted. You can see it in their care plan if they are toileted or not. So one solution …who are at risk are put on a two hourly turn. So that is decided – yes. I've discussed it - two hourly turns charted up. The next day no two hourly turns charted up. It's sitting there but day shift - not been touched - hasn't been done. (Dorothy)

Sub category: Filling in the gaps

The registered nurses themselves, began to fill the gaps in care in order to ensure care delivery took place. For two participants, looking for caregivers took a lot of their time. They perceived these caregivers were hiding. For a third participant, caregivers' hiding was related to being frightened of caring for residents and usually happened when there were agency staff who had not cared for residents with dementing illnesses.

Together with the hiding strategies of caregivers, management decisions had led to caregivers not being present when the resident needed attention and the registered nurses made the decision that to spend time looking for them was counter productive.

In two facilities, the caregivers were allowed by the organisation to take their breaks immediately after the residents had completed their meals. The caregivers would disappear to do this usually leaving only the registered nurse on the ward. The participants would then be attending to resident's needs for cups of tea or using that time to talk with families. The participants objected to the caregivers leaving the area at

a time, they perceived, that residents had care needs, but their objections to management did not lead to any change in practice. On occassions, they would call the caregivers back or go to find them talking together. The participants felt, however, that this search was using their valuable time and continued with the strategy which I coded as 'filling the gaps in care'.

> So the whole place is left so I don't leave the nurses' station. I have my break there because it's a time when relatives come and lots of things happen during that time when everyone is off and many times they take an hour's break. I thought it would be quite easy to just say "we are going to have this group go off at this time" and they just absolutely refuse … refuse to do that. (Dorothy)

Filling in the gaps in care also involved calming residents and or their families. One participant described an incident where a male resident had become distressed when a caregiver had spoken roughly to him.

> She said [name] turn over" and he said "I don't like being talked to like that. Keep her out of my room. " A lot of them, it doesn't matter how much you tell them "That's not the way to speak to a patient". That's the way they speak to them you know. The way they cope with their work basically. They sort of shout at people, even on night duty. (Jan)

For the rest of that day, that resident was provided with choice. He phoned his daughter who spoke to the participant and, eventually, the incident settled.

> We have to give him all the choices we can at that point. Like if he doesn't want to get up, he doesn't get up. If he doesn't want to be washed at that point, he doesn't have a wash. This can go on until the afternoon you know with this particular man because he's upset. And instead of calming him down and reassuring him. They've made him angry resistant , you know unhappy. (Jan)

Registered nurses connected with residents, and noticed that caregivers connected with residents at times during care, or sometimes when they had some

uncommitted time. The participants encouraged these 'windows of connection' because they perceived the benefit to the resident.

> Often I find the nurses sitting in the room with them. ..With their feet up and reading a magazine or something. But actually, I don't actually say anything about that because ummm they are there with them and they can …they say the odd thing to them and kind of give them some company. So that works quite well. (Jan)

The major strategy the participants used to try to ensure care needs were addressed, was to increase their supervision of caregiving staff.

Sub category: Increased supervision of caregivers

At the beginning of this study, I had thought that the supervision of caregivers was going to be the process which was most salient in all of the participants' data. I then recognised the strategies the participants used to develop organisational support, which meant that supervision did not need to be as intense. These strategies are described in the process of 'focusing on the resident and the family'. In contrast, within an institutionalised structure of care, when there is staff inadequacy, and systems which are not supportive, supervision becomes a major strategy to ensure that resident care is attended.

Sub category: Watching and instructing

Caregivers' work was noticed, checked and monitored, in between other tasks. They listened to how residents were spoken to, they noticed the residents' responses to care, and, depending on the situation, used a number of strategies to intervene. On many occasions participants reported that residents were spoken to in ways which were less than respectful.

> I find supervision quite difficult. It's difficult to do without getting in the caregiver's way. You really just have to do it here and there as you are going around the ward giving out drugs. The two things, the main things I look for are privacy and warmth. There's more than that actually. The way they speak to the patient … you know the sort of respect they are giving. (Jan)

The participants also watched for particular care deficits related to nutrition and fluids, maintenance of mobility, and skin integrity. They sought to correct these care deficits within the time constraints created by the inadequacy of staffing.

> I've tried different methods. I mean that issue is a huge issue. All the caregivers sitting down in the different lounges when they are supposed to be giving out drinks to the residents. So I say, "Has everybody been given a drink" They just stare at me. (Dorothy)

> And so I am constantly saying, "Who's looking after Mrs …? OK you haven't looked after her properly. She needs you know to be fed. You've got to make sure she's eaten enough. How much has she eaten?"(Jan)

Caregivers are pulled up, interviewed, told how to, and directed to attend to particular care needs.

> I know there is quite a lot of work to get her up out of bed, but that's one of the issues where I work, is that many people unless you say "Please get so and so up for dinner" and you may have to repeat it every day. To get them up. They prefer to leave them in bed. So that to me is very basic care. (Dorothy)

When the institutional structure is such that the authority to direct care rests mainly with the management, conflict and problems with care delivery were, in the main, taken to management.

Strategy: Pulling in Management

The strategy of 'pulling in management' was used by both the registered nurse and the caregiver. There were two ways in which participants reported their efforts with management in trying to ensure good care delivery. The first set of strategies involved caregiver work. The second set of strategies involved system change. The effectiveness of these strategies was variable.

Sub Category Reporting up, reporting down

'Reporting up, reporting down' related to the ways in which management became involved in the disciplining and supervision of both caregivers and the participants. Caregivers, who were resistant to registered nurse input to change their care practices, were reported to management. Caregivers who did not like the registered nurse pulling them up, also reported the registered nurse to management. At the same time management would report down, for example, in telling the registered nurse to give a verbal warning to a caregiver. Caregivers who were considered difficult were shipped between wards to see if different registered nurses could make a difference. The responses to 'reporting up and reporting down' were varied. Some events gave rise to the disciplinary process of verbal warnings followed by written warnings. At other times, the registered nurses' reporting up was met with no response at all. At all times, when the participants talked about reporting caregivers, the issues were about inadequate care of residents. This inadequate care ranged from verbal abuse to inadequate physical care.

> We had a girl say "Why didn't you deal with this with me first instead of taking it to the nursing supervisor?" The thing is it's not something that you can talk about giving a second chance. It's serious abuse and so it has to be dealt

> with not just on a ward level. Some things you can. You can say "Look you haven't covered that person enough". That sort of thing and supervise that that's happening but with real abuse it happens when you are not there. That's the trouble. So its got to be dealt with pretty seriously right away (silence). (Jan)

When the registered nurse was reported, the issues were usually connected with the way in which the registered nurse had worked with the caregiver. Some complaints were unofficial, and were about the registered nurse wanting the caregiver to do something that they were not wanting to do, and management would be pulled in to deal to the situation. These issues were difficult for the registered nurse and they began to consider whether it was their approach towards the caregivers which was causing the conflict.

> So they do say no. She finally went. The manager sent her. But in many instances, they won't do it. They won't do what you ask. So it looks as though there is an interpersonal relationship problem which I work really, really hard at trying to prevent. (Dorothy)

> I am not allowed to shout you see so I've got to walk all the way down and get somebody to go and get them another … Sometimes I just go and do it myself. It's much easier. (Jan)

The participants who worked within this framework of care, who were consistently working with inadequate staff, used strategies to pull management into changing the care practices within the facility.

Sub Category Speaking up

'Speaking up' occurred in relation to wanting overall change within the facility and did not involve a particular staff member. The strategies used in 'speaking up' involved, putting it in writing, discussing issues at meetings, talking things over with management, and going to personnel who were at the highest level in the organisational

structure. The issues which were spoken about included physical care practices which were not working well, documentation practices which were not working towards enhancing resident care, and staffing levels. One participant was most uncomfortable with this strategy and called herself a 'whistle blower', but at the same time, was not willing to give up on the issues.

