Understanding the Nursing Home Care Processor: An Ethnographic Study

By

Hui-Wen Chien

RN, M. Gerontology (University of Sydney)

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LIST OF ABBREVIATIONS

ACSAA	Aged Care Standards and Accreditation Agency
AIN	Assistant-in-Nursing
CAM	Care Aggregated Model
CNA	Certified Nursing Assistant
DDON	Deputy Director of Nursing
DON	Director of Nursing
EN	Enrolled Nurse
GP	General Practitioner
GSO	General Service Officer
LMO	Local Medical Officer
NSW	New South Wales
RAO	Recreational Activity Officer
RCI	Resident Classification Instrument
RCS	Resident Classification Scale
RN	Registered Nurse
SAM	Standard Aggregated Model
Sr	Sister
USA	The United States of America

ABSTRACT

Aim and significance: The aim of this research was to explore the phenomenon of Australian nursing home care from the perspective of those who provide and receive it. Its focus is on the processes of 'quality care' provision and the meanings and evaluations that care providers attach to their work. In other words, its purpose was to shed light on the practices based on a conceptualisation of care that is entwined with the mechanisms of 'care' production and identity creation, or what actually happens in the daily life of the complex social phenomenon that is a nursing home. A related aim was to add to understandings of clinical nursing competence and develop tools that will assist nurses to conceptualise and implement positive change in this setting.

Background: The provision of care to our elderly has become a major concern with the ageing of the world population. This is occurring in the context of decline in the capacity of families to take on the responsibility of elder care, and of increasing commercialisation of medical care. Governments have responded by shifting their responsibilities from direct care provision to become auditors of the business of care provision that is supported by public funding. However poor care delivery has largely been hidden from the public gaze. Governments present themselves as having systems in place, creating the illusion of rational control; in reality, like the market economy, there is a 'black box' of unknown factors driven by human impulse.

The aim of this study was to open up the black box of 'quality care' to direct observation, drawing insights from the literature on organisational culture and with a focus on the frontline worker and the construct of quality assurance. Specific research objectives were to:

- Document the beliefs and attitudes of care providers towards elderly people in general and the needs of nursing home residents in particular
- Elicit the range of meanings and evaluations that care providers attach to their work
- Describe their constructions of 'care' and 'quality of care' and the organisational factors they believe to impact (positively and negatively) on their ability to provide it.

- Through in-depth understanding of a particular setting, generate grounded theoretical insights into the phenomenon of quality of residential care that are more widely applicable

Method: The study adopted a paradigmatic bricoleur approach, seeking to develop connections between a diverse range of methodologies. These included combinative ethnography, phenomenology, hermeneutics and traditional grounded theory. Conceptual insights were drawn from organisational studies, psychosocial nursing and coping theory.

The research site was an Australian for-profit suburban nursing home. The student investigator conducted more than 500 hours of participant observation, recording extensive field notes which were analysed through the perspective of a hermeneutic *middle way* horizon that directed an augmented constant comparison traditional grounded theory approach. Additional data were collected through formal indepth interviews with six key stakeholders. Interviews were tape recorded, transcribed in full and analysed to reveal themes that were brought within a hermeneutic circle that spiralled recursively from the whole to the part and back to the whole.

Findings: Eight key interrelated factors in the production of care within the nursing home were identified: internal and external accountability (the accreditation system); economic considerations; management and training; advocacy; characteristic of residents; care providers' working conditions and environmental stressors; organisational culture; and the work/care styles of individual care providers. I have categorised the latter into two main types: 'tortoises' and 'hares'. This typology is then used to generate a process-driven schematic diagram that tracks a hypothetical novice care provider through the process of learning how to produce 'care'.

Specifically, I found that nursing home 'care' is the outcome of a complex social process involving the interplay between resident, relative, care provider, proprietor, quality assessors and government within the phenomenon of the nursing home. Such care, indeed the phenomenon of the nursing home itself, is not a stable, controllable entity but is in a constant state of flux – what I refer to as a moral ecology.

In their everyday practice, care providers devise a construction of 'quality care' that is more clearly grounded in their own worldviews and the development of the own identity

than in the formal quality assurance system of standards, guidelines and evaluations.

Conclusion: Understanding the 'black box' of processes that produce care is the key to identifying courses of action that will improve care outcomes. The study findings also question the validity, assumptions and significance of the accreditation system, which only identifies some of the component variables, disregarding both the complexity within the 'black box' and failing to acknowledge that the quality of care outcomes is overwhelmingly dependent on individual care providers.

STATEMENT OF DECLARATION

The research presented in this thesis was carried out under the supervision of Associate Professor Cherry Russell (Postgraduate Coordinator, Ageing & Human Development Research Group, the University of Sydney).

I certify that this thesis entitled, Understanding the Nursing Home Care Processor: an Ethnographic Study, submitted for the degree of Doctor of Philosophy, has not been submitted for a higher degree to any other university of institution.

I also certify that this thesis has been written by me and that any help I received in preparing the thesis, and all sources used, are acknowledge within the thesis.

Signed. [redacted]

Hui-Wen Chien

Date...Aug. 24. 2009.....

I certify that Hui-Wen Chien's thesis is ready for submission.

Signe [redacted] .....

Associate Professor Cherry Russell

Date.....31/08/09.....

CHAPTER ONE: INTRODUCTION

Aim and significance

The purpose of this study is to understand why people have different conceptualisations of *quality care* within a nursing home and how this situation came about. To understand and explain this, it was necessary to develop *thinking tools* that unpack the 'blackbox' of these conceptualisations, in order to facilitate an improvement in that *quality care* provision. Serendipitously, the nursing home that was the focus of this study underwent re-accreditation during this period, thus presenting an opportunity to evaluate the validity and reliability of the accreditation process itself.

Personal interest in the topic

A registered nurse with thirteen years experience working within hospitals in Taiwan, I decided to undertake university nursing studies in Australia. Whilst undertaking undergraduate studies I took on vacation work as an Assistant in Nursing (AIN)[1] in a rural nursing home. From this initial work experience, my interest in Australian nursing homes and the provision of quality care therein grew into an academic pursuit. Once I had achieved Australian nursing registration, I studied nursing homes as a research topic for my Masters level studies in which I focused on nursing home policy comparisons between my native Taiwan and Australia. On entering the PhD program, my research focused on the question of why there is such variation in care provision between nursing homes and amongst care providers themselves. A particular incident reported in the Australian media ensured my ongoing commitment to the challenges of understanding the concept of 'quality care'. The report told of 57 residents in a particular nursing home who had been subjected to kerosene baths, resulting in several residents suffering second-degree burns and blisters. It also reported that one 84 year old woman died two days after being bathed in kerosene; the baths were intended to control a scabies outbreak (Lohr & Head 2000 p. 1).

[1] The AIN is equivalent to a Certified Nurse Assistant (CNA) in the USA.

As a registered nurse, this seemed bizarre treatment. It was explained that the use of kerosene is a 'bush remedy'[2] for skin infection control. There continued to be many such media reports, which lead to an increasing public concern about the quality of nursing home care in Australia. In time, questions were being raised about the adequacy of the legislation guiding residential aged care, the Australian Aged Care Act (1997). Unfortunately, such reports continue unabated - a recent incident involved residents suffering a mice plague, until a victim, marching in a veteran soldiers' parade revealed the situation to the media.

Media reports also questioned the reliability of the accreditation process and its ability to maintain quality care outcomes. A report revealed a nursing home to have failed thirty out of forty-four expected outcomes; including in the areas of health, clinical care, nutrition, hydration, continence management, mobility, rehabilitation and infection control (Nolan 2008 p. 1). Firsthand experience confirms that nurses, do not, in general, make a connection between their daily work and the accreditation system. Their view is narrowed to seeing only the production-line of work that produces the required documentation for accreditation; nurses offering clinical care provision was understood as a separate activity.

During 2000, I took on a quality coordinator's position and gained my first real knowledge of the Australian accreditation system. In 2002, in that same role, I took part in a second round accreditation. I remained in that position of quality coordinator until 2005, and in 2006 returned to Taiwan. Consequently, I have extensive experience that informs my understandings of the Australian accreditation process, both as a registered nurse and as a quality coordinator; in the latter role, I dealt with the preparation of documentation for accreditation and devised, with the guidance of the Director of Nursing (DON)[3], management practices to improve care outcomes. While my personal experience confirms my motivation for this study, it is also important to understand the key philosophical underpinning of this thesis; that is, philosophical hermeneutics.

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[2] A bush remedy is a self-administered treatment that might be used when you do not have access to a doctor, or if you prefer traditional treatments without paying for a doctor's service.

[3] The DON is the head of nursing and direct management of staff and process within an Australian nursing home.

The hermeneutic perspective

From a hermeneutic perspective it is incumbent upon me, as the author, to explain the 'what and why' of my own understandings within a hermeneutic framework; that is my own *fore-structures*, *historicity, facticity* and *tradition*[4], assessing the context of academic disciplines in which my research question is embedded (Koch 1996; Butler 1998; Fleming, Gaidys & Robb 2003; McManus Holroyd 2007). McManus Holroyd (2007 p. 4) believes that, to begin the process of understanding, such as in the early phase of a research study, a researcher needs to reflect firstly upon their own "fore-projections or pre-understandings and the meanings that exist within them in an effort both to determine their legitimacy and to contain their influence on new understanding." Such fore-projections result from my own history, culture, language and socio-political experiences; they constitute, as McManus Holroyd puts it, "the familiar horizons of my lifeworld".

My Taiwanese background gives me an orientation more aligned to collectivism than individualism (Hui & Triandis 1986; Hui 1988; Christopher 2001; Christopher, Richardson & Christopher 2002), and an adherence to the principles of filial piety (Oxfeld 1992) in respecting and safeguarding the interest of my elders. For example, in my extended family, I was primarily cared for by my grandparents, while my own parents worked very long hours to support the family. Consequently, I have a positive perception of the elderly and a belief that we should offer them the best care possible. I also believe my Taiwanese background explains my commitment to following rules, an acknowledgment of authority and a desire to not lose face by breaking strict social rules.

Own personality

The set of personal characteristics particular to each researcher are also an integral component that influences the researcher's perspective (Dingwall 1992; Glaser 1998a, 1999, 2002a; Silverman 2005). To describe myself, I might apply Albert Einstein's saying that "it's not that I'm so smart, it's just that I stay with problems longer". I would

[4] These hermeneutic concepts are defined here: *Fore-structures* are heurist prejudices allow understanding to take place, a context, horizon and ground; *Historicity* is how historical understanding is understood as a way of our being within a situation and the world; *Facticity* is "all the already-defined aspects of us that another person could describe using such forms as "He is...", "She was...", "He likes...", "She tends to...", and so on." (Foulds 2007 p. 22); *Tradition* is "the total background of practices, vocabulary, concepts, and hypothesis that humans bring to a project" (Thompson 1990, p. 65).

also describe myself, using Isaiah Berlin's (1953) analogy, as both a 'fox' and a 'hedgehog': "the fox knows many things, but the hedgehog knows one big thing". To explain the analogy further, I am primarily a 'fox', but I push myself to take on 'hedgehog' characteristics. As a 'fox', I am "deeply impressed by the flux, variety and uniqueness of human phenomena", while as a 'hedgehog', I am "driven by a compulsion to fashion a unifying relating principle which would draw together the varieties of experience and discipline them under a single vision" (Wolin 1954 p. 485).

Glaser's approach to grounded theory which, according to Glaser himself (1978) and others, is to seek clarity and simplicity in explanations in developing models for understanding, appeals to me as my approach is to keep things simple and seek to make connections between ideas. Glaser (1978) acknowledges the need for creativity and is acknowledged as having a more *laissez-faire* approach to research than that of Strauss and Corbin (1990) who have a more rigid, step by step emphasis. According to Glaser (1999 p. 838), three important attributes characterise a grounded theory researcher; these are "an ability to conceptualize data, an ability to tolerate some confusion, and an ability to tolerate confusion's attendant regression".

My learning style demonstrates 'right brain' dominance according to Intelegen Inc. (2005) in that I employ holistic processing. I work from the whole to the part and from the part back to the whole, rather than using a linear sequence-type approach. I process information with creativity calling upon hunches and intuition rather than having a strict focus on methodology, which in the extreme case can be described as "methodolatry" (Janesick 1994). I work as a 'researcher as bricoleur' (Denzin & Lincoln 1994), and rely upon the use of metaphor, puzzle solutions and visual mapping to make sense of my research (Ortony 1975; Gadamer [1960] 1975, 1989; Morgan 1980; Richardson 1994; Vedder 2002; Greenwood & Bonner 2008; Van Maanen 2008).

I have average intelligence but believe that I have an above-average 'emotional intelligence' that, according to Goleman (1996 p. xii), includes "self-control, zeal and persistence, and the ability to motivate oneself …, read emotions in other …, self-restraint and compassion." In terms of acceptance of change, I believe I reside, following Rogers (1995), with the 13.5 percent of the "early adopter" segment of the population who are "open to new ideas but will accept them only after serious consideration" (Manns & Rising 2004 pp. 9-10).

I will relate these personality characteristics to my approach to research. I endorse Packwood and Sikes (1996 p. 336) statement that "[i]t takes a lot of courage to decide that we do want to change the accepted metaphor of *Research as Recipe* to one that is personally as well as professionally meaningful". I also agree with Bateson that as a qualitative researcher, I have become a philosopher in the "universal sense in which all human beings … are guided by highly abstract principles" (Bateson 1972, cited in Denzin & Lincoln 1994 pp. 12-13) but I add, tardily.

Overview of thesis

This thesis is a hermeneutic text containing a recursive spiral between the whole to the part - that is, individual chapters of thesis reflecting stages of the research - and the part back to the whole -of progressing within it research stages and to final written thesis. The thesis also presents data in order to allow the reader to assess it as an original data source, and thus be able to join the hermeneutic circle on the level similar to the researcher. This strategy, together with the use of audit trails and defining the researcher's influence, leads to 'trustworthiness' as an alternative to the positivists' 'rigour' (Sandelowski 1986, 1993; Koch 1994a, 1998a, 2004).

The thesis contains six chapters: *Introduction, Background, Methodology, Delivering and Assessing Care, Talking about Care, Discussion, Conclusions and Recommendations.*

Chapter 2: Literature Review

Chapter 2 provides a review of the literature about nursing homes, and begins with an explanation of Australian strategies in the provision of care services to the elderly. This is, ultimately, broadened to include international literature, in particular, that which deals with the American experience, to give a perspective that focuses on the issues in the United States of America (USA). Briefly, the Australian system prior to the introduction of the Aged Care Act (1997) had a focus upon the evaluating of residents' needs which underpinned a system of subsidies that were based upon perceived staffing requirements. After 1997 subsides were based upon residents' needs categories but were not tied to staffing levels, which gave proprietors a free hand to spend subsidies as they saw fit.

Chapter 2 goes on to review the outcomes of the 1997 change using several sources including government and industry reports, as well as academic research. It covers issues such as the decline in numbers of registered nurses in Australian nursing homes and an

evaluation of the contribution of the Aged Care Standards and Accreditation Agency Ltd (ACSAA, or 'the Agency') [5] to improving actual care provision. The literature for the USA reveals a focus on retention, turnover and Minimum Data Set/Resident Assessment Instrument findings. This indicated a focus on nursing homes being measured and understood according to business concerns and clinical outcomes rather than quality of life issues. It was important to include an exploration of the literature the focus of which is the frontline worker, and the literature that deals with culture change strategies embedded within organisational culture and climate perspectives. This chapter considers the issues of quality assurance (Donabedian 1966, 1968, 2003), stress and coping (Park & Folkman 1997; Park, 2000), communication between care provider and resident (Williams Kempe, & Hummert 2003), resident autonomy (Bandura 2000), quality of care (Pearson, Hocking, Mott & Riggs 1993), quality of life (Oleson, Heading, Shadick & Bistodeau 1994) and ethical or ecological perspectives (Aroskar 1995; Brinkmann 2004; Tronto 1993, 1998).

Chapter 3: Methodology Studies - design and method

This chapter deals firstly with the underlying philosophical tenets of philosophical hermeneutics that I have adopted for this research. This has lead to the creation of a 'recursive research as bricoleur' strategy (Denzin & Lincoln 1994), in designing a research paradigm and methodology. In essence, I talk about my adoption of a combination of a combinative ethnography (Baszanger & Dodier 2004; Rennie 2000, 2005, 2007), imbued hermeneutical grounded theory (Glaser 1978, 2004) with elements of phenomenology (Koch 1996, Turner 2003, Fleming et al. 2003). I have also been influenced by Paley's (1998) authentic hermeneutic adoption, Carper's (1978) nursing knowledge, a moral ecology perspective (Munhall 1982; Aroskar 1995; Brinkmann 2004) and Purkis's (1994) use of the 'social' in phenomenology.

Initially I commenced my participant observation from an interpretative ethnography perspective after Van Maanen (1973a, 1973b, 1975, 1979a, 1979b), but reoriented it towards Baszanger and Didier's (2004) combinative ethnography, whilst Glaser's grounded theory became a heuristic *thinking tool* (Wacquant 1989), with a Rennie (2000,

[5] The Aged Care Standards and Accreditation Agency (The Agency) is an independent company limited by guarantee, and subject to the *Corporations Act 2001* and the *Commonwealth Authorities and Companies Act 1997*. It is the body appointed by the Department of Health and Ageing as the accreditation body under the *Aged Care Act 1997*.

2005, 2007) hermeneutic underpinning. My prime focus was the presentation of narrative accounts (Van Maanen 1973a, 1973b; Benner 1982; Addison 1989; Thrift & Thrift 1996; Koch 1998b; Maggs-Rapport 2000; Paterson & Higgs 2005) of the hermeneutic Heideggerian *ready-to-hand* mode of experience; that is *praxis* or ethics in action. The research was undertaken primarily as participant observation: interviews with six key informants and the research site itself, a suburban Australian nursing home where, I undertook five hundred hours of participant observation over a period of two and a half years.

Chapter 4: Delivering and Assessing Care

Chapter 4 presents the observation data from my participant observation, featuring the key observation vignettes of care provision and care provider, resident and relative behaviours as well as the general observational culture, climate and ambience of the nursing home. In particular, it deals with a focus on the observational window of mealtimes and the nursing home's two accreditations. It goes on to make comparisons between weekday and weekend care provision and the provision of care by individual care providers.

Chapter 5: Talking about care

Chapter 5 details the data gained from the interviews with six key informants: Resident Tim, Relative Max, Registered Nurse (RN) Lily, RN Helen, AIN Andrea; and finally DON Nancy. These are also presented as vignettes and in storytelling-type format (Benner 1982; Addison 1989; Koch 1998b). This chapter focuses on the participant's conceptualisation of quality care. The conclusions of the interviewees indicated a dichotomy regarding care providers: those who "had a good heart", and those for whom it "would be better to work in a fruit shop". Finally, this chapter also reports the experience of accreditation and the need for re-accreditation and the subsequent outcomes.

Chapter 6: Discussion and Conclusion

This final chapter draws together the data and analysis from the participant observation and interviews and uses a Venn diagram of eight factors that impact upon the 'blackbox' of quality care conceptualisation. It also uses a schematic diagram that tracks the trajectory of a novice care provider to present an explanation of the concept of the processor of care production in action. The thesis offers a heuristic thinking tool that asks the 'why' question regarding the nursing home phenomenon of the conceptualisation of quality of care provision. It notes that previous research has focused on only ethnographic description that

avoids the 'why' question. There is a grey, rather than black and white, understanding of our social world - the 'middle way'. This relates to the 'notion of duality' in Giddens' (1984) structuration theory, in which "two elements are interdependent and no longer separate or opposed, although they remain conceptually distinct". This also is related to Bourdieu's notion of a "praxelogical form of knowledge" (Bourdieu 1972 in Wacquant 1987). Finally, there is a brief section given over to recommendations and a noting of a single but all encompassing limitation of the study.

CHAPTER TWO: BACKGROUND

Introduction

This chapter presents an overview of primarily Australian literature on nursing home aged care while also including relevant international literature. It highlights information specific to my research focus of residential aged care and, in doing so, provides a frame of reference within which to situate this research.

Despite scant Australian research into the internal construction of residential aged care, it has been shown that a key contributor to resident wellbeing is the level and quality of professional staffing (Nay, 1993; Anon, 1999; Armstrong & Witham, 2001). The centrality of staff characteristics, attitudes and behaviours to the construction of care in such settings has been demonstrated in international studies (Goffman, 1961; Gubrium, 1975; 1991; 1995; Peace Kellaher & Willcocks 1997). Overseas ethnographic studies (Goffman, 1961; Kayser-Jones, 1981; Willcocks et al. 1987; Diamond 1992) have shown that the organisational context of residential aged care is predicated on routinised structures and physical task performance – what Gubrium (1975) has called "bed-and-body work". Gubrium's ethnographic study of 'Murray Manor' examined the social organisation of nursing home care through an analysis of how its everyday work is performed. Kayser-Jones (1981) focuses on the issues of both clinical care and quality of life, and looked at mealtimes, death and the core issue of how care providers are defensive about their work and their accountability. This ethnographic research shows that there are multiple factors that influence the quality of care in nursing homes. In an earlier cross-cultural study of nursing home care in the United States and Scotland, Kayser-Jones (1981) identified inadequacies in the physical environment, staffing levels and a lack of supervision as influencing factors.

Bogdewic (1992, p. 53-54) identifies six "thinking tools" for the conduct of participant observation: *who, what, when, where, why* and *how*. These thinking tools have provided the guiding principles for this research in its attempt to adopt a multi-variable inductive interpretation of 'who is, what is, when and how things happen', in relation to the provision of 'quality care'. This approach acknowledges the significance of the 'blackbox' (Silverman & Adams, 1994); the *how* and *why* of the 'real' mechanism that underpins

quality care provision, from *inputs*, through *process* to *outputs*. This approach fits neatly with Donabedian's (1976; 2003) model of quality assurance with its interrelated components of structure, process and outcomes.

Of the six thinking tools, the *why* question is the primary focus of this research, as it has not been fully addressed previously nor viewed from a hermeneutic perspective. The ethnographies of Gubrium (1975), Kayser-Jones (1981), Diamond (1992), Nay (1993), Farmer (1996), Goffman (1961) and Willcocks, Peace and Leonie (1987) address the *what, when, how, where* and *who* questions, but have less of a focus on the *why* question. Answering the *why* question necessitates looking into the 'blackbox' for explanations of poor care provision.

This literature review follows, in part, the approach suggested by Glaser (1978) in a classic description of Grounded Theory Methodology:

> Grounded theory's very strong dicta are a) *do not do a literature review in the substantive area and related areas where the research is to be done,* and b) when the grounded theory is nearly completed during the sorting and writing up, then the literature search in the substantive area can be accomplished and woven into the theory as more data for constant comparison. (Glaser (1978 p. 67, emphasis in original)

In conducting my review of the literature, I was cognisant of the existence of divergent approaches to this aspect of a research project. Glaser (1978), for instance, strongly advises researchers to avoid reviewing literature in the project's substantive area prior to data collection, recommending instead that this kind of information be incorporated into the final stage of theory development. This is to ensure that one's responsiveness to the data is not unduly coloured. Strauss and Corbin (1994), on the other hand, emphasise the importance of relevant literature in contextualising the research. Thus in my initial review I did not consult three key texts (Bowers & Becker 1992; Bowers, Esmond & Jacobson 2000; Foner 1994) which deal directly with staff experiences of care provision in nursing homes. These sources were reviewed after my theory had emerged, when they provided important sources of comparative data.

In taking this approach, I have been able to make valid comparisons between the findings of this study and those of Bowers (2001); especially with a view to elucidating what had changed in the preceding year in relation to care providers in nursing homes. Consequently,

these three texts are referenced in this chapter but are not used in the Discussion. They are however, used in the discussion chapter of this thesis.

Literature review perspective

This literature review deals with two key issues: The first is a consideration of current literature as it deals with the issue of the production care in a nursing home, and the second is to consider literature that supports the theoretical framework developed in this research. This review highlights the connection between ideas and authors and builds an ecology of understanding. It is important to strive for impartiality in research based on observation. Gadamer (2004), Heidegger ([1927] 1962), Glaser (1978) and Tellis-Nayak and Tellis-Nayak (1989) raise the issue of the 'worldview' of care providers in nursing homes and how these worldviews impact upon their care provision. The worldview of observers and researchers (in hermeneutic terms, "forestructures", "tradition" and "historicity") influences the choice of literature for review (Van Maanen, 1979a; 1979b). Initially, the research that I considered to be most relevant was that of Tina Koch (1992, 1996, 1998a & 1998b; Koch & Webb 1996; Koch, Webb & Williams 1995), because it brought together the work by Donabedian (1976, 1988a, 1988b, 1988c, 1988d, 2003) on quality assurance, hermeneutics and routinised care (Baker, 1978, 1983).

The Australian View of Aged Care

On 1st October 1997, *The Aged Care Act 1997* replaced the *National Health Act 1953* and the *Aged or Disabled Persons Care Act 1954*. 'Ageing in place' was the key philosophical concept underpinning the Federal Aged Care Reform process that removed the separation between nursing homes and hostels that had necessitated residents physically relocating as their care needs changed. Instead, the Reforms aimed to ensure that residents could remain in the one location – to "age in place" (NSW Department of Health, 2000).

The new Act saw two key changes; the first being that aged care services were required to be accredited by ACSAA, in order to receive the Federal government subsidy on which their financial viability depended. The second change was the establishment of a funding structure centred upon the Residential Classification Scale (RCS) which aimed to match residential aged care funding to the care needs of residents "irrespective of whether they are located in a hostel or nursing home" (NSW Department of Health 2000 p. 21).

To achieve accreditation, facilities were required to demonstrate 'continuous improvement' in the quality of care they provided. A subsequent review (Gray 2001) identified some improvements on the previous system as a result of the reforms, especially in relation to the physical environment, but reported that standards of care in some facilities remained unacceptable. Major ongoing problems were identified, and a set of evaluation standards was developed to assess how well facilities were addressing these issues. Despite this, there remains a concern that monitoring process have become intrusive and rigid, with an over-emphasis on documentation of compliance with standards. As a result of this, it has been claimed, staff are overwhelmed by paperwork, seriously overworked, and are frequently unable to meet even the basic needs of their residents (Braithwaite 2001; Armstrong & Witham 2001; Gray 2001; Pearson, Nay, Koch & Rosewarne 2002).

Under the Standards and Guidelines associated with the Aged Care Act 1997, providers are required to develop their own "operational system" for satisfying the quality of care criteria. The rationale underpinning policy in this area is that providers should adopt a personalised, flexible, resident-centred approach to care in a homelike environment (Braithwaite, Makkai, Braithwaite & Gibson 1993). Yet there are no criteria for evaluating the less tangible, humanistic dimensions of care, such as the quality of social life and interpersonal interaction. Rather, the focus is on financial accountability and proven effectiveness of care strategies, as measured by staff performance indicators and other quantifiable outcomes (Gardner, 1995). Documentation has focused, not surprisingly, on demonstrating *measurable* improvements, such as increased resident privacy through lower room occupancy levels.

Yet, as British researchers Peace et al. (1997) have argued, such changes may amount to little more than window-dressing, and do not in themselves change the overall nature of care in such facilities. Current funding structures appear to offer little incentive for facilities to reorient their practices towards less measurable dimensions of social and emotional care. From a care provider's perspective, there are tensions and contradictions between the provision of physical and emotional care (Setterlund, 1998).

This study accordingly seeks to understand how residential care providers interpret 'quality of care' and how they experience 'care work' as an everyday practice within the specific relational setting of an aged care facility. The nature of such practice is multi-faceted or multi-layered and includes, among other dimensions, the *symbolic* and the *interpretive*.

What people *do* - and how they interpret or make sense of what they do - are social practices fundamental to understanding social phenomena (Russell & Schofield 1999). These interpretations are simultaneously informed by what individuals themselves bring to the task in the way of pre-existing beliefs, attitudes and values, and by the organisational structure and culture that prevail in the setting.

The following section presents an overview of aged care in Australia; it provides a brief account of Australia's aged population, its health status, residential care services and the Australian quality assurance framework related to the quality of Australian residential aged care.

Older People and Aged Care in Australia

The population aged 65 years and over in Australia is growing rapidly. In 2001, nearly 2.4 million people were aged 65 years or over, 13 percent of the population. The number is expected to increase to reach 6.6 million, about 25 percent of the population by 2050 (Commonwealth of Australia, 2003a). Ageing is often associated with the onset of disabilities that restrict participation in a range of activities. Older Australians are an important and rapidly growing group with an increasing need for health assessment and monitoring and services that address those needs. Recent projections conclude that a person aged 70 has a 36 percent chance of needing high level residential care during their life time (Commonwealth of Australia, 2003).

In 1998, dementia, including Alzheimer's Disease, was reported in 22 percent of people aged 85 years or more. Of the estimated 97,800 people aged 65 years or more with dementia in that year, 96 percent had 'severe or profound' disability, with only 2.8 cent percent having a disability classified as 'moderate' or 'mild'. In 2002, around 167,000 people aged over 60 were estimated to have dementia. This is expected to increase to 199,000 in 2010, 276,000 in 2020 and 555,000 by 2050. It is estimated that, currently, 37 percent of low level care residents and 60 percent of high level care residents have some form of dementia (Commonwealth of Australia, 2003a). When frail, older people can no longer be assisted to stay in their own homes, care is available in aged care homes. Institutionalisation is thought to enable a transition of care-giving responsibility and burden from the informal to the formal system (Keefe & Fancey, 2000; Commonwealth of Australia, 2003).

The level of dependency care needs in nursing homes has significantly increased. People who enter nursing homes are generally more frail now than was the case previously. In such situations, many residents in nursing homes only stay a short time after their admission before dying (Angus & Nay, 2003).

Nursing Home Statistics

On 30 June 2003, there were approximately 3,000 aged care homes in Australia providing 150,786 beds for residents (Commonwealth of Australia, 2003). With a mixed services ownership, the majority of nursing homes are owned by religious and charitable groups (65 percent); private providers account for 25.8 percent of nursing homes, while 8.7 percent of nursing homes are government owned :

Year	Religious and Charitable	Private	State/Territory Government	Total
1996-1997	62.5%	25.9%	11.6%	100%
1999-2000	63.4%	27.1%	9.5%	100%
2002-2003	65.5%	25.8%	8.7%	100%

Source: Commonwealth of Australia (2000); Commonwealth of Australia (2003)

Statistics show that approximately seven percent of people aged over 65 live permanently in residential aged care facilities. The average age of residents is 83.2 years. About 64 percent of high-level care residents enter the facility upon discharge from hospital. The average length of stay in aged care facility is 36 months with 35 percent staying less than one year and 22 percent staying more than 5 years. The occupancy rate for aged care homes is around 97 percent for permanent residents (ABS, 2000; Commonwealth of Australia, 2003).

Quality Assurance Framework

Key to residents receiving a high quality of care is a quality assurance system that was introduced under the Reforms. The quality assurance framework is comprised of the following elements: *standards of care, accreditation framework*, *building upgrades* and a *complaints mechanism*.

Standards of care

The four Accreditation Standards cover (1) management systems, staffing and organisational development; (2) health and personal care; (3) resident lifestyle; and (4) physical environment and safe systems. There are 44 expected outcomes: nine outcomes in management, 17 outcomes in health, 10 outcomes in lifestyle, and 8 outcomes in environment, with explicit criteria specified for each outcome (Appendix A).

The Accreditation Framework

To ensure an aged care service is providing a high quality of care to its residents, the Agency manages the accreditation process, which supervises ongoing compliance with the Accreditation Standards. They do this by conducting visits without notice and review audits, as well as by providing support contacts and liaising with the Department of Health and Ageing about homes that do not meet the Standards. The Agency also provides education and information to all parties.

The philosophy of the quality framework as stated by the Agency is that "the quality management process must begin and end with the residents, reflecting their rights and needs and the improvement of the care and services provided by the service" (ACSAA 2001b, B1). The Agency's key theoretical tenet is a focus on nursing homes' developing a continuous improvement, quality assurance system of self-assessment that is "responsiveness to residents and their right and needs" (ACSAA 2001b, B1-B2). The accreditation framework consists of five elements that are considered in the audit for accreditation: the four Accreditation Standards with forty-four outcomes, user rights, quality buildings, concessional and assisted ratios; and prudential arrangements. During the accreditation process, aged care providers are assessed against these criteria.

To ensure the aged care service has an effective structure and process, the nursing homes in the first round of accreditation (between 1999 and 2000) had to demonstrate fulfilment of the 4 standards and 44 outcomes by interviews, observation and a paper statement. This paper statement was supported by a documentary paper trail. There was an emphasis that there should be a 'quality management' system in place to maintain and monitor quality assurance. By the second round of accreditation (2001-2003), the Agency required an additional demonstration: a "process" of actions by the nursing home of a quality management system and outcomes by which it could be evaluated. The format for demonstrating adherence to the standards and outcomes now shifted from a paper format to

an electronic self-assessment 'desk audit' package (see Appendix B), in addition to supportive onsite documentation obtained during accreditation visits.

The process for accreditation includes two main steps, the self-assessment (desk audit) and actual on-site assessment (site audit). The Agency's approach for the desk audit is to let the approved provider carry out a self-assessment which focuses on what the service "SAYS it does"[6], what the service "DOES" and what "RESULTS" are achieved. Additionally, the service needs to consider the improvement actions or plans that need to be undertaken. Two to three quality assessors[7] appointed by the Agency spend at least two days undertaking the accreditation inspection to verify the content of the self-assessment audit form by seeking out documentary proof, as well as observing and interviewing staff, residents and relatives (ACSAA 2010). The Agency takes into account the assessors' reports and decides whether or not to accredit the service (Attorney-General's Department 2007). The assessment team decide whether the nursing home is an approved provider that is 'compliant', 'non-compliant' or 'non-compliant with serious risk'. At the same time, there are two higher ratings that can be awarded, 'accreditation with merit' and 'commendable'.

If the nursing home is 'non-compliant', it is given a time period ranging from weeks to months (depending on what they had failed) to comply with the standards. After that period the quality assessors judge whether the nursing home is able to comply with the standards; if it passes, the nursing home receives an amendment to their accreditation. Additional to this process of attempting to become compliant, a nursing home may have further conditions placed upon it in the form of sanctions that restrict its operating conditions; these include sanctions such as restricting new resident admissions or requiring ongoing supervision. Once a service has achieved accreditation, it will still receive ongoing "support visits" from a quality assessment team on a scheduled visiting basis or by spot visits. The purpose of a support visit is to review progress and to provide support to the facility in its ongoing quality improvement activities (ACSSA, 2001a; 2001b).

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[6] The bold capitalisation of these key words is the emphasis writing style adopted by ACSAA to draw attention to its key tenets.

[7] Quality assessors undertake a training program and are sourced from variety of backgrounds including nursing, health care, business management and education.

After the Reforms, the first round of accreditation took place between September 1999 and December 2000. A recent government report (Commonwealth of Australia 2000) noted that during 1999-2000, the Agency had conducted 1,505 accreditation site visits, 148 spot checks and 530 support visits. Only small number of home homes were given sanctions due to non-compliance with the accreditation standards. By the beginning of 2001 there had been a total of 2,938 homes accredited. A further 20 homes were taken to be accredited for six months because exceptional circumstances. Some substandard providers were identified and sanctions were imposed. Only one aged care service (identified as neither a nursing home nor hostel) did not meet the accreditation requirements, and closed when its subsidy funding was stopped (Gray 2001).

Building upgrades

The quality of the physical environment is part of the quality of care criteria and is required to ensure the quality of the physical safety and comfort of the residents. To achieve certification, a residential aged care home is required to be assessed to meet and found to meet a certain minimum of building standards in relation to fire safety, security, access, hazards, lighting, heating, cooling and ventilation (Gray 2001 p.8). This assessment is based on certification by independent licensed building contractors appointed by the government. Any uncertified aged care services cannot charge their residents accommodation bonds and charges.

To encourage upgrades of existing buildings to meet this certification, the government offered grants to nursing homes that were paid in monthly instalments over a ten-year period. With these new arrangements, upgrades occurred across the aged care industry, and nursing homes that could not be upgraded sought redevelopment or sold off their bed allocation licenses to new investors[8]. The Government spent an estimated $1.4 billion on building upgrades, rebuilds and new buildings in two years (Gray 2001; Commonwealth of Australia 2002a). By 30th June 2000, 98.5 percent of all services (hostels and nursing homes) had achieved building certification.

[8] Each nursing home when accredited has a license to offer a bed capacity for that nursing home. This bed capacity is an asset that can be transferred to a new management of that nursing home, or transferred to a new nursing home once the prior nursing home closes. Each area has an allocation of beds based upon population, meaning that there are a limited number of beds per area.

Under the ten year forward plan for ongoing certification, all the aged care services were required to make further improvements to the fire, privacy and space standards for existing residential aged care buildings by 2008 (Commonwealth of Australia 2000 pp. 4-5). The standards set requirements for existing buildings as well as for new buildings. For existing buildings, the standards set a maximum of no more than four residents in any room, six residents per toilet and seven residents per shower. These standards will need to be met by the end of 2008. For new residential aged care buildings, a maximum service average was set of 1.5 residents per room, while no individual room could accommodate more than two residents; there could be no more than three residents per toilet and four residents per shower. These standards came into effect on 30 July 1999 (Commonwealth of Australia 2000).

In 2001, the *Two Year Review on Aged Care* report prepared for the Commonwealth Department of Health and Ageing stated that the requirements for upgrades of the residential aged care building quality had been well accepted, and a high level of compliance towards the 2001 certification requirements was evident (Gray 2001). The report indicated that a specific objective of the reforms was to achieve a "substantial improvement in the quality and quantity of residential buildings", and that "considerable progress" had been made towards this objective (Gray 2001 p.xxv). Progress was also noted in improvements in *privacy* and *space* for residents, although the report acknowledged that substantial investment in capital works was needed if the standards were to be met.

Complaint mechanism

The fourth element within the quality assurance system is a complaints mechanism. To ensure the quality of care services, the government established two systems available to anyone (including the resident, family members and carers) wanting to make a complaint about an aged care service. This can be internal (within the aged care service) or external, to the Aged Care Complaints Resolution Scheme (Commonwealth of Australia 2002a). If a complaint is not resolved through negotiation or mediation, a Complaints Resolution Committee will decide what the parties must do to resolve the problem. An independent Commissioner for Complaints oversees the process to ensure that complaints were dealt with fairly and expediently.

Review the Reforms

This section reviews the relevant Australia reports on the current reforms to understand the system implications and impacts on practices.

The accreditation process

An early review of the reforms, Gray (2001) noted improvements which more effectively linked the accreditation process with the complaints and sanctions processes, and ensured that all aged care providers were "brought under scrutiny". There was an increased identification of poor standards of care. In a qualitative study of the first round of accreditations, Grenade and Duncan (2002) interviewed services providers (DON, manager, carers, RNs, quality coordinators) in Western Australia (WA) about their own experience with the accreditation process. The results indicated a positive experience with the accreditation process, and that providers perceived a vast improvement on the previous standards monitoring system. The study also identified extremely high demands on facility staff, a lack of consistency amongst assessors and increased cost to facilities. There were three main aspects identified as stressors for staff: high workload, a demand for documentation, and the site audit experience itself.

Braithwaite (2001) pointed out significant problems related to the current accreditation process and consequently the provision of quality of care. These are that spot checks are conducted without notice and that quality assessors "are not conducting rigorous inspections before giving facilities a clean bill of health for three years" (p.445). Braithwaite concluded that an accreditation audit is a 'ritual of verification' intended to 'comfort' shareholders, yet the accreditation process is in fact "no more useful in evaluating the quality of investments than it is in assessing the quality of nursing homes" (p.445). The literature highlights the concept of the 'audit society' as put forward by both Power (1997) and Pentland (2000), where paper trails of measureable inputs and outcomes are held in higher importance than more intangible outcomes including whether residents are well, happy and healthy.

The Commercialising of Nursing Homes

The literature describes a high level of funding for the nursing home industry but first-hand experience in nursing homes presented a picture of great pressure to do more with less staff and resources. This research sought to reconcile these two apparently contradictory aspects

of nursing home management and to understand how they related to the quality of care offered to residents.

It is something of a 'taboo' to talk of nursing homes as businesses for profit, since this immediately raises the question whether profit is achieved at the expense of care. Some authors believe that such a trade-off is occurring in Australian nursing homes. Pearson et al. (2002, p.11) believe that "minimal staffing limits" have "perpetuated the understaffing dilemma as profit motives influenced levels of care available".

Since the introduction of the 1997 *Aged Care Reform*, there have been many changes in the residential aged care sector, including an increase in funding from the Commonwealth and via user contributions; along with the building certification and introduction of accreditation to ensure quality of care (Gray 2001; Commonwealth of Australia 2003a). These changes have stimulated restructuring and investment in the aged care sector at an increasing rate. An early review of the Reforms (Commonwealth of Australia 2000) concluded that the aged care industry was viewed as " a secure place for investment" as a consequence of increased income and investment returns resulting from the accommodation payments. The report concluded that institutional investors were engaging with the industry as evidenced by the fact that a $128 million bond issue was fully subscribed (p.6). Gray concludes that the residential aged care industry is "viable" and can be expected to achieve a reasonable return on investment (12%); and that this remains the case even when substantial expenditure is required for rebuilding to meet the 2008 certification standards (Gray 2001 p. xxvii).

The care subsidy

Under the *Aged Care Reform 1997*, the funding and administration of hostels and nursing homes were placed under one system, allowing aged care homes to offer the full continuum of care. The changes meant that residents were able to stay in one location as their care needs increased, provided the aged care home was able to ensure appropriate care. Services were no longer identified as 'hostels' or 'nursing homes', but rather as 'residential aged care services' (Gray 2001 pp.5-6). The subsidy that is intended to support people to be able to stay within residential facilities is based on an estimation of the level of a resident's 'dependence' and need for care, and on their ability to pay (their 'user contribution') (Kendig & Duckett 2001; Gray 2001). The system of accommodation payments (bonds and charges) was set in place to provide aged care services with a

funding stream to upgrade and maintain buildings. In 1999-2000, aged care service providers received about AU$803 million in bonds; the average daily accommodation fee being AU$11.15. Sixty percent of services derived income from accommodation bonds, while 38 percent had levied accommodation charges. (Commonwealth of Australia 2000). The calculation of a resident's contribution was based on either an asset or an income test. For residents who possessed assets over the threshold figure (excluding the family home), an accommodation bond was required on entry to a nursing home. This could be paid as a lump sum, or on a monthly basis to cover a five year period. Income tested residents paid a daily accommodation fee by deduction from their pension (Commonwealth of Australia 2005; Department of Health and Ageing 2007).

The Productivity Commission (1999) reported on the nursing home subsidies that were being paid for the approximately 140,000 Australians who were in residential aged care at that time. The cost of care was met largely by the Commonwealth Government which, in 1997-98, paid an estimated $2.9 billion in subsidies to nursing homes and hostels (p. xi). The proportion of funding provided varied depending upon each resident's care needs. On average, the Commonwealth directly provides about 75 percent of funds for resident care, with 25 percent coming from resident contributions and other sources (Gray 2001). In 2002-2003, the Government paid for residential care at eight different levels of resident dependency. The average national cost per utilised place was approximately AU$29,000 (Commonwealth of Australia, 2003). A review of the government's funding of the aged care sector as of 1995–1996, revealed that the Government spent $2.46 billion on residential aged care. The outlay in 1999–2000 was $3.6 billion. There was an increase of $1.1 billion (or 44 percent) over the four years to 30th June 2000 (Commonwealth of Australia 2000). In 2003-2004, the total expenditure on ageing and aged care was estimated to be some $6 billion (Gray 2001).

Resident Classification Scale (RCS)

The subsidy provided to aged care providers is based on as estimate of the level of care required by a resident. The Resident Classification Scale (RCS) has been used for this purpose. The RCS is not a tool for determining actual care provision for each resident, but makes funds available for, amongst other things, the registered nurse to devise a care plan for the resident in liaison with other care professionals. The decision how to spend those funds, and the level of service offered, is left primarily to the registered nurse in liaison with other health professionals, including allied health professionals, pharmacists and

doctors; while also being influenced by the proprietor's business priorities. The RCS may be summarised as an appraisal system for the allocation of appropriate funding to meet the needs of the residents, rather than for determining what needs should be met (Gray 2001). A specific objective in the design of the RCS was appropriately fund the high cost of caring for people with dementia. Prior to the introduction of the RCS, funding structures created financial "disincentives" for providing care to this group (Gray 2001 p xxix). Within the area of dementia care, the RCS has led to increased recurrent funding and improved recognition of the real costs of providing care for residents with dementia (Gray 2001).

The RCS is comprised of 20 questions, which are given variable response weightings to give a score of up to 100 points. The level at which a resident is classified depends on the number of points scored. The RCS assessment is designed to cover the full spectrum of residential care needs, as well as to enable appropriate funding to be directed to all residents, regardless of their physical location (as per the 'ageing in place' policy). In practice, each resident needs to be assessed when they enter a nursing home for the first time or from a transfer, then annually and when their individual condition changes. An RCS assessment demands a lot of documentation and evidence, and relies heavily on a RN tracking a new resident, observing them for 21 days or 7 days for a continuing resident (see Appendix C). The RCS assesses residents on a scale from 1 to 8. A score between 1 to 4 (inclusive) leads to a 'high care' classification, while a score between 5 and 8 (inclusive) leads to a "low care" classification. According to the scale, in 2002 in New South Wales (NSW) the following payments applied: scale 1: AU$109.97; scale 2: AU$99.46; scale 3: AU$85.64; scale 4: AU$60.81 (see Appendix D).The connection between the funding of subsidies and the requirement for adequate documentation of care is made explicit by the Department of Health and Family Services (1997 p.1-2) which states that the standard of documentation is "critical" when a facility is attempting to demonstrate the quality of care provided to residents and the outcomes of that care.

Staffing levels and Labour Costs

Following the introduction of the new funding mechanism and the Reforms, the staffing levels of registered nurses were heavily affected (AIHW 1999; 2003). Prior to the 1997 reforms, the funding to nursing homes was split between two modules CAM (Care Aggregated Module) and SAM (Standard Aggregated Module). Funding for staff wages came under the CAM module, which allowed a nursing home proprietor to use a pool of

government funding to employ an appropriate mix of nursing; that is a DON, Deputy DON (DDON), RNs, Enrolled Nurses (ENs) and personal care staff (AINs) to meet the residents' care needs. The SAM module provided funds for proprietors to pay for all nursing home infrastructure costs, which included wages for domestic and administrative staff, a Recreation Activity Officer (RAO), General Service Officer (GSO), food, laundry, cleaning, plant, equipment and a return on investment (Department of Human Services and Health, 1995). Under the CAM/SAM approach to funding the care needs of the residents was directly tied to the level of funding and to who undertook the work. With the change in 1997 from Resident Classification Instrument (RCI) to the RCS, funding focussed only on resident care needs without regard for the nursing staff required to cater for those needs. Consequently, the proprietor was left to determine how the funds were to be spent. This meant, in practice, that while proprietors could be seen to comply with accreditation standards and guidelines, they also had the flexibility to redirect funds towards greater profit margins.

From 1997, the employment of RNs was the key issue. The numbers of RNs employed was based upon residents level on the RCS rather than on explicit nursing care needs. Consequently, from within this new paradigm, evidence emerged that some proprietors were limiting the number of residents to a figure below the prescribed staffing requirements whilst maximising funds available to them (Braithwaite, 2001; Gray 2001; Pearson et al. 2002).

Taking Registered Nurses out of Nursing Homes

With the 1999 reforms, aged care providers "argued successfully that nurse to resident ratio should be removed from the award" (English 2000), leading to decline in the number of registered nurses in nursing homes (AIHW 1999; 2003). This view is supported by the Australian Nursing Federation (Illiffe 2000) which stated that the Reforms were the catalyst to reducing RN staffing levels. There were many voices arguing against RNs being taken from the frontline fearing their loss would have a significant negative impact. English (2000, p.1), for example, quotes the Federal opposition Labor spokesperson on health, Jenny Macklin, who "revealed that aged-care officials had not carried out spot checks of nursing homes in two years". English reported that there was no accountability in place for the $3.5 billion a year given to care providers by the Commonwealth government, so that it was unknown "how the funding is spent or whether it is even spent on residents in care" (p.1).

A consequence of the 'ageing in place' philosophy of providing services to enable older people to remain in the community has been that older people entering nursing homes "have a high degree of dependency and frailty both in high level care and low level care" (AIHW 2000 p.5). As a result of this change within the resident population, there is recognition of the further increased critical role that registered nurses play in delivering expert care (Edwards and Forster 1998, cited in Cheek, Ballantyne, Jones, Roder-Allen & Kitto 2002). Despite this increased need, the number of RNs working in nursing homes declined between 1993 and 1996 (AIHW 2003); this is despite an increase in resident numbers and an increase in the proportion of residents with higher care needs (Cheek et al. 2002). Cheek et al. (2002) suggest that "attracting and retaining registered nurses in residential aged care is in crisis and this is a particular concern given that there is a general shortage of registered nurses both at the national and international level" (p. 5). Given the critical need to understand changes in the RN staffing within nursing homes, it is surprising that accurate data on the numbers of RNs and other care staff is not available (McDonald 2001; Commonwealth Australia 2002b).

Within the debates about staffing within Australian nursing homes, the emphasis has been primarily upon registered nurses as they have a strong voice because of their high status position in nursing homes and through their union, the NSW Nurses Association. In contrast AINs, RAOs and GSOs have less of a voice, because of their relatively low status within nursing homes and on the national stage. This is, in part, due to their being split in union representation between the Health Services Union and the Liquor, Hospitality and Miscellaneous Union. Being the loudest voice in the aged care sector, registered nurses were able to position themselves in order to be part of the strategies developed to maintain and then increase their numbers, while issues about AIN staffing levels remained unvoiced. More broadly, the reduction in RNs providing care to aged care residents occurs within a "neo-reform period" in aged care "dominated by theories of economic rationalism, enshrined in legislation based upon market principles and by implication, the provision of care at the cheapest possible price" (Angus & Nay 2003 p. 130). The employment of registered nurses is a key cost that proprietors attempt to reduce as much as possible as it bites into their profits, especially as the wages of registered nurses increase. Pearson et al. (2002 p. 11) point out that "minimal staffing limits [have] perpetuated the understaffing dilemma as profit motives influenced levels of care available". Observers of the industry

(e.g. Illiffe 2000; Gray 2001) suggest that staffing is the key element determining profit returns for proprietors.

Although RNs may leave the aged care industry for personal or family reasons, a significant number leave in response to what they perceive to be poor pay and conditions; including low pay, a shortage of qualified staff, lack of funding and equipment, inadequate resident care and excessive documentation (Pearson et al. 2002). High staff turnover reflects this dissatisfaction. The Senate Community Affairs Reference Committee Inquiry into Aged Care heard that staff turnover was a major concern for many aged care providers (Angley & Hewman 2002). At the same time that the number of registered nursing working in nursing homes was decreasing as a result of the 1997 reforms, so too was the overall level of staffing (Gray 2001). As a consequence, there has been a "negative change in the skills mix, with many staff not having the necessary training or qualifications" (p. 96). Because the emphasis is now on care outcomes *per se,* there is little acknowledgement that care outcomes are dependent upon staffing levels (Gray 2001). This is a distraction from a key issue in resident care, the ratio of staffing levels to residents' needs, which had been the focus under the CAM model. This criticism is not unique to Australia. Munroe (1990) provides a North American perspective that speaks of this broader conflict between profit margins and quality care. Munroe cites authors including Shields and Kick (1982) who believe that a over-reliance on unskilled nursing staff "jeopardizes" quality of care and suggests that "such action produces a trade-off between operational costs and quality" (Munroe 1990 pp. 263-264).

With this in mind, this research asks whether the CAM/SAM staffing to resident needs models would produce better provision of care than the accreditation framework based upon documentary derived care outcomes. It also calls into question the model of staffing based upon clinical models of experience in relation to staffing mix for documented care outcomes with suspect validity and reliability. The issue of the of lack of registered nurses (and other nursing home care staff), underpins the research focus of this thesis, because it causes us to question the reliability, validity and causal effects of accreditation and raises questions about what the primary purpose of a nursing home should be – a location where appropriate care is provided or a commercial venture?

Criticism of the Aged Care Act 1997

The Australian Nursing Federation's chief criticism of the Aged Care Act 1997 was that it undermined the "authority" of the DON who, in the ANF's view ought to have the "ultimate day-to-day responsibility for nursing care decisions" (Illiffe 2000 p. 1). Instead, care decisions would be in the hands of nursing home proprietors who lacked accountability and were potentially motivated more by profit than by the needs of residents. The removal from nurses' industrial awards[9] of previous requirements of nurse to resident ratios, was a prime concern for the ANF. Unions maintained pressure on the government by further criticism published in the media; this time by the *Guardian* newspaper reporter, English (2000). In the context of the controversy around the *Riverside* nursing home incident, the paper reports that

> The Australian Nursing Federation (ANF) has stepped up its actions over the Howard Government's disastrous nursing homes policy which has resulted in aged residents being mistreated, and in the case of the Riverside Nursing Home in Victoria, being forcibly removed as a result of incompetent and bungling government intervention (p. 1).

An ANF spokesperson criticised the Commonwealth Government's response of the Riverside Nursing Home scandal has having been "appallingly" handled "from go to whoa", and accused the government of mishandling complaints of residents, their families and staff (in English 2000). The Union believes that self-regulation by the aged care industry had failed as a result of the Commonwealth Government's "pursuit of economic rationalist policies" (English 2000 p. 1). The lack of regulation is reflected in the assessment of the Australian National Audit Office (ANAO) which concluded that the ACSAA was "unable to measure if and how" it was effective in improving the quality of care for residents, since the Agency did not do its own benchmarking (ANAO 2003 p. 63). It recommended that the Agency "develop indicators to measure and demonstrate sustainable improvements across the industry and over time" (p.72).

[9] Awards are binding legal documents that set out conditions for employees that had to be adhered to by employers and are regulated by the federal government.

Having reviewed the Australian aged care system and identified the current concern for the provision of quality care as it relates to Registered Nurse numbers, this chapter will now focus on literature that deals with other factors that influence the quality of care within the context of residential aged care. The following factors have been identified in the literature: ethical perspective; quality assurance; communication; resident autonomy; frontline worker; stress and coping; training and job redesign; organisational issues.

Ethical perspective leading to concerns

For the Australian perspective, the work of Tina Koch and her colleagues reviews nursing as an ethical endeavour. It considers nursing's relationship to a broad range of issues, including quality assurance (Koch1992), quality of life (Koch 1994b, 2000; Annells & Koch 2001; Annells, Koch & Brown 2001) and models of nursing (biomedical model of routinised care) (Koch & Webb, 1996; Koch, Webb & Williams 1995). This research views nursing through a hermeneutic lens, which itself has an ethical underpinning, as it seeks to maintain an ethical identity while attempting to understand the world around us (Koch, 1994a, 1994b, 1995, 1996 and 1999).

Koch (1992 p. 785) refers to the Donabedian model of a quality assurance process (Donabedian, 1988a, 1988b, 1988c), which is composed of three interrelated components: *structure, process* and *outcome*. Koch notes that these three components are inseparable. Dingwall (1992 p. 162) makes a similar point in reference to Donabedian (1976), that there has been an over-emphasis on evaluation of outputs: "What outputs can one get for a given basket of inputs?" (p.162). A consequence of measuring outputs, such as 'performance indicators', is that problematic aspects of *process* may be ignored and, more importantly, ethical practice may be compromised. As Dingwall (1992 p. 163) puts it: "If a hospital is assessed in terms of its mortality rate, its staff is likely to devise ways of ensuring that patients are recorded as dying somewhere else". Dingwell identifies such approaches with a neoclassical economic paradigm in which utilitarian considerations feature (1992 p. 162). This approach resembles Power's (1997) 'audit society', in which accounting methods are applied in other domains, with detrimental effects.

Dingwall (1992), like Koch (1994, 1996) - and this research - is interested in the 'blackbox' that has been left out of the thinking process; the influences that intervene between individuals, incentives and sanctions. To understand this, a methodology is required that is "capable of capturing the dynamic aspects of the organisation rather than

simply logging its movements from one point in time to another" (p. 163). Such a methodology requires the researcher to be on the "inside", to be "watching and listening", and to study the documents which participants produce to "orchestrate or justify their activities" (Dingwall 1992 p. 163). Dingwell provides a case study of the television series *Fawlty Towers* to illustrate how, in "pathological" organisations, management strategies aimed at cost rationing lead to subversive behaviour by staff, and consequently the "subversion of the whole enterprise" (p. 70). This position echoes Donabedian who stressed that: "Without personal commitment to quality in our work and pride in accomplishing it, no amount of organizational machination will suffice to safeguard it" (Donabedian 1988b, cited in Koch 1992 p. 785).

One of the key questions of this research is that of accountability, and ethical constructions of care providers, proprietors and even governments in relation to the provision of care to our elders. The term 'quality assurance' incorporates the notion of "professional accountability" (Koch, 1992); a fundamentally ethical issue in nursing care provision. Koch and colleagues sought to unravel these complexities within the organisations that offer care to the elderly. She calls into question two perspectives on older people and their care: the 'biomedical model' and 'routinization of care', drawing on Baker's (1978) notion of 'routine geriatric style', which describes a 'conveyor belt' way of organising care. Pearson et al. (1998) define the biomedical model as seeing people as reduced to their biology, "made up of cells, which then make tissues, which then make organs, which then make systems" (p. 43). Ethically, on this view, people are "almost like machines". With regard to the routinisation of care, Nay and Closs (1999) observe that routines have the tendency to "stifle holistic practice", privileging tasks over people. For nursing staff, caring activities that do not involve physical tasks are "not seen as nursing, but as an interruption to the routines" (p.183). Nurses may resist routinisation since their identity may be tied-up not only with their capacity to perform particular tasks, but also with their commitment to the caring process (Gastmans 1999 p. 214).

Gastmans (1999), like Carper (1978), stresses that a morally virtuous attitude is integral to nursing, since nursing practice takes place within a relationship – that is, between the nurse and the patient. Adopting a caring moral attitude is appropriate since it constitutes "a sensitive and supportive response of the nurse to the situation and circumstances of a vulnerable human being who is in need of help" (Gastmans 1999 p. 216). Tronto (1993, cited in Widdershoven 1999 p. 251) conceptualises caring as an almost all-encompassing,

organic, human phenomenon, a "species activity" by which we "maintain, continue and repair our 'world'". Care, in this conceptualisation, includes "our bodies, our selves and our environment, all of which we seek to interweave in a complex, life-sustaining web". Within the nursing context, such an approach would foster an "attitude of openness and receptivity" to requests for care, since this is the basis for the "building up a caring relationship" (Gastmans 1999 p. 216). Nurses, therefore, require "moral competence", that is, "the ability to live life in a manner that is consistent with one's personal moral code and role responsibilities" (Taylor 1995 p. 2). Using a hermeneutic perspective, the centrality of ethics in nursing is elicited by Tschudin's (1994) statement that "[e]thics is not only at the heart of nursing, it is the heart of nursing" (cited in Cortis and Kendrick 2003 p. 79).

Given the importance of the caring relationship as the fundamental basis of ethical nursing care provision, it is noteworthy that some nurses may seek to establish relationships with some patients in preference to others. Byrne and MacLean (1997), in a study of registered nurses and non-nursing staff (AINs), found that registered nurses were reluctant to communicate with residents with dementia. Similarly, Mott and Kingsley (1999, p. 221) found that nurses preferred to interact with those residents with higher cognitive function. This raises the question for me as to whether selecting who to care for on the basis of level of functioning is in fact unethical, or at least discriminatory?

In contrast to an ethical care relationship, some nurses engage, rather, in 'defensive work' aimed at protecting their institution or their self. This work 'skews' the nurses priorities and leads to an "acceptance of substandard care and a diversion of attention from therapeutic work" (Weiner & Kayser-Jones 1989 p. 37). The extent to which nurses use their 'selves' - physically, cognitively and emotionally reflects their degree of 'engagement' or 'disengagement' (Kahn 1990 p. 692).

This interaction between care providers and resident ultimately raises the dual issues of quality of care and quality of life, a discussion of which follows.

Quality of Care, Quality of Life

In Australia, we do not follow the American system of Minimum Data Set/Resident Assessment Instrument, which is a comprehensive system aimed at monitoring quality care and clinical outcomes. This system consists of forms that must be completed by nursing homes. This creates a type of benchmarking system at a national level, but also for

individual nursing homes. In comparison to the American system of explicit measures of clinical outcomes for residents, Australia relies on an accreditation system for nursing homes that uses paper-based documentation of clinical outcomes and processes. The documentation incorporates four core care standards: Standard 1: management systems, staffing and organisational development; Standard 2: health and personal care; Standard 3: resident lifestyle; and Standard 4: physical environment and safe systems. These four standards are underpinned by 44 expected outcomes (nine outcomes in management, seventeen outcomes in health, ten outcomes in lifestyle, and eight outcomes in environment with explicit criteria specified for each outcome) (Appendix A) .

The Australian approach to a quality of care is theoretically underpinned in Donabedian's (1966, 2003) triad of structure, process and outcome. Yes, quality of care compared with quality of life (QoL) is a different matter entirely. Courtney, Edwards, Stephan, O'Reilly & Duggan (2003) characterise QoL as having objective and subjective elements. Objective elements include economic circumstances, housing and functional status, while subjective elements includes, for example, morale, happiness, and life satisfaction. QoL of people entering a nursing home was measured by Edwards, Courtney and Spencer (2003). Of greatest importance was the interaction between staff and residents, followed by the availability of private rooms, control over choice of roommate, the availability of specialised care (e.g., dementia or palliative care), the availability of allied health services, the existence of an activity program and, finally, food related matters. In pulling findings like these together, Farvis (2003) found that in residential aged care settings, residents' primary vision of care was that it should have a home-like atmosphere. Such an environment would be composed of many "intangible threads" that created "an ambience of welcoming reassurance and security" (p. C 1). This is supported by the findings of Hammer (1999) that older people who "felt at home" had the greatest life satisfaction, feelings of security, autonomy and purpose. This was in contrast to those older people who did not feel at home, who were "anxious, angry, and depressed, and were consumed by a desire to be elsewhere" (p. 10). Living in a public domain raises issues of privacy, which were found to be a key concern for residents in a Dutch nursing home (De Veer & Kerkestra 2001). Privacy had four aspects: the first was privacy related to the characteristics of the building; the second, privacy in relation to care staff's response to residents; the third concerned the choice and control over time schedules and activities, and the fourth was related to the amount of disturbance caused by other residents (p.10). The

experience of privacy varied not only between individuals, but also on aggregate between different nursing homes, leading De Veer and Kerkestra to suggest that "feeling at home is not only individually determined but can be influenced by the nursing home's management policy" (p.10).

The next aspect in the construction of a model of the quality of life for residents revolves around the issue of family and friends, including advocates that act on behalf of residents. These people are of critical importance to care recipients; Koch et al. (1995), in a study of acutely ill patients in a hospital, found that patients were reliant upon their relatives or friends for food, and those without those advocates "endured and went hungry" (p.188). These relationships may, however, be fraught. Nay (1996, 1997) points out that family carers experience mixed emotions on placement of a loved one in a nursing home. Emotions range from guilt (at having gone against the loved one's wishes) to relief (from being able to share the burden of care). The stress and emotional burden of caring is not removed once a relative has moved to the nursing home. Nay (1997) explored relatives' phenomenological experience of the nursing home, finding that there were two (opposing) major horizons: "feeling central to care" and "feeling marginalised". Both of these experiences may arise from the role of being a carer of a person in a nursing home, which Bowers (1988) found to include the monitoring of staff care, teaching staff appropriate caring behaviours, and protecting the resident. Of particular interest in Bowers (1988) findings is the reasons that carers felt the need to monitor care. This was because of staff's poor communication, the reluctance of staff to work with carers, and lack of staff continuity. Conversely, the trauma experience by carers on the placement of a family member in a nursing home may be eased in circumstances where the carer sees the nursing home as a "welcoming, homely environment" (Nay 1996). Staff attitudes that can enhance a positive experience foster a partnership between relatives and nurses in which there is "an atmosphere of collaborative caring through sharing perspectives, not just tasks and functions" (Kellett 1999 p. 1479). This collaborative relationship "acknowledges shared humanity and involves the exchange of expertise and value", leading to a sense of belonging and attachment to the nursing home (Kellett 1999).