> Probably that's one of my biggest struggles because you know I've suggested in writing, in dialogue with the manager, among the caregivers and then in writing to the manager that we need staggered breaks because they all go off to tea at the same time except one part time person who actually goes off and smokes with the people off. (Dorothy)

There were two facilities where inadequacy of staffing led the registered nurse to perceive there was not enough time to meet everybody's expectations. Other participants had described similar situations when they either talked about previous experiences or other facilities from which some residents had transferred to their facility. The notion in grounded theory that 'all is data' means that this data could be used and compared with other participants' experience and observations.

> I keep getting clients from there because they are just not cared for…The care. They've got a gorgeous place but the care is just not there. As long as people are able bodied and able to care for themselves, that's fine, but as soon as they are too fragile, they just go downhill quickly. Simple things like UTI's that are very common. Well it's not picked up. (Victoria)

Registered nurses working within an institutionalised structure of care where the framework for care is based on routine and tasks and where the staffing is inadequate, perceive they have little time to meet the resident's care needs in the way they would prefer. They then focus on the task and the routines of care and build into that routine actions which will assist the resident to maintain their physical health. They consistently try to ensure that good care is delivered to the residents of the facility at the

same time as they try to maintain windows of connection with the resident. Within this focus, they increase their supervision of caregivers and they pull in management to deal with individual and collective issues. What then are the consequences of these processes? I have named the consequences of these processes 'escalating distress' and 'doing to the resident'.
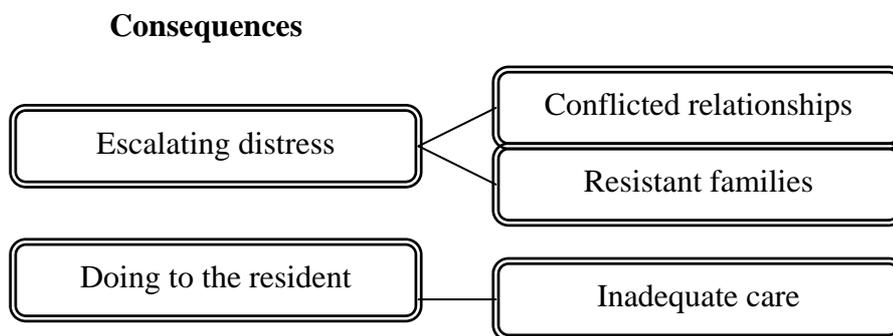
Consequences

Figure 16. Consequences: Focusing on routine and tasks

Consequence: Escalating Distress

I named this category 'escalating distress' because the consequences were about interpersonal conflict, as well as about personal distress experienced by the participants when they perceived that they were unable to deliver adequate resident care under these conditions. Participants also described the distress of families and residents in response to inadequate care or disrespect. The interactions between management, registered nurses and caregivers; the way in which the facility organised according to tasks and routines, and the absence of valuing of each other within the caring context, served to create conflict within the staff who were feeling pressured.

> I must say that one or two are much more gentle in approach. It's difficult because sometimes I think the more bullying ones are much stronger and better at the caregiving

> job. I mean they sort of very physically resilient but they get
> their work done pretty well. But often the patient feels
> completely overwhelmed by it all. It's a bit of a tough
> physical job I think you know. You've got to be fit to do it.
> (Jan)

Within this environment, the residents' reactions were described as either fearful and anxious, passive or aggressive.

> It's sad because it's putting them in a situation where they
> are very anxious you know. (Long silence). (Jan)

In effect the reactions were similar for residents, families, participants and caregivers. For example, caregivers were reported to become defensive when guided in care. Residents were reported to become angry and upset when spoken to roughly. Relatives were talked about as being angry when they perceived their family member was not being cared for adequately. Finally, the registered nurses talked defensively when they recounted the pressures of trying to meet their own and others expectations for good care in conditions that seemed to counter the notion of good care.

> Some relatives are able to accept that there is a basic level of
> care and that's all and that everything else that they need to
> provide themselves. They need to bring in extra food…. to
> come in and perhaps read them the paper and perhaps do …
> They come in and think that we should do it all but we
> haven't got the manpower to do it all. (Jan)

Sub category: Decreased job satisfaction

Two participants were not enjoying their work. There were times when they felt a sense of satisfaction. For Jan, that occurred when more time was available and she could spend more time with the residents. For Dorothy, it was the satisfaction of making a difference to individual residents in the course of her work and the subsequent feedback from families.

> Four different relatives have spoken to me about how they appreciate when I am on what a difference there is, which is complementary. (Dorothy)

At the completion of our interview, Jan said that she had not realised just how much her work situation was 'getting her down'.

> I come home and I think, "Why do I do this" and it's the anger of the relatives that gets me, not the patients. It's that their expectations aren't being met you know and a lot of it is guilt that they feel, pushed onto us. (Jan)

For Dorothy the situation was not sustainable and she has recently resigned her position.

> I can call myself sometimes a whistle blower. It's not easily accepted. I don't want to be a whistle blower (silence). (Dorothy)

> I can't accept. I can't accept that kind of. I actually can't accept it . (Dorothy)

Consequence: Doing to the Resident

This category of 'doing to the resident' related to the outcome for care delivery. When staffing is inadequate there is little time to concentrate on the resident's preferred way of receiving care. Both facilities where the focus on 'routine and task' was accompanied by inadequate staff were private hospitals where the residents were extremely frail. Including residents in developing care goals is a time consuming process. Time for this process was not built into the organising framework for care, and staffing time was not allocated towards developing collaborative care plans.

Caregivers did not interact with families in terms of attending family meetings, and family meetings were not held regularly but on an 'as required' basis.

Whereas I 'spose the caregivers are a bit divorced from the rest of the care. You know they don't ... they are not talking to the doctors … and they're not talking to the relatives much so they are not actually. I guess there is less accountability in some ways. Like we know how **angry** that relative was about this and so we have got to try and tell that to the caregiver. But she didn't actually face them. (Jan)

The participants perceived that there was a direct relationship between the inadequacy of staffing, the organisational system, and the quality of care.

It makes it sound like the place is a terrible place. In fact I would not like to be in a hospital like ours. I've worked in a number of geriatric hospitals and I would not like to be in any of them. Especially if you are a gentle person who's quite sensitive. Very traumatic. I think they have to close down basically. To shut down to cope with it. (Jan)

Participants described their perceptions of inadequate care which was the outcome of these conditions.

Sub category: Inadequate care

Inadequate physical care included, for example, fluids not given to residents, meals not completed, skin care not attended to, showering and drying people roughly, and care directions for preventative care not being carried out.

One way to get more fluids in is to start a fluid balance chart. It's documented so you have some idea but that has to be supervised **extremely** carefully. We have a person on a fluid balance chart all the time. Many many days, often, they've written nothing on it except for when I am on duty.

Most caregivers will say, "I haven't got a pen" (silence). When you ask … If I put somebody on a fluid balance chart I would usually say to them. Could this person be given this type of fluid… like it's asking a particular person to do it. It may be done or may not be done. (Dorothy)

Another participant described how lack of time impacted on the quality of care.

> I actually think the caregivers have got too many patients. They are actually exhausted by the time they have finished doing their physical care and they haven't got time for the extra. They haven't got time to do … they might take them around to the lounge for something and then they will leave them there because they are off doing another patient. So it is constant thing of where the patient says "You left me here too long and I wanted to go to the toilet". This is constantly happening because they are off with another patient. They haven't got time to follow things through. I guess it's the money thing. (Jan)

The third set of codes in this category of 'doing to the resident'related to the emotional aspect of care delivery. The participants described actions such as speaking roughly to residents, making fun of residents, hurrying residents up, telling residents what to wear, and consistently not meeting residents and family requests.