Moving from the issue of the resident's reaction to nursing home life and then to their relatives' involvement as an advocate for the quality of care, this chapter will now look at individual themes that relate to these issues, thus allowing the development of a working conceptualisation of quality care. The first of these issues is communication.

Communication

To understand how these themes relate to the issue of quality of care, it is important to place them within a context. Koch et al. (1995) do this by placing communication within the context of routinisation of care, care deprivation, depersonalisation and geriatric segregation. Following Baker (1978), they speak of the inflexibility of daily routines, an "emphasis on physical activities at the expense of psychosocial needs", as well as prioritising a ward tidiness and the expectations of senior staff over the needs of patients (Koch et al. 1995 p. 190). A key psychosocial need is the need for social engagement, particularly communication between residents and care providers.

In a study of the conversational style of enrolled nursing with elderly nursing home residents Gibb (1990) found that the communication style was "task-oriented" and at the same time had "social and supportive components". Nursed displayed skill in "interweaving of each of these components so as to achieve a balance between an 'expert style', characterised by control and directness, and a chatty, social style which facilitates a reciprocal interaction between persons of equal status" (Gibb 1990 p. 1). Symer, Brannon & Cohn (1992) focused upon the relationship between tasks and the types of communication that flowed between care providers and residents. They found that there existed two key approaches to care provision, a *routinised* and an *individualised* approach. They recommended a restructuring of caregiver work that would move away from functional care routines towards alternatives including a resident-centered approach to care, and the permanent assignment of staff to residents. In a similar vein, McCallion, Toseland, Lacey & Banks (1999), found that a personalised training program for nursing assistants that aimed to build communication skills, had a positive outcome for dementia residents who appeared less depressed, less verbally and physically aggressive and were less likely to 'wander'.

Despite these successes, it is clear that not all nurses have developed effective communication with nursing home residents. "Elderspeak" is a term coined to describe a communication style that includes inappropriate terms of endearment, the use of collective pronouns, and shortened sentence length when talking to older people (Williams et al. 2003, p. 249). Such communication runs the risk of "unknowingly reinforc[ing] dependency and engender[ing] isolation and depression in residents, contributing to the spiral of decline in physical, cognitive, and functional status" (Williams et al. 2003 p. 249).

Resident autonomy

Another important issue in the provision of quality care is that of resident autonomy, which may be inadvertently undermined by care staff in their efforts to provide the best possible care (Brocklehurst & Dickinson 1996; Mullins & Hartley 2002). Nursing home staff faced with the challenge of respecting resident autonomy and simultaneously adhering to nursing home standards "often experience a frustrating ethical conflict" (Mullins & Hartley 2002 p. 35). This issue of ethical conflict and an engendering of stress require an examination of the frontline worker[10] and their responses to working in a nursing home.

The frontline worker

One of the key features of the response of frontline workers' to working in nursing homes has been their high turnover and low retention. Frontline workers are integral to good quality care, providing an estimated 80% to 90% of resident care (Smyer, Brannon & Cohn 1992; Bowers et al. 2003). Given this, high turnover rates are a major concern. Turnover rates have been found to range between 40% and 400% (Bowers, Esmond & Jacobson 2003). As well as being a concern for continuity of care, higher staff turnover adversely affects staff morale and the cost of care provision (Bowers et al. 2003).

This has inadvertently led to a strong research focus upon such workers (Waxman, Carner & Berkenstock 1984; Bowers & Becker, 1992; Smyer et al. 1992; Foner 1994; Bowers et al., 2000; Stone & Wiener 2001; Bowers et al. 2003). Shields and Kick (1982) note that despite the fact that the primary reason for admission to a nursing home is the need for nursing care, most care in a nursing home is provided by unskilled personnel such as frontline workers, CNAs and AINs (in Munroe 1990 p. 263). This has led them to question the appropriateness of traditional "bottom-heavy'' staffing patterns in the context of nursing home care for an increasing proportion of residents requiring more intense levels of nursing services. Frontline workers have been found to respond to a perceived lack of order, organization and control in nursing homes, with high job turnover; although greater turnover was found to occur in better quality homes with good employment conditions (Waxman et al. 1984). Waxman et al. suggest that greater involvement in decision making processes may improve retention rates.

[10] Frontline worker in this study refers to the key carer for the resident, that being the AIN in Australia and the CNA (Certified Nursing Assistant) in the USA.

Wilner (2001) contends that frontline workers, such as AINs, are often viewed as "an amorphous mass of people" who do work that other people would not do. This devaluation of the role of frontline workers, makes it difficult for them to gain satisfaction from their work. Yet, there is no question that their work is critical, since they provide the greatest proportion of hands-on care, as well as interaction with residents. In addition, they often function as a conduit between residents and the RNs (Waxman et al. 1984). Despite their devaluation, frontline workers may see their work as valuable since they are "there for" the residents (Goins 2002).

Some research has addressed possible causes for poor retention of frontline workers. They may feel unappreciated, undervalued and "personally and professionally dismissed" (Bowers et al. 2003 p. 37). In addition, factors relating to organisational context also affected retention. In for-profit nursing homes, these have been found to include: low salaries with few benefits, limited opportunities for advancement, inadequate training, chronic understaffing and lack of opportunity to contribute to care planning (Bower et al. 2003). Bower et al. (2003 p. 42) make some suggestions that are applicable to both the USA and the Australian context[11]: care providers should have a sense of "being respected and they are being treated fairly [and that] their individual expertise and commitment are recognized and valued by supervisors and administrators", both in wages and in praise.

Finally, Kopiec, Caffrey, Hallock, Field & Engel (2000) and Wilner (2001) point to the realities of being a frontline worker, which has prompted me to delve into issues of stress and coping, along with strategies to improve the work environment. Kopiec et al. (2000) highlights the fact that frontline workers experience work-related injuries which, along with the physically demanding nature of the work may lead to their leaving the aged care field. Other factors identified by Kopiec et al. (2000) include emotional stress resulting from "observing human suffering and death, and witnessing and partaking in inadequate patient care" (p. 4). Wilner (2001 Ch.7-7) sums this emotional stress from a frontline worker's remark: "If you think it's easy, think again. Its demanding and overwhelming, especially your first day. EVERYTHING will hurt … including your heart".

[11] Australia does not appear to have the same problem of high AIN turnover that the USA has with CNAs. This assumption of mine in 2003 was later confirmed by Richardson & Martin (2004) cited by Flavel (2007 p. 109): "the aged care workforce does not appear to be in crisis or even under serious stress".

Maslow's Hierarchy of Needs

Benson and Dundis (2003) use Maslow's (1954) 'Hierarchy of Needs' model to make linkages with the issues of care provider satisfaction, motivation, coping and control within the work environment. Benson and Dundis (2003, p. 315) talk of "the challenges of understanding and motivating employees in a rapidly changing health care industry" and believe that Maslow's Model can address workforce concerns such as "the need for security and freedom from stress, social belongingness, self-esteem, self-actualization, altered work/social environments, and new opportunities for learning and self-definition".

Stress and coping

Parallel to Maslow's theories has been the theoretical framework of stress and coping; in particular the work of Park and Folkman (1997). The 'Meaning-Making Coping' Model (Park 2000) is presented in Figure 1.

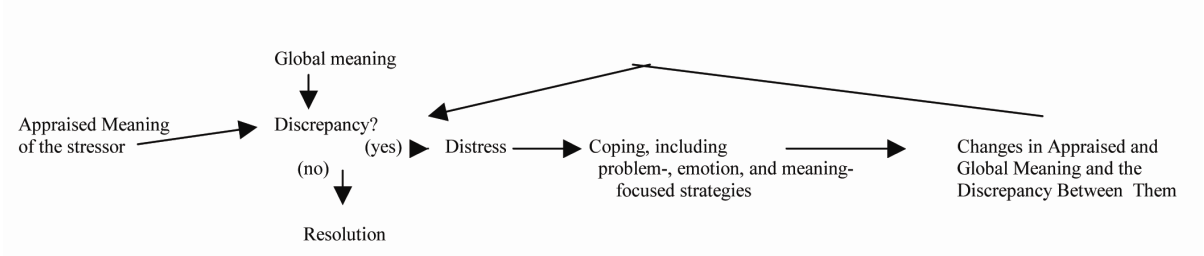

Figure 1: The Meaning-Making Coping Model (Park 2000, p. 1)

In this model, a chain of responses occur when a person is confronted by a stressful event. Initially, they appraise the meaning of the event ("What has happened?"), then they will try to "determine the extent to which this appraised meaning is discrepant with their global meaning system" (Park 2000 p. 1). In earlier work, Folkman and Lazarus (1980), in the 'Ways of Coping checklist, identified two coping strategy categories, 'problem-focused' and 'emotion-focused'. The 'problem-focused' category includes items "that describe cognitive problem-solving efforts and behavioral strategies for altering or managing the source of the problem" (p. 224). More generally, Folkman and Lazarus (1985) suggested that people often use both problem-focused and emotion-focused strategies when dealing with any one problem (Healy & McKay 2000). The use of avoidance as a means of coping has been found to be associated with an increase in depressed mood and lower job satisfaction (Healy & McKay 2000).

Work stress does appear to reduce with age, however. Older human service workers were found to have significantly higher job satisfaction than younger workers, and, although "job dullness was predictive of satisfaction for all workers, it became increasingly important in explaining job satisfaction with age" (McNeely 1988). In a more recent Australian study, Humpel and Caputi (2001) found a similar relationship between work stress, years of experience and emotional competency which gives insights into young novice care providers working in aged care.

A Hermeneutic Perspective on Stress and Coping

Widdershoven (1999 p. 249) makes an explicit connection between stress, coping, identity and hermeneutics in speaking of coping as social interaction in terms of "sharing experiences of anxiety, making them explicable by developing stories around them, people can find new ways of dealing with their emotions and new ways of responding to the situation". The issue of 'burnout' arises within this context of coping strategies, the individual's identity as realised in their *Dasein* - or 'being-in-the-world' (Heidegger [1927] 1962), and how well the individual fits into a nursing home environment.

Burnout

'Burnout' among professional nurses was reported as early as the 1970s (Maslach 1978, 1982; Jones 1981; Hare & Pratt 1988), and more recent studies have addressed burnout in particular contexts, including work setting (Cronin-Stubbs & Rooks, 1985), nursing responsibilities (Yasko, 1983) and patient characteristics (Vachon, Lyall & Freeman 1978; Hare & Pratt 1988). This area of research has continued (Heine 1986; Hare & Pratt 1988; Berg et al. 1994; Harrington 1996; De Rijk, Le Blanc, Schaufeli & De Jonge 1998; Demerouti, Bakker, Nachreiner & Schaufeli 2000; Koivuka, Paunonen & Laippala 2000; Leon, Marainen & Marcotte 2001; Aiken, Clarke & Sloane 2002; Evers, Tomic & Brouwers 2002); and given its significant, burnout is a focus for this study. Quite recently, building on the work of Heine (1986), there has been interest in taking a closer look at frontline workers.

Hare and Pratt (1988) defined burnout as "a syndrome of emotional exhaustion, depersonalization of clients, and a reduced sense of personal accomplishment" (p. 60). Burnout is common amongst staff - both professional and para-professional - who work intensively with people with who have "severe social and health problems" (p.60). In a study in long-term care facilities, Hare and Pratt (1988) found that para-professional nurses

were significantly more likely to experience burnout (emotional exhaustion and depersonalization) than were professional nurses. Guilt and a sense of inadequacy are common responses to not being able to meet residents' needs, particularly when it becomes increasingly difficult as a result of time pressures (Heine 1986). Residents are affected by nurses' burnout, since burnt out nurses interact differently with residents. They may stop speaking with residents, fail to provide timely care, or completely ignore requests for assistance (Heine 1986).

This raises the issue of threats to moral integrity that result for pressures leading to burnout. Kelly (1998) makes the link between moral and ethical value, adaptation to the work environment and the subsequent selection of a coping strategy—such as avoidance—in the process of preserving moral integrity. In a study of graduate nurses' adaptation to the "real world" of hospital nursing, Kelly found six stages in the adaptation process: *vulnerability; getting through the day; coping with moral distress; alienation from self; coping with lost ideals;* and *integration of new professional self-concept* (Kelly 1998 p. 1140).

A result of nurse's burnout and stress may be physical or emotional abuse of residents, as well as "more subtle" actions including neglecting patients' right to privacy, confidentiality and decision-making (Heine 1986). According to Heine, this is more likely to occur when "employees work day after day with confused residents who do not know who they are or where they are" (p. 14). Leon et al., (2001) also discusses the burnout in frontline workers, noting the high levels amongst frontline workers resulting from difficult work that is both physically and emotionally demanding; coupled with low pay and poor career advancement opportunities. The authors note, however, that aged care providers who have improved work cultures were able to improve retention rates. Strategies that increase the autonomy of frontline workers, such as introducing self-managed work teams (SMWTs), has been found to improve retention rates and improve job satisfaction (Yeatts & Seward 2000). This approach "almost automatically" provides the frontline worker with "a new dignity and will formalize respect for her and her work in a way that speaks much louder than words" (Dawes 1981, in Yeatts & Seward 2000 p. 360).

In dealing with stress and pushing towards better care outcomes, there have been a variety of strategies that cluster around 'sensemaking' (Weick 1995) in organisations, job redesign (Briner & Reynolds 1999; Mäkinen, Kivimäki, Elovainio, Virtanen & Bond 2003; Adams & Bond 2003a, 2003b), dementia interventions (Brodaty & Gresham 1989), culture change

strategies and issues of satisfaction (Moyle, Skinner, Rowe & Gork 2003), and organisational climate (Bowers 2001; Farmer 1996).

Stress and the Workplace

Research into workplace stress in the hospital nursing context sheds light on workplace stress in the nursing home context. Hospitals and nursing homes have similar embedded traditions in terms of interaction with patients and the organisational environment. In addition, they often share staff that move between these 'two worlds' (Tellis-Nayak, 1989). Dewe (1987a) and Troup (2002) investigated coping and stress for nurses working in New Zealand hospitals. Dewe (1987b p. 489) identified six strategies used by nurses, including: *problem-oriented behaviour; trying to unwind and put things into perspective; expressing feelings or frustrations; keeping the problem to yourself; accepting the job as it is* and *trying not to let it get to you.*

Three main strategies for reducing work-related stress have been identified (Lazarus 1992 in Long 1995):

> 1. Alter the working conditions so that they are less stressful or more conducive to effective coping.
>
> 2. Help individuals adapt by teaching them better coping strategies for conditions that are impossible or difficult to change.
>
> 3. Identify the stressful relationship between the individual or group and the work setting." (Long 1995 p. 3).

Sense of control is crucial to coping with stress (Troup & Dewe 2002). This may work by improving empowerment, and hence "the opportunity to exercise different forms of emotional coping even in those encounters where there are no other forms of control available" (p. 352). As job satisfaction for the frontline worker increases, there is consequent retention of staff for the proprietor.

Satisfaction and retention of staff

Smyer et al. (1992), in a longitudinal study of Nursing Assistants in four American nursing homes, assessed the single and combined effects of two interventions: skills training and job redesign, intended to improve performance by increasing knowledge and motivation. Although knowledge improved, performance (as rated by supervisors) did not. Smyer et al.

concluded that "initiatives to improve the quality of care by improving staff training [will not by themselves] dramatically improve the quality of care and the quality of life in nursing homes" (1992 p. 332). They conclude, further, that there may be two differing agendas, one being "to improve quality of care and the quality of life in nursing homes", and the other being "to improve staff satisfaction and morale and, hence, to reduce turnover". Job redesign and culture change strategies developed by administrators "were less likely to support and advocate approaches that might negatively affect staff satisfaction in the short run, regardless of the longer-term impact on quality of care" (Smyer et al. 1992 p. 332).

The effectiveness of some organisation-level strategies, such as job redesign, to reduce organisational stress and turnover has been questioned (Briner & Reyolds 1999). Some have argued (e.g. Tellis-Nayak & Tellis-Nayak 1989) that the stresses that care providers bring to work and which may have a bigger impact on them than their working environment itself: "nursing home quality is tied closely to the social background of the staff and the institutional culture of the nursing homes" (Tellis-Nayak & Tellis-Nayak 1989 p.308).

Organisational structures may impact on levels of occupational stress through staff levels. Adams and Bond (2003a) investigated the relationships between the number of nurses and ward organisation and found that wards with fewer nurses were more hierarchical in both their structural organisation and in attitudes to care provision. A consequence was "lower standards of nursing practice" (p. 287). When wards had larger numbers of nurses, they were less hierarchical, and displayed "devolved" organisational structures, although standards of nursing practice were not associated with higher staffing levels. Nurses who worked in environments seen to include "multidisciplinary collaboration" had higher levels of coping ability and job satisfaction (Adams and Bond 2003a). These authors conclude that although nurses personally benefit from larger staff numbers, there were limited benefits for quality of care practices, and that what needs to change is ward cultures, staff attitudes and nurses' competence (Adams & Bond 2003a p. 291). This is supported by research that shows that "patient-focused work allocation, opportunity to write nursing notes and accountability for patient care contributed to nurses' satisfaction with supervision and personal growth" (Mäkinen et al. 2003 p. 299).

In terms of satisfaction within a nursing home, there are two key perspectives, firstly the satisfaction with the care provided and secondly, the satisfaction with the work of the care provider. In discussing the first perspective, Moyle et al. (2003) note that, in the Australian context, job satisfaction was found to be related "to workplace flexibility, residents, working within a team environment and dedication to the service of optimal resident care" (p. 168). Conversely, they found dissatisfaction was linked "to working with unskilled or inappropriately trained staff, laborious tasks such as documentation, staffing levels, tensions within role expectations and the increasing need to be available for overtime" (p. 168). It may be that some care workers choose this setting because it affords them the opportunity to make a real difference: "they value their role in improving the quality of life for older people" (Patrick 1986, in Moyle et al. 2003 p. 174). Working unpaid overtime gave some care workers the opportunity to demonstrate their dedication to older people, although it also created conflict (Moyle et al. 2003). Satisfied employees are important because they are less likely to take shortcuts than a dissatisfied employee. Moyle et al. (2003 p. 168) conclude by saying that "In spite of different role expectations, long-term nursing home care is reported to be a very satisfying area in which to work".

Working with the frontline worker's motivations to provide quality care as a source of satisfaction are the added strategies to provide training and job redesign to facilitate this goal.

Training and Job Redesign

The topic of training, staffing numbers and job redesign - including change culture strategies - reveal significant divergence of views within the literature and represent a focus for this research, which seeks to clarify these divisions. Wilner (2001) asserts that "staffing numbers alone have a significant effect on quality of care and quality of life in nursing facilities", while Adams and Bond (2003a p. 287) concluded otherwise in their study investigating the relationships between satisfaction, staffing numbers and quality of care. A study by Spector and Takada (1991) which examined mortality, functional decline and functional improvement in 2,500 residents in 80 American nursing homes over a six month period, revealed that higher staff levels and lower turnover of registered nurse was associated with functional improvement. This finding, however, was not supported by Adams and Bond (2003a), who found no link between staff numbers and standards of nursing care.

It has been proposed that adequate knowledge and skill will provide frontline staff with the competence and confidence necessary to provide high standards of care (Wilner 2001), however, training in itself may be insufficient to improve resident outcomes, including quality of life (Smyer et al. 1992). Issues in the personal life of the frontline worker also need to be addressed; difficulties for frontline staff in the "world in which they live" (i.e., outside the nursing home), impact on "the world in which they work" (Tellis-Nayak 1989 p. 307). Conversely and at the same time, the nature of the institutional culture within a nursing home can compound the difficulty of their outside personal life, which may lead a self-perpetuating cycle of burden that carries over to the care they offer residents (Tellis-Nayak 1989). Positive institutional cultures – a 'culture of caring' consisting of shared values and behavioral norms – support care staff and may be as important in facilitating quality care as adequate numbers of frontline staff and acceptable turnover rates (Lekan-Rutledge et al. 1998). Lekan-Rutledge et al. describe indicators associated with exemplary nursing homes including a "unique philosophy" and "moral culture", with a high degree of involvement of senior administrative and clinical staff. Such a culture was not seen to depend on staffing to resident ratios. Supportive relationships, with residents and co-workers, flourish in such an environment, facilitating a sense of personal gratification from the work itself, and improve both the retention and morale of frontline staff (Monahan & McCarthy 1992).

This idea, put forward by Monahon and McCarthy, makes the final links in this literature review on the topics of organisational culture, climate and focus upon the characteristics of the frontline worker. The final topic for this literature review is that of *change culture strategies.*

Organisational Culture and Climate

Before we can study Bowers' (2001) insights into organisational culture and climate proper we must first remove the blurring between the concepts of 'climate' and 'satisfaction'. Schneider and Snyder (1975, p. 318) make an argument for the 'logical and empirical distinction' between the concepts of satisfaction and climate if "a) both variables are properly conceptualized and (b) each variable is assessed according to an appropriate level of analysis". Climate can be defined as 'how individuals feel about an organization' (Schein 2000 in Bowers 2001 p. 6); 'climate' is immediately experienced and is best conceptualised as "an individual experience, rather than an enduring organizational

attribute" (Bowers 2001 p. 6). Furthermore, 'climate' is 'climate *for* something' (Bowers 2001). Therefore, in the context of nursing home care provision, climate refers to the climate of providing quality care provision. Organisational climate has generally been seen to reflect an organisation's "surface attributes" rather than its "depth or undercurrent". Yet, the latter is more relevant to organisational climate. For this reason, much research on attitudes, beliefs and feelings is relevant to organisational climate (Bowers 2001). Therefore, a distinction between climate and satisfaction - as well as their relationship - begins to emerge.

Bowers (2001 pp. 6-7) clarifies the relationship between organisational culture and climate, by first defining organisational culture as "a shift away from attitudes and feelings to a greater focus on values, meaning histories, the development of shared or disparate understandings, and the relationships among cultures within a single organization." Bowers (2001 p. 7) draws a clearer definition in stating cultures relationship to climate "is generally understood as something about meanings that endures over time, socialization, and values. It is seen as the infrastructure that is reflected by, but not synonymous with, organizational climate." After having provided these thinking tools, Bowers moves on to connect this to the issues of long-term care, making reference to the culture change initiatives of The Eden Alternative, Pioneers, and Wellspring. Bowers makes the pointed remark that:

> While these three initiatives have experienced considerable marketing success, there is a lack of clarity and consistency about exactly what these culture change initiatives consist of, whether/how they are achieved, or the outcomes that can be expected as a consequence. (Bowers 2001 p. 12)

Bowers further states that "The little research available on these culture change initiatives has failed to demonstrate consistent understandings of culture or culture change and has been unable to demonstrate consistent relationships between 'culture change' and either resident or worker outcomes" (p.12). Organisational culture and climate is important to the mix that helps to create a moral ecology of understanding of care provision in nursing homes. This moral ecology accesses hermeneutics, ethnography and phenomenology together as 'a researcher as bricoleur' strategy (Denzin & Lincoln 1994).

Culture change strategies

There are three main culture change strategies in the USA that have attempted to improve care outcomes and the environment of nursing homes whilst increasing the retention of care providers. These are 'Eden Alternative' (established in 1991), 'Pioneer Network' (established in 1997) and 'Wellspring Innovative Solutions Inc'. ('Wellspring') (established in 1994). The three approaches have been grouped together in the literature as 'culture change' programs, but they each have different emphases and strategies for implementation. What they have in common is a need to state their outcomes in reducing retention and turnover of staff.

Goins (2002) gives an overview of a USA non-profit nursing homes provider, the Lutheran Services for the Ageing (LSA) that incorporated both the Eden and Wellspring perspectives. He observes that LSA has made the recruitment and retention of quality staff a high priority and have embraced the Eden Alternative which is "designed to eliminate loneliness, helplessness, and boredom in facilities by introducing children, plants, and animals to create a more homelike environment" (Goins 2002 pp. 114-115). Similarly, the Pioneer movement, Goins reports, is focused on creating environments in which people "want to live and work" (Goins 2002 p. 115). Eden Alternative and Pioneer utilise culture change strategies to address staff turnover in order to address its negative impact on facilities' budgets. Goins then makes the link to care providers' engagement with their work and the residents by saying that "good quality direct care requires a connection between residents and staff, and new staffers don't know which resident likes cream in her coffee and who likes to sleep late in the morning" (p. 115).

In more detail, the Eden Alternative started in 1991 and now, as Thomas, its founder, claims, has 15,000 Eden Associates and adherents in 300 registered homes. These organisations are located in the USA, Canada, Europe and Australia (Thomas 2009 pp. 1-2). Thomas describes the model as "a powerful tool for improving quality of life and quality of care for those living in nursing homes, [and] there is often improved staff satisfaction and retention and significant decreases in the overuse of medications and restraints" (p. 2). Misiorski (2003) a leader in the Pioneer Network, states that it was formed in 1997 by 33 long-term care professionals who gathered "to discuss non-traditional approaches to long-term care that would support vibrant living environments for

nursing home residents" (p. 1). An evaluation by the Pioneer Network (reported in Misiorski 2001) of the program's implementation in nursing homes, reported:

- A decrease in the number of residents suffering from significant weight loss.
- A reduction in the number of dietary supplements prescribed by physicians from 72 to 14.
- A doubling of staff productivity with turnover down to 9.4%
- A reduction in the number of residents using briefs from 53 to 3.
- Significant reductions in the numbers of sleep, psychotropic and anti-anxiety medication prescriptions.
- A drop in the incidence of pressure sores from 11 to 0.

The organisational culture is, according to Misiorski (2003), "resident-directed", rather than "institution-directed". Misiorkski states that:

> To create a person-centered culture, it is necessary to fundamentally transform an organization's values, structures, and practices. The traditional hierarchical structure of the nursing home, which places power in the hands of the leadership staff, must be flattened so that more control is shifted to residents and those closest to them. (Misiorski 2003, p. 2)

Misiorski highlights the need of close connection between frontline workers and the residents, when she says that consistent assignment of frontline workers to residents enables workers to "get to know a group of residents and care for them as individuals" (p.2). Self-evaluations by programs using the Pioneer philosophy have reported positive outcomes "staff turnover, resident and family satisfaction, census, and clinical outcomes" (Misiorski 2003 p. 2). In a similar vein, the final change culture strategy, 'Wellspring, according to Stone et al. (2002 p. 1), "seeks to change the clinical quality of care and the organizational culture of its members". Wellspring was founded in 1994 by an "alliance" of eleven independent nursing homes in the USA. It was fully operational by 1998.

Of the three strategies, Wellspring has attracted the most research attention (Bowers 2001; Reinhard & Stone 2001; Stone et al. 2002). Reinhard and Stone (2001 p. 1) state that

Wellspring offers "a promising approach to improving the well-being of nursing home residents by improving care and reducing staff turnover". Stone et al. (2002) states that the outcomes of implementing the Wellspring strategy were an overall improvement in nursing home quality and improved staff retention; over a four-year period, retention rose from 70 to 76 percent, while among non-Wellspring homes in the same American state, the retention rate fell from 74 to 68 percent. Bowers (2001) reflects that the role of 'leadership style' in organisational climate is still a matter of debate, and evidence from the Wellspring implementation tends to suggest that it plays a significant part.

Reinhard and Stone (2001 p. 1) point out that Wellspring's strategies include the following:

- developing and implementing model practice systems at the provider level;
- establishing quality assurance systems internal to nursing homes;
- strengthening nursing home staff; and
- improving regulatory standards - through development of appropriate outcome measures, for example - and tightening their enforcement

Benefits from the introduction of programs that improve organisational culture and thus improve staff retention would be lost if proprietors sought to take cost savings as profit (Smyer et al.1992). Such scepticism is reflected in views of job redesign and culture change as being primarily about improving quality of care for residents to improve marketability of a nursing home (Smyer et al. 1992).

This value judgement regarding what defines and is reasonable for a 'quality of care' is the focus of this research. This research asks the 'why' question of why is it that care providers hold their particular conceptualisation of 'quality care', in other words: what influences this conceptualisation, and how did it arise?

Summary and research objectives

This chapter begins with a summary of the Australian view of aged care provision and details its approach to a quality assurance framework by instigating an accreditation system based upon chiefly a desk audit of documentation that demonstrates that a continuous improvement process is in place. The quality assurance framework assumes that if such a process of continuous improvement is in place and that its standards and guidelines are

fulfilled, then quality care is guaranteed to reside within that nursing home. It outlines the components of the Australian Aged Care Act (1997) and draws attention to the shift in emphasis - as indicated by critics - of its overt push to the commercialising of nursing home care by placing more power in the hands of proprietors. Critics talk of the aged care reforms being a shift to a neo-reform period dominated by the theories of economic rationalism based upon market principles.

In making this assertion, critics detail the shift in the process of the evaluation of needs of residents through the RCS and the allocation of subsidies based upon this heuristic device away from the previous system, CAM, in which funds were allocated based upon staffing positions to relative needs of the residents. Chief within this change of philosophy is the break in the accountability of funds received to where they were actually spent and whether they were spent at all. Critics point out that the current position allows proprietors to determine where the subsidies they receive are spent or absorbed in profit, with the only accountability being a paper trail of packaged outcomes and processes.

Of concern to impartial evaluators of the new system has been the decline of registered nurses with nursing homes and the ongoing moves of the industry to further shift emphasis from registered nursing to more lowly paid care providers. From this focus on staffing, reference is made to the American focus on retention and turnover concerns and their reliance upon outcome Minimum Data Set/Resident Assessment Instrument findings which appears to be at the expense of quality of care concerns. However, there are some voices being raised in the area of ethical issues; quality of care and quality of life indicators; communication, engagement and ‘elderspeak’; as well as a general move to recognising the role played by the frontline worker.

From reviewing the position of the frontline worker this review moved on to talk of the issues revolving around them and the strategies to address their concerns. Of prime importance, I detail the frontline workers work experience and tie that in to the recurrent research theme of retention, turnover and satisfaction. Finally, it brings these issues together as a cluster of strategies sourced from an understanding of organisational culture and climate and culture change strategies to resolve nursing home industry problems. The interesting issue raised from the literature is whether these solutions are aimed at improving retention and turnover with the assumption that this will improve care outcomes or whether they are just to maintain staffing levels to in order to maintain profit.

To answer this question and those raised within this study, a methodology that matches the complexity of the phenomenon of nursing home care needs to be utilised. The specific research objectives are to:

- Document the beliefs and attitudes of care providers towards elderly people in general and the needs of nursing home residents in particular
- Elicit the range of meanings and evaluations that care providers attach to their work
- Describe their constructions of 'care' and 'quality of care' and the organisational factors they believe to impact (positively and negatively) on their ability to provide it.
- Through in-depth understanding of a particular setting, generate grounded theoretical insights into the phenomenon of quality of residential care that are more widely applicable.

CHAPTER THREE: METHODOLOGY

This chapter begins by presenting the design and theoretical underpinnings of this research, along with ethical considerations. The research site and participants are then described, as well as the rationale for the choice of research site. Following that, each of the two main data collection methods are described, participant observation and in-depth interviewing. Within each of these sections, I present both the data collection and data analysis procedures. The chapter finishes with a short Afterword describing changes in the research site that evolved after the period of participant observation.

Research design

A phenomenological methodology underpins this study of the Golden House Nursing Home. Data was collected using participant observation, in-depth interviews and access to documents. Analysis of the data (fieldnotes, transcripts and documents) utilised a method adapted from grounded theory methodology (Glaser & Strauss 1967), which involved the application of codes to text which were then compared and for similarities and differences. Higher order themes were developed which resulted in the analysis reported in later chapters of this thesis.

The research is underpinned by a fusion of Heidegger's ([1927] 1962) and Gadamer's ([1960] 1975) philosophical hermeneutic perspectives. In addition, I have adopted a 'combinative' ethnographic method which aims to "identify the different forms of action in which people may engage along with the possible combinations between them" (Baszanger & Dodier 2004 p. 10). The resulting core methodology is, then, a blending of philosophical hermeneutic phenomenology and combinative ethnography. I have used an 'iterative recursive *bricoleur'* approach; a modification of Denzin and Lincoln's (1994) concept of 'researcher as *bricoleur'*. The notions of 'iteration' and 'recursion' are used to reflect my journey in production of the final 'thesis'. The typical journey of thesis construction is linear; moving from research question through the literature review, data gathering, analysis and 'writing up' (Wolcott 1990). My approach is, rather, 'recursively iterative' as it follows the 'hermeneutic circle'; a metaphor taken from Heidegger to "describe the

experience of moving dialectically between the part and the whole" (Koch 1996 p. 176)[12]. I try to create instances of 'fusions of horizons' to arrive at a final resolution of the thesis text. 'Fusion of horizons' indicates the coming together of 'horizons', or perspectives, of people interacting with each other in a stance of openness which leads to better understanding (Gadamer 1976). Temporally, my recursive iterative technique seeks to be embedded within a hermeneutic circle or spiral (Paterson & Higgs 2005; Butler 1998) which is enacted in drafts that then interacted with each other within subsequent redrafts, and the totality of the redrafted thesis continues until the final thesis was completed.

Practice ('praxis') and routines within a nursing home are best understood as being enacted by individuals who seek to maintain and create their identities and understanding through praxis. 'Praxis' is a term used throughout this thesis, and has been defined as a:

> type of human engagement that is embedded within a tradition of communally shared understandings and values, that remains vitally connected to peoples' life experience, that finds expression in their ordinary linguistic usage, and that, rather than being a means through which they achieve outcomes separate from themselves, is a kind of enactment through which they constitute themselves as persons in a historical community (Dunne 1993 p. 176.)

Within this context, the research question has been viewed from a fundamentally ethical-moral horizon. This has allowed me to investigate what happened within the nursing home from a cultural perspective within a 'moral ecology'. A 'moral ecology' (Aroskar 1995) asserts, is the "interrelatedness of all the organisms in a system, and informs the idea of nursing as a moral community of interrelated clients, nursing caregivers, and others who contribute to patient care goals" (p. 135). This takes into account the realities of ethical obligations of "a community of interrelated and interdependent moral agents [who] are responsible and accountable for choices and their potential consequences to coworkers, as well as to patients" (Aroskar 1995 p. 136). Brinkman (2004 p. 57) sees the "human world"

[12] I do not entirely agree with this interpretation of the 'hermeneutic circle'. I take Heidegger's detailed explanation in stating that the hermeneutic circle has movement from the whole to the part and then from the part back to whole adhering to the 'medial' or 'middle way'. That is, the whole is 'a priori' and 'constantly a whole' and that the parts and the whole are "interdependent and no longer separate or opposed, even though they are conceptually distinct" (Jackson 1999 p. 549). Within the hermeneutic circle we are dealing in wholes, that is the understanding of each person.

as a moral ecology, since it is "a meaningful world with moral properties that present human beings with moral reasons for action". Brinkman sought to indicate the interrelatedness and complexity of interaction within the context of care provision at both the micro- and macro-levels. This ties in with both Heidegger's and Gadamer's philosophical hermeneutics, which is underpinned by 'praxis'.

Phenomenology, as a methodology, has been used by researchers in multiple ways. It is common, particularly in nursing research, to conduct 'phenomenological' research as an LER, 'lived experience research' study (Paley 1998). Paley claims that such an approach misrepresents phenomenology, and is "a betrayal of Heidegger", since it is based entirely upon "subjective perceptions" and assumes the incorrigibility of the participant (Paley 1998 pp. 817-818). In contrast, I use Heidegger's phenomenology to understand the phenomenon of 'quality care' provision. My focus is to use Heidegger's conception of *Dasein*. *Dasein* - 'the thing in itself' - is the hermeneutic term for ontological human existence. It is contrasted with the term *Verstehen* which corresponds to understanding and interpretation. I use *Dasein* to link *identity*, *praxis* and *practical coping*, in the context of this research.

This strategy sought to place phenomenological insights within the ethnographic context of the individuals' cultural interaction and meanings (Purkis 1994). That is, to 'put the social in', to produce an account consisting of exemplars ('vignettes') that are consistent with the tenets of both phenomenology and combinative ethnography. Within a practice-based discipline such as nursing, work is accomplished between social actors working within a culture, a 'moral community' (Carper 1978; Aroskar 1995).

The presentation of narrative accounts in this thesis reflects the Heideggerian hermeneutic 'ready-to-hand' mode of experience. The 'ready-to-hand' mode is one of Heidegger's ([1927] 1962) three modes of 'being', along with 'unready-to-hand' and 'present-to-hand'. The 'unready-to-hand' mode of experience is a temporary transition mode when something startles you from the everyday 'ready-to-hand' mode of experience. An example of this would be putting the wrong key in the door and finding the lock will not turn. You then question the process of unlocking/opening a door which, in the course of previous successful openings, had never been questioned. In the context of providing care in a nursing home, an example would be whilst giving routinised care the residents questions

how and why the AIN is doing what she or he is doing. This pushes the AIN to the 'present-to-hand' mode of experience to evaluate their care provision.

During the research process, I moved through Heidegger's two other modes of experience, 'unready-to-hand' (a startled rupture of 'habits of the mind') to 'present-to-hand', at which point I was able to commence the category and thematic formations. Within 'present-to-hand', I accessed a constrained 'classic' grounded theory (Glaser 2002b; Glaser & Holton, 2004), whilst working with Gadamer's (2004) triad of understanding, interpretation and application. As the study proceeded I included the perspectives of organisational studies (Weick 1976, 1989; Schein 2000; Bowers 2001) individualism-collectivism (Hui & Triandis 1986) and coping theory (Lazarus & Folkman 1984).

In sum, I followed an ethnographic storytelling focus of vignettes within a descriptive typology (categorising and theme creation) whilst simultaneously maintaining a hermeneutical reflexive 'middle way' perspective (Addison, 1989). The *bricolage* allowed me to create heuristic hermeneutic 'thinking tools' (Bourdieu 1976, 1989), after which I was positioned midway along the nomothetic-idiographic continuum. This midway position is acknowledged by several ethnographer authors, particularly those of the so-called 'literary turn' (Van Maanen 1973a, 1975; Denzin 1999; Richardson 1994, 1999) who adhere to the principle of theoretical insights with narratives. As Denzin (1999 p. 510) states, an ethnography "refuses abstraction and high theory. It is a way of being in the world … it seeks to understand how people enact and construct meaning in their daily lives".

At the same time, however, this research has included a nursing perspective that advocates a review of nursing research and practice (Carper 1978; Thorne, Kirkham & MacDonald-Emes 1997; Tronto 1998) as well as a recognition of nursing being a 'moral community' (Carper 1978; Gibbs & Schnell 1985; Aroskar 1995; Wurzbach 1999; Johnson 1999). The study aims to facilitate the following: clinical competence and the awareness of the care a recipient needs; identifying tools to conceptualise and control practice to create positive change; and to present the results in such a way as to allow their adoption within the culture of nursing. The ethical considerations for conducting the research will now be discussed.

Ethical Considerations

For a general ethical research framework, I looked to Stake (1994 p. 244) who talks about minimising risks to participants, including enabling them to avoid embarrassment, loss of standing and self-esteem. Therefore great care was taken to protect all parties in the research from any risk that could occur as a result of their views being given directly or indirectly during the research. Secondary to the risk consideration is the recognition that my involvement in the research scene, including by conducting interviews, influences that scene; I am in effect, "meddling with the social tissue of an organization" (Turnbull 2002 pp. 118).

Ethical approval was obtained prior to the commencement of the study through the Human Research Ethics Committee of the University of Sydney. To communicate fully the objectives and processes of the research, an information sheet (Appendix E) and an informed consent form (Appendix F) were developed and used. Information about the study was provided to participants prior to participation in the interview. All participants gave permission for interviews to be recorded by digital recorder. The identities of all participants were protected by the use of fictitious names within this study, and identifying information has been removed from this thesis. 'Golden House Nursing Home' is also a pseudonym; details of its location, appearance as well as the activities and routines that occur within it, have been anonymised to prevent it being identified. There was an assurance of anonymity given through the coding of data, and personal details were kept extremely confidential.

Throughout the study all research files and data sources (i.e. voice recordings stored on compact disk, transcripts, field notes) were stored in a lockable filing cabinet, located in my home office as well as a copy being located in my supervisor's office. All the computerised documents were protected by a password within an Adobe Acrobat file format. Only I and my supervisor had access to the data collected during this study. All the data files and voice recording (interviews and reflective memos) were stored in compliance with University policy, and will be retained for seven years in a secure, lockable filing cabinet in the School of Behavioural and Community Health Sciences at the University of Sydney. After seven years of the study being completed the material will be disposed of using the University of Sydney's confidential waste service which is managed

by the University security division. I will keep all these data secure for a further five years at which time they will be destroyed.

Selection of Site and Participants

Selecting the Nursing Home

The site of the research was Golden House Nursing Home. Golden House is situated in a leafy suburban setting in Australia. It is a small nursing home consisting of 64 beds arising from the union of a pre-existing modified large family home - built more than 50 years ago - and a newly constructed purpose built conventional nursing home. The building has street frontage from its original setting and resides with neighbouring large family houses on a quiet suburban street.

There were two reasons for the choice of Golden House as the research site. The first was that they allowed me access without any conditions and secondly, since it had passed the first round of accreditation in 2001, Golden House was due for its second round accreditation. This allowed me to experience an actual accreditation process. Fortunately, in making contact with the Director of Nursing (DON), she spoke on my behalf to the proprietor of Golden House, allowing me to gain access to the research site. The management also allowed me to participate in their daily work and in their preparations for accreditation.

The residents at the time this project was conducted were made up almost exclusively of residents with profound disability such as dementia, mental illness, multiple physical disabilities, and required full assistance from care providers. Only a few residents were autonomous in carrying out their chosen lifestyle within the nursing home. Eighty percent of residents at Golden House are of Anglo-Saxon background, with about 80 percent of these first language English speakers. Of these residents, there were varying degrees of communication difficulties, brought about by dementia, depression, psychiatric or cognitive impairments, illness or physical disabilities brought on by, for example, stroke. The remaining 20 percent of residents speak primarily in a language other than English, having limited English abilities. Overall, only ten percent of all residents are able and/or wished to communicate effectively in English. As a consequence, there is only a small amount of social-based verbal interchange between care providers and residents. Instead, I

heard care providers speak to residents in a manner that has been described as 'elderspeak'; that is, an ageist language style that infantilises older people (Williams et al. 2003).

Participants

The human resources structure of Golden House and most nursing homes in Australia is comprised of the following positions: Proprietor, DON, DDON, RN[13], RN educator, AIN, RAO, GSO (kitchen hand, chef, laundry, handyman). At the time my research began, there was no DDON employed, since the proprietor would not permit the DON to advertise the position. The management structure brings up the issue of power relationships and raises the question: Who has the power? How is this power dealt out? Is it filtered through the organisation? Does a hierarchy exist and/or a democracy and/or worker participation?

The Director of Nursing, DON Nancy, at the commencement of this study, had been in that position for six months. Prior to that she had had no contact with Golden House and knew none of its employees. She therefore arrived at Golden House as an 'unknown outsider' with no prior experience as a DON but with substantial experience as an RN and DDON. As this research project developed, there were changes of the management of staff brought about by DON Nancy, who created a new management team. The majority of the new management team were handpicked from people outside the nursing home, giving the new DON key staff members that she felt able to rely upon. Existing staff, who felt they could not work within the new culture or who became redundant to needs, were encouraged to leave by being made aware of new expectations and that their roles would change with the appointment of outside staff.

DON Nancy had worked in the aged care sector, especially within the nursing home industry, for more than 17 years. The incumbent DDON had been working in the industry even longer, twenty years, having been at Golden House for more than five. Within the first month of my fieldwork, the DDON resigned from her position due, she said, to her family moving to another state but the consensus view of staff was that she left because she had not been appointed as DON. More than a year passed before a new DDON was

[13] The DON, DDON and RNs are referred to as 'sister', which is abbreviated in writing to 'Sr.'. This is an historical Australian/European title but not an official title for signing documents. I believe the use of the term 'sister' relates to both a sisterhood of nurses and recognition of the history of religious-based nursing care. If fact to make a distinction even further Australian's use the term 'sister-of-the-cloth' in recognition of a helper/RN who is a religious sister. The term 'sister' or 'sister-of-the-cloth' is not a term used for example in Taiwan since we don't share that historical background.

appointed, after the proprietor finally gave in to the DON's request for help[14]. This position was filled from the DON's 'brought in' management team.

Golden House has a pool of 13 RNs to call upon. By regulation, an Australian nursing home must have at least one registered nurse present at all times. The registered nurse is required by regulation[15] to offer clinical care and maintain clinical and accreditation documentation. Having permanent RNs has been common practice in Australian nursing homes. Although there are no regulations that require a proprietor to have permanent staff (as opposed to engaging agency staff or a pool of casuals), generally, Australia registered nurses try to seek at least one permanent position[16] to receive the benefits of long service leave[17]. However, common practice in most Australian nursing homes, to my knowledge[18], has been for permanent staffing of registered nurses as a result of a combination of 'best practice', the desire of staff and the convenience of proprietors. We have not had the American problems of high turnover and RN staffing availability, perhaps because of long service leave entitlements.

In Golden House the key permanent day shift RN is Sr. Lily who works Monday to Wednesday on a permanent basis. Another RN, Sr. Helen, is contracted to work as an Educator one day a week and offers herself within the casual pool of RNs. Sr. Au works on the Friday night, Saturday and Sunday morning shifts permanently; she is also responsible for the weekend staff's education. Sr. C works on the Saturday and Sunday night and

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[14] From my own nursing home experience of more than 8 years it is not common practice to leave the DDON position unfilled for such a long time. The new DDON was only in that position for 3 months prior to Golden House's accreditation which would have demanded as an expectation and unstated standard that there was a DDON.

[15] Since undertaking this study there has been a push for Enrolled Nurses (ENs), who have one year fulltime college training and are paid (in 2006) at the rate of AU$15, to administer medication and clinical care instead of RNs, who are university trained and paid at the rate of AU$26.

[16] In Australia you could only have one permanent fulltime shift as a RN within the hospital health care sector, whereas there is no restriction within the nursing home sector. Therefore you could have multiple permanent positions/shifts (day shift (6:30am – 3pm, afternoon 4pm – 9pm, night shift 9pm – 7am) within the nursing home sector or mix with the hospital sector.

[17] 'Long service leave' entitlements accrue over the length of service, and is often taken as payment in lieu of leave when ceasing employment with a particular employer. The generous long service leave entitlements in Australia may be related to the strong unionisation of nursing in Australia.

[18] I could find no statistics of the question relating to permanent staffing positions to hours worked within a particular nursing home. Only recently there has been census taken of staffing levels and types of staff within nursing homes, prompted by the decline in RNs.

Monday morning shifts permanently. All other RN positions are from a casual pool of staff. As the proprietor avoided appointing a DDON for almost a year, this left only the DON who worked fulltime Monday to Friday allowing for a continuity of care. Finally, DONs and DDONs, according to their industrial award[19], are not paid penalty rates[20] for working on weekends and public holidays; consequently they are less likely to work at those times since they will already have worked long hours during the week.

Golden House has a pool of fifty-two AINs to call on. They fill six AIN morning shift positions, four of the evening shifts and two of the night shifts. Golden House also employs two fulltime RAOs, one contract physiotherapist (part-time) who works for three to four hours per month and a trained physiotherapist assistant (senior AIN) to carry out basic physical exercise for residents from Monday to Friday. Within the GSO category Golden House has one full-time and one part-time laundry worker (laundry officer), and two full-time and four part-time kitchen workers (catering officers). They contract out their cleaning and this is done four hours a day, from Monday to Sunday. They share a handyman with another nursing home from the same group of nursing homes[21]. The handyman works for Golden House three days a week, with the remaining two days working at another nursing home.

Apart from the physiotherapy services, Golden House provides a number of services for residents onsite, including: physiotherapy (once a month); aromatherapist (every day); contract hairdressing (every Tuesday); podiatrist (when necessary); optometrist (regular visit); dentist (when necessary), speech pathologist (when necessary); dietetics (when necessary); clinical pharmacist (Government contract) and twelve doctors (either GPs - General Practitioners, or LMOs - Local Medical Officers) who care for patients within the nursing home.

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[19] An award is a determination made by either the Australian Industrial Relations Commission or an equivalent state body. It provides wage earners in the same industry the same conditions of employment and wages as each other.

[20] Penalty rates are increases on hourly rates of pay due to working outside normal conditions e.g., working on public holidays, working in isolated regions, dealing with difficult environmental (extreme heat or cold) or social conditions (war zone).

[21] The proprietor owns another two other nursing homes.

After having provided a basic description of Golden House Nursing Home and its staff, I will now describe this study's methods. The two main methods, participant observation and in-depth interviewing will be described in turn. Within each of these sections, the methods procedures for data collection and analysis will be described.

Participant Observation

My fieldwork extended for more than 28 months and entailed over 500 hours of participant observation. I started this study from the position of the phenomenological rule that it is more important to seek understanding than to be explicitly bound to a methodology, eschewing the tenets of a Cartesian 'scientific' paradigm. My approach was to have a recursively developed *bricolage*, blending an interpretative ethnography (after Van Maanen 1973; 1979) with and Glaserian (1978) 'classic' grounded theory, underpinned by philosophical hermeneutics. As the research progressed, hermeneutics became a much stronger imperative with a more global 'middle way' perspective taking frontstage. This brought to the fore the additional perspectives I gained from reading Bourdieu, Ricoeur and Giddens. Also influencing my perspective was the notion of 'sensemaking' (Weick 1995) and Actor Network Theory (Latour 1987). The interpretative ethnography became oriented towards Baszanger and Didier's (2004) combinative ethnography, whilst Glaser's grounded theory became a Bourdieu conceptualised heuristic 'thinking tool', with a Rennie (2000, 2005 and 2007) hermeneutic underpinning.

Participant observation has been used as a data collection method in ethnographic studies of nursing home for many decades. Two influential ethnographies are those of Gubrium (1975) and Diamond (1992). These two works will be considered here for their methodological insights, which influenced my data collection process. Residential aged care is predicated on routinised structures and physical tasks; Gubrium (1975) describes this as 'bed-and-body' work which lends itself to ethnographic investigation. Gubrium's (1975) ethnography of the nursing home, '*Murray Manor'* was based upon fieldwork observations of care provision and social interactions of staff members and nursing home residents, viewed through the observation window of *routines*. I will briefly consider key issues from Gubrium's (1975) ethnographic study that I found to be relevant to my research. Firstly, management focused upon 'talking', 'planning' and 'making policy' rather than putting a system in place that could make real change and be evaluated. Secondly, staff relied upon and promoted a routinised care model. Thirdly, management

believed that 'the policy' is not to blame for problems, but that it is staff who step outside of the organisation and become individualised carers that is the real cause of problems, and lastly, visitors could act as advocates for the residents.

In a similar vein to Gubrium (1975) use of ethnography is Diamond's (1992) study of the elderly in nursing homes. It too was a valuable source of methodological inspiration. Diamond (1992) like myself, used a participant observation perspective that revealed the power relationships and realities of the elderly within nursing homes and broadened his perspective to including wider cultural drivers upon care provision. What Gubrium (1975) and Diamond (1992) share is their focus upon the value of ethnographic studies which having a long observation window. This allows for a deeper understanding of the complex social dynamics of the organisation counterpoised against its care provider's and the resident's strive for self-identity. In addition, the ethnographies contribute to models of understanding which emphasises the importance of members' constitution of place and the social worlds of residents in nursing homes. It is this development of models of understanding and thinking tools that I wish to develop as an outcome for my thesis.

I have tried throughout the research process to conduct research that leads to 'trustworthy' conclusions, where trustworthiness is the conceptual equivalent in qualitative research to 'validity' in quantitative research (Lincoln & Guba 1985). I have tried to achieve this by the use of 'data triangulation' (Denzin 1978); that is, obtaining data on multiple spatial and temporal occasions, and by 'methods' triangulation; that is, obtaining data by using multiple methods which are described below. In addition, I used rigorous procedures for data collection; field notes were written as soon as possible after events occurred and transcriptions of interviews were checked for accuracy. Data analysis was inductive and grounded in the data and did not impose prior theoretical schemes. I have also tried to convey sufficient information to the reader for them to assess the quality of this research. I have given detailed descriptions of procedures and the processes by which I arrived at my interpretations. Furthermore, as 'reflexivity' is generally considered essential for assessing the quality of qualitative research (Kitto, Chesters, & Grbich 2008), I have throughout described my role in the research as well as reflected upon it.

Specific data collection techniques used in this study were participant observation and in-depth interviewing. The use of multiple data collection techniques has been described "data triangulation" (Denzin 1978). Although triangulation is often used to improve the

'validity' of research since it is believed to assist in accessing the 'truth' (Tobin & Begley 2004), in the hermeneutic approach adopted here, 'triangulation' serves the purpose of highlighting differing facets of care. I will now explain in greater depth my approach to the research. Instead of using the term 'triangulation', I use the term 'blends' (Swanson-Kauffman 1986), since triangulation implies an autonomy of each of the methodologies, while I am seeking a 'coming together', an 'openness' between the methodologies and, to some extent, a loss of each methodology's autonomy. I am seeking a methodological 'fusion of horizons' (Gadamer 1976).

Data Collection Procedures

Starting point

Since the purpose of ethnographic research is to obtain and display, in as much detail as possible, the understandings and meanings constructed by people as they undertake daily activities, I focused upon daily activities and particular routines. The focus on routines is consistent with my study's emphasis in nursing models of care and evaluation (Pearson et al. 2005, Koch et al. 1995; Koch & Webb 1996). At the same time, routines underlie my 'middle way' philosophical hermeneutic perspective on understanding, identity, ethics and *praxis,* as well as 'sensemaking' (Weick 1976).

The central techniques for collecting the data were those of participant observation, in-depth interviews and accessing documentation. In my case, I not only had free access to attend all types of internal meetings or education programs, I also accessed textual data in the form of accreditation reports, carers' meeting minutes, government agencies' reports and complaint documents. These documents resurface through this report of the research. Within the process of collecting data, I also made use of a diary to document my research journey; a reflexive process that heightened my sensitivity to the context and my role in it (Koch 1996; Richardson 1994; Glaser 1978). This personal reflective diary recorded my worldview, and the insights, puzzles and experience that confronted me whilst undertaking this study. All of this was part of the development of my iterative recursive *bricolage*.

Establishing rapport

To establish good rapport with all stakeholders at Golden House was, I believe, a requirement for the success of my fieldwork. Establishing rapport was crucial in encouraging all the informants to have confidence in me and to open up in talking to me about their experience. As staff became familiar with my presence, we all began to realise

that I could offer my experience as a successful quality coordinator to help them navigate through the unknown field of the accreditation system and continuous quality management. Through this fortunate opportunity I gained access to all areas within the nursing home for my research with a legitimate reason for being there and asking questions. I undertook multiple roles in addition to being a visiting researcher; including facilitator, adviser, volunteer clinical educator, recreational officer, tea lady, as well as a mentor of staff through the process of accreditation preparation. My core intention was to be accepted as part of the community of Golden House, giving me access to the complete vista of the nursing home phenomenon - without 'going native' (O'Reilly 2009), whilst at the same time, not being too much of an influence upon it.

Having established contact with key staff members I focused my observation days initially to when these informants were on site; while making them aware of my intentions to ensure that my presence would not become a burden. On average, I spent up to 16 hours a week at Golden House. As all the staff and residents knew that I was, at that time, an actively working RN (in another nursing home) they addressed me as 'Sister Hui-Wen'. In that capacity I was able to assist them when required by perhaps feeding a resident; as such I was genuinely 'participant-as-observer'. I did not want those with whom I came into contact to have the feeling that they were being watched, as would have been the case if I had insulated myself from the community of Golden House and passively recorded my observations. Consequently, I became accepted as a member of the Golden House community, being able to freely move around to observe the intact phenomenon of Golden House openly and without distortion.

I was able to make observations at different times and days of the week. This allowed me to make comparative observations between weekend and weekday care provision. Staff at Golden House perceived me as a 'trouble shooter', giving advice about problems with accreditation and maintaining their quality improvement culture. However, I was able to maintain some distance as a facilitator and was able to observe the actual situation without changing it significantly by my presence.

Shadowing people as an observation technique

As participant observer I quickly became familiar with the day-to-day operation of Golden House. I became involved with the care providers' daily working lives as well as the living activities of the residents and relatives. I observed both day and afternoon shifts, taking on

a variety of roles from active participation, to making observations at a distance, to 'shadowing' a care provider or resident. This 'shadowing', as a data collection technique, enabled me to "observe the very complex way in which the effects of successive commitments in composite situations are embedded in these people" (Baszanger & Dodier 2004 pp. 25-26). The purpose of 'shadowing' a person for a period of time (for instance, from 7am to 5pm or mealtime) was to understand as closely as possible their interaction with people around them.

Positionality and being blinkered

After the initial observation phase, I then went through a reflective stage and started to question what it was that I was collecting and the rationale for what I did collect. This is being reported here, in the spirit of a personal 'confessional tale' (Van Maanen 1979b, 1988). I had to acknowledge that my positionality and embeddedness had an effect upon what I collected and what I refrained from collecting. I realised that this had become an issue and discussed this with my supervisor, coming to the conclusion that I was 'too familiar' as a result of being an 'insider' within the nursing home setting. I had become 'blinkered' from many things around me. My pre-existing perspectives of nursing home care had 'blinkered' my window of observation and its perspective (ability to observe and focus), though I was not initially aware of this 'blinkering'. After my first few visits to the field I started to ask myself what I wanted (or needed) to observe and how (or where) to start.

Because I was so familiar with the environment of a nursing home, I could not divorce myself from being a RN at a nursing home, whilst at the same time attempting to take on the discipline of a researcher. Within Golden House, I had mixed these two positionalities together, placing myself into a position of conflict and confusion. There are many things that can be seen and heard from the field but it all depends upon how one positions oneself as to what perspectives are seen and what are hidden. For instance, as an RN, I had become used to encountering AINs walking past a resident who was visibly disorientated and needing direction, and yet I would not offer help to that resident because I prioritised in my mind the duties for which I was directly responsible. In other words, I had become used to rationalising my own behaviour and those of care providers around me. In Heideggerian terms my 'practical coping', 'ready-to-hand' experience had taken over. I did not see it as inappropriate for either the care provider or myself to neglect or ignore the resident's need

for assistance. This was part of the culture of being overworked and having to prioritise what needed to be done.

Now, as a researcher, I had to step outside my own insider positionality and embedded structure of an experienced RN to start to ask myself why the care providers behaved in such way. This insight brought about focus and direction within my field observations to undercover the facts in regards to these puzzles of care provision, whether what I had accepted as a reality was in fact a falsehood. With effort, I was able to divorce myself from 'the familiar environment' to look clearly to a stripped away view of what 'naturally occurred' in that setting. Suddenly, I was not only seeing clearly from a different perspective but also willing to listen to a different voice. All of these insights point to the growing recognition of my philosophical hermeneutic underpinnings, with the chief aspiration of openness and fusion of horizons and of alternative *Daseins*.

This issue of positionality and embedded structure was a double-sided coin; on the one hand, I had to be wary of it, whilst on the other hand, I could take advantage of some aspects of it. In being aware of this, I was entering the field with 'foreshadowed problems' rather than with 'preconceived ideas' (Grbich 1999). At this point, a more subtle issue emerged parallel to 'blinkering' relative to the insider position. Previously I had been an 'insider' who is familiar with the inside world (nursing home), but now I had become an 'outsider' (researcher) at Golden House, a similar environment but a different 'setting'. Within the discipline of my research of using a hermeneutic circle (Koch, 1996) I reflected within my body of work and my dual positionality and embeddedness, having to consider this duality of the insider/outsider phenomenon. That is, I was an outsider at Golden House and I am an insider as RN already inoculated by an ongoing history of working in the nursing home industry. This inoculation was a strategy for survival within the stressful nursing home working environment; yet while it protected me, it also blinkered me.

Data Analysis Procedures

My observation field notes recorded the daily routines such as showering, cleaning and toileting, within the context of the time-based production-line of care provision at Golden House. Once I had established the routine pattern of activities locked to the daily timeline I sought to record the variations in the provision of these care duties by individual care providers and their interactions with those with whom they came into contact. Using the pattern of routines as a reference, I then was able to record behaviours and activities that

were 'atypical' of daily events, or which did not appear to logically fit into the prescribed stated duties of staff. It was this that gave me cause to reflect upon their meaning; for example, a care provider wandering, joining in singing with entertainers. Having established the range of activities, I attempted to *cluster*, *chunk*[22] and *filter* these observations into categories which allowed me to funnel them into a manageable conceptual whole or gestalt. The process is like a *schema*, an ontological whole emergence of what was always there, waiting for parts to prompt it in our minds. It is less about the parts creating the whole for a totalisation perspective, than an acknowledgement of the 'middle way' perspective of the whole (a prior understanding), the parts to the whole thus working within the hermeneutic circle. Within the manageable chunks of observations, I was then able to note variations between individual care providers creating a stream of variations and connections between activities, consequences and behaviours of care providers.

At the stage of observational saturation, I decided to manually sort the record strips on which I had recorded my observations. Much like putting together a jig-saw puzzle, I sought elements of commonality between individual record strips (in effect, categories) and chunks of ideas to bring the scattered data pieces into a whole relationship. I tried to keep the whole in mind whilst interrogating the data. This involved "opening up" and keeping open to possibilities, since "to truly question something is to interrogate something from the heart of our existence, from the centre of our being" (Gadamer 1975 p. 266). I wrote down my ideas and worked through my fore-structures. From this process came new categories that provided a tentative framework, allowing me to assemble the observational data into a snapshot of nodal significance. From these nodes of significance I then referred to an adapted statistical process of ascertaining the power and frequency of the relationships between each snapshot node, further funnelling all my data to a manageable whole. This is how I developed the schematic conceptual framework diagram entitled "The Eight Interrelated Factors in the Production of Care" (Figure 2, p.164).

At this stage, armed with a tentative conceptual framework (a whole understanding), I went back into the field to check for observational outliers; that is, observations that ruptured the conceptual whole and were brought within the 'present-to-hand' mode of

[22] I am using 'chunk' here in the sense of a series of routines or 'command' stored in the brain that can by 'run' as if on 'autopilot' (Koster 2005). This is similar to Heidegger's 'hammering'.

experience. Thus the task was to work these incongruences back into the whole through the hermeneutic circle, moving to and fro from the whole to the parts and the parts to the whole. I used the real-life observational window of mealtime as a test-site to evaluate my conceptual framework. Once happy with my conceptual framework I next looked to define the relationships between the eight interrelated factors viewed through the observational window of mealtime, producing a schematic diagram of the process of production of care in action. In the end, I sought a confirmation of my conceptual framework through the blending of my observational data, interviews, my reflective diary, my hermeneutic circle and the literature.

In-Depth Interviews

In this section I describe the process of data collection and analysis related to the in-depth interviews with six key stakeholders of Golden House. They are resident Tim; relative Max; RN Lily (Sr. Lily); RN Helen (Sr. Helen); AIN Andrea; and DON Nancy.

Data Collection Procedures

A semi-structured interview technique was used as it allows me to adapt questioning to the participants' understanding of the research topic under discussion. The six interviews took place after more than a year of participant observation fieldwork and analysis, together with informal conversations throughout that period. The individual interviews provided a unique opportunity to reveal each participant's 'own story' whilst bringing together, under common topics, a collective summary of all the interviewees.

The interview topics were based initially upon a set of broad topics (see below) then followed by a set of 'follow up' questions which evolved based upon the ongoing observations and analysis of previous interviews. Within each individual interview there were 'follow up questions' to confirm and understand what 'they had said in their own terms' (Appendix G). The broad topics for interviewing staff were:

- Can you tell me about yourself and your work experience before you came here?
- Can you describe what your work entails? Is there a typical day? What is it like?
- Can you tell me something about the residents? What is it like for you to work with elderly people?

- What are the most and least satisfying aspects of your work here?
- If I were to ask you for a definition of 'care' in a nursing home, how would you describe it?
- Do you believe the residents receive quality care? Why/Why not?
- Are you involved in a direct way with the accreditation process? Can you tell me about that?
- If you could change anything about the way care is provided to residents, what would it be?