> This lady was actually crying …. So you knew something was wrong with her and she didn't want to tell me because she was too scared to tell you because they are frightened of repercussions from nurses .(Jan)

In contrast to earlier processes within this substantive grounded theory, there was little time in this context to get to know residents. 'Getting to know' the residents occurred as a result of ongoing interaction rather than as a planned action towards care involvement. Time was a constraining factor due to inadequate staffing. Because inadequate staffing was related to caregiver knowledge, skill and attitude as well as numbers, the registered nurse became more involved in supervising staff. This in itself used time and added to the constraints of care delivery. Decision making was centralised and decisions about how to set the framework for care, were made outside the sphere of influence of these registered nurses. They then built care into the routine to try to ensure that care delivery was appropriate for particular individual residents. In this context, there were fewer descriptions of valuing behaviours, and leadership

actions, which built the team towards focusing on resident care. Subsequently, there was data which suggested that caregivers, and registered nurses, were not valued in the same way as described in the process of 'focusing on the resident and their family'.

The consequences of rushing and the pressure to meet expectations together with the absence of valuing, led to escalating conflict with distancing behaviours amongst staff as well as between staff, residents, and their families. The distancing behaviours in themselves then led to defensiveness, and a push pull situation began to emerge between staff, and between residents and families. The overall consequence was that of escalating distress.

The above conditions also had implications for the quality of care. Residents or their families were not included in care planning. The consequences, in terms of care outcomes, were inadequate physical and emotional care. The social aspects of care were slotted into times when an activities person was available, and time constraints led to minimal interactions with the residents.

In this setting the registered nurse participants experienced distress and powerlessness. Both participants, however, expressed that they had experienced the same processes in other facilities, and wondered if this was the context of care for many aged care facilities. One participant described strategies she used when staffing became further constrained. I named this process 'focusing on safety'.

Process: Focusing on Safety

The following dimensional map serves as a guide to the description of 'focusing on safety'. There were two variations between the process of 'focusing on safety', and the previous process of 'focusing on routine and tasks'. The first variation was that the

staffing levels were very low in relation to the resident numbers. The second variation was that the participant employed different organising strategies and moved her focus towards maintaining safety. The remaining dimensions which led to this process have been described previously. This section focuses on the staffing ratios, the strategies used by the registered nurse, and the outcomes for resident care delivery.

My initial analysis, led me to call this category 'losing focus'. When I returned to the process to re examine the data, I realised that this naming was inappropriate. While I was attracted to the name and it sounded dramatic, it did not reflect what was actually going on in the data. Rather than 'losing focus', the participants were focusing in a concentrated way on maintaining safety in very trying conditions. The following dimensional matrix outlines the dimensions of 'focusing on safety'.

Table 7. Dimensional matrix: Focusing on safety

Perspective	Severe time constraints	
Context	Institutional hierarchy	Inadequate institutional support
Conditions	Very low staff to resident ratio	Inadequate staffing levels
Strategies	Keeping safe	Getting through the work Focusing on physical
	Noticing and shutting it down	Not checking Keeping focused on must do's
Consequences	Cascade of negative care outcomes	Increased accidents Increased resident agitation

Condition: Very Low Staff to Resident Ratio

There were two instances of very low staff to resident ratios which were described by this participant, Jan. The first was when there was a shortage of caregiving staff during a morning shift or there were more residents than usual and the registered nurse was expected to care for two patients as well as her usual work. The second occurred when the participant was supervising across two wards on an afternoon shift.

> And then things can go really wrong you know because you've got no time …you're running. I mean it's terrible, the patients think you're her caregiver but you're constantly being called away by the doctor, by other nurses, by relatives ringing, It just doesn't work and I've said that very very strongly too. You know to the administration. (Jan)

This incident was described by one participant yet reflects a situation in which many nurses find themselves. The process was echoed to some degree by Rose.

> … the hardest challenge is when you end up managing the day to day and you see the projects that you've got planned slipping further and further and further away and you look there and you think I've actually made no progress. I'm just kind of in this holding pattern.That's the hardest thing…so you have all these wonderful ideas to do but they sort of get put on hold because of what needs to be done immediately right now to get us through the day. (Rose)

When I asked myself how maintaining safety was different to refocusing on the resident, I realised that there were some major differences. For Rose, the staffing levels were not so acute and she and the caregivers knew the residents so well that they could maintain a focus on doing what was best for this resident. This was where her knowledge and the systems she set in place for resident centered care, could inform her in the decisions she needed to make when staffing was low. For Jan, the system which was in place was already conflicted and lower staffing led to a precarious situation which she called variously 'working at the extreme' and 'a whole system under stress'.

What strategies were used within this context of extreme stress? Two main strategies were used in this context, those of 'keeping safe', and 'noticing and shutting out'.

Strategy: Keeping Safe

'Keeping safe' involved focusing on physical safety. Prioritising work into 'must dos' was how this occurred. Administering medications, finishing work before the next duty came on, and attending to safety, were prioritised. There was a heightened awareness of the potential for mistakes to be made.

> It's easy to make drug mistakes and forget things and you know referrals to physio and things can be just forgotten because you've got so much of a load on your own you know and yeah and that's always a worry. You've always got to watch that you're not getting beyond your functioning … good functional ability you know with busyness. (Jan)

There was also limited time to continue to supervise caregivers closely because of the time taken with managing the clients who had been allocated to her care.

Sub category: Noticing but shutting it down

The reason for 'shutting it down' was that the participant had an awareness of what could be achieved, and not achieved, when staffing numbers were so low. There was an awareness of the impact on the residents and the lack of availability of the registered nurse. It was noticed that resident agitation increased and that care delivery was rushed.

> I think you are constantly noticing but shutting it down. Because there is only. You have got to deal with absolute things that are going to be checked. You have got to make sure you haven't mucked up the morphine. You know there's major things that are … that you have to have done by the end of your duty. And when you are under stress you have to get those things done first to make sure they're right.

> You've got to look after safety ... That's the thing that is difficult. You can get more falls because people aren't being supervised properly and major falls could happen all the time. I find that I notice things which I know aren't right and that's frustrating. Especially to do with feeding and drinking and things like that.(Jan)

Consequences: Cascade of Negative Outcomes

Under these conditions of extremely low staffing levels, care tasks are rushed, and accidents do occur. The agitation of staff is communicated to residents and there can evolve a spiraling cascade of events which are difficult to overcome without an increase in staffing levels.

> Things don't get looked at. Like catheters you know that can be things just get missed. People get skin tears and nobody knows where or how it happened. Drug mistakes can be made because she has got to do two different rounds and pulled by different needs in between. And you probably get an increase in people calling out because they don't feel they are being cared for. I think everybody feels on edge. You are just working at the extreme. And the nurses are passing that on to the patients. They are saying "Look, we've only got …we're one nurse down today. Be quiet. We can't manage to do more than this" (Voice stern and high). It's a whole system under stress really. (Jan)

When staffing is adequate, yet caregivers could be seen moving into task oriented work, participants would work to shift the practice towards the individual resident. I described this in the earlier process of 'shifting focus towards the resident'. At those times, the participants had the ability to intervene to prevent these negative care outcomes. During this process of maintaining safety, there did not seem to be the time to do other than try to minimise the negative care outcomes.

Conclusion

In this second chapter of findings, I described three processes which were uncovered in the participants' data. The first process was that of 'shifting focus towards the resident', and described how registered nurses would encourage care practices towards individual residents. This shift of focus occurred when they perceived that there were different possibilities for resident care and when they had sufficient time to work towards those possibilities.

The second process, that of 'focusing on routine and tasks', described the situation which led the registered nurse to focus on the routine and tasks of resident care delivery. Within the context of an institutionalised structure of care, where the care framework is that of routine and tasks, and when the staffing is inadequate, the registered nurse builds particular resident care needs into the routine, as she works to encourage the organisation to change their care framework. A feature, which emerged in this context, was the emotional response which occurs when there is inadequacy of staff and when the pressure of getting through the work becomes the goal of care. In these conditions, resident care outcomes are poor, and distress increases as families become agitated, and staff conflict escalates.

Finally, when staffing is further decreased, the registered nurse focuses on safety as the bottom line, and notices care which is not appropriate but shuts it down because of an inability to attend to the resident's care needs. In these conditions, there can be a cascade of negative events which lead to loss of skin integrity, falls and increased resident and staff agitation. In Chapter Seven, I discuss these findings and consider the limitations of this study together with recommendations for future research in this area.

Family

Staff
Focus

Resident

Facility
organisation

Individualised
philosophy of care
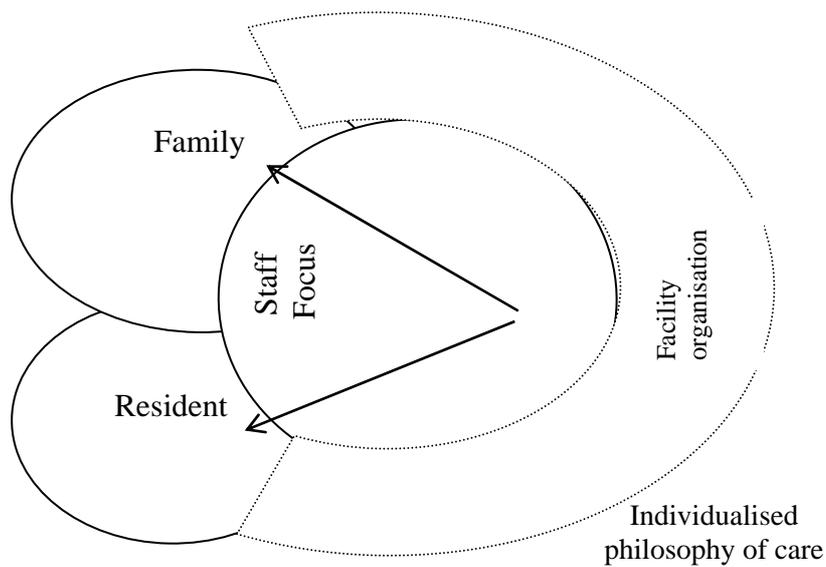
Figure 17. A comparison between two structures of care

Resident

Facility
organisation

Staff
focus

Registered
Nurse

Family

Institutionalised
Structure of care
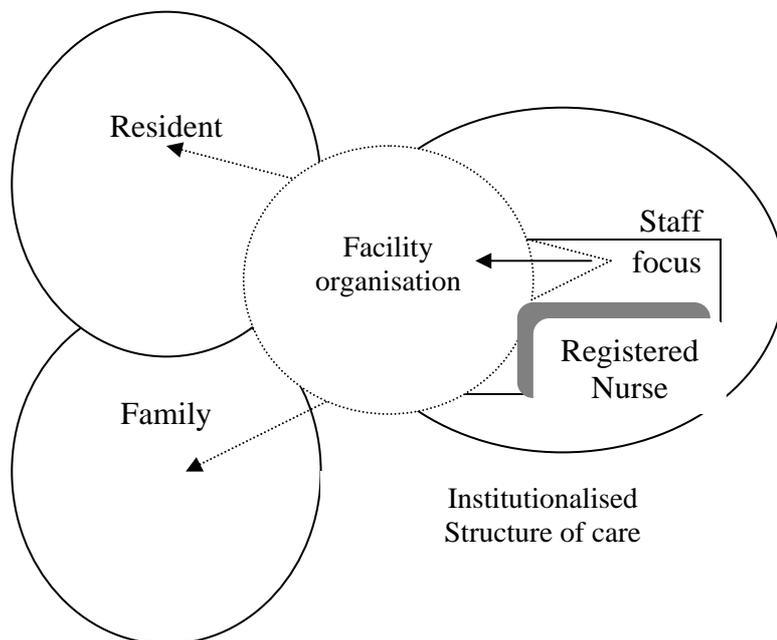
CHAPTER SEVEN: DISCUSSION OF RESEARCH FINDINGS

Figure 17, diagramatically represents the relationships between organisational structure, participants, staff, residents, and families, that became evident through an analysis of the participants' data. The different positioning of these relationships impacted on the participants' work in residential care. The substantive grounded theory of 'shifting focus', reveals that registered nurse work involved the participants shifting their focus at different times in order to ensure that care delivery was achieved. The context in which this shift in focus occurred, was related mainly to the institutional organisation of the facility and the conditions which triggered a shift of focus related, in the main, to staffing. In this discussion I will consider firstly, the relationship between registered nurses' work and the two differing institutional structures. The relationships between residents, families, and staff in these two institutional settings will be considered. The second focus I will take in this chapter will be to explore the adequacy of staffing and how this adequacy impacted on the participants' work in the different organisational structures. Throughout this discussion I will consider the research findings in relation to the literature and in relation to Government policies as they are in New Zealand at the time of writing.

Organisational Patterns of Care

The way in which organisations influenced work in this study is congruent with the findings in similar studies. Yeatts and Seward (2000) describe nursing homes which are "typically very traditional, with a clear hierarchical structure and chain of command" (p. 358). Wright and McCormack (2001) describe a person centered and

individualised approach to care. Similar contrasts between organisational structures are described in other studies (Kayser-Jones, 1996; Tonuma & Winbolt, 2000).

An organisational emphasis on routine and a contrasting organisational emphasis on people, was found in this research project. How were these organising structures different? The first difference was that management was either centralised or decentralised. The second major difference was in the centrality of the philosophy of care. All of the participants worked in facilities where there was a stated philosophy of care. There was a relationship between these two factors. The facilities with a decentralised structure organised according to their philosophy of care. There was evidence of their structure supporting the individual needs of residents. However, those with a centralised management structure organised according to routine, rather than philosophy of care requirements. An example of these emphases can be seen in the following statements from the participants.

An emphasis on routine:

> Because you don't like to go off and leave that undone because the next person comes on.. and they haven't got a baseline to start from. They don't know where you are with it. …you can't leave it half-done you know. (Jan)

> These caregivers can move quickly. They move far too quickly doing their tasks. Incredibly quickly to fulfill really good care and they are allowed to be seated. (Dorothy)

An emphasis on people:

> Then none of us mind saying to the next shift "We haven't done it". And that's cool. I think that's really important. But I mean we all try to do what we can. (Sally)

> And I have more or less driven into them what the priorities are. If I leave instructions that such and such a thing could be done if they have time, that is not a priority. If there is something a resident wants or something happens then they don't worry. They do that first. (Alice)

> I ask first and do our best to cater for what they want.
> Because I am lucky. We are a small rest home and we have
> got plenty of time to do that. Oh not plenty of time, but are
> able to do that. (Victoria)

I do not want to present these two ways of working as mutually exclusive. Each pattern had elements of the other. For example, participants who worked in an institutionalised structure of care would spend individual time with residents and encourage individualised care practices when the conditions (mainly adequate staffing) were available to them to do so. At the same time, those participants who organised towards an individualised philosophy of care would describe times when, due to staffing conditions, they needed to redouble their efforts to maintain a focus on the resident and their family.

Centralised Organisational Pattern and an Institutional Structure of Care

In residential care facilities where the management processes were centralised, management and administration staff decided how care delivery would be organised, the staffing levels that were required for each shift and the patterns of work that were to be followed. The shifts were focused on the routine of care tasks. The efforts of some participants, to shift this focus from routine tasks to individual care, were resisted. For example, both Dorothy and Jan perceived that staff taking a break straight after the residents had their meals, meant that either the meals were rushed in order that staff could go on break, or that staff were not around to assist when the participant was busy with medication rounds. The registered nurses also found that it was difficult to attend to the medication round and supervise the meals at the same time. Both participants found the situation to be problematic in terms of client care, but could not change the practice, as it was an allowable practice according to management.

> They serve the meal and they feed the clients that aren't up. And they're quick. They go quickly [tape unclear here] because they all have their breaks the minute they are finished. (Dorothy)

The participants in these instances were concerned that residents were not receiving sufficient nutritional intake, and were not enjoying the social occasion that meals could engender. Their requests to management for a change in this practice were not successful. Meal times in nursing homes have been studied extensively and the conditions described by these participants, echo those which several authors note as conditions leading to a high risk of inadequate nutrition for the residents (Crogan & Shultz, 2000; Kayser-Jones, 1996; Kayser-Jones & Schell, 1997a, 1997b). Crogan, Shultz, Adams and Massey's (2001) study explored the barriers to nutrition care for nursing home residents. They found that one of those barriers was related to management practices. For example, short staffing leading to inadequate time and poor communication between the caregivers and the registered nurses. While the participants in this research project were not successful in their requests for a change in care practices at meal times, they did perceive that they could effect change in other areas.