The interviews used open-ended questioning techniques focused around broad topic areas including the participant's background and experience in aged care, an account of their everyday work practices in the facility, their views about resident care in general, and the formal quality improvement process in particular, and their evaluations of their contribution. The interviews were semi-structured and varied in their focus depending upon the interviewee and the timing of the interview with respect to the development of the theoretical framework, but shared the following common elements:

- An understanding of their worldview and life experiences that might impact upon their mindset towards the elderly and their 'quality of care' conception.
- A description of care within Golden House nursing home and their understanding of what comprises 'quality care.'
- The interviewee's assessment of whether residents in Golden House nursing home received 'quality care.'
- What was the interviewee's work, life, or relative visiting experiences within Golden House.
- A description of the staff in Golden House in regards to an evaluation of their personal characteristics, working style and relationship with colleagues, residents and relatives.
- The factors that might impact upon the 'quality of care' in Golden House.

- The importance and impact of Accreditation to oversee 'continuous quality improvement.'
- The interviewee's perception of the elderly and in particular residents within Golden House.
- How would the interviewee improve the 'quality of care' for residents at Golden House.
- The hypothetical question of "If you could change anything in Golden House, what would it be?"

The Interviewees

The interviewees[23] were purposefully selected (Silverman 2005), on the basis that they would be able to give diverse perspectives relative to the question of the conceptualisation of 'quality care' and provide insight into the theoretical development. Initially I had intended to interview only care providers. However, I decided to widen my perspective to include one resident (Tim) and one relative (Max). After 13 months fieldwork at Golden House, I conducted the first interview. Some information about the individual participants is given below.

Resident Tim

Tim was one of the few residents at Golden House Nursing Home who was mentally alert (not suffering from either dementia or a mental illness) and at the same time was able to communicate without any impediments caused by problems with language, hearing or speech. We had many informal conversations prior to this interview where we talked about his life in and outside of a nursing home, together with his thoughts in general, covering issues such as his criticisms of politics, people and other residents within the nursing home. During these informal conversations and from considering what Tim talked about, I realised that Tim's voice (his ideas and perspective) would add richness to my research journey. As Tim said to me that *"… just come to talk to me, I tell you everything you want to know!*". I was therefore pleased having gained his trust that he happily agreed to participate in the research project.

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[23] In Chapter 5, I give a summary of the characteristics of each the interviewees.

Relative Max

Relative Max became my second interviewee. Max was one of the many relatives who had involved themselves within the everyday activities of Golden House. He saw himself as the residents' (his father and others) advocate. Max volunteered to help Golden House in many ways, for example assisting staff with shopping for supplies, repairing broken furniture and building a kennel for Peter, the pet therapy dog. Basically Max sought to be known to all staff with the belief that this would engender good care delivered to his father and at the same time his presence would act as a deterrent to care providers in a vigilance role.

Max made a traditional Italian lunch and dinner every day for his father, washed and provided a change of clothes and stayed with him at least four or five hours each day at Golden House. Max was the dutiful son as part of his Italian tradition/obligation but as revealed in the interview did not admire his father because of the way his father had treated him. Max tried as much as he could to provide, and encourage Golden House to provide, the best available care. For example Max donated to Golden House an expensive lounge suite that was familiar to his father so that his father would have a sense of home. His father reacted positively to the lounge suite, taking up residence in the foyer where it was placed.

Max's involvement presented the horizon of the relative and an informed participant observer as his work experience as a cleaner within a large international company gave insights of the workings of an organisation. He was able to provide me with his views of the organisational culture and how that applied to Golden House in the context of issues such as housekeeping, food services, quality of staff and management. I suspect that Max made the complaint to the Department of Health (about physical abuse of his father) that brought Golden House under investigation and later reaccreditation by the Accreditation Agency, with sanctions being imposed upon them. The complaint incident serendipitously changed the direction of my study as it brought a body of data regarding issue accountability and the validity of the accreditation process.

Sr. Lily

My third interviewee was RN Lily (Sr. Lily). The main reason I asked Sr. Lily to participate in my research was that she was one of the few registered nurses who held a permanent position at Golden House. She worked the day shift Monday to Wednesday as well as being a casual available to fill gaps in the work roster at other times, including

weekends and even night shifts. Consequently Sr. Lily's variety of shift experiences, allowed me to gain an insight into the different groups of care providers and their construction of quality care. Sr. Lily's experience of a range of shifts allowed me to develop the idea of nursing shift subcultures based upon the work of Brooks (1999) and a focus on the handover procedure between shifts (Payne, Hardey & Coleman 2000). I became particularly interested in the changeover between the weekend and weekday shifts.

Sr. Lily is a talkative person, as she describes herself:*"…always has something to talk to people."* She smiles and laughs all the time, although she also displays a strong mind and determination to carry out her own ideas about management and delivery of care. Her management style drew my attention because she always follows staff and talks to everyone (resident, relative, visitor, staff, management, and visiting doctor) which, from my point of view, mirrored a hermeneutic openness and seeking of understanding. Sr. Lily's hermeneutic openness and seeking of understanding relates back to the *middle way* position that underpins this thesis which needs some further clarification before moving on to describe the other participants.

The middle way position reflects Gadamer's ([1960] 1975, 2000) focus upon a holism as being within the hermeneutic circle, his insistence of *being-in-the-game* which operates at "a level that is prior to dichotomy of subject-object". This 'being-in-the-game' position is analogous to playing a piano; you may not be focussing on the technique of striking the keys or reading the notes from the music, but rather you may be enveloped in the interpretation and presentation of the music. This corresponds to the understanding can exist between people during a discussion. Within interactions between people, events and culture, there is interdependency between the "I" and the "Other/Thou". This is a necessary condition for understanding. A position of 'openness' challenges the individual's own horizon, allowing a movement towards a 'fusion of horizons' with others. Looked at from this perspective, a 'fusion of horizons' is akin to 'empathy', in placing the self in the shoes of another to seek their perspective while at the same time reflecting upon one's own perspective. It does however, go deeper than that, as Gadamer (1989 p. 361) explains:

Openness to the other, therefore, includes recognizing that I myself must accept some things that are against me, even when there is no one else that forces this on me … it is the other, who breaks my I-centeredness, by presenting me something to understand" (Gadamer, 1986, cited by Schmidt 1996 p. 267).

Sr. Helen

The fourth interviewee was Sr. Helen. With her roles as the Educator and Quality Coordinator, Sr. Helen was also my point of contact to develop informal working relationships with the staff at Golden House as I helped them prepare for accreditation and developed some educational resources for them.

AIN Andrea

AIN[24] Andrea became my fifth interviewee. Andrea was a good informant because she had worked at Golden House for over 23 years and appeared to be the key care provider/mentor and role model for novices entering Golden House. This expert to novice relationship allowed me to reflect upon Benner (1984) but to widen that orientation to encompass the role of sub-culture adoption which became the major theme of this study.

Most novices were attached to her for initial training and orientation as she set the standard of care provision by the example of her own work and team working. In the interviews with Resident Tim, Relative Max and Sr. Lily they all spoke of AIN Andrea being a good nurse and giving good care that could be trusted. In particular, in Max's interview, he mentioned Andrea in regard to the issues of appropriate care, resolving complaints and his general feeling as to whether care provision could be improved at Golden House. From my own observations of Andrea she worked without rest and was constantly looking for ways to service the care needs of the residents, whilst some other care providers wandered away or stood with their hands in their pockets.

DON Nancy

The last person to be interviewed was DON Nancy. The DON should be the key informant in any nursing home, as she manages the day to day running of the nursing home. The DON is the key person to implement the business goals of the proprietor whilst attempting to fulfil the criteria of the standards for accreditation. The DON is the first point of official contact with any nursing home and the conduit for a researcher access to other informants

[24] The Australian designation of AIN, is an industry recommendation that has become prerequisite for working in a nursing home as encouraged by the Aged Care Act (1997). The course is based upon a 1 year full-time apprenticeship model, comprising 400 hours of classroom teaching and clinical observation. Alternatively, people may undertake the coursework and then seek a clinical placement (at reduced hourly rate) in an obliging nursing home which may lead to a position. Those unqualified but having current employment within the industry may undertake the coursework to gain the qualification.

within the nursing home. The DON is a key player in setting the climate and organisational culture of a nursing home through her implementation of the management strategies, the selection of staff, liaising with the proprietor, as well as public relations.

The DON is very much like the captain of the ship attempting to steer it into calm waters and avoiding danger whilst, at the same time, being controlled in the background by the proprietor. The DON is the public face of the nursing home, being praised when things go well but becoming the scapegoat when things go badly. DONs appear to wield power but, in reality, are at the mercy of the proprietors who control key variables influencing the production of quality care outcomes. With the coming of the Aged Care Act (1997) the process of accreditation changed, bringing into play a new set of tasks and responsibilities for DONs with little or no support for them to be able to adapt to that sea change.

The Interview Situation

The interview locations varied, for instance, in resident Tim's case, we talked primarily in the privacy of his own room, whilst the interviews of relative Max and Sr. Lily took place in the private meeting room of Golden House. The other three interviews were conducted outside Golden House, in the privacy of participants' own homes, this being their preferred location where they felt comfortable to talk to me, either in their study room or around the kitchen table in the presence of a family member.

Interviews with staff lasted on average one and a half hours, but the interviews with resident Tim (2hrs 45m) and relative Max (2hrs 45m) were longer than expected. Max, in particular, had prepared for his interview with three to four pages of notes and presented great detail and insight into the phenomenon of nursing homes as posed by my questions. Digital recording was used in all interviews as being non-threatening, the presence of the recorder being quickly forgotten and producing a digital format that could be easily accessed with software applications.

Data Analysis Procedures

Organisation of data

I transcribed both observational and interview data in full. I recorded as much as possible, all aspects of data that would help my understanding, even such details as speech patterns (pauses, inflexions, stutters, mannerisms, slang) and body language (Turner 2003). I added asides in the text to help refresh my initial understanding of what had been said. The

transcriptions were recorded in a table consisting of five columns. The columns were: possible category/theme notes, time, who (spoke), the text of what was said (transcription); and a reflective note that might lead to a future thematic understanding. The process of accessing this large amount of data and utilising it was helped by consultation with my supervisor (Appendix H) and by consulting the work of Silverman (2000, p 68) who led me to ask what *puzzle* am I trying to solve? What is the whole picture of the puzzle?

I chose to use paper-based card index sorting and allied Microsoft Word procedures to organise the data from the interviews. I utilised the technique of making screenshots of expanded and closed versions of the categorical hierarchies with the Outline view of Microsoft Word from interview transcriptions and my developing grounded theory. For the data from the observations I used physical sorting of observations that were then transposed into a preliminary concept map of a tentative grounded theory. Data incidents were cut in paper strips and manually sorted.

Initially I chose to create a table format within Microsoft Word but this proved to be cumbersome so I eventually developed a very simple text file of transcriptions sections and comments. The sections of transcriptions were colour-coded as well as meta-tagged with key words of developing themes and categories to aid in later searching. Once each transcription was completed, copies were made to allow for rearranging and forming into clusters of key themes and categories; to facilitate this I utilised the 'Outline' view within Microsoft Word. This function allows for the manipulation and display of segments of text that are stored within hierarchical paragraph headings allowing for the nesting of related segments and the movement of those sections within the total document.

Procedures for Analysis of Interview Data

To analyse the interview data, I listened to the recording of interviews to access any emerging concepts or themes that may require further elaboration or that could be incorporated into subsequent interviews. This process helped me to develop an evolving theoretical framework born from the observation stage and ongoing interviews that gave me focus and clarification to continue my interviews. According to Wolcott (1990, p. 18), "the major problem we face in qualitative inquiry is not to get data, but to get rid of it!". Following Wolcott's advice I set out to navigate through my data and map connections of commonality of thought by each informant, binding these ideas onto a conceptual skeleton

of shared themes. What emerged from this process was a different focus from my initial theoretical framework but at the same time consistent with it.

The results of the analyses of fieldnotes and interview transcripts were further analysed and synthesised. The resulting analysis is presented in this thesis.

Afterword

Some events and management changes at Golden House after I completed my data collection are significant and relevant to this study. After the big push for accreditation and its successful outcome, Golden House entered a period of laxness, either through key staff taking leave or care providers becoming laissez-faire. This situation is similar to Lieberman and Cheemalapati's (2003 p. 2) "'yo-yo' pattern of compliance in which facilities correct deficiencies one year and have recurring problems the next". This culminated in an incident whilst the DON was on holiday. Max's father either had a fall or was abused by a care provider. With the DON away the situation got out of hand. A stronger complaint of physical abuse was made which brought in the Department of Health and later triggered ACSAA to subject Golden House to a re-accreditation process.

In the midst of the crisis the DON returned and became the scapegoat for Golden House's problems. When she could no longer cope with the stress, she applied for, and was granted, long-term sick leave just before the sanctions were imposed. With Golden House in disarray, those staff who were able to leave, left. Subsequently, Golden House failed to meet the standards of accreditation arising from these investigations and failed to retain accreditation without sanctions being put in place. With the DON's reputation tarnished, the DON never returned to Golden House. I was interested to follow up these incidents as three cycles of new management came in for a brief time and then left, leaving Golden House in further disarray. They would not support me to continue my study at Golden House and I have not returned since.

In-depth interviewing provided me with an extremely rich body of data which, combined with the observation analysis and my own reflective notes allowed me to develop and explain my theoretical framework. The following chapters present my findings, beginning with an account of actual care delivery at Golden House oriented around the observational 'window' of mealtime.

The following two chapters present the findings of the research.

CHAPTER FOUR: DELIVERING AND ASSESSING CARE AT GOLDEN HOUSE

This chapter presents an account of routines and practices within the frame of 'a typical day' at Golden House. The ethnography narrative is a composite of over two years of participant observations of the actual care provision in Golden House. The aim is to show how 'care' is embodied within everyday life at Golden House and to provide vignettes that define key aspects of care provision. These vignettes are presented as stories about everyday routines at Golden House through capturing which it is possible to compare practice as of different care providers.

From a research perspective, "mealtime" is an excellent observation and analysis window for the following reasons:

- Mealtime allows for an observation of interactions between residents, relatives and service providers; it is the main opportunity for social interaction within the nursing home.
- Mealtime is an activity that is recurring, essential and important to the wellbeing of the resident (Davies & Snaith 1980b; Pearson, Burghardt & Nay 1997; Gastmans 1998; Burger, Kayser-Jones & Bell 2001; Pearson, Hocking, Mott & Riggs 2003; West, Quellete & Quellette 2003)
- Mealtime involves a cross section of care providers in its preparation, budgeting and delivery.

Mealtime is one of the most important aspects of care provision for the wellbeing of residents; at a minimum, it is essential for adequate care within nursing homes, as its poor implementation may lead to residents' malnutrition (Gaskill Black, Hassal, Sanders & Bauer 2008). As a social process, it involves a relatively short series of recurring actions and possible vignettes that are played out each day in a nursing home. Within the mealtime routine there is a subset of aspects to choose from such as mealtime communication, interaction activities and feeding activities. Each of these presents a variety of observable

acts by care providers such as being responsive to verbal and non-verbal requests, feeding technique, maintenance or reduction of resident's agency and autonomy and so forth.

In fact, I would argue that a microcosm of quality of care, mealtime becomes one of the most telling activities allowing a snapshot or distilment of general care provision within a nursing home. If care providers can't get mealtime right I contend that this is a strong indicator of the type of care given across all activities within a nursing home. As well as being as an important activity in itself, I will argue that it reflects the overall standard of care. The following are drawn from my observations meal service in private rooms and the public dining room at breakfast, lunch and dinner.

Vignettes: Weekday mealtime: The public place

By 8 a.m., most residents have already had their shower and are nicely dressed. Most are sitting up waiting for their breakfast to be served in the dining room or their own rooms. Others, however, are falling asleep in their chairs, possibly because they have been woken so early (5am) or because they regularly fall asleep during the day. An outsider might wonder why. One explanation may be that residents who wear incontinence pads need to be checked every two hours throughout the night, while those who need to be positional turned are woken every two hours during the night. There are two dining rooms in Golden House, a large (over 20 seats) dining room in the new section and a smaller one (up to about 10) in the old section. They are serviced by two teams of three staff members. AINs Sonia and Elaine, both very senior AINs, work full time during weekdays in the new section of Golden House. They provide care firstly to residents needing to be fed in their rooms before joining the last member of their team in the large dining room catering for the majority of self feeding residents.

As mealtime is a key activity demanding all available hands, other staff members pitch in at breakfast and lunch to deal with the workload. Consequently, kitchen staff assist in serving and picking up meal trays. I also observed two Recreation Activity Officers (RAOs) who are normally timetabled to normally start their shift[25] just after breakfast (8:30am),

[25] AIN shifts are the following: day shift 6:30 am to 3pm; afternoon 1:30pm to 9 pm; night shift 9pm to 7am. RAO shifts are: day shift and weekday only 8:30am to 5pm. Catering staff (chef and kitchen hands) have a designated shift the same as AIN day shift but in reality work unpaid depending on their commitment at least one hour before the shift starting time.

joining in to help the AINs in the task of offering breakfast to the residents. Also during weekdays there is one GSO (General Service Officer) Tina, who is actually laundry staff, who helps out, plus Sarah the aroma therapist who helps at lunch time.

In the centre of each table, ostentatiously clad in a bright table-cloth, there is a single plastic flower - perhaps intended to symbolise a "restaurant experience". Old style country music is playing on a radio in the background of the chattering of voices. Care providers present the resident's breakfasts on individually name-tagged trays. This is both to ensure dietary specific meals go to the appropriate residents and to provide an attractive food presentation. This is intended to encourage an interest in the meal to maintain nutrient intake and as a symbol of care to the resident. There is an effort to give an impression of at least a hotel style of breakfast delivery and presentation rather than that of a production line kitchen.

AINs take their time feeding those residents (about half) who require assistance, placing a napkin around their necks to cue them that they are going to eat and to prevent mess. They talk to them and to other care providers, thus creating a sense of a communal social setting. At breakfast there is no evidence of attempting to rush the residents to complete the feeding task; instead there is laughter all the time within a relaxed atmosphere. The kitchen lady comes out of the kitchen to talk to residents and receive feedback that the residents are satisfied with their breakfast and that everyone has had enough to eat while she cleans away the finished cups and plates.

In general, the weekday breakfast takes up to 45 minutes to complete (similar to the main meal at lunch time) with everyone appearing calm within a peaceful early morning social activity. After the remnants of breakfast have been taken away to the kitchen, the care providers clear the dining room and then hand the care of residents over to the two RAOs before going for their own 10 minute break. The RAOs rearrange the breakfast table settings to accommodate their activities. After returning from their break, the AINs finish showering residents before handing them over to either the RAOs, the aroma therapist or the physio aid. At this time the RAOs inform the residents of the activities for the day.

Andrea and Mary: The private face of mealtime

The following vignette presents my participant observation of AIN Andrea who, I believe, is archetypal of a conscientious care provider with high levels of self-accountability. The

observation situation is of Andrea feeding the challenging resident, Mary, who has dementia and is totally dependent. It takes place in Mary's private room. Care provision sometimes occurred away from public settings (such as the dining room), where staff actions were open to scrutiny. In this vignette, I was as a participant observer as I fed another resident in the same room as resident Mary was being fed by Andrea.

Andrea has a set of routine approaches to feeding the residents. She asks the resident, "Are you hungry?" Then if the residents do not respond promptly, she tries to focus their attention by perhaps shaking their body at the shoulder, very gently. Andrea needs to use one hand to hold (control) the resident's hands and the other to spoon feed them. If the resident keeps talking it is very difficult to feed them, but Andrea feeds this type of resident and keeps talking to them, not allowing the resident to dominate the exchange. I observed Andrea leaning next to the resident's ear and saying:

> Mary, lunch, you have to eat, Mary, just eat, I give you lunch, I give you lunch, and I take you go back to the bed, Mary, please eat lunch and be quiet.

She takes her time, spending more than 25 minutes to feed some residents. Andrea does not rush residents, unlike some other care providers. If, for example, Mary starts coughing because she has not swallowed her food properly, Andrea will wait for her to regain her composure. According to Andrea, Mary needs to be pushed; if you continue feeding her she will finish it all, but very slowly. Andrea said to Mary "Don't talk too much, or else you will choke!" As Andrea reported to me,

> I found that many nurses don't finish feeding Mary, I saw that myself, I feel very bad, so I always feed the difficult one when I'm the one on duty.

Andrea uses directive talk to make the feeding successful and pleasant for the resident. She says that she says things like, "Listen to me, I am going give you some to drink." Otherwise, Andrea says Mary will start being noisy again, rather than focus on eating. At the same time Andrea clasps Mary's hand tightly to keep her attention on the feeding activity. Andrea told me that Mary's son comes to visit, but every time only for a short time then leaves, with Andrea saying that she never gets the opportunity to talk to him. "A lot of residents have nobody." I observed on several occasions that Andrea would take responsibility for the entire group of difficult residents, while leaving the easier residents

for her team members to care for. On this occasion she had let me feed a resident who had no difficulty eating and was a faster eater.

The novice and the mentor

After I had fed this resident, we were joined by AIN Wendy. Andrea talked to Wendy about various specific meal and feeding requirements and did not digress into unrelated chit chat. Andrea answered very patiently all the questions that the novice AIN Wendy asked, and appeared happy because she took those questions as an indication of Wendy's *engagement* (Kahn 1990, 1992). Andrea told me that there are about nine (of a total of 20) residents who need to be fed in this section of Golden House. What impressed me was Andrea's patience with her novice team member, her demonstration of interest in the novice's questions and Andrea's thoughtful responses. It appears to me that Andrea takes pride in her work and places importance on what she and her team do for the residents at Golden House.

The vignette also shows Andrea acting as a mentor to AIN Wendy as both of them continue feeding the residents. Andrea is also modeling behavior, such as using small talk voice to capture the attention and interest of the residents. For example, Andrea said to resident, Joy, "You are a very naughty girl today, Joy!" (Joy had apparently "played up" when Andrea showered her that morning). Andrea spoke to resident Joy, not at her (Williams et al. 2003), including her in our discussion even though she may not be able to respond, rather than as a topic of our conversation. AIN Wendy mirrored Andrea's example by saying to a resident, "Come, come on, finish your drink, you can do it!" raising the pitch of her voice in encouragement. I observed that AIN Wendy followed Andrea in what she expected her to do.

In comparison, I observed other care providers talking at residents, not wanting or expecting a response from them as they used them as a focus of conversation with a third party. When Andrea was not around, the same novice care provider AIN Wendy gave up feeding Mary within ten minutes, even though Mary had received less than half of what Andrea achieves on a daily basis. AIN Wendy stated to me that Mary was not hungry but on reflection about feeding and other tasks performed by AIN Wendy and her team members, it seemed to me these care providers demonstrated a consistent mindset of allocating equal time to achieve the completion of tasks irrespective of the resident's individual circumstances. In the informal conversations I had with those care providers

they explained their rationale that every resident had to be fitted into an allocated time within the care provider's schedule to allow these care providers to take what they received to be their hard won "*extended breaks." T*hese longer breaks are not supposed to happen as care providers have regular designated rest breaks. These extended breaks are in addition and are taken even though they may not have successfully completed their tasks. Here we have a conflict of nursing home cultural and ethical values or, an issue of *praxis*. Although working quickly and efficiently is laudable within high workloads, it should not be at the expense of quality. It appears to me the prime motivation of some care providers is to work quickly in order to have extended breaks rather than using the designated time to provide quality care.

Outpointing and priority Run

This behaviour I gave the term *outpoint* to designate the point in a process timeline where one may leave the task having made an attempt, but not having completed the task due to variables outside one's control that would be accepted by one's colleagues (for example, the resident was 'not hungry' or 'uncooperative'). The intention would be to return to the resident after a break to reattempt the task or allow a colleague to make an attempt. This *outpointing* strategy would be deemed acceptable within a nursing home culture but would be dependent upon the follow-up being instigated. The problem is that some care providers abuse this strategy by working to the *outpoint* but not enacting the follow-up, placing an ethical weight upon their colleagues to do the follow-up.

This scenario creates a *symbiotic* relationship between two ethical sub-cultures, those of one group who leave tasks unfinished (having reached the *outpoint)* and those who feel obligated to take up the slack and complete the task even though they had already fulfilled their own obligations. A similar strategy to *outpointing* is that of another designated the term, *priority run*. A *priority run* is when a care provider would be expected to deal with an incident because of their proximity —a resident requires or seeks attention such as when toileting is needed or an attention buzzer pressed—but the care provider indicates that they are already involved in a higher priority task and can't deal with this issue as they deem it of a lower order. Consequently this lower order incident will be addressed by another care provider allowing the nearest care provider to deal with the higher priority. The concept of *priority run* is based upon trust that the initial care provider has a legitimate claim to a higher priority. It seemed to me, however, that some care providers use it a trick to avoid

work tasks they find unpleasant such as toileting. During my "shadowing" of several care provider I observed them abusing the concept of priority run when there was in fact no higher priority for them to go to. I describe these care providers as active *wanderers,* embarked upon *phantom priority runs* whilst projecting an ethical façade of a busy committed worker.

Care providers like Andrea have taken it upon themselves with/without direction for main to take up, slack lift by wanderers. Other care providers prefer the looseness[26] of not being able to be held accountable with a custodianship designation. This would not allow outpointing or priority run to be used to avoid work commitments.

Weekday lunch

Lunch is the main meal of the day in Australian nursing homes, which (unlike hospitals) only operate a single shift in the kitchen. This is done to save money. Nursing homes like to get the most out of the kitchen staff's time and avoid run over time, by having lunch as early as possible. Nevertheless there is a nursing home industry norm[27] that lunch should not commence before 12 midday. This is adhered to by the weekday staff of Golden House but not by the weekend care providers. As mentioned earlier, from my experience, most of the catering staff begin work (unpaid) at least one hour before their shift commences so as to avoid being rushed off their feet by fitting into the *routinisation*[28] of nursing home care (Koch & Webb 1996).

At lunch, there is an atmosphere of social engagement similar to what prevails at breakfast. Most of the care providers make themselves available to help out at lunch. Normally there are six AINs, two RAOs, one laundry staff member and one aroma therapist helping residents with their meals in either of the two dining rooms or in the residents' room. This

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[26] Looseness could I believe be similar to Weick's (1976) idea of care providers seeking to be decoupled or within a loosely coupled system or in Granovetter's (1973) sense having weak ties.

[27] A *norm* is practice that people follow but that there is no law or regulation to police it, rather it is a self-imposed ethic. A similar *norm* is that resident should not be put to bed before 4:30pm. I believe these norms exist out of an attempt to be seen to 'do the right thing' in terms of that the practice would be reasonable to expect from an ethical perspective of offering quality care and would be well looked upon by quality assessors.

[28] Koch & Webb (1996, p. 955) talk of "The term 'routine geriatric style' was coined by Baker (1978, 1983) to describe the 'conveyor belt' way of organizing care in the wards she studied."

number is usually swelled in by the presence of five relatives, who assist their resident family members in the main dining room, and several others who daily bring in homemade meals for their parent to be fed in their rooms; relative Max is one of these.

My observations during weekday breakfast and lunch mealtimes suggest that care providers seek to maintain and develop the highest level of functional ability of the resident. They do this by encouraging a variety of levels of feeding from autonomous (self feeding) to supported (cutting up food) to total dependency (placing food into the resident's mouth). As with breakfast, the main lunchtime meal is not rushed and the residents are encouraged to eat their fill. Some of the AINs in particular are very patient, questioning and encouraging the residents to eat. The duration of the similar to breakfast: on average up to 45 minutes to complete the full cycle by preparing the tables for the next round of recreation activities. As part of the philosophy of providing a "restaurant experience", as well as maintaining the quality of the meals and a sense of autonomy for residents, they are asked by the care providers to rate their meals. Overall, what I observed of Andrea's interaction with Mary, and of weekday mealtime provision in general, adhered to the relevant care outcomes of the government's Residential Care Manual; in particular the guidelines, *Nutrition and Hydration, Behavioural Management*, *Choice and Decision-Making* and *Catering, Cleaning and Laundry Services.* Copies of the relevant guidelines are provided in Appendix I. Andrea provided Mary with empathy and understanding of her fears and dislocation brought on by dementia, and was able to successfully feed Mary and other difficult residents in a way that respects the person's agency as meeting appropriate nutrient intake values. In other words, while Andrea was around, residents received good quality care. Not all weekday mealtimes, however, produced this kind of result, as the following vignette demonstrates.

Resident Alma: a 'wanderer'

Resident Alma has a short concentration span with limited communication skills due to dementia. Her personality can quickly swing from sociable, saying 'hello' to everybody to argumentative when confused or not getting her own way. Aided by a walking frame, Alma is the wandering 'Queen of Golden House' to avoid conflict she is given a wide berth by care providers and residents alike but needs physical assistance to be seated from a standing position. She prefers to sit by herself at a portable bed table for meals and has her own seating requirement of a high backed chair (for back support) with arm rests.

Upon her *throne* she sits on an air ring (cushion), holding her own drinking cup filled by her own supply of juice that is provided by a relative. With the day shift AINs fulfilling Alma's requirements, she is content to follow this familiar routine which has a calming effect on her and makes for a peaceful mealtime.

The following vignette demonstrates the haphazard approaches of two AINs, Vicky and Shinny, who, by disregarding the individualised care and communication strategies of Alma, who has dementia, turned a normally successful meal into one of conflict and confusion. The following scenario occurred during a weekday evening meal timeslot outside the influence of the dayshift care providers, such as AIN Andrea. In shadowing resident Alma's normal evening meal routine, I observed her hovering, waiting to be seated on her 'throne'. Instead of attending to Alma, AIN Vicky cared for other self-feeding residents. When AIN Vicky eventually turned to Alma, who had wandered off, she tried to stop this by directing Alma to an unfamiliar seat next to another female resident. Alma hesitated knowing that this was not her usual seating arrangement and became confused:

AIN Vicky:	'Alma sit here (pointing with her finger and pulling the chair away from the table as a visual prompt)!'
Alma:	'What I do!'
AIN Vicky:	'Eat!'

AIN Vicky then placed Alma's tray down on the table, pulling the chair out further for her to sit down (a visual prompt). AIN Vicky demonstrated her impatience with Alma's hesitation and slowness by walking away to attend to another resident, leaving Alma mid-stream in a state of confusion.

At this point Alma started to get agitated; she didn't know whether she should sit down or follow AIN Vicky to her customary sitting arrangement. With Alma looking around for help and direction AIN Shinny, who was feeding other residents at the same table, started to seat her in an unaccustomed chair with Alma resisting, pushing AIN Shinny aside and wandering off visibly upset. None of the AINs at this point followed Alma, who walked out of the room and disappeared down the hallway, clearly disgruntled. She did, however, eventually return to the dining room herself but on returning late did not receive her meal at that time. I do not know whether a meal was given to her later on as the meal routine had reached its *outpoint*.

Not all AINs are blessed with Andrea's altruistic nature or consistently follow and adapt individualised successful care delivery strategies for the residents. What Alma's incident reveals, I believe, is a lack of *engagement* (Kahn, 1990, 1992) by those care providers who appear to work within a very narrow receptivity of the resident's needs. They tend to generalise all the residents as being the same, offering a common basic recipe of care provision that ignores individual needs of each resident. At the same time, I believe, this lack of *emotional engagement* was a 'coping strategy' (Folkman & Lazarus 1980) to numb themselves from the challenges faced in the stressful working environment of nursing homes.

In this case the care provided did not fulfil the requirements and expected outcomes of the standards and guidelines. Without the influence of AIN Andrea, AIN Vicky reverted to the care provision approaches of her peers. This brings up the issue of whether a care provider's care delivery is dependent upon the supervision of others in terms of accountability, is autonomously constructed by themselves or is influenced by their peers. It also raises the question of the influence of team work upon the quality of care provision as opposed to working alone where the care provider is only accountable to herself. Tied to these issues is the notion to which I have previously referred as *loose* versus *attributed/fixed* accountability; that is, whether or not the care outcomes for a resident can be traced back to the care provider.

Weekend meal services

The following four vignettes presents weekend mealtimes. In comparison to weekdays, on weekends there are only six permanent[29] part time AINs - missing are the two RAOs, one GSO and one aromatherapist who normally works at lunch time. On weekends, Golden House is effectively understaffed by three or four people. This lower level of staffing during weekends is common across the nursing home industry, and may be intended to contain costs. Therefore, at Golden House, there is only one RN in charge with six AINs on the morning shift, and four AINs in the evening, one cook and kitchen hand.

[29] In Australia a worker normal hours is 38 per week, above that they have to be paid overtime which is equivalent to weekend penalty rates. The weekend AINs are employed as permanent part timers which grants them their penalty rate but they can also work during the weekday up the collective total of 38hrs.

These particular weekend care providers are permanent part timers who have worked at Golden House on weekends for at least the last six years. In conversation with me, they revealed they have another permanent part time job in another nursing home as well as permanent full time weekday jobs in the other nursing home. Two of the weekend AINs are a married couple who work in multiple nursing homes seven days per week, up to a total of 91 hrs each per week. From my experience as both an AIN and RN within the nursing industry, I know that this is common practice among both groups. RNs, for instance, can work full-time weekdays in a hospital and have multiple part-time weekend positions within nursing homes. The four vignettes were characteristic of what I observed regularly over 2.5 years. Each illustrates a different aspect of poor quality care during weekend breakfast mealtimes, and demonstrates the generally poor environment within the dining room.

Environment

In the dining room, I noticed that the room was starting to heat up as I felt the heat of the sun coming through the open window. The outside temperature was expected to reach 36-38° C on that day but most of the residents were seated, at an open window. On such a hot day the expected practice would be to close the windows and curtains and have the air conditioning, or at least the fans turned on. The room temperature in the big dining room remained too high, risking dehydration and heat stroke for the frail residents, apart from it being an uncomfortable environment.

Although this dining room was part of the recently opened extension and had an integrated air conditioning system, the proprietor had disabled it to save money. Therefore the care providers had only one big fan, which they had turned on. Unfortunately the fan was useless when the curtains, window and door are all open; allowing heat to engulf the room. As well as being too hot, the residents were exposed to alternating periods of bleak silence and blaring rock music coming from a television turned to MTV[30]. Even if anyone had wanted to watch the television, its location directly opposite the window meant that it was virtually impossible to see.

[30] Music Television, a program of rock music videos.

Clearly the weekend care providers had less consideration of the negative effects of environmental factors on the quality of the experience for residents during mealtime than their weekday colleagues. I consistently observed this failure to create a pleasant, conducive environment for mealtime. I could not understand why the care providers left the residents in such an obviously unpleasant environment. All they had to do was turn on the radio when they passed it, close the curtains and window and turn on the fans before the room became too hot. Providing a comfortable environment for residents is a core component of AIN training— at the same time, the staff on duty did not ensure that this was done. Interestingly, neither spot checks nor accreditation are ever carried out on weekends. Is this because DONs and DDONs can't work on weekends? And what does that say about the validity and reliability of the accreditation process?

Weekend burnt toast

During the whole period of my observations the toast given to residents at weekends breakfasts was invariably burnt, dry and hard. Most of it was not eaten, unlike the weekday toast which was always consumed. None of the AINs appeared concerned about the quality of toast they handed out to the residents; they never queried the kitchen nor sought to replace the burnt toast when they came back with more breakfasts containing more burnt toast. I investigated the mystery of the burnt weekend toast, and learned that the kitchen had not only different, but fewer, staff during the weekends: one cook and one kitchen-hand, compared to a cook and two kitchen-hands on weekdays. Even so, it is hard for me to imagine how kitchen staff can continuously burn toast without some awareness that this does not measure up to an adequate standard, particularly when all the toast is uneaten.

When I informed the DON of my observations, she told me that she was aware of the situation and had asked the on duty weekend RN to find a solution but that this had been unsuccessful.

Mealtime in an unpleasant environment

The third vignette—again consistent over the period of observation involves resident Mrs S's roommate not having her urine-soaked incontinence pad changed and Mrs S being left in smelly dark environment as she attempted to eat her breakfast. The differing behaviours and practices between weekday and weekend care providers are highlighted by the following observations and again relate to systemic failures rather than isolated incidents.

During the weekend breakfasts I observed resident Mrs S having her meal in her room, as the AINs reluctantly changed the urine-soaked diaper of her roommate in the next bed. The room was full of the smell of stale urine and dark because the curtain between the beds was closed, without the bed head light being turned on for the resident. This made it very difficult for the resident to see her own breakfast. The room was full of the strong overnight smell of urine, stinging your eyes and nose.

In comparison to this almost workhouse[31] scene during the weekends, on weekdays I smelt no urine odour in this room, meaning that her roommate had been toileted on schedule by both the nightshift and possibly the dayshift. Subsequently, Mrs S either ate her breakfast in her pleasant sunlit room, content with her own company as her roommate ate in the dining room or went to eat in the dining room herself.

Mrs S.: breakfast and standards

Many questions are raised as to how this could have come about. Judging from the smell of the stale urine and the fact that the urine soaked resident was still in bed whilst breakfast was being served, I can only surmise that both night shifts had not bothered to change the diaper, leaving it to the day shift to change, and that the morning shift of AINs had not followed toileting schedules[32] and priorities before commencing breakfast. From my observations of normal weekday practice in Golden House, the priority is that all the residents are taken to the dining before any breakfasts are served and that all the resident's breakfasts are ready to be served at the same time.

In my reflective notes, written on the days of my observation, I noted that the weekend AINs did not seem to see these circumstances as being inappropriate. In fact these haphazard practices had become routine to them. The obvious question is where is the supervision of the AINs by the on duty RN (Au) that allows them to remain unaccountable for their actions. I attempted to be an advocate for Mrs S, turning on the room light and speaking to the on duty nurse RN Au. Although RN Au did take action to put an end to the practice in the short term, it resurfaced quickly as those AINs without a sense of self-accountability required constant supervision to keep them on track. Unfortunately this

[31] See Townsend (1981) on conditions for the elderly within the workhouses of Britain of the 19th century.

[32] Toileting schedules demand that residents are changed before commencing the breakfast routine, therefore day shift put off changing Mrs S. roommate's incontinence pads.

practice was not eradicated as I witnessed its continuous reoccurrence during the period of my observation at Golden House.

In following up this vignette, dilemmas were raised for me as a nurse researcher as I knew that, by talking to the DON and RN Au, I may compromise my ability to gather information from these AINs as they would perceive me as an 'informer'. But I could not ignore these indignities.

A resident struggles to drink

The fourth vignette, again consistent throughout my observation period, was that although weekend breakfast starts around the same time as weekdays, the weekend breakfast is finished in about 25 minutes compared to the weekday 45 minutes. With the same number of allocated AINs, but without the assistance of the two weekday RAOs; this means, one AIN may be looking after twice as many as residents the weekday AINs, even though the majority of residents are dependent upon these AINs to feed them.

There is next to no socialisation between the AINs and the residents; when communication did occur, it was generally perfunctory and instrumental. The ambiance of the weekend breakfast was stark and bleak: no colourful tablecloths, and a soundscape of alternating silence and unbearably loud rock music from the TV. Most of the individual meals were presented to the residents without a serving tray or a protective lid, this especially being the case for residents who have their meals in their rooms. The adoption of this non-standard practice by the majority of AINs must be disappointing to the kitchen staff who send out the breakfasts from the kitchen upon a very presentable tray with an attractive placement setting, and name tag for each resident. The weekend AINs have adopted the practice of grouping the same food items, such as bowls of porridge or plates of toast, together on a new tray for distribution rather than leaving the meals on their individual trays. I do not understand the rationale for re-traying the food for distribution: it has somehow become accepted practice at the weekends.

Typical of the weekend breakfast care provision are the following observations of AIN Agnes. She starts by serving breakfast to residents who are able to feed themselves, with most of the meals being presented to each resident without a serving tray or a protective lid. After distributing these meals she starts to spoon feed dependent residents two at a time: a practice which is unacceptable, and inconsistent with her formal and onsite training. She

performed the spoon feeding at a very fast rate, almost 'forcing' the food into the residents' mouth.

I also observed AIN Agnes placing a hot drinking cup (with a lid) in the hand of one resident (Nina) who was incapable of drinking by herself due to dementia. Nina struggled for more than 25 minutes to move the drinking cup to her mouth without success. This confronted me with another ethical dilemmas should I go to help the resident or wait until the AIN came to assist because I wanted to see the result? My research self, and I somewhat to my shame, waited to see what would happen as upon her return to collect the cup , AIN Agnes quickly helped Nina to consume her drink. From my observations I know that this was not an isolated event; Nina struggled a vain attempt to drink every morning, in what was clarity pattern of behaviour between the resident and care provider. On further questioning of AIN Agnes she told me that, 'oh, she's like that, don't worry!'

Compared with atmosphere the social extended family experience of weekday lunchtime, the weekend dining room is quiet, the residents and care providers are disengaged, and even the relatives are caught up in the repressive, unwelcoming ambience. The table settings are bare flowers. Seating arrangement has not changed since breakfast, because there are no recreational activities on weekends. Most weekends, lunch is served 10 minutes earlier than the designated time of midday. Rather than providing a restaurant experience, weekend dining more closely resembles a production line cafeteria. There is little consistency in the practice of AIN's delivery of meals to the residents during the weekends. Some AINs double-stack trays on trolleys, and then present the individual trays to each resident. Other AINs, such as AIN Florence, bring out trays bearing the components of the day's meal, then distribute each component to the residents, dispensing with individual tray-presentations altogether.

With skeleton staffing levels on the weekends (no DON, DDON, Nurse Educator or RAO), only the core AINs are available to serve meals. On many occasions AIN Florence was left alone to serve all 20 residents in the main dining room while the other two AINs in her section served residents in their rooms, only returning half way through service. On one occasion I observed AIN Florence collecting the finished first course meals and piling them on the same trolley from she was dispensing which desserts at the same time. When AIN Stella returned to the dining room some 15 minutes after lunch had started, she fed the

remaining four residents who were unable to feed themselves two at a time. By then, these lunches were cold, since Golden House, at the time did, not have thermal meal-covers.

The AINs appeared to allocate residents and tasks amongst themselves rather than prioritising the tasks that needed be done in the right order to offer the best level of care available. Their primary focus appeared to be to complete breakfast as quickly as possible - in about 25 minutes, so they could spend an unscheduled 20 minute break on top of the scheduled 10 minute break taken by the weekday AINs. To add to the breakdown of weekday practices, all but one AIN (whom the others ostracised) took their extended break altogether in the staff room (where they ate a "free" breakfast), instead of staggering their breaks to ensure appropriate supervision of residents. The one conscientious AIN, Gina, ate her breakfast (which she brought herself) in the allocated ten minutes and then returned immediately to her scheduled duties. AIN Gina's isolation was explained to me by the other weekend staff, as being the result of her limited English language skills. Could it also have something to do with her standard of self-accountability? My reflective note from these observations is that the absence of weekend supervision, with only one registered nurse in the whole building, AINs are accountable only to themselves in their delivery of care. Under these circumstances, most care providers seek out shortcuts and set their own schedule in order to maximise free time.

One important variable in the weekend lunch scenario is the presence of relatives. When relatives are in attendance, feeding is usually done more slowly and is more likely to be completed. Most days, including weekends, two relatives (Ms Lee and Ms Ann) visit and feed their relatives in the large dining room; at times, up to five relatives may be present on weekends. This changes the dynamics of AIN care delivery. Not only do they provide for the needs of their own relatives (reducing the AINs' workload) but their presence also introduces a more social atmosphere on residents. On these occasions the weekend care providers exercised restraint in the speed of delivering lunch and attempted to be more sociable themselves. It was clear to me that, the presence of the relatives affects the performance of the care providers. As noted earlier, spot checks and accreditation assessments never take place on weekends although weekend incidents make up the bulk of complaints by relatives at Golden House. Overall, issues of supervision and accountability emerged as key concerns around the standard of meal delivery during weekends.

Accreditation days at Golden House

In a previous role, as a quality coordinator RN, I had been in charge of developing and implementing the quality assurance procedures for a nursing home twice the size of Golden House. Complimentary to this task I was responsibility for creating a framework of processes and documentation to support a self-assessment application for accreditation ('desk audit') by ACSAA. Attachment B is an example of part of this self-assessment documentation relating to the vignettes of this chapter. I had also been involved in a second round of accreditation at another nursing home six months before Golden House was required to undertake their own second round accreditation.

A new Australia accreditation system for nursing homes was ushered with a first round in 2000. Within a maximum of three years, second round accreditations took place with a main focus on nursing homes being able to demonstrate that they had in place a *continuous improvement* quality management system. This *continuous improvement* was to be demonstrated substantively by an audit trail of documentation, limited interviews and direct observation. Parallel to this second round accreditation was a process of *building/facility certification* that attempted to weed out poor quality nursing home facilities. The building certification focused upon issues of access (lifts and door widths), lighting, fire systems and building structure integrity. As Golden House's original building was an adaption of a large old family home it required renovation. In fulfilling this requirement, the proprietor also chose to build extensions which were subsidised by Federal Government funds.

In this section, I compare the everyday practices of Golden House as I had been observed them over more than a year with what happened on the two weekdays of their actual accreditation. To the best of my knowledge, accreditation is only carried out during business hours on weekdays. As noted earlier, DONs and DDONs, the key management informants, are only available on weekdays and, as far as I can ascertain 'The Agency' quality assessors only work on weekdays. I have never heard of a weekend accreditation or spot checks having been done of a weekend. Consequently, weekend care delivery is a blind spot within the accreditation and spot check processes.

Many of the weekday staff told me that there is not any difference for them in how they work on accreditation days. They said that they did not want to rush too much, or else there

is nothing to do after they finish all the showers and have made the beds. They like to take their time to do their work properly which for some AINs is a source of both social contact and satisfaction. However it does tend to cast doubt on the complaint of some AINs that they do not have enough time to do their work. From my experience and observations, those AINs who make that assertion are the ones who regularly finish their work to the *outpoint* and take the most undesignated breaks.

Overall, it appeared to me that during this weekday accreditation the AINs had their 'serious face' on and were cautious of their actions. They seemed more alert than normal in undertaking their tasks, with not much laughing and talking taking place under the gaze of the quality assessors.

By contrast the DON and DDON appeared to be under a lot of stress, unable to sit down to concentrate on their everyday work. Recreational activities such as morning exercises, bingo or sing-alongs followed their everyday routine. During these two days, the residents stayed in the dining room longer than normal, with the RAO running activities longer than on normal days. There were many new cups and plates on the dining table which failed to reappear after accreditation had taken place.

The entire nursing home became very quiet, as there was not much laughter and talking among care providers[33] and residents. All the AINs showered the residents in silence and the residents did not make much noise either. On a normal weekday AIN Ron and Andrea were always laughing as they ran around the rooms, talking and joking with residents and other care providers.

The beds were made as soon as residents left them to be toileted and showered, unlike normal practice, most of the showers were done before breakfast. Normally, bed making is done later, suggesting that the AINs had worked harder and faster than they usually did. This left them with more time to spend with the residents. They told me they chatted with residents to avoid being seen to be doing nothing and to keep the residents quiet.

[33] I used the term care providers as a collective term for AINs, RAOs, GSOs and any other direct care employee of Golden House.

Occupational Health & Safety Standard 4.5

Occupational Health & Safety is a key component of the Standard 4 Physical Environment and Safe Systems Standard. During accreditation AINs were continuous in using a mechanical lifter and other manual handling techniques correctly to transfer residents. Normally Andrea and her colleagues do not use the mechanical lifter at all. All care providers were highly alert in washing 'their hands' and did not venture to the kitchen to have a break, as they would normally. The kitchen staff all wore their protective clothing of a hat, apron and gloves, which they normally did not do. The AINs, instead of going into the kitchen, which they were not suppose to do, stood outside to take delivery of the food trolleys.

From my experience of 'playing the game of accreditation', I had sought to alerted Golden House to ensure that all care providers were seen to carry out 'infection control' principles (by washing hands frequently) and not enter the food preparation area of the kitchen.

The Living Environment -Standard 4.4

The general environment of Golden House appeared clean and tidy, there were no bad odours at all as air fresheners—had been purchased at the DON's own expense. Normally during early morning and shower time, there were odours of urine and faeces in the rooms or hallway. Two days before accreditation, two platforms were built outside the laundry. The linen bags could be placed on these so to avoid becoming dirty when placed directly on the concrete driveway. The laundry and other staff told me that they had asked for these platforms for a long time; for accreditation they appeared.

The laundry staff (Tina) also showed me the new clean linen baskets for each individual resident. The old ones had been broken for many years. Tina had requested new ones, but the proprietor continued to put off the purchase. Before accreditation, the DON had used her own money to buy new baskets then demanded to be recompensed by the proprietor. During the accreditation period of two days what surprised me and others as we walked along the hallway of the new section of the nursing home was that the air conditioning was working. I had never experienced it working previously. As one senior AIN remarked to me:

> Sister, have you noticed that we have air condition on here (the hallway)? We didn't even know we have air condition in this area! How lucky we are today! I hope everyday is accreditation day!

Over many months of my fieldwork, the weather became very hot, with temperatures dramatically increasing during the day from 36-45℃. The air conditioner in the main dining room had already been out of order for a long period of time. According to the DON, she had already done her best to have the air conditioner repaired but the proprietor did not want to fix it straight away. He complained that the care providers had broken it by playing with the remote control of the air conditioner consequently he was in no hurry to repair it. At that time, the DON said to me that 'the proprietor should have bought a good quality brand air conditioner in the first place, rather than this kind of no name and cheap air conditioner!' To cope with the excessive heat, two big fans were brought into the dining room, but aroma therapist Sarah still brought a complaint to the DON supporting the latter's demands on the proprietor to remedy the situation.

The DON believes cost was the main consideration. Instead of fixing the air condition, the proprietor directed that all fans in the dining room should be turned on. According to Sarah even with the fans on it was still too hot for many residents, causing them to become dizzy. She told me that "the DON did her best to convince the proprietor to have the air conditioner repaired but the proprietor is mean and doesn't want to spend any more than he has to in making a profit!"

According to relative Max, the handyman had discovered that the air conditioner was not in fact broken but simply turned off .I was also told that the air conditioning ducts in the resident's rooms in the new section were actually dummies, they were unconnected to air conditioning system. Once the two days accreditation was completed, the air conditioner was turned off altogether. However, the impression of having air conditioning was duly noted in the final accreditation assessment report, rated that 'All rooms have electrical fans and the communal areas have air conditioning'.

In general, the assessment team were satisfied with the clean environment at the time of assessment. They were impressed by some of the attractive furnishings in the communal areas. They were also satisfied with the security of the front gate and garden area, as they were with the electrical tagging record of all equipment within Golden House.

Unfortunately, the quality assessors were not able to discover the truth under the facade of the everyday living environment at Golden House.

Resident's lifestyle

The residents' lifestyle during these two days did not change, it was "just another day". They were, however, unusually quiet. This may have been because care providers stayed with them when they finished their normal routine work instead of normally disappearing to have a break and were attentive to their requests. Special attention was focus to some of the normally noisy residents, who appeared to have become a priority for the care providers' attention. Some AINs responded to my inquiry about this change of behaviour saying that the 'residents making so much noise does not give a good impression, therefore we'll try to stop it before it happens'.

Noisy or wandering residents were not the only objects of concern, they were well looked after. Relative Ms B told me the AINs labelled her a 'troublemaker' because she regularly lodged complaints about her mother's care. She said the AIN were so worried she might go to talk to the quality assessors, they watching her constantly during her visit. Ms B mentioned this to some AINs at mealtimes, she commented to some AINs: "Why is it only on accreditation that the entire table settings appear and all the new glasses are brought out for the first time?" Ms B. did not in fact make any complaint or talk to the quality assessor. She enjoyed the activities in the dining room with her mother during the first day and did not come at all on the second day much to relief of care providers. I wondered at the time if Ms B was able to put her vigilance away for a day to have some quality respite time for herself because she knew her mother would be well looked after on the second day of accreditation.

Quality assessor interviews

Many care providers, relatives, and residents were interviewed by the quality assessors. I had a talk with those interviewed when they had finished. Most of them responded that the quality assessors were very good, did not ask them difficult questions and put them at ease. Resident Tim told me that he had lied to the quality assessors, but he was proud of what he had done. As he described the interview:

> "He (the quality assessor) had a clipboard and he got all the questions there and he asks you the questions…" How's the food Tim, is the ... or you been looked after

> alright Tim, does the staff doing a good job, Tim?...because I was told by Andrea and my mate [DON], when he (quality assessor) comes, don't tell him nothing about your bed don't tell him you make it, or you go down to the shower by yourself, or you get showered by yourself, make out or tell him that all the staff look after you, the same as look after him (referring to Mr P who is totally dependent upon the care providers)…I didn't tell him I shower meself and I make me bed, and I change me bed, because Andrea and me mate in the office [DON] said don't tell him all them things because you're here to be looked after, meaning me [pointed to himself], but don't tell him that you do everything, make out that all the staff here look after you, so when he (quality assessor) came here and sat there for about a half hour and asked me all the things, I told him the right answers!

Tim maintains his social status in the nursing home by having direct contact with those staff members who may act as an advocate for him. By asking Tim to say certain things, the DON and AIN Andrea demonstrated their need to have the quality assessors not hear about the reality of the actual care given to residents. Tim goes on to say:

> Ten minutes after he [the quality assessor] was here… she [the DON] knew!...And by the time he [the quality assessor] went, she [the DON] and Andrea was in here saying yeah you've done a good job Tim, in other words…Yeah! Well, I said everything correctly when I was asked!

In the end, everyone (DON, Andrea, Tim and I) had a laugh at Tim's 'confession of his lies', however, Tim earnestly told Andrea: "I followed your instructions and I told them what you want me to say!" Tim appeared very happy to tell Andrea what had been said in his interview. Accreditation days are the rare occasions when a resident can sound 'important'. Relative Max was not on the relative's list to be interviewed by the quality assessor, but he participated voluntarily. Immediately following his interview, Max approached me to discuss it.

> He [the quality assessor] asked what you think about Nancy [the DON]? What you think, if you had any complaint? What you do? Did anybody, mainly Nancy tell you where to complain? I [Max] said, 'Well, I have no idea (where to make a complaint when asked)! I have no idea, but if you keep asking, you will find where to go, where to knock, you know! But because was …in noticeboard [the information about making complaints is available on the noticeboard at Golden House]…otherwise before that I didn't know where to complain. But using commonsense you can go to the Health

> Department…maybe to Centrelink[34] or to some other organisation. I wasn't that black [negative in response] but at that time I didn't have a very good idea. ... Then he (quality assessor) said… about …the care, they do all right? I said, No bother, not too bad! The food, this and that …all the interview not longer than ten minutes! And… so I couldn't say a lot but I said few things, you know! I said, 'I am happy! The place is run alright! The boss is ok! The staff is ok! The food is ok!

Max said that he did not take the opportunity to make a complaint to the quality assessor when he had this chance to do so, saying instead that the care was 'not too bad' not requiring a complaint. Max appeared disappointed that the quality assessor only talked to him for ten minutes. When the quality assessor asked some of the care providers about the 'funeral service issue', they had tears in their eyes. After the interview, Sonia, one of the care providers told me what happened.

> When the assessor asked us about the funeral issue, Ron suddenly mentioned about Mrs H who did not have family and had died in hospital few days ago. Mrs H had stayed with them for few years and they all felt very upset about the lost of her. The funeral will be held tomorrow, normally staff from Golden House go to funeral with it not mattering if they had have family or not. The assessor was very impressed because we spoke from our hearts; it was not something we made up. The assessor told us, 'you can tell everyone that assessor make you cry'. Everyone then laughed!

Meal services – Standard 2.10 & Standard 4.8

At lunchtime the quality assessors were served their meal in the office, it had been specially prepared by the cook and was not what was served to the residents - it was more like restaurant quality food. Residents' lunches on days on which accreditation inspections occurred, were somewhat better than the usual lunch; since it included a piece of fresh fruit – on this occasion, a banana. The tray presentation was also better – it was up to Golden House's weekday standard - very pleasant to look at in an effort to motivate the residents to eat. The care providers took their time to serve the lunch and feed residents - this is also quite normal for a weekday lunch time but quite unusual for a weekend.

[34] Centrelink is a federal government agency that provides social services and referral of services to the public.

No other mealtimes were assessed during this accreditation. The assessors then went on to talk people and to examine the documentation regarding the proper following of procedures. The outcome of the two days of assessment approved Golden House as compliant in all the 44 outcomes for assessment and no negative comments were made on the final statement. Golden House was granted a three year accreditation. They have been scheduled for regular support visits (once a year) within next two and a half years before they have their next full accreditation (the third round).

The triggering complaint

After Golden House's successful second round accreditation I continued to conduct my fieldwork for a further 12 months, during which time, RN Lily and DDON resigned for personal reasons. After passing accreditation the proprietor attempted to restrict his budget to maximise profit. Following the resignation of the DDON, the position was not filled for ten months and only then because the DON threatened to resign.

The proprietor only employs casual RNs rather than permanent staff for reasons of budgetary constraint (they don't receive annual leave, sick leave or paid for public holidays) and when casuals are hard to find, no staff are employed leaving the DON as the designated RN as well as the DON. I observed DON Nancy coming on duty at 6:30am to give the medications and supervise all staff members whilst also carrying out her normal DON duties. The proprietor consistently refused to use any private nursing agency RNs, claiming they were too expensive despite the difficulties this caused for the DON. One must remember that DON Nancy, whilst having to deal with the shortage of RNs was also without support of a DDON, consequently there was not enough time to supervise the provision of quality care. It was at this time that some of the relatives complained about the quality of care. DON Nancy reported that she had no time to talk to residents, relatives, and other visitors and consequently could not help to solve their concerns. She was herself very stressed during this period. With DON Nancy unable to address the concerns raised by some of the relatives, they felt they had no option but to contact the Department of Health.

This research has been unable to ascertain how much time passed between accreditation and the Department of Health receiving the actionable complaint letter. Golden House did however receive a notice of investigation from the Department of Health five months after being accredited. This notice of action was received by Golden House whilst the DON was

on holiday and was dealt with by the newly appointed DDON. An anonymous letter of complaint was sent to the Health Care Complaints Commission (HCCC)[35] in which poor care provision and abuse by care providers was alleged to be systemic at Golden House. It also alleged that despite complaints being made to the staff, the situation remained unchanged.

The complaint noted that "when a relative complains to the DON that a resident has been maltreated by a staff member, the DON gets angry with the resident instead of disciplining the AIN involved". This complaint (to the HCCC) was then referred to the Department of Health and Ageing (the Department) with the Department documenting that they undertook a spot check—an unannounced visit to observe staff practices, where they interviewed staff members, residents and reviewed relevant documentation.

The spot check was carried out while the DON was on holiday, the acting DON (later the DDON) was only in that position for one month. I was half way through my interviews having already spoken to resident Tim, relative Max and RN Lily when the DON contacted me about the complaint issue (on her return from holiday). AIN Andrea was the first person I interviewed who was aware of this visit. The spot check took place on the weekend and so weekday staff had not been involved.

The DON provided me with a copy of the Department's findings and allowed me to quote from this document as part of this thesis. In reviewing these findings, it must be remembered that the Department's criteria for quality of care are not explicitly stated, they do however implicitly reference the Accreditation Standards and Guidelines. The Department of Health makes findings based on observations of actual care provision whereas the Agency reviews nursing home documentation to determine the level of care delivery and improvement required:

- Residents' meal trays are being removed too quickly, the priority being that kitchen staff leave on time rather than that residents are fed or self-feed without being pressured.

[35] The HCCC is a state funded health initiative rather than federal government pseudo agency at arm's length of the private enterprise Aged Care Standards Agency (the Agency).

- Some residents are left sitting in their chairs for very long periods, especially those unable to communicate.
- Some of the room temperatures on the day [of assessment] were not sufficiently cool for the comfort of residents and relative (in the rooms with fan only or no fan)
- A number of residents in multi-bed rooms stated that they were feeling uncomfortable from the day's heat…[they reported that]…the room temperature control is often seasonally inappropriate, and 'out of order' signs are places on several air-conditioning units when they simply have not been turned on.
- The nursing home cleaning standard appears poor.
- That 'Director of Nursing is not attentive to relatives' complaints and suggests as a resolution strategy that they take their resident/elsewhere.

The report stated there should be a review of the roster so that "the weekday evening ratio approximating 1 AIN to 13 residents." From my subsequent interviews with AIN Andrea, RN Helen and the DON it became clear the DDON did not take this matter seriously and was slow to put into action strategies to resolve the issues to the satisfaction of the Department of Health, despite understanding that the problem was in fact serious. The weekday dayshift staff were not aware of the Department's inspection and it seems likely that the visit took place on a weekend with no forewarning given to the RN in-charge. In such a circumstance, RN Au would be expected to contact the DDON directly and enter the information into the *hand over journal*[36].

During the three weeks following the DON's return, the Department was still making inspections of Golden House, it was at this point that 'The Agency' became involved. The Agency's initial investigation was undertaken between 9am and 5pm on weekdays only. They reviewed documentation, made observations and interviewed staff, residents and relatives. While the Agency agreed with the Department's findings, they did not conduct

[36] The *hand over journal* is a book that logs a summary of events that have taken place during the RN's shift so as to inform the next shift of state of play of Golden House. Its record is used to draw the attention of the new shift RN to ongoing issues that need to be attended to and to events that had taken place during the prior shift. Its content is made up of clinical care priorities, if any incidents have taken place and maintenance requirements.

any of their investigation on weekends. The DON was given two months to demonstrate the required improvements of care delivery.

After this two month period, the Agency again reviewed the standards of care at Golden House but remained unsatisfied and determined that a full three day re-accreditation of Golden House be undertaken. In this full re-accreditation Golden House failed to comply with 36 of the 44 care outcomes. As a result of failing accreditation, Golden House was issued with a two month sanction penalty that disallowed them from taking on any new residents (although the government continued to pay for residents who were currently at Golden House).

In failing accreditation, it was also determined that Golden House should be reviewed regularly by the Agency and other government bodies.

Outcomes for Golden House

In reality, the cost of such sanctions is chiefly to diminish the reputation of the nursing home, and although this is understood to be an indirect financial penalty (Braithwaite & Westbrook 2005, 2006), a two month sanction on admitting new residents had no financial repercussions at Golden House. It was already at full capacity and during this period, no relative removed their family member from Golden House. The issue of alleged abuse was never investigated fully and was ultimately removed from the agenda of issues to be resolved at Golden House.

Summary

This chapter provides a picture of the actual care provision at Golden House over a considerable period. It is difficult to achieve adequate understandings of the actual quality of care provision in any nursing home in just two days of a normal accreditation visit. Further, while ever accreditation outcomes are also influenced by the Quality Assessor's own experience, interpretation, observation skills and sensitivity, longer site visits may be helpful in making more sound determinations, determinations based on thorough and accurate observations and investigations which at the same time maximise impartiality.

CHAPTER FIVE: TALKING ABOUT CARE

Having witnessed the actual care provided in Golden House through participant observation, I conducted interviews with people who worked in, lived in or visited Golden House to understand the 'quality of care' provided from a number of perspectives. This cross section of informants includes the following six key stakeholders in the order in which they were interviewed: resident Tim, relative Max, RN Lily, RN Helen (educator), AIN Andrea and DON Nancy. The interviews of resident Tim, relative Max and RN Lily took place after Golden House had passed accreditation but before a complaint was made that triggered an investigation. The interviews of RN Helen, AIN Andrea and DON Nancy took place whilst investigations continued and sanctions had been put in place by the Department of Health and Ageing.

This chapter will present, the perceptions and interpretations of 'care provision' and the 'quality of care' as well as some of the organisational factors that the interviewees believed impacted (positively and negatively) upon the care provided in Golden House and lastly, their relationship to those factors. The chapter's structure and organisation, in presenting the intact narratives of each interviewee in the form of a hermeneutic text (Vitz 1990; Tappen & Brown, 1989; Tappen, 1990) allows the reader access to the hermeneutic circle and the ability to judge the trustworthiness of this research (Koch, 1996).

Resident Tim

Resident Tim is an Anglo-Saxon Australian in his late 60's and has lived in Golden House for 2-3 years. He came to Golden House because of his physical disabilities following a fall and a subsequent period of hospitalisation. Resident Tim was interviewed two months after Golden House had passed accreditation but before a complaint was investigated by the Health Care Complaints Commission (HCCC). Resident Tim[37] described his life in

[37] Tim is a very special and interesting individual who has lived a challenging life due to his genetic physical handicaps of partial blindness and brittle bones. The impact of these handicaps became apparent early on in his life and has followed him with varying degrees of severity. He was recommended to seek nursing home support after the insertion of a metal plate to repair his hip as it was believed by his treating orthopaedic

Golden House nursing home as being better than his previous living accommodation, as it is bigger and because he doesn't need to do any shopping, cooking or washing.