There was the opportunity for some input into institutional life through committees, meetings, and individual communication. Jan was effective in being able to employ another staff member when she complained about the staff to resident ratios. Complaints that went to management were dealt with promptly. Heidi was listened to by management, and was used by both caregiving staff and management, to convey informal messages and provide an assessment to both 'sides' about the day to day happenings in the facility. Dorothy, however, was not able to effect any change and has since left the facility where she worked. On the whole, participants experienced this style of organisation as problematic and not flexible to change in the routine.

Decentralised Organisational Pattern and an Individualised Philosophy of Care

The way that participants experienced a decentralised organisational structure, was that they had authority for making some decisions. For example, in hiring staff, and in being responsible for the organisation of their staff. However, some participants needed to work within the larger facility structures, for example, to assist with weekend staff cover. These participants' conversation regarding change was different to the other participants, in that they would talk about a deficiency in care practices and immediately after would talk about what they had done to change practice. A contrasting example in this institutional context is about meals. Susan found that staff members were beginning to rush meals. She then changed the staff patterns of work so that meals were leisurely social occasions for the residents. In short, some participants experienced more authority and autonomy in their work life if they worked within a structure of care where management was more decentralised.

In the facilities where the aim was towards an individualised philosophy of care, time was deliberately put aside for getting to know the residents and their families. It is this feature which Gooder (2001) talks about when she says that getting to know a patient must be an organising factor in the health professional's care management. Gooder says this, because the residents say that they want to be known, and that, they and their families, want to be participants in their own care.

A person centered approach leads to individualising care (Bowers, Esmond, & Holloway, 1996; Bowers, Fibich et al., 2001; Lauver et al., 2002; Lutz & Bowers, 2000). Current Government policy requires that care is person centered, in that clients and their families are to be involved in the development of their own care plans, which as far as possible, are to be focused on the residents' individual preferences for care.

This directive is emphasised in terms of specialist dementia units (Ministry of Health, 2002a). It is including the residents and families in the decision making that seems to be a central feature of person centered care. Residents can receive very good physical care, and have access to group activities in an institutional setting. They can be treated with kindness and compassion. This can all happen without the resident or the family being part of the decision making with regard to care preferences. Similarly, an organisation can have a client centered approach and staff who may not know how to put that approach into action. As this study demonstrates, there are a set of conditions and activities which, if present, can build towards a client centered approach.

Research reports that residents (Bowers, Esmond, Holloway, & Norton, 1996; Bowers, Fibich et al., 2001; Forbes & Hoffart, 1998; Stone et al., 2002), family (Bowers, 1988a; Janzen, 2001; Kellett, 1998; Walker, 2001), and staff (Banaszak-Holl & Hines, 1996; Brannon & Smyer, 1994; Featherston, 2000), experience more satisfaction when they are included in the care team, are valued, and are supported in their various roles.

For unregistered staff to be more supported in their role, the registered nurse needs to step in and lead the team. This can be difficult, if the registered nurse is too busy with tasks which leave her or him with too little time to focus on developing the care team. Crogan and Shultz (2000) report that unregistered staff would appreciate more guidance when working with people who have conditions and care needs which are beyond the caregiver's level of education and training. Providing guidance can be difficult for the registered nurse if the management does not enable the registered nurse to make decisions with regard to the shift for which she or he is accountable. In these

instances of being too busy or being restricted, there is a tension between completing care tasks and developing caregiver practice.

Unregistered staff need and deserve to have the registered nurse available to form a collaborative working team that can provide appropriate and individualised care. Many staff who work in residential aged care are working with very frail residents who have complex interacting physical conditions. They are working in an environment that requires increasing documentation from Government to demonstrate the quality of care the resident receives. To achieve these aims in an organisation where the emphasis is on task and on routine, is very difficult as the research findings demonstrate. Yeatts and Seward (2000) support the findings of this study. They state:

> NH's [nursing homes] often try to promote warm, nurturing bonds between staff and residents while maintaining a paramilitary command structure and although this can be done, it will never be done well (p. 358).

Maintaining an individualised approach to resident care is more effective when there is commitment to, and an understanding of, the concept from an administrative level through to all staff. An individualised care plan arises out of the processes of getting to know the resident (Coker, 1998; O'Sullivan, 2002). As Gooder (2001) notes, time must be organised for the purpose of getting to know the resident. Yet the way in which a facility is organised can reduce the time available for the registered nurse to get to know the residents and their families in order to be able to develop the depth of knowing that is required for individualised care (Bowers, Lauring et al., 2001; Jones et al., 2002). An example in this study is that of the admission processes and the relationships with families. Again, these findings mirror other research which demonstrates that families consider they have an important and necessary ongoing role

in the care for their family member who is in institutional care (Bowers, 1988a; Kellett, 1999; Nolan & Dellasega, 2000).

Participants in the institutionalised structure of care, perceived that relationships with residents and families, could range from friendly, through to difficult and conflicted. Jan noted that there were a lot of angry families who perceived their needs were not being met, and she was unable to find a way to meet those needs. Dorothy noted that families said that care was better when she was on duty. Heidi met families only occasionally as many families worked during her time on duty. Jan and Heidi described the admission in terms of tasks to be performed or completed depending on what administration had already done. They were not always involved in the admission process. There were few institutional activities that were described as involving families in celebrations. Family and resident care review meetings were not part of the usual process of care in these facilities.

Participants working in an individualised structure of care talked about families very differently. Admission was a process of getting to know each other. Rose who worked in charge of a small dementia care unit, which was part of a very large complex, described the admission process as occurring over time and her description mirrored the remaining participants' descriptions. Rose would begin the process of 'to and fro' between individual assessment, family input, and care staff input. This would be an ongoing process until she felt she knew the resident and the family very well. Rose explained that this strategy was important to enable her to provide appropriate care. She also explained that if she did this, she would be able to pick up the minute changes in the resident's condition that she could act on, and maybe avoid an episode of acute illness for that resident. All participants who could individualise care had

regular family review meetings. There were regular celebrations or activities that involved families, for example, picnics. So that families could attend these activities, Susan held them on weekends. Sally, Alice and Victoria had open door policies and were always available if families wanted to talk or had a problem. The participants worked hard to develop relationships with the families so that if there was a problem with the care or the facility, the family would feel comfortable to complain. And they did. The participants described the times when care was not as it should have been and participants described the immediate action they would take to investigate complaints and take the appropriate actions to correct the problem. A central organising feature in this type of setting, was the presence of the registered nurse in the role of leader, facilitator, encourager, role model, and teacher. The registered nurse, who is able to incorporate these ways of working, can make a great deal of difference in residential care, if the management processes enable him or her to do so.

Staffing and Staff Management

I had thought that staffing numbers would be one of the difficulties reported by registered nurses. While staffing numbers were a salient feature of the participants' discussions, the staffing attitudes, knowledge and skill, also featured. The same constraints to staffing adequacy are described by Bowers and Becker (1992), who note that nurse aids are constricted by the requirements of the formal organisation to complete work in particular times while at the same time fitting in with the requirements of other staff. In other words, nurse aids are to be seen as 'fitting in' with the culture of the organisation as determined either by management or by other staff.

In this study, the context in which staffing adequacy was more problematic was described in relation to those facilities where the management structures were hierarchical. In these settings, it seemed that the caregiving staff, the registered nurse staff, and the management, were distinct and separate in their operation. For example, the caregiving staff were not a part of the doctors' visits, or the family meetings but were a part of the problem solving of client problems from time to time. Participants described an 'us and them' situation which on some occassions could become quite polarised, with the caregiving staff not taking any direction from the registered nurse. These comments were perhaps the most distressing in this study and require some discussion.