> If you're living in a flat in Greenborough (38where he lived before come to nursing home) it's only small, but here (Golden House), it's bigger, like the rooms big and all the hallways are big, and you can go outside, you can walk around a lot here! I don't have to do nothing. (resident Tim)

Tim has a very narrow focus of his own personal space (his room) and has a small group of confidantes with a declared objective of looking out for himself. Despite living in a nursing home, it is important to Tim to be able to maintain his independence, for instance, showering himself, dressing himself, making his own bed, and walking himself with assistance of a walking frame. He enjoys the autonomy to do what he wants.

Tim's other main focus relates to the quality of the meals he receives. He believed this was related to the quality of the staff such as his key care provider AIN Andrea. He believed that quality staff selected quality produce allowing him to maintain a good bowel movement, something we all take for granted. A good bowel movement for the residents of nursing homes is an important issue as constipation leads to discomfort, irritability and medical complications if not treated quickly.

Tim indicated that the care he received in Golden House is *basicall*y the same everyday throughout the week. The adjective *basically* is used loosely in Tim's case as he had to work hard to make weekend care comparable to weekday care. I reminded him of the differences he had described in the level of care he received on weekends compared with that of the weekdays.

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surgeon that Tim would not be able to walk without risk of further fractures. Tim has a very special way of talking, he likes to 'talk to himself for instance, "… see you in the morning, Tim.". Tim has a typical older style working class man's style of English that I have not much familiarity with. There were many special ways of Tim's talking – such as Mondee [Monday] Fridee [Friday] and meself [myself] which made transcribing an interesting process for me. As I tried to translate and transcribe the interview 'as verbatim' format.

[38] In using quotes I use curved brackets "( )" to give extra information to give context, whereas I use square bracket "[ ]" as words I've had to inserted into text to make it more readable.

Independence and autonomy

Rather than imposing a closed routine upon him, AIN Andrea helps Tim to maintain his autonomy by providing him with a variety of choices, allowing him to do things as he likes for himself whilst providing direct assistance when it is needed. For example, on Mondays to Fridays she clears an *unobstructed path*[39] to the shower and in the shower room itself, Tim is able to get into the shower room without any problem. Whilst Tim showers himself, Andrea returns frequently to check on him, she then wheels Tim back to his room where he dresses himself. Monday to Friday, after Tim's shower, Tim makes his own bed with the clean bed sheets Andrea has prepared for him to use. Here is what Tim said about how his day starts with Andrea's arrival at work:

> Twenty to six, twenty-five to six this morning. So she (Andrea) brings the trolley (shower chair) in, wheels me to the shower, and then leave me on the trolley and I turn on the water on and then I shower meself[40], and then I wipe all meself, and then ... if she's not around, sometimes if she is around, she pushes me back on the trolley and I come back here and I got no clothes on, … only a towel on, then I sit there (pointing to where he sits on the side of the bed), and then I put the clothes on, dress meself, and then I listen to the radio, because by the time I come back from the shower maybe (thinking) oh… five past six. I like to make own bed, I like to do as much as I can…it's the way that she (Andrea) allows me to do things my way and gives me choices. (resident Tim)

Accordingly, on weekdays, Andrea leaves a fresh towel on the end of Tim's bed ready for him when he gets up for his shower. This routine gives Tim a sense of ownership of the towel, this being important to him, much like being in a hotel guest. Tim enjoys having a fresh clean dry towel every weekday and likes this level of service which implicitly acknowledges his ability to shower himself. Tim wants to maintain his dignity and a level independence whilst acknowledging the support of Andrea. Andrea facilitates his agency, his ability to do things in the world around him and to have his own outcomes.

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[39] Weekend care providers primarily leave an obstructed path made up of shower chairs blocking clear access for Tim to the shower room and in the shower.

[40] 'meself' = 'myself'

In general, Tim wants to show that he does everything himself and that he is not dependent upon the care providers[41] even though care providers like Andrea are eager to offer assistance. In facilitating Tim's ability to do as much as he likes—albeit with some element of the risk of falls—Tim is not imprisoned by dependency[42] (Miller 1984) and obligation[43] (Poole & Rowat 1994). He obviously also likes the equality of power relationship, respecting AIN Andrea for her ethics of care. It's a matter of Tim feeling that he is in control and that he has his own autonomy and a sense of agency. Tim likes to maintain his own personal physical and psychological space, thinking of Golden House as a boarding house rather than a nursing home.

Two types of care providers

From Tim's interview, it is clear that he distinguished two types of AINs at Golden House. He describes Andrea and Sonia and a few of the weekday permanent care providers as good ones. For instance, Tim described Andrea as "more active, more running around, more obliging, more better!" In response to the question of the quality of care at Golden House Tim addressed this sensitive issue by referring to AIN Andrea being at the heart of the quality of care at Golden House:

> Oh, well that! Not because Andrea here, but even if Andrea wasn't here, the nursing home's alright, this one! See so they've been here for a while [Andrea 23yrs and Sonia 15yrs in Golden House], they're alright! Not because one's Greek and one's not, like, but what Andrea does for me, she'll do for everybody else. Like she's just a kind person or a very obliging person that helps everybody or goes out of her way to do something for someone, doesn't matter if it's me or some one next door. It just Andrea, like, she's the same for me as the same as someone along the hall. (resident Tim)

In terms of Andrea being the anchor that holds the quality of care from drifting away, Tim emphasised that everyone depends upon Andrea:

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[41] I use the term care providers to denote not just the AINs but to include RAOs and GSOs.

[42] See Miller (1984) on nurse's creating a patient dependency model.

[43] See Poole & Rowat (1994, p. 426) on patient obligations of having to give "something in return for the service provided."

> Well! I spose [suppose] they think the same that I think about Andrea because she been here so long and she's very obliging and ... and that same [treats all of the residents equally well] to everybody, and if the DON wants somebody and she comes out office, and there is another nurses there in the morning, and come right up to three o'clock. And every time she seems to come out of the office, it's yeah, Andrea. She even wants Andrea to come up to ask her something or she wants to ask her something. She does seem to be singing out to any other nurse, it's always Andrea.
>
> …yeah. Andrea answers the buzzer all the time. So, she's what I said [raises his voice's pitch dramatically], Andrea's better than the lot of others, whereas where she's here seven days a week or four days a week, or, or whatever she's doing she (is) more active, more running around, more obliging, more better! (Resident Tim)

By contrast, Tim described another group of care providers as "Lazy." Tim gives a comparison between weekday showers and weekend showers.

> …because Andrea only works Mondee - Fridee[44]. Saturdee and Sundee I do it meself. Tim does the lot! … instead of somebody [AINs] coming here [Tim's room] and bringing the trolley [shower chair], I walk down [the end of hallway, shower room]. I just put the towel around here [on the walker], and I take the towel and the washer down there and then I shower… then I dry and… then I just walk back here [Tim's room] again.
>
> …if I go down Saturdee or Sundee - if there's nothing [appliances such as shower chairs, lifter etc] in the shower… well that's alright, but if there things are in the shower, I had to move them all out meself. See… so I do all on Saturdee and Sundee. (resident Tim)

However there are some advantages—as seen in the following passage—of Tim having to fend for himself when taking his weekend showers as he is left to himself without

[44] Tim uses the '-dee' endings to replace '-day' endings for days of the week. These expressions are common variants used by some working class speakers of Australian English.

supervision which allows him to have a 20 minute hot shower. The downside would be that if he had a fall or a stroke, he could die and nobody would know.

> Because I go in there [shower], because with the aches and the pains I got, if I go to the one around the corner [shower] of weekends. Well it's [hot water] feels good on the body. Makes the soreness goes out, out of the bones, makes me feel good. …. when I'm by meself, and nobody else looking after me, … I sit in the shower and the water is hot I can sit there longer, but if … Monday to Friday when go along there with Andrea, maybe 10 minutes and I'm out of the shower and back here, but if I go …on weekends, when there's no Andrea, I can sit under shower for maybe oh 20 minutes. See, I can just have water on. (resident Tim)

Tim next explains when Andrea is not there he has to do everything himself every day.

> If Andrea goes on holiday for five weeks I have to go backwards and forwards seven days a week, all by meself [myself]. Because there's no Andrea, and ... the others don't worry about me and I don't worry about the others…I have to go backwards and forwards seven days a week, by meself [myself]. I want the clean sheets and pillow slips, Andrea talks to [AIN] Sonia ... once a week give Tim the clean sheets and pillow slips. So, Sonia brings them around here to me! (resident Tim)

AIN Andrea gives Tim a fresh towel for use over the weekend when she leaves for home on Friday. Tim uses it on Saturday and Sunday because the weekend AINs do not give him a fresh towel unless he asks them directly. Tim has the expectation that he should be given a towel every day, making the statement "Everyday everyone gets the clean towel!" as if this statement is part of his charter for the rights of residents.

On weekends care providers follow their own routines of processing the residents through each of their tasks and do not encourage autonomy in the residents. The weekend care providers appear to be more interested in facilitating a sense of dependency in the residents and as such do not provide Tim with a towel placed on his bed. The weekends, and other times when Andrea is away, leave Tim to deal with AINs who do not carry out the best practice care approach of supervising Tim but prefer to sit and talk to him as a means of avoiding work. As Tim says himself, "The weekend ones are lazy…Oh, yeah! … they used to come and sit around and talk to Tim too long!"

Supervision Embargo

Tim points out in the following passage the difference the presence of the DON makes on weekdays to that of her absence on weekends. To Tim, the lack of supervision of weekend AINs is one of the key elements in weekend care providers being 'Lazy'. He stated,

> …[during weekdays]… I don't worry about it much, I know she's [DON] out there and sometimes she'll come in here [Tim's room], if I'm sitting here and Andrea around, they'll come in here and she'll come in here and want to know how I am, what I been doing and all that. But other than that she's, I just know she's there! But other than like she's not here Saturdee [Saturday] and Sundee [Sunday] that's all! (resident Tim)

He goes on to highlight what to him are the obvious reminders of the better quality of care provided (and workload taken on) by the weekday AINs compared with the weekend AINs.

> …because, Nancy [DON] only works from on Mondee [Monday] to Fridee [Friday], she doesn't come in here Saturdee [Saturday and Sundee [Sunday)'. See so there's no boss on weekend, that just Sisters [one RN registered nurse]. That's all! You see the difference five days a week, yeah! (Tim)

Tim next describes how the weekend care providers stay in his room to avoid work and watch television.

> …and there's no boss [DON] the weekend! See! So [staff play up)]! Ohhh! Yeah, they [weekend staff] come in here [Tim's room] and talk to me! [sounding annoyed - invading his private space]… Because [emphasising his remarks by tapping on the table] they were coming too much sitting there, talking too much and watching the TV too much, without going when the buzzer rings instead of going along and helping someone who is ringing the buzzer along there, they were getting other nurses to do it. They were in there sitting on their bum! See…a lot of them [weekend care providers] were coming here, sitting down [he point out the table and bed where the weekend staff sit, he emphasising by tapping the table' like you [me the researcher] talking too much but not doing no work [no doing any work]. (resident Tim)

The problem of weekend care providers coming into Tim's room and watching his television was resolved by the RN who reported it to the DON.

Mealtime

Tim has his own preference for food; he especially likes salads and fruit, with the hot meals having to be hot not cold. I observed Tim receiving his lunch towards the end of our interview, he had a smile on his face, as a consequence of being the first one to get his meal and it still therefore being hot. I can see the steam coming from the meat pies. All the fruit is fresh! On eating his hot meat pie (steam still rising from it), Tim remarked with satisfaction, Tim always gets the meal delivered first because he's in room one and the kitchen is just up the stairs. Tim is very satisfied with this arrangement as stated below:

> I always first one. Yeah! The first one, see! Lucky one, Well I see, I get this ... the fruits. And they're hot Tim [identifying himself]! In fact they're really hot Tim! I'm very happy to have fresh fruit. And Oh pie! that's all I like!

> Anita [weekday cook] brings my lunch down early than others, so ... I get ... it's more better here [Tim's room] for Tim than it is up there [the big dining room] and it's more better for Tim than even around there if I went around there, it still be worse around there [the big dinning room] than here, because it's just up the stairs the kitchen see and it's more convenient here and I'm here nearly all day by meself [myself]. (resident Tim)

Apart from praising the quality of the food, Tim emphasises the importance of his daily bowel movement, believing this relates to the fact that he likes a lot of fruit. The problem is that the proprietor[45] seldom provides fresh fruit and this is more particularly a problem on the weekends because Andrea and other care providers bring in fruit from their own homes for him to eat over the weekend. This is part of their strategy to help him deal with the variation of food quality over the weekends.

> I eat prunes, may be [pause thinking] four or five prunes, I eat them every day, like five days and eat on the weekend too, which helps makes me bum work. Plus I eat

[45] As evidenced by Golden House's menu, and verified by an informal interview with the DON, the proprietor's restrictive budget does not often provide for fresh fruit.

> fruit, you see you see Andrea gave me apples [brought from Andrea's home] and I got oranges too what Andrea gives me, I got banana in there which Anita [weekday cook] gives me, that's the woman you seen going out the gate, so I eat a lot of fruit. Oh! Yes, the knife, Greek knife, Andrea gives [to] me, so I can peel apples tonight before I go to bed. (resident Tim)

Tim always eats more on weekdays also, because 'the cook' [Anita] will come and talk to him and allow him to put in his own order. From my observation, I found that kitchen staff come into Tim's room to say 'good-bye' before they go off duty. This confirms my observation that Tim has a very close relationship with particular care providers and as a result, he gets better care provided to him. Tim having a voice (being accepted and given autonomy) results in better care for him but this raises questions about the care provided to residents who don't have a voice and are perceived by the care providers differently. As stated in Chapter 3 – Methodology, I chose to interview resident Tim as he was one of the few residents with no cognitive deficit, capable of having a conversation. This makes Tim attractive to talk to as a diversion for care providers and an excuse to avoid work; they do this to the point however, of being an annoyance to Tim.

In contrast, the weekend cook does not make the effort to talk to Tim and as a result Tim refuses to eat the main meal, only eating light meals on the weekends. Tim mentioned that he's not happy with the weekend food service, which he said was because:

> Anita [weekday cook] is not in the kitchen in the weekend, so different people in the kitchen the weekend.

> I don't eat at the weekend. I have breakfast on Saturdee [Saturday] and Sundee [Sunday], midday I don't eat dinner, I eat tea tonight, weekends.… the meals is different… Ohh no good it's too cold, and it's no good and it's the same all the time. So I don't eat it [said in a monotone uninspired voice]! If the food's not bad, if I eat it I eat it, if I don't want eat it I don't won't eat it. But I can eat breakfast, because it's only *Weetbix*[46], tea or coffee, uh couple slices of toast, uh and baked bean or spaghetti, or egg.

[46] *Weetbix* is an Australian breakfast cereal of wheat biscuits that you have with milk.

> I am a little bit fussy, I don't [eat] fish on Fridee, uh! … when I was living at home, with my brother, we used to eat good fish, maybe may be twenty dollars a kilo. [Golden House only supplies small frozen No Frills[47] brand 'fish fingers'[48]]

Relative Max

Max is the retired middle son of a resident with advanced dementia. Max is in his sixties and lives at home by himself. Max's father had been in Golden House about eighteen months. Max is one of the few relatives at Golden House who is there every day, from about 10 am till after dinner at 6 pm (might go out to an engagement, or stay there to for an activity such Bingo, whilst volunteer to help run Bingo, repair the piano, undertake maintenance jobs such as repairing chairs and tables) to bring in his father's lunch (large meal, Max's father has large meals – is a big eater, eats nursing home food as well). Max is always there with his father at mealtime, bringing in homemade meals for lunch and dinner of Italian food such as spaghetti, risotto and soup (his father has to eat pureed or soft food, whilst other residents have sandwiches or fast food , easy to prepare food tinned spaghetti, baked bean, scrabbled eggs and toast (small proportion). Max's father has his lunch at the same time as everyone else in his own room not in the dining room with the other residents. Max's father shares his room with three other men who are bedridden, Max's father was ambulant till he fractured his hip about three months before he died (had developed pneumonia and passed away in hospital about six month after the interview).

Max is of Italian descent having lived in Australia for over 50 years. Relative Max was interviewed 5 months after Golden House had passed accreditation but before a complaint had been processed by the HCCC. Relative Max's schema[49] relating to the quality of care focuses upon environmental/housekeeping issues, food service, the care delivered to residents, and an understanding of the factors that influence the quality of care. Max's criteria for the core components of quality care differs from those that accreditation

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[47] *No Frills* brand name is a supermarket in-house product line that's premium is on price rather than quality.

[48] Tim prefers quality fresh fish that you would by at fish market rather than low quality mass produced fish products like fish fingers which are small crumbed rectangular pieces of cheap quality frozen fish.

[49] "Schema, as first defined by Bartlett (1932) and Piaget (1952), describe data structures in memory that represent knowledge about concepts. Categorization theory describes the formation and use of natural and social concepts of objects by individuals to organize their worlds." (Dutton & Jackson 1987 p. 78)

emphasises - process and outcomes. His are more closely aligned to blackboxed[50] components - care provider's *good heart*, *good will*, *good work* and g*ood management*. In talking about *management,* Max is the first interviewee to highlight the blackboxed effect of the proprietor as a key variable in determining care possibilities and reminding us that Golden House is foremost a business for profit not a charity. Overall the best measure of the quality of a nursing home from Max's point of view is that care providers and management have a *good heart* and *good will*. This brings into our horizon both Heidegger and Gadamer's hermeneutic emphasis, mentioned in previous chapters, that of *praxis* (ethical practice) and *phronesis* (practical knowledge).

Clean and comfortable environment

Max is very much aligned to the concept of *praxis* - he terms the AIN's work as *duties of care*. Duties of care from Max's view point include fundamental responsibilities that include maintaining Golden House as clean and tidy. In combining *praxis* and *phronesis*, proper cleaning is one of the duties of care. Proper cleaning demonstrates your respect for the resident and is part of Max's moral code for himself and others. Max sees the environment of Golden House as a fundamental first indicator of the quality of care, a kind of *moral ecology*, after Aroskar (1995).

> The first thing you see the quality care is about the environment…because, can't just to dump people in a cell, you know. You don't give a good life to them, you know! (relative Max)

Max described the proprietor of Golden House as having a *"Lack of Heart, a misery!"* in regard to not turning the air-conditioning on whilst making false claims that it was broken.

> Yeah! You sweat, you know! Thirty-nine, Thirty-eight is nothing, what about forty-two! So... when I saw that, …the air-conditioning unit was nothing wrong, only had to do check the power board…and only have to do, put the switch on… that is a trick!

[50] The 'blackbox' is the hidden mechanism, actions or assumptions that underlie or realise processes such as quality of care provision - processes that are intermediate between inputs and outputs. In a cognitive context, assumptions that inform our reasoning and actions may become 'blackboxed' or hidden from our daily awareness. This relates to the construction of paradigms (Kuhn 1970), and to schemas of understanding (Bartlett 1932; Piaget 1952).

> You (proprietor) idiot, you don't want to get to run this unit, this because you don't want to spend the money, you see! "It's a misery!" (relative Max)

> … about fortnight ago saying that's broken…It wasn't broken! All he had to do, went to check when everything is ok. He (technician) ask to[go] to the power board, ok! Click! (role-playing flicking the switch with ease showing contempt that the switch had been left off on purpose, emphasised with his sound effect!) Put the switch [on] then (clapping his hand again to demonstrate how easy that was and why hadn't it been done earlier) it's all right! That, that' lack of heart (Max shows his contempt by the way he emphasises his pronunciation of the word 'heart')! You see! See, lack of heart! Lack of respect (mostly towards the residents but also to the care providers), you know! Nancy (DON) had to follow… his (proprietor's) recommendation. (relative Max)

> … Nancy (DON) should have been informed… as to what was happening rather than being made a fool of when everyone became aware that the proprietor had turned off the air-conditioning secretly to save money. (relative Max)

Max believes that consciously reducing the quality of care in favour of maximising profit demonstrates a lack of respect for the residents, he believes that the residents deserve better treatment. In an informal conversation, the DON stated that she had believed that the airconditioning was broken and was angered that she had been deceived by the proprietor. Such deception undermines the status and authority of the DON and her self-esteem as she was made a fool of by the proprietor.

Mealtime

A quote from my interview with Max explains his criteria for judging the quality of the food – it must be fresh. A vignette is then provided where he recalls a conversation he had with resident Jenny one weekend mealtime:

> …the food must be fresh! They have to have protein and vitamins! Well prepared! And hot, not cold! (relative Max)

> One day…I went by past and I said to Jenny [resident], How was you Jenny? At dinnertime!... this food I don't like it [role-playing resident Jenny reply in the voice of a frail elderly woman]!' 'Why? [Max asked] Oh, it's cold [role-played Max as Jenny said]!' 'It's it's uncovered... [role-played Max as Jenny said]. I don't feel like to eat it! [role-played Max as Jenny said]'. I said 'Well ah, the microwave was just next door!' I asked her, 'Can I heat it for you?' She said 'Yes!' then she ate, then she ate it [after heating the food resident Jenny was happy to eat it]. (relative Max)

Max's analysis of the poor food preparation was:

> You just have to use commonsense, now. Now, could get cold from the kitchen, in ten minutes or not heat it at all, you see, who knows! Which step you follow, it's been heated [Max bangs hand on table] or it's been not heated at all [Max bangs hand on table]! You don't know, but other times, she was, or he was not happy to eat because food was cold anyway! Not because of the size! But not hot! This is careless you know! (relative Max)

Max's example regarding a cold meal being served to resident Jenny whose room is opposite the nurse's station and close to the food preparation area, reflects a systemic problem, one of poor food preparation, when all food appears (at times) to be cold when it should be hot. This example also reflects Max's compassion and concern for the residents. The meals should be covered, not only to keep them warm but also for reasons of hygiene. Max role-plays the frail elderly resident's voice to emphasise of the poor care provided to her in her last months before her death. This also shows Max's compassion for the elderly. To Max, commonsense is one of the main foundations/principles of care giving. Max believes (and I agree with him from my own experience) if a designated hot meal is cold it would most likely be the main reason for residents not eating it, particularly if they weren't really hungry. Mealtime is very important firstly for the health of residents in that they need to maintain their nutrient intake to avoid malnutrition and dehydration, common problems in nursing homes (Davies & Snaith 1980a, 1980b; Castellanos & Wellman 2000; Pearson et al. 1997), secondly with regard to the quality of life (Bond & Corner 2007; Annells & Koch 2001; Annells et al. 2001) and lastly as a reflection of the quality of care given to the resident (Williams et al., 2003). If residents' meals are not provided with the

appropriate requirements of presentation, quality and feeding technique, they risk not receiving their required nutrient and bodily intake.

In Max's view the weekend AINs are emotionally disengaged and careless (Kahn, 1990, 1992, 1993) in allowing the food to become cold by removing its cover[51] and letting it stand as they go on to another task. In serving the meals in a manner that is non-standard, these weekend AINs ignore the best practice technique they would have been trained to perform and as followed by the weekday AINs. As a consequence, resident Jenny complains: "I don't feel like eating this!", and would probably not have eaten it had Max not intervened and reheated it.

An essential part of good care is in encouraging residents to eat, as one of the prime problems for the elderly is in maintaining an adequate food intake. At the same time, serving food cold is an indicator of a poor standard of care and of how poorly care providers and their delivery of care is supervised. It reflects the culture of the nursing home, as Max explains: 'That's good enough for them, but would you eat a cold meal?'

This disengagement and lack of supervision also impacts at the other end of mealtime when food is taken away before some residents are finished. Such a practice ensures failure in two important measures of mealtime success: residents' motivation to eat and their ready access to meals. Food should be hot and residents should have all the time they need to be fed, whether this requires the assistance of a good feeding technique or simply to eat it themselves - this is not something that happens on weekends at Golden House.

Two types of care providers

Max distinguished two types of care providers at Golden House, one has a 'good heart'; 'good will'; and the other is 'not nice'; 'not gentle and too tough'. Max's statement also points to the issue of some residents receiving harsher treatment than others, even by different staff. Max stated that some residents are perceived as "difficult" or "troublemakers" and do not receive the patience and understanding they require.

[51] The meal comes out of the kitchen hot—from my observation—and has either a plastic covered or plastic film 'Gladwrap' to retain its heat. However the weekends AIN remove this cover as part of their nonstandard routine allowing the meal to become cold.

Max emphasised that the quality of the care providers is *"there for all to see"* implying dismay that the accreditation assessors did not see the poor care provision on weekends. Golden House, having passed all 44 outcomes had been granted its second round accreditation leaving Max at the time of this interview sceptical about the accreditation process. Consequently he came to his interview with four pages of point-form notes, summarising the issues he wanted to talk about. Throughout the interview he checked with me as to whether he had covered those points and mentally ticked each point when it had been covered. Although Max made the point to talk to the assessors during accreditation, he did not reveal examples of poor care provision, instead he adopted the strategy of being a friend to Golden House in order to engender good will for his (resident) father through him. Having seen this strategy fail and sensing that my research would allow him to present his concerns with anonymity, he held nothing back.

'Good heart' care providers

Max defines one group of AINs—those that provide quality care—as having the attitude of '*hating to see mess*'. They also take pride in the quality of work that they do as it gives them job satisfaction. For these AINs, good care equals '*Good Heart*!' AINs having '*Good Heart*', give good care to all residents, that's their nature. Max provided me with a list of those he considered to be good care AINs and said they were working from their hearts. He believes that '*Good Heart*' is a common characteristic of good care AINs.

> Some nurse I tested, they are nice, gentle and good here (their heart). Sonia, I am sure! Andrea the Greek lady! Oh, Yes she is very good. And Sandra, and Joan… As I said already! …But I can't say just one or two… there is a group of maybe three, four, does it…which they do good…All the time they're from your hear yeah! they have a good heat! (relative Max)

Max perceived another group of AINs as being careless and is emphatic in stating that good care providers are a product of their personal character traits that is 'What you are!'

> If you want to do good job all the time, or you just careless, you know! If you are lazy no way you can do good job! I don't mean about the country or the culture, what you are (emphasizing these words with conviction)! Ok! You see! (relative Max)

When asking Max if he believed that training can make a difference to the AINs behaviour, Max states that training won't influence people, if they don't want to do it, they don't do it. Training has little effect if care providers don't want to do their work. It's not a matter of not knowing what to do, they just don't want to do it. Max believes that good care comes from the heart of the individual care provider! Good care provision derives from their, character traits and their outlook, according to Max.

> If…well again they have better training but they don't want do it, they don't do it, well…you know. (relative Max)

'Not nice not gentle, too tough and bloody lazy' care providers

This second type of AIN, according to Max, are those who are "not nice, not gentle, too tough, and bloody lazy".

> …but the tall Yvonne [AIN]. A lot of people don't like her, because she's too tough, she shouldn't work in the nursing home! Its not kind of her job!' She's not nice to resident! I mean with these people [residents] you got to treat them like a babies! I said to Ms B about Yvonne, as Ms B said 'Yeah, you must see when nobody around she does even worse!

> I saw another two [AINs], again not my father only, to all residents! Some are tough! …they have to lift you up, to get changed, to have a few steps of walking, you know! They not gentle! Ok! They just grab you, hold quickly. It's not good, but unfair!

> Because, first of all you don't know that woman or man how fragile can be or really is! Which you can hurt him or her! And it's not nice to say "Come with me!….even when they feed them, they just don't wait to swallow the first spoon of food, just shovel food, in their mouth in their mouth, one after another!

> …when they try to give him or her to toilet what they just pull up their cloth but they don't pull the cloth just, nicely around, you know. Come here! 'Take your jacket off! (relative Max)

Max goes on to say that these 'not nice' care providers are careless and in a hurry to finish work; working without consideration for the resident; working without thinking. From my observation these AINs like to work by themselves, this removes any sense of accountability, either by peer pressure or authority, to ensure quality care. Max gave two examples of poor weekend care provision, the first, collecting the resident's meals before they are finished and the second, pouring a cup of tea down the sink rather than helping the resident to drink it.

> One night in the big activity room, to Barbie (resident)… I was there… Barbie had to eat her dinner. When… Yvonne (AIN) come to collect the tray ok! …that some food still on Barbie's tray (bangs hang on table) eating. She is still eating, she hasn't finished perhaps just stopped for rest…why Yvonne (AIN) remove the tray from her if she's not finish yet! (His face expression shows he is very angry, as he stands up for Barbie). You mean you are lazy! You careless! You are in hurry, but who care! Because you got to feed them, you let them, pick at it… you got to let them… have enough time to finish… (Max bangs hand on table) because I (Max) am a fast eater. I can eat it in ten minutes, may be may be they take half (Max bangs hand on table) an hour! So why you collecting the trays? Do (Max sighs in frustration) the people who already finished! Don't go just ah, there without err know what you doing, ok! Barbie was hungry then! (relative Max)

Max gives his second example of a weekend AIN pouring a hot cup of tea down the sink instead spending the time to assist the resident to drink it by holding and positioning the cup at their mouth.

> The kitchen (kitchen hand) brought down some hot drink. They placed three or four cup in a small table in room number nine with my father is. …Ok! Now, they (AINs) got to wait for the next hour or less to let them drink to people who cannot do it themselves ok! Lucky, I was there … and I let my father drink, myself ok! But what about the other self? For Mel and Jim (roommates of Max's father) . …They left the cups there, what happen was, as I left the room not longer than thirty seconds, to have a look through the door (front door), to sign the book (the visitor's signature book, just placed on the front entry) or what I had (to do), on the way back quickly, *this nurse* (*whispered* Max) alright! This nurse, I suspect she throw out the drink in the hand basin. (relative Max)

Max states in the following quote that he is concerned for residents who don't have a relative, an advocate to make sure they are being properly cared for, what happens to them. He then categories these types of AINs as having no interest or commitment to their work, stating that they only come to work for the money.

> …if nobody (family or other relatives) there, how can you know they feed or give them a drink? …You lack of interest, you come here (work) all for money, not to take care of, your job, not to perform your job properly, you know! (relative Max)

Max then describes himself as an investigator/advocate in getting to bottom of what really happened and goes not the analysis the AIN's behaviour.

> I went to check the hand basin, and I saw some stain. She (AIN) didn't wash the basin properly… because, *the rush you know*! (Max *snarls*) … She [AIN] back to me for three to five seconds but when I saw her [he stands up] I was stand[ing] in front of Nancy's [DON] office direction and she was coming out from the man's toilet from lady toilet near my father … with a, with cups on her hand, which you think you could give them a drink in thirty second, because you're bloody lazy, excuse me the word , you know!
>
> Oh well, I don't like to spend three or four minutes with them, just let me be mean, in the hand basin and forget about them! [Max role-plays the care provider think aloud) *which means you are an idiot!* (Max snarls)

Max imagines the mindset of the AIN not wanting to spend the short time to give the drink to the resident and instead deciding to be mean and disregard the needs of the resident by pouring the provided drink down the sink to save themselves time.

Supervision Embargo

As mentioned in earlier chapter there is a nursing home industry-wide embargo placed upon DONs and DDONs which restricts them from working on the weekends thus eliminating a prime deterrent factor on lazy AINs and exacerbating poor weekend care provision. The DON consequently becomes totally dependent upon her weekend RN to safeguard the weekend quality of care but the weekend RN can only have an influence if she is standing over the AINs and watching them during key routines, which is not possible.

The problem is that key routines where one would like to supervise AINs, such as showering and mealtime, are the times when the RN is busy giving out *required medication*[52] across the nursing home. Consequently, when the RN actually has time to supervise the AINs, they are spread across the nursing home on tasks that are not a priority for observation. Contrary to the weekends the DON is a free agent to roam the nursing home, observing key routines and thus not dependent upon RNs to make observations. Max believes that even in the absence of management staff, the AINs should follow the set routines as defined by best practice. Supervision, management, leadership and self-accountability are all issues that Max is aware of and to which he brings his insights.

Another consequence of this lack of supervision mentioned by Max, is that AINs—particularly weekend AINs flaunt the expected routine of putting to residents to bed at a reasonable time (say 7pm), instead attempt to put them to bed as early as possible.