Nay (1998a) discusses the context of aged care nursing and suggests that nurses, unwittingly, enter into infantalising and dehumanising ways of being with residents. Residents in response, seem to 'toe the line' in the interests of receiving at least some of the care they need.

In an effort to make sure that residents were not disadvantaged or treated poorly, some participants deliberately worked towards having transparency in their system. One participant described how she made sure that she worked in direct care with each resident to build a relationship with them so that they would feel safe to complain if they needed to. She also developed relationships with the families for the same reason. The other registered nurses who were on duty would regularly take on direct care assignments and all people 'kept an eye out' for any signs of untoward behaviour towards the residents. The participants described that staff were very clear that the boundaries around care included the way in which care was delivered and the tone and manner in which residents were addressed. The way in which a number of

participants described this process sounded like there was no room for neglect or abuse, and if any did occur, it would be picked up, noted, and addressed immediately.

In contrast, those participants who described caregivers as rough, rude or neglectful, did not seem to have the same level of support from their administration or management. In spite of reporting these instances in one case, no action was taken. It is also important to note that in another of these instances, the caregiver's rudeness to clients was exacerbated when staffing was poor. In yet another instance, there seemed to be a general malaise where the caregivers just could not envisage another way of carrying out care. The participant reporting this situation, described the caregivers' behaviour in response to the malaise as 'sitting down' for the majority of the shift. In this instance, the leadership did not seem to be forthcoming in setting the boundaries of practice for these staff and as the participant was not seen as having authority, her efforts towards a change in care practices were met with resistance.

It would seem that where there is a more effective leadership which is focused on the resident and their family, the support systems for staff are such that they feel valued as part of the team, and are aware of the boundaries which have been set for care processes. Additionally, the transparancy of the care frameworks and care processes are such that any neglect of the client is noticed very quickly and addressed. The participants who worked in these facilities had a higher staff to resident ratio than those participants who worked in an institutional structure of care. Those participants who worked with higher staff ratios were not sure what the future held, and those with lower staff ratios were concerned that it would never get any better. All participants talked about funding as problematic.

Funding for Residential Aged Care

The current Government recognises that funding has not kept pace with demand in recent years (Minister of Social Development, 2001). Without exception, the participants within this research study referred to funding as critical to their ability to either continue to provide a high quality of care or to increase the quality of their care. The owner managers all stated spontaneously that they took less profit in order to maintain the quality of care. Most of the participants could not see how they could continue to provide individualised care if the response from Government did not improve.

The owner managers could not see that they would stay in the aged care sector unless they received more funding and support from Government. At the time of writing, there has been some increase in funding, however, there has also been a corresponding increase in expectation to meet the legislative requirements of the Health and Disability Services Safety Act (2001). The national contract between Government and 800 aged care facilities, has increased the need for education and services provided within residential aged care. The participants were not complaining about the current expectations for care. They were pleased about the increase in expectation for national standards to be met within this health care sector. They recognised the need for professional, social and fiscal accountability. Their concern was about their ability to meet the expectations within the current funding levels. Once again, funding does not seem to be keeping up with demand. Demand in this context is about a high quality of care and legislative requirements to demonstrate that a quality of care is indeed, being provided.

The current and laudible trend in Government policy is for participation and consultation with older people and their families. Some participants stated that they could not continue if they could not develop the relationships with residents and family, which, they considered were vital to the quality of care they could deliver. For other participants, taking the time to develop those relationships was very difficult and in some cases almost impossible, as they struggled with providing care under conditions of limited staffing and high levels of resident dependency.

The notion of a seamless continuum of care contains the word *and* rather than *or*. For example, there is a requirement for high quality community care *and* high quality long-term residential aged care. Regardless of where the service is provided, the need for education and training, a commitment to participation, consultation and valuing, and adequate funding remains.

There is a danger that because of the emphasis on community care, the needs of those in long term care may not receive the priority they deserve. For example, the Health Workforce Advisory Committee (2002) states a need for training of health care workers within the community setting, but does not state whether that community setting includes residential long term care. At the same time, the national contract for care providers of long term care, has a requirement for education and states that the New Zealand Qualifications Authority Framework courses are the required education for health care workers. Manchester (2003c) reports that Ruth Dyson, the Minister for Disability Issues, is working with special interest groups to develop caregiver training, which will be delivered without cost to both workers and service providers. There are post graduate courses available for registered nurses working in aged care. These courses, however, can be costly and it is difficult for some registered nurses to obtain

release time to attend courses. Added to this, some participants have noted that there are registered nurses working in aged care who do not seem motivated towards maintaining currency in their practice. The current environment of aged care facilities is that the resident dependency level is changing and there is a need for registered nurses to maintain and further develop their clinical skills.

Outcomes of Resident Care Delivery

Registered nurses are charged, by virtue of their registration, to provide best practice approaches to client care and not to place residents at risk (Nursing Council of New Zealand, 2001a). Some incidents in this study, highlight the tensions between the responsibilities of nursing registration and the responsibilities of an organisation to support appropriate decision making within the scope of that registration. Who is accountable? When the registered nurse perceives that there is a routine related to meal times, which may place some residents at risk of developing impaired nutrition, and the organisation does not perceive that there is a need to change care practices, is the registered nurse still accountable for the care practices which are in place? There needs to be more clarity for registered nurses around these issues.

Enrolled nurses and unregistered staff work under the supervision of a registered nurse (Nursing Council of New Zealand, 1999a). In order to meet their regulatory authority, registered nurses need to be supported to enact that authority. However, as this study illustrates, when there is an emphasis on routine and the pattern of that emphasis has been in place over a long period of time, it is very difficult to encourage either management or staff to adjust to a different approach which would enable the registered nurse to have more input into how the care patterns are to be organised. These issues have been raised by some participants who took part in this

study. The scope of this research however does not enable answers to be provided for all the questions.

Research Strengths and Limitations

The participants in this study were knowledgeable, articulate, and willing to describe their work practices. My experience tells me that they were a unique group. All participants had taken some responsibility for updating their practice albeit some to a lesser degree than others. All participants talked about colleagues they had worked with who were not interested in updating their knowledge and who did not provide effective role modeling for unregistered staff. They also knew of many registered nurses that worked in aged care who did not have the passion for the specialty that most of the participants demonstrated. I was unable to recruit any of these registered nurses into the study.

That the participants were a unique group, has had an impact on the findings. The positive aspect was that I discovered what processes can enable a more client centered approach. In this way, I have learned a great deal and can compare these findings with my own experience. I find myself responding to complaints about gerontological nursing with comments like "We need to also consider whether the conditions of work enable them to provide quality of care or not". I also find that I can be articulate about what structural changes can enhance the quality of care for residents and their inclusion in care practices.

The group of registered nurse participants in this study was not representative of the range of registered nurses that work in residential aged care. The range of facilities which the participants described, was representative across the facilities with which I have had experience and which are described in the literature from the field. When I presented my findings to participants, those participants who had worked in a number of facilities could position their current and previous facilities or could position their own facility at different stages of development along the continuum of focus depicted by the model illustrating the findings of this study (Appendix G).

Colleagues and clinicians, however, have noted, after seeing this model of shifting focus, that there seem to be a number of participants who describe a client centered approach and they wonder if this gives a false impression of aged care work in New Zealand. My reply is that that could well be the case. There are a number of points to consider here. The findings are based on a grounded theory dimensional analysis of the registered nurse participants only. I did not do participant observations. Despite this, there was a good range of agreement in the interviews to demonstrate the relationships between the concepts described in the findings. I believe that participant observation could have not only strengthened these findings but would have included other perceptions, including potentially those of families, residents, management, and other staff. Because of these factors, this study has limitations.

Future Research

This study raises a number of questions related to residential aged care. How one enacts leadership qualities to develop person centered care needs to be explored more fully. Research, which includes Maori and other ethnic groups, would provide information with regard to how registered nurse work is perceived by these groups, and

could inform future service delivery to these populations. There needs to be further study into how care facilities are organised. I would like to see future studies which included the experiences of residents, their families, and staff from all levels of the organisation. Such studies could provide further information about how to deliver a high quality of care to older people living in residential aged care. The information gained from future studies could continue to clarify the type and nature of the resources that are required if service providers are to meet the requirements for client centered care.

CONCLUSION

This research demonstrates that providing appropriate care to residents in institutional care is a package deal. By that I mean that a number of conditions need to work together in order to sustain a high quality of care delivery. I have realised, during this project, just how pivotal the organisation of a care facility is to the quality of care which can be delivered within that facility. The philosophy or central belief systems set the tone and the process for the rest of care. If a nurse operates out of a personal philosophy which is about delivering individualised care, and they work in an institutionalised structure of care they could experience the conflict that some participants have described. Some of these participants experienced wanting to take time to get to know the resident, and yet the way in which care was organised, meant they did not have many opportunities to use time in this way. In contrast, when a registered nurse is working in a structure where the focus is on the resident, and management processes work to involve the staff in the decision making process, the registered nurse can take the time to get to know the resident, develop staff knowledge and skill, and generally provide leadership in the facility.

The participants in this grounded theory study demonstrated that the underlying process of their work was to ensure resident care was carried out. Under conditions where the registered nurse perceived that she had the ability to work from a philosophy of individualised care and there was adequate staffing, she focused care on the resident and their family. In these contexts, there was a supporting framework which enabled this focus throughout the whole of the facility, and staff were supported and developed in maintaining their focus towards individualised care, with positive care outcomes and enhanced job satisfaction. During times of less than optimal staffing in these

conditions, the registered nurse would refocus on the resident and the client and administration work extraneous to client care would be put aside for a later time.

All participants regardless of the way in which care practices were structured in their facility, worked to shift the focus of staff from routines to tasks. This shift usually occurred when staff became routinised in their work, when there was extra time or when there was a collective change process happening in the facility.

Some participants found that the structure in which they were working was more institutionalised. In these instances, the registered nurse organised to include client needs within the routine which already existed. Because the work pattern of staff in this structure of care was set by management, the registered nurse had little power or authority to change the pattern of routine even though there was evidence that the care practices were disempowering for the resident, families were unhappy with care, and the staff responses were less than adequate. In this structure of care, when staffing levels were severely constrained, the registered nurse organised the shift towards maintaining the residents' physical safety.

These findings demonstrate, that to provide client centered care within an institutionalised structure of care can be very difficult to achieve, even though current Government policy expects that care will be planned in partnership with clients and their families. These findings also demonstrate that while staffing numbers are important for providing adequate care, staffing knowledge, skill and attitude, are also important factors which impact on the quality of client care. The research project raises questions related to leadership and quality of care in residential aged care. Further research needs to be carried out in this area to more fully explore the consequences of organisational patterns on the quality of resident care.

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APPENDICES

Appendix A   Example of Initial Coding

Appendix B   Initial Coding

Appendix C   Conceptual Model Nvivo

Appendix D   Participant Information Sheet

Appendix E   Participant Consent Form

Appendix F   Glossary

Appendix G   Diagram: Shifting Focus: How Registered Nurses in Residential Aged Care Organise their Work

Example of initial coding

Date, time and line references have been removed for ease of fit

Categories/Code/Invivo codes	Shorter phrases	What is this an instance of?	Memos
What I see is happening there is that it's actually what nurses do is the most important thing	Nurses make a difference in gerontological nursing	Outcome of supervisory processes - Making a difference	I haven't put this in so far as a code however it is a these which is present with Sally but with Jan it's how the absence? Leads to variance in care? Lets move on because this comes up later in this transcript and I will think about it again then
What I do with my skills is what actually makes the difference for your day to day	Nursing skills make a difference	Outcome of supervisory processes - Dimension of Making a difference - Nursing skill level	Nursing skills the presence or absence makes a difference. This can be readily supported with literature – skills though are different to knowledge skills are putting theory into practice In this instance where Rose is working with older people who have a dementing illness
What I do can be the difference between those frail years being really good or those frail years being really unpleasant	Making a difference	Outcome of supervisory processes - Making a difference - outcomes on quality of life	The outcome of nursing skill will make a difference either positive or negative to the resident's quality of life.
Modeled after (Eaves, 2001)			

Consequences

It's all is done for you. Ummm you loose challenges. There's no challenges. Ummm. Yeah its ...you wake up in the morning and think.. "what have I got to look forward to"? you know...you've got um and so you've got people asking you "is anything happening today" you know and usually there is very little but like there's a bit of occupational therapy but its pretty limited...It lasts for an hour or so . and that's their day you know.. not much going for them There is nothing to ...you know they haven't got a ....There is nothing to sort of challenge them There's no bills to pay, there's no cat to worry about there's nothing. There's absolutely nothing they've got control of. Which is a very very, I feel um difficult situation to cope with cause really there's no stimulation. They're reliant on visitors which really. ..They can't even make them a cup of tea you know. And the hospital, we can sometimes give them a cup of tea but it's not under their control. It's horrible. You've got to be very very umm philosophical I think to cope with it or very hard or something. I don't know. I find the sensitive ones are the it just destroys them basically And there is not a lot the nurse can do about that. We haven't got a lot of time you see. Ummm. I often think... Even if...it's still the problem of not being in

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Handwritten margin notes:

Working against older person

looking for stimulation

Limited perceptions of can do.

cause - organization of activities

→ overcoming - looking for stimulation

→ not much going for them
a bit   OT   Theres nothing to .
limited

Working against older people

challenges <
no control
no bills
no cat to worry about
no cup of tea
not able to offer Hospitality

Divorced separated from usual living

limiting LIFE.
limiting living

- ? Challenge to cope with difficult situation.

Coping

- limited perceptions of can do - Sometimes assist

- Perceptions of Resident's life.
Horrible

limited perceptions of can do.

cause.

Time

2.

Appendix C
Nvivo Modelling
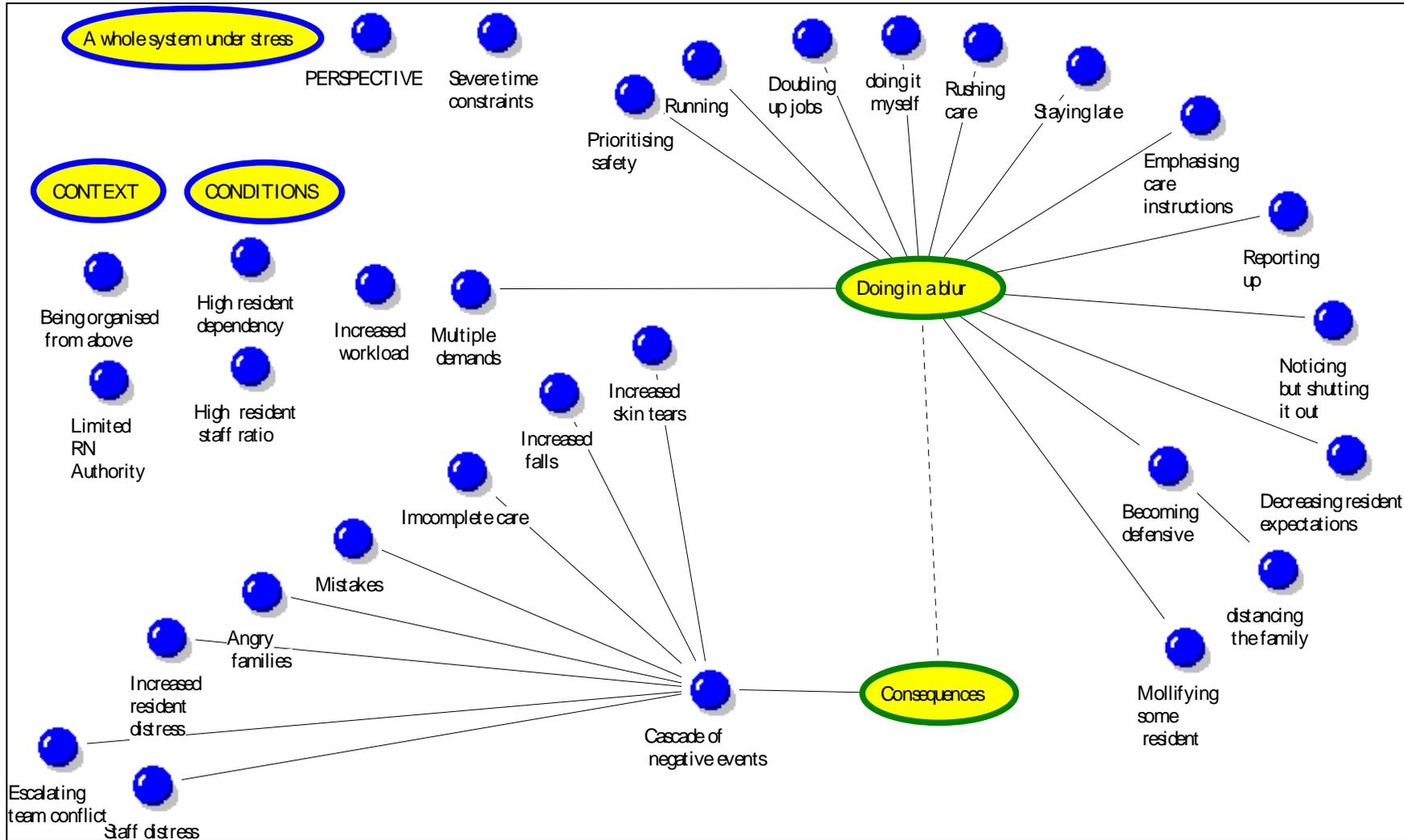
PARTICIPANT INFORMATION SHEET

I am a nursing lecturer enrolled in a Masters of Health Science
(Nursing) degree at the Auckland University of Technology. I am
specialising in gerontological nursing. A mutual colleague has given
your name to me.

For my thesis topic, I am exploring the role of the registered nurse in
residential aged care. My research topic concentrates on the processes of care delivery
to older people from the perspective of the registered nurse.

The findings of this study will assist me to develop a better understanding of the work
that registered nurses undertake in this specialty. It is hoped that this understanding can
guide the nursing profession, policy makers and community groups in future decisions
regarding the structures and processes that guide nursing work in residential aged care.

I invite you to participate in this research. Your participation will be by way of an
audiotaped interview of approximately 60-90 minutes. The interview will take place at
a location and time convenient to you. I may also invite you to a second interview.

The findings of the study will be made available to you. All interview material will be
kept in a locked filing cabinet. Confidentiality of your name will be maintained in the
writing up of this study and any identifying features will be left out of the study. You
have the right to withdraw from this study at any time with no consequence to yourself.
If you find that emotional distress occurs as a result of your participation in this
research project, counselling will be made available to you.

For registered nurses who are Maori, I have consulted with Kawa Whakaruruhau at the
Auckland University of Technology, School of Nursing & Midwifery. They have
agreed to enter a consultation process to ensure your safety during the project. For
registered nurses who have English as the second of their languages, if you would
prefer, I will provide an interpreter to ensure that the process of consent is correctly
explained and the interview is correctly transcribed.

If you are interested in participating I will meet with you and answer any questions you may have. After our discussion, I will wait two weeks before contacting you again to give you an opportunity to consider your participation.

> Barbara McKenzie-Green
> Auckland University of Technology
> Phone: 917 9999 extension 7157
> E-mail: barbara.mckenzie-green@aut.ac.nz.

If you have any concerns you do not wish to address with me, please feel free to contact my thesis supervisor:

> Jan Wilson
> Auckland University of Technology
> Phone: 917 9999 extension 7808

For Maori Registered Nurses who have any further questions regarding the bicultural processes of the research the Kawa Whakaruruhau contact person is:

> Caroline McKinney
> Auckland University of Technology
> Phone: 9179999 extension 7741

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, madeline.banda@aut.ac.nz ,917 9999 ext 8044.

Thank you for your time and interest.

Barbara McKenzie-Green

Approved by the Auckland University of Technology Ethics Committee on 12th November 2001 AUTEC Reference number 01/107

Consent to Participation in Research

Title of Project: Registered nurses' work in residential aged

care: A grounded theory study.

Project Supervisor:J. Wilson

Researcher: Barbara McKenzie-Green

I have read and understood the information provided about this research

project.

I have had an opportunity to ask questions and to have them answered.

I understand that the interview will be audiotaped and transcribed.

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 tapes and transcripts, or parts thereof, will be destroyed.

I agree/ do not agree that the data collected during this research can be kept

by the researcher and used in conjunction with future research studies in

this area.

I agree to take part in this research.

Participant signature: ....

Participant name: <click here and type the subject's full name>

Date: <Click here and enter date>

Project Supervisor Contact Details: Jan Wilson, Auckland University of
Technology, Ph: 917 9999 extension 7808
Approved by the Auckland University of Technology Ethics Committee on
12th November 2001 AUTEC Reference number 01/107

Glossary

Aotearoa: (Maori) Land of the long white cloud. In this country, many discussion papers and articles refer to Aotearoa/New Zealand or New Zealand/Aotearoa in recognition of the two national languages, Maori and English.

Enrolled nurse: An enrolled nurse is defined in the Nurses Act 1977 as a nurse whose name is recorded on the roll of nurses. Legislation restricts the scope of practice for enrolled nurses, requiring them to practice under the supervision of a registered nurse or medical practitioner (New Zealand Health Information Service, 2002).

Iwi: In some contexts roughly relates to tribe however in the following quote, tribe is referred to as hapu (Durie, 1999).

Kaumatua: Refers to an older Maori. The following quotation best describes concepts relating to this role.

> Despite several generations of Western influence, Maori society generally retains a positive view towards ageing and elderly people, affording them status and at the same time expecting them to fullfill certain defined roles on behalf of the whanau (family) and hapu (tribe and community) (Durie, 1999).

Private Hospitals: Old people's homes (New Zealand) care facilities, nursing homes (Australia and the United States). Facilities where the residents level of dependency is such that there is an ongoing need for skilled nursing care over 24 hours.

Registered Nurse: A registered nurse is defined by the Nurses Act 1977 as a nurse whose name is recorded on one of the Registers of Nurses (New Zealand Health Information Service, 2002).

Residential aged care: Long term care which is provided for older people in facilities. Facilities that care for the most dependent people are known as: Private Hospitals, Old peoples homes (New Zealand) care facilities, nursing homes (Australia, U.S.A, U.K). Care facilities where residents receive assistance with personal care are known as rest homes (New Zealand), hostels (Australia) and assisted living (U.S.A).

Unregulated caregiver: Also called nursing assistants, nurse aides or caregivers "A person who provides help to health or disability consumers while they are receiving treatment or services. The help that caregivers provide varies widely but usually includes assistance with activities of daily living and simple aspects of the treatment or services. Caregivers may be employed but cn also be voluntary in some areas of work. There is no special law that regulates either the training or the work of caregivers. They cannot undertake activities, which are licensed, like prescribing medicines. But they could legally provide most nursing services which are not licensed"
(New Zealand Nurses Organisation, 1998, p.1).

Shifting focus – How registered nurses organise work in residential aged care

A grounded theory study

Philosophy of individualised care

Shifting focus

Institutionalised structure of care

Resident

Family

Care processes

Supporting admin tasks

Focusing on the Resident & the family

Resident Family

Care processes

Supporting admin tasks

Re focusing on Resident

Care tasks

Supporting admin tasks

Resident

Care processes

Family

Shifting focus towards the resident

Care tasks

Resident

Supporting admin tasks

Care processes Family

Care tasks

Supporting admin tasks

Resident safety

Family

Adequacy of staffing

Focus on routine and task

Focus on safety