> May be it's the rule of here. But my family, to tell you the truth, six o'clock is bit earlier, why you don't go seven thirty or eighty o'clock…you tell me what's that! I don't know, you see! It's another care (another quality of care issue) you see! Because, you want to finish the job as soon as *you can and then you go have rest* (spoken in a *derogatory, snarling way*), you know! Yeah, probably!. Because... Nancy (DON) or some others supervising, elsewhere! (relative Max)

Max laments that without supervision and the threat of accountability workers in any industry will try to do the least amount of work possible and you can't change that unless the worker makes themselves self-accountable and takes pride in their work.

> For example, at the time of five or six o'clock. At the latest... they (DON and supervising staff) go home, ok! Then, now once again when the boss is not around…the staff still have to perform their job, their work, and with much less pressure, you see! It's always to follow them stupid prat, you know! Now, the less you do when the boss is not around, the better is for you (AINs), it's wrong! But we won't loose it, won't change the reality of work, you know! (relative Max)

[52] Required medication is a component of medication management where a medication has to be giving within a window of opportunity to maintain its effectiveness.

Max believes that some care providers are not suited to working in a nursing home and may be better equipped to working in a fruit shop.

> And that's not the type of care...lack of care against or towards of the residents, you know! You do that job because you have to, you obligated to do, not because you wish to do it! Well, this is not your kind of job, go to, would go to work in fruit shop! (relative Max)

Accreditation process

Max maintains that good housekeeping is important and asks why Golden House doesn't maintain the high level of activity/organisation that was evident leading up to accreditation. Max mentioned that having a clean nursing home is no longer enough to survive accreditation; the nursing home has to have a quality control system in place all the time. Quality of care directly depends upon all the care providers doing a good job all the time' not working hard just leading up to and during the accreditation period.

> There is some um, care here which we talk quite oftenly (pause) there err, one was err contacted the accreditation time…here, you know! They give you say in week ahead we come there to investigate, ok! Somebody they come. They have to come here suddenly without notice! Which would be better! [Max emphasising his words] You think that will be better? (Relative Max)

I agree with Max that giving a nursing home notice of accreditation isn't a good idea as it allows the nursing home to present a false impression. Max believes a well run nursing home will have a consistent high quality of care all the time. If a nursing home is found not to be covering the basics of good management in both human and clinical care provision, equipment maintenance and hygiene, it should be shut down.

> Better (pause) in a way that they can see if there is clean, well run or not too bad or not good at all, you know! But then, put this way, if the condition is good everything go forever! (a well run nursing home has consistent quality care) Now, if they plan of this supervisor, they can cover, all right! (if nursing homes know that accreditation assessors are coming they can cover up inadequacies). If the place, not too good maintained but ah hygiene, err this and that you know. Now that, in that case, if just take all severe or strong, they can shut this place! (Max bangs the table with his hand to emphasising a point) (Relative Max)

Max goes on to say if a nursing home can't cover the basics, you can't defend them in the face of community expectations. Even though Golden House passed accreditation, the staff had to work very hard at the time, clearly indicating that the care provided before accreditation was nowhere near what was presented during the two day accreditation period.

> Then you can't face them (can't defend the nursing home) for the community, its not even good. You understand that? Arhh, well it's all up to the staff then…to do good job all the time (Max bangs table)…with accreditation period or not. (bangs table) To run the place good. And and again when the (accreditation is coming then only at that point they offer good care, what's the point), that's all I can say with accreditation, um…the accreditation was passed but they had to work even harder everyday! (relative Max)

Max states the real quality of care in a nursing home can only be seen in spot-checks, when the assessors "see the real thing".

> You see! That's what I can do with it, that what it is, about accreditation, ok! That's why somebody recommends to come here (Golden House) without telling you! Then, Spot-check! They will see the real thing! (relative Max)

According to relative Max its up the management to choose the right people that have the core attributes of "a good heart, good will, good working will" and good outcomes will be "there to be seen!" all of the time, not just a pretence during the period of accreditation or not there at all during the weekends.

> …when the assessor coming, it's a bit of trouble for us because you have to find somebody else to make a comparison against which you don't find any better, may be you find even worse. That's, the place you go, you know! Then again, it's all up to the management, to the staff if they have a good heart, good will, good working will, it's all there to be seen! It's all there, you know! But also to keep an eye…of what the staff doing! And *it's all there*, you know! (relative Max)

RN Lily

RN Lily has worked as a registered nurse in Australia for over 16 years having come from the Philippines. RN Lily's interview took place 5 months after Golden House had successfully gained accreditation for 3 years, having passed the 4 standards and all 44 outcomes. A month after this interview she left Golden House due to family commitments. RN Lily is the only registered nurse who has a permanent shift Monday to Wednesday (24hrs per week) and that being the case is the DON's prime registered nurse who is able to keep what is happening in Golden House on track. RN Lily also has had experience of different shifts in Golden House, those being: afternoon and nightshift weekday and weekends. She describes her character as:

> I just want to finish what I haven't finished, for that day. Otherwise I'll be in trouble. That's me, my conscience comes clean. I always like that and I have to do it! Finish everything, before we go. I feel…Obligated. Our obligation. (RN Lily)

RN Lily has great compassion for the older residents in general but for residents with behavioural problems in particular she demonstrates great care. Listening to the residents is part of good communication and is very important, particularly in dealing with residents who have dementia. This approach gives Lily work satisfaction.

> I'm satisfied… I enjoy doing my job and knowing about the residents and some of their behaviours and ah their different behaviours and how you, you can manage them. It is, it's fulfilling thing for me, especially when some difficult behaviours, the nurses cannot, cannot ah handle them. And then when they call me, and then go up to that resident and then just talk to them, they will calm down…They will calm down! I think it's because, I have mostly especially dementia (residents). I know when to go near that person even if he is very aggressive, when not to go near him or when to go near him… you can analyse when to interfere with that behaviour. (RN Lily)

> You have to be compassionate to them! You have to have this because especially with this old people, you have to talk to them nicely. And assuring, reassuring conversations and let them talk, let them talk whatever they want to talk and listening is a good and important thing for them that you have listened, and then that that

> diverts them from their behaviour. Yeah, and then perhaps you give them a cuddle or whatever you can make them at peace. (RN Lily)

> And you know…like when resident behaves, because you know her behaviour already and you know how to control that behaviour. So, that's, and then you just, it's easy for you to manage that one because you know how to handle them already. You have to getting used to their behaviours and their under tantrums and their confusion. (RN Lily)

> If there is some diversion, or you can let, the recreational officer take them and give them some activities, if you want them or let them walk within outside just to, to divert some of their behaviours, difficult behaviours. (RN Lily)

RN Lily preferred to talk less about the actual practices at Golden House and more from her own beliefs and experience working in nursing homes in general. She provided both a description of what constitutes ideal care and the actual nursing home care provision at Golden house.

Home away from home

RN Lily's view of nursing home care is that it is a home away from home. Nursing homes have a great responsibility to create an environment that suits individual residents, but she acknowledged that this presents difficulties.

> The care in the nursing home, is more of like, you treat the residents like to upmost (almost) like living at home!...So this resident wouldn't feel alienated to this place, so they have, in the end it's only manner…But sometimes it's quite difficult you live in this kind big environment, so many people come and go and share, and then there's noise then…It is very difficult, it is! It has to be… it's a big a responsibility also, a nursing home. (RN Lily)

From RN Lily's point of view quality of care is about comfort, reassurance, autonomy and choice. As she said:

> …is to give the utmost physical, mental and stability of the residents, and comfort giving them reassurance. That they are mentally secure and physically, that their taken

> care of and they are being fed properly, dressed properly when they cannot do it, so! It's assuring them that things they can not do, we do it all for them. (RN Lily)

> …that they [AINs] have to be conscientious on their job. They have to individualise their care, for not, they have to do it the same thing on the other resident, they have to be individualized… Because not two people are the same! Yeah, some people prefer to its individual differences. They have to know every patient's likes and dislikes! Specially with their routine, routine cares. (RN Lily)

> They (the residents) should have their voice, the nurses should listen and then give them, a little bit of time and then they (care providers) have to come back and say 'Do you want to have your shower now or a' (role-plays negotiating with resident) or even if, after the shower you can go back to bed, if you want to. Its just compromise. You have to let them know that you care, after the shower were clean and things like that…You have to give them some feeling of choice, control, autonomy that kind of things. (RN Lily)

Actual care provision

In this section, RN Lily describes the care provision as routine, a production-line model and the issues that influence the quality of care provision and care outcome. In general, she believes that nursing home care provision is routine and production-line in its processes.

> I think it's already in their (care providers) mind that have to finish this, you have to finish the job first! So that's means they don't treat resident care as a holistic, whole person care…They just doing the routine. it's the routine one for them! Oh, it happens everywhere. People work in nursing home like that. (RN Lily)

Further, the issues that influenced the quality of care provision and care outcomes for RN Lily included: registered nurses and DON's supervision of AINs, the presence of the relatives, the individual care providers' character, self-accountability and the proprietor's tight budget.

RN supervision

RN Lily described her style of management and emphasised that supervision can make the difference on care outcomes. She tries to teach the AINs that they need to keep the RN informed about the residents' condition, but at the same time she seeks to allow them some autonomy when giving care to the residents. RN Lily pointed out that some care providers have a limited ability to understand these points due to, for instance, cultural background, language and other factors.

> My main goal…is to let the staff be aware that they have to work in a safe and proper way… and the residents! To achieve! I want to achieve… I want them to report everything what is happening to residents (stated strongly), like excoriation (strip off, remove skin), even if they do that every day, and if they still have these… the creams that are for them, and like the bowels are swelled or if are open or that have to report to me all those things! (RN Lily)

> But if you don't tell them, they won't they…You have to go after them, you have to keep on reminding them 'Umm people, behaviour chart please' (role-playing talking to care providers) I cannot…get them to do tasks without hounding them…You get cranky with them. Because by the time you check, their already gone, you cannot go after them!... So the next day…I have to go after them the next day, why are you are not writing this (sounding annoyed). For example, with the behaviour chart, it's… must for them to write everything about the resident! So that the doctors can see, and they can manage the residents. (RN Lily)

> I just ah let my staff aware, be aware that, they have their jobs to do and I have my jobs to do and we have um, I can not be following them all the time, so they have to do it in a proper way. That, I don't have to go after them. But because some of the staff just wants to do, if they are not watched…Some of them, some you can trust, you can trust some of them, but some just watching the RNs and then they just do what they want to do! When you are watching them they do better … They will do a bit, the right thing…But I can't be watching them all them time, unless I have some partner and there has to be, what I mean is some educators to keep an eye on them.

> I will just to tell them about the objectives of their jobs and the importance of their jobs to the residents and they have to do things. Like if they do it to the resident, they have to think about themselves in the foot of the resident, on the feet of the resident. What I mean if sometime they become a patient like this residents, are they gonna or will they like the treatment they are give them, the way they give them! So just, self indulgence, like you have to put yourself first in those people you are taking care of. But for some staff, because of their own culture, their language barrier, their comprehension level …of course it will affect some of them. (RN Lily)

The role of training

RN Lily suggested that education can make difference for care providers in doing their work properly. From her point of view thorough basic training leads to nursing staff having an understanding of what they are expected to do and offers no way out of their obligations to do the right thing. Care providers could then be held accountable if they weren't doing the right thing because they had been trained to follow the proper procedure. Unfortunately, it is not compulsory to provide care providers with education at Golden House according to RN Lily.

> …it should, because it gives them a reminder what proper things they have to do. So that the nurses can really, can think what is right and what is wrong with their jobs! But here (Golden House) we have educator, but Education not as you know really the education. Here is not as very compulsory or whatever comprehensive! (RN Lily)

However, RN Lily observed that AINs retain their old habits and attitudes to residents that result in poor care provision despite training (especially care provider who has a Certificate III).

> What I have observed by certificate three, even if they have did some certificate three their still sticking to their old, you know to their old way they do things…Because they want to finish quick so they finish quick and they relax after that. But you keep on, you keep on telling them, 'there's no hurry, you've got eight hours to do everything, that's enough for you there's no hurry, just do it (claps hands – in frustration) in a gradual way! I say to them, You don't need to hurry, to hurry up the residents… because some of the residents didn't want to be hurried, that when they get cranky! I

> tell you I saw many staff… I think most of them. Because they want to finish everything! In one go! So it doesn't matter what you tell them they still do… (RN Lily)

RN Lily then goes on to analyse why the care providers do what they do - she believes it is very often about 'routine' coming before quality. The task itself comes first thus reducing the 'resident' to something less than a whole real person.

> I think it's already in their mind that you know, have to finish this, you have to finish the job first!... they don't treat resident care whole person care Holistic, yeah…They just doing their routine…It's the routine one for them!... Oh, it happens everywhere just like nursing home culture. (RN Lily)

RN Lily noted that during the week there are more RNs as well as a DON to supervise the AINs which for some care providers, makes them more concerned about the level of care provision they offer. RN Lily used her own experience of weekends to explain that some weekend care providers are too relaxed because there is no supervision. RN Lily believes that care providers themselves become institutionalised within the organisational culture and climate that pervades weekends in nursing homes. She went on to describe how weekend care providers know how to avoid supervision and accountability by keeping a lookout for the RN in order to avoid her.

> RN Lily view is that if management provided proper staffing levels and supervision with consequent accountability, quality care would be easier to achieve.

> The care is different with the weekdays. Because with the matron (DON) around I think, during the weekdays, the matron around, they're more likely careful. And because once there is a complaint, they know it goes straight to matron. They can be attended to matron right away.

> While on the weekend we have to trace who's doing the, who's the person who is not doing properly then, just … I think the staff work on the weekend are more (pause to think) more relaxed. That is because, there's, the boss is not there, only the RN, and the RN is so busy that they can't do anything.

> It's very hard for the RN, especially if she's alone …With this number of residents…And the staff are already have been here for years and very institutionalized as well and they know when to get away! Sister (RN) is not there, you know they're just watching!... because they know that there is only one RN…and she(RN) can not be always on their back…I have to finish my job first before going after them (care providers)! Otherwise, I'll be the whole time here. So the best plan for the management, proprietor. There should be another RN who can really watch…

> More people to supervise them (care providers), the quality will be much more simple. More people, more people to check on the nurses (AINs). (RN Lily)

This raises the question, if RNs are also not self-accountable or have no management or supervision ability, how will they be able to supervise AINs and make them accountable? According to RN Lily it is the DON's responsibility to check that the RN is competent and that the quality of care is maintained over the weekends. Unfortunately, while the DON cannot work on weekends to check the quality of care and RN competencies, she must rely on the weekend staff to report things to her.

> But who will know that is of the matron (DON) to check! If that RN is functioning properly on the staff! So if this is the case if the RN not doing their supervision properly)! If it will be with the extra RN plan, that means that RN (pre-existing lead RN) is not doing her job. (RN Lily)

This statement highlights RN Lily's identified dilemma - even if the RN wants to supervise the care providers properly she hasn't the time to do it. RN Lily doesn't want to personally admit that she can't do all that she knows she should do, just as Andrea avoids responsibility for other care provider's poor care provision.

If an extra RN is required to improve supervision, there is a fear that this will be perceived as a short-coming in the work and ability of the pre-existing lead RN because it would remain her responsibility to follow-up any issues of concern. RN Lily raised the issue that the DON has her friends in key positions which not only limits her authority but gives those staff preferential treatment fostering an abuse of their favoured position.

> So but if she is doing her job following them up, or things like that so, things can be improved! And she has to have limits when to be nice to them (care providers).You have, you have to! you know from your job, you have to do your job and friends, you can be friends, but when it comes to work you have to do your work! You have to let them know that. (RN Lily)

Presence of relatives

RN Lily confirmed her belief that the presence[53] of the relatives influences the care providers' behaviour in providing the care.

> Relative, yes [said firmly]! Yes! Because once they know that the relative is that strict for the residents…that they, wanted this to be done for the residents, they will do everything to make that resident, comfortable, clean and presentation and ready for them when they come in. But if no relative, no relative just [clicks her fingers as a sign of care provider escaping accountability)] do them routinely that's it! Is that not true? That [the way the situation is]! (RN Lily)

RN Lily suggested that the positive side to having relatives present is that they influence care provision in a positive way. If however, the relatives become too 'fussy' the situation can become difficult between the relatives and the care providers but RN Lily believes ultimately that relatives complain in order for their resident to get better care, to maintain quality care for the residents.

> I think relative is very…a good influence, big influence on the care of the residents. It is!...That makes them (care providers) more aware that, 'We have to be careful, in case they sue me against the relatives are always complaining this and that!' (role-playing an intimated and scared care provider) (RN Lily)

> But if the relative is very fussy…The more there will be, they worried about the relative's complaints and they will offer suitable care… but that gives them

[53] See Fisher, Hindhorst, Matthews, Munroe, Paulin & Scott (2008) on the staff attitudes and behaviors regarding family presence in the hospital setting,

> sometimes…the staff gets irritated by the relative, you know! Sometimes they can over exaggerate, accentuate their complaints. (RN Lily)

> What I think about the complaint this thing, what is the purpose for them (relative) to make the complaint… To have a better care for their resident! To keep an eye on the residents, the way they want it to keep quality care for the resident. That's just human, that's. What, that's, the whole aim there for everyone should do to maintain quality of care for resident. (RN Lily)

Two types of care providers

RN Lily has identified two types of care provider, a good care provider and a 'just doesn't care' care provider. The former is always aware of the individual resident's care needs. Understanding that the care has to be for the individual resident's benefit. The 'just doesn't care' care provider is the opposite.

Good care provider vs. 'doesn't care' type of care provider

> …good care providers should be always aware of what are the needs of their individual resident's. (RN Lily)

Good AINs report the health status of the residents and any accidents that may have occurred. RN Lily gives an example of causing possible accidents to residents by being in a hurry and working alone. Good care providers report resident accidents, demonstrating a sense of responsibility. On the other hand, 'just doesn't care' care providers, tend to cover up incidents.

> Some nurses really are very good on the residents! Sonia is good. And Andrea because they do their residents one at a time and in a very organised way.

> …Because with Sonia she always tells about the residents what's up. What they see in them, if this thing have being reported, they keep, she keeps telling me everyday, about that…Yeah she's a responsible, you can rely on her." (RN Lily)

> Some others just doesn't care. Some our staff just keep it to themselves or they said, you will just say they forget and they will think that it, happened a few days ago and they did not think that ah that it is to be reported. Because it has been reported already. (RN Lily)

Proprietor's tight budget

RN Lily described the food provided as a reflection of quality care but said it was difficult to judge the food appropriately because much of it had to keep the special needs of the residents in mind. She emphasised however, that there was no variation in the menu at Golden House.

> The food is so general and because I don't taste the food/puree, I don't know what, what the kitchen is preparing for that (resident's diet). Especially, they are very plain. I don't know if they are making diabetic food for them or…But, mostly I think in the nursing home they not putting too much sugar there, or too much salt in there, it's just enough for the ah residents that because there's salt and pepper there, or sugar that is for them too if they wanted sugar or wanted more salty it's for them to choose, so. I think that's how they're prepared in the kitchen. They like the food I haven't heard um any relative that, they say they like the food! That's as far as I know, they love the food. But the food are prepared like same food on a Monday, same food on a Tuesday, same food on a Thursday that's it! There is no variations! I don't think there is variations there. (RN Lily)

RN Lily pointed out that the budget for food and staff is tightly restricted by a proprietor who is not willing to spend money on these essentials and that this has an obvious flow on effect on the quality of care. The major thing that affects the quality of care is money. The financial side! Because if the proprietor can just spend all… not really all, to the normal way… provide all these for the comforts of the residents!

> And make a nice place for them and provide all the good food and, provide enough staffing! Very important…Staffing is the best, because if there is not enough staff…if have enough staff, much better …because, everyone won't be a hurry and will be look after, because enough staff. (RN Lily)

Accreditation Process

RN Lily didn't have direct involvement to the accreditation at Golden House, but has had experience of accreditation in other nursing homes. She understands that the role of accreditation is to improve the standard of care.

> The accreditation is to improve the standard of care it works in most of the areas. It works, because it has to be the standard has to be monitored at all times …to uplift the health care. So there is continuity of like improving. (RN Lily)

RN Lily does not think that nursing homes should be informed before accreditation takes the place. She suggested also that there should be spot-checks without notice. The Agency would then be able to see the services the proprietor claims but does not deliver, as well as the false paper trail of documentation. RN Lily described quality assessors as being hoodwinked, and not seeing the real situation. Proprietors cover up their wrong-doing and manufacture a paper trail.

> They should use spot-checks and they will know what is not there. Their eyes is farce…There is too much farcicality in this, they (assessors) should not let them (proprietors) know (when they are coming) (said in a high pitched voice)! Because, once they've (proprietor/management) aware, they will do all the fake things here. It's true in everywhere. Because people can make up a lot of things like the paper work, document. Just up the lot or artificial, all bullshit! So, the accreditation people should come, to the place that they have to check on the spot. So they (quality assessors) will know, what is wrong with the nursing home… let the proprietor unprepared. This is like in a normal situation. That's when they (assessors) can catch them (proprietors/management). And see what is not there Normally! Not normal! (RN Lily)

RN Helen

RN Helen has a Fuji/Indian background having worked as a registered nurse in Australia for over 25 years, the last 10 years of which she has been working in nursing homes. RN Helen was interviewed 16 months after Golden House had passed accreditation and five months before the HCCC commenced an investigation. This investigation had triggered an ACSAA reaccreditation process which resulted in Golden House failing over half of the outcomes, leading to sanctions being placed upon it by the Department of Health and

Ageing. During this time, DON Nancy was on sick leave, having been replaced by a temporary DON.

RN Helen holds dual roles as the Nurse Educator and the Quality Coordinator and was my initial point of contact for developing informal working relationships with the staff at Golden House as I helped them prepare for accreditation and in the development of educational resources. RN Helen has always worked seven days per week. She presently works thirty-eight hours per week full-time (day shift) in another nursing home in addition to her sixteen hours (day shift on her days off) at Golden House. She often will pick-up, on average, relief short shift work (four hours per session) at Golden House, giving her another sixteen hours per week, a total work commitment of seventy hours per week. RN Helen says that she likes to work, likes people and sees her work as part of a social life that includes the DON, RN Lily, Andrea and even Max.

RN Helen has a strong religious belief as is evident in this interview. I believe this influences her worldview and how she responds to her work and to the residents. RN Helen has had a long term working relationship with the DON, they have worked together for many years. When the DON took up her position at Golden House, she asked RN Helen to come to work with her in the positions of Educator and Quality Coordinator.

Home Away From Home

RN Helen's nursing home care is about the involvement of the physical, emotional and psychological needs, quality life and security of residents. Care in a nursing home is about making the residents happy, comfortable and generally contented. This is also a quality of care and quality of life issue from RN Helen's view point. In this interview RN Helen describes the resident's physical health needs and her focus on making the nursing home a home-like experience. She believes that care providers should strive for this goal from the first day the resident arrives till their last breath of life.

> We try to make it home like… I mean you can never replace their home, their lifestyle, because that's the last stage of their life, so we try to make it as close as possible to a home environment that would make them feel happy, feel settled! (RN Helen)

Routinisation of Care[54]

RN Helen conceives care as being provided within a production-line of interlocking constraints, as care providers work within a fixed timeframe. The care is seen as a process of routines such as toileting, feeding, showering, physical activities, recreational activities and many others.

> In the timeframe we could sort of try to fit in all their all the care that they're suppose to receive. Within the timeframe …the nurses work … like you individual shifts, know like individual shifts! Comes like eight hours and so on. So there's twenty-four hours care! And another lot comes in, another eight hours. So like you have toilet period, we have your meal times, we have the showers and so on, everything is all time, you know is all time! (RN Helen)

RN Helen pointed out the difficulty in fulfilling the needs of each individual resident is due to a lack of time and staffing (both the AINs and the registered nurses to supervise them).

> We (RN) got all their individualise care plans, so each resident is sort of being look after according to their needs. I mean as close as possible, you might…not be able to meet all those individualised care needs of residents everything that they need! But at least, if you have enough staff and so on and be able to work…in the timeframe. (RN Helen)

RN Helen believes that her role is to primarily manage the AINs and other care providers, to devise a plan of work within the timeframe available to them whilst trying to meet, as much as possible, the needs of each of the residents. She pointed out that care provision within a nursing home has lots of gaps but she that attempts to fulfil all the resident's primary needs and at least partially meet the residents other needs. The gaps in resident care provision come about in her view through a shortage of AINs, which can only be overcome by care providers working more quickly or taking shortcuts to be able to meet the primary needs of residents. Residents inevitably do not have all their individual needs met.

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[54] The term 'routinisation' is discussed by Pearson, Vaughan & FitzGerald (2005).

> Maybe we might not complete the physical and all, the physical activities…exercises, the RAO activities and so on…I mean all those things all be included that eight hour period. Within a time, a timeframe to be able to you know, to cater all those needs! I mean there a lot of gaps there… might not be able to meet their physical needs.
>
> We always have not enough staff to provide those care… the other part like the emotional needs and so on and be able to sit quietly with resident, be able to talk to them individual and give individualised needs. But you know, that sort of thing they suffer. (RN Helen)

RN Helen acknowledged the reality of nursing homes being 'businesses for profit' in that profit comes at the expense of increased levels of individualised care.

> I mean an ideal situation you cannot like a business, if there's only a limited number of staff, that acceptable level of staff that can work there. In reality, those staff have to work so hard to be able to meet all those things. (RN Helen)

Quality of care

RN Helen emphasised that AINs need to respect residents at all time as if the resident is their own family member.

> Quality care is includes loving care, understanding, caring and loving. Caring as if looking after this patient as if it' s their own, or how, or looking after the patient as they would like to be looked after, if they were in their place….instead loving care and understanding that's what they need. I believe that residents in Golden House receive quality care. (RN Helen)

Quality of care for RN Helen is a multifaceted concept. It includes a well-designed, functional and clean environment, within a pleasant homelike atmosphere of family and community involvement serviced by good AINs and at adequate staffing levels.

> …being able to meet all those needs! I believe the physical needs, emotional needs, psychological needs and in specifically good care, being able to meet all those things, and bring it and having a good quality staff you know, and… enough staff be able to look after these residents…and caring and understanding staff. (RN Helen)

The involvement of family and community can help to fill the gaps that are not able to be met by nursing home care providers. Volunteers are also welcome in nursing homes to fill the gaps created by the shortage of the staff. Staffing levels are only one factor in determining care outcomes.

> I feel that the family and other you know outside communities can come in and fill in that other things that the nurses are not able to meet…they being able to sit down with their husband and be able to keep them individualized attention and so on! Like for instance, like Golden House, the recreational officer brings up all different community. (RN Helen)

Two types of care providers

RN Helen talks about the existence of different types of AINs within a nursing home organization. Different groups of AINs working together in an organisation is very common according to RN Helen. She pointed out that even in the best nursing homes where she has worked (in all her years of nursing (Cumberland)), there are still two group care providers, *'good'* and those that will 'play up'! As she described those 'play up' care providers as:

> Well, I think you see them everywhere… if you go to Cumberland (nursing home), there will be good staff and there'll be one's that will play up.…the Cumberland instance is totally different, and that's probably one of best nursing home I ever work in! And I think that goes for (every nursing home) and the same thing too. (RN Helen)

> With Golden House you'll see the ones that are not so enthusiastic about their work but see other ones who are much more responsible and much more hard working. And take more pride in their work! And caring at the same time! Well they can, if you put them together, they can influence each other …if mixed. If you put the ones that plays up together…the 'not so good workers' together, you don't expect to get the same good result! (RN Helen)

> You'll probably find that there will be a lot of gaps there in their work and you'll probably if you follow them, you will find that you know their work it'll be really under standard level you know so you'll be disappointed. So they can be quite a

> problem so it's creates more worry for you! You know for the RN in charge. It's always advisable to keep the best grouping together and not to mix 'not so good worker' with a 'bad worker'. (RN Helen)

> You have to put the one that not so well with more responsible sort of staff… but it's hard to know it will change the bad one, it's depend, if…an individual person, probably depends on why you know, the reason why they're there in the first place. (RN Helen)

RN Helen conceives the character traits of those 'play up and not so enthusiastic' AIN's as the following:

…some of them are probably are just defined by nature, more defined (already a fixed character) and they don't like to be rules so be orders, or else they don't like to be they don't like to be told… or probably just sheer laziness, they just lazy…and perhaps not so caring and don't the have understanding about, what they are doing…and immaturity. (RN Helen)

RN Helen explains how she manages the 'play up and not so enthusiastic' AINs by the utilising the following strategies:

> …with the staff [AIN] normally, staff work in pairs…I'll…put that difficult person that doesn't work properly…I'll put her with the most experienced nurse [AIN] who is more reliable and being able to the teach nurse and keep eye on the nurse.

> I wouldn't put someone that's inexperienced…With somebody else that's not so reliable. But I would pick one of them, the most experienced nurse available, can pair them together…so they can work and I just keep on eye you know on them, that way, and then put the experienced nurse will be able to tell me how she's (inexperience) getting on and so on! Well, perhaps I'm looking at Sonia for who's has years and years of experience…she's very reliable. You don't have to tell her everything, she has a lot of initiative…Sonia is very experience and reliable nurse and better approach to some body else… and she's mature too that's…to be able to make workload more manageable. (RN Helen)

RN Helen's idea is to place more emphasis upon the fitting into the machinery of the production-line of care with no mention of the quality of care outcomes. From her point of view novice AINs not only need to have the ability to manage their daily tasks for residents but also need to learn from a senior AIN who may act as a role model or mentor.

> …well they [experienced AINs] can teach them. They know they got to work within the timeframe as well…So they got to finish certain works, at certain time. So they can able to fit in their meal break as well. And paper work…and plus their toileting… So I mean all these things, if you follow somebody that experienced…that they can learn and you pick, I think you'll learn from there. (RN Helen)

RN Helen goes further to describe the possible motivations of why people become AINs, suggesting they work in nursing homes because they need to work but this being the only work they can get this makes them quite different to those AINs whose motivations are caring for others and the satisfaction they get from their work.

> …and perhaps you know a lot of them (AINs) are there because they need the money. And perhaps others…are there for other reasons. Well, most of the people that are doing are bring to this kind of low, low paid work, I mean this kind of job anyway, they probably can't get jobs elsewhere, so they're stuck with that kind of low paid difficult work.…that kind of work, …but you will find the ones that are really caring and ones that are not really caring. And the ones that are just there to get their money and out they go [leave when they've had enough or not have their hour renewed] (RN Helen)

RN Helen characterises AINs who 'play up and (are) not so enthusiastic' as those who are just there for the money. These AINs exhibit no emotional engagement, commitment or work ethics, being in the end a liability and eventually having to be pushed out because people can't tolerate them - this is easier said than done.

> And I guess, you know it will be those people in a nursing home and depends on how they are, I mean if become too problematic, you know you can probably just eventually get weeded out. You know, they, I mean eventually, you can't tolerate people like that in a nursing home. (RN Helen)

Quality of Care Determinants

RN Helen also pointed out other factors she believes influence care outcomes: the characteristics of the residents themselves; the DON's problematic management strategies tied to poor communication channels; the proprietor's imposed budgetary constraints; and finally the presence of relatives.

Resident's Characteristics

Residents with behavioural problems require a lot of the AIN's time and consequently a nursing home is a stressful working environment with pressure placed upon care providers to choose an appropriate coping strategy[55], according to RN Helen. The work pressure arises from the need to undertake the arduous routine tasks that are locked into a fairly inflexible timeframe, managing residents with behavioural problems and being generally understaffed in either in numbers and/or those with appropriate work ethics[56]. A successful nursing home also must try to meet everybody's needs, including those of the AINs, residents, relatives and management; a feat which is next to impossible.

> We try as much as possible but I think sometimes… we can't meet all those needs because of the our pressure like it is hard work to looking after these people, like looking after their needs, showering them, the behaviour! You got to be able to control their behaviour at the same time, it's just…take a lot of time…and then toileting them in between… and then feeding them and then when you see you got an institution like that there's so many residents to look after (whispers). But you have try to meet everybody's needs as much as possible. Well it's tough! (RN Helen)

> And then toileting them in between (in between all these disruptions)…and then feeding them as well, and then… and when you see you know you got an institution like that there's so many (residents) to look after (she whispers)! (RN Helen)

[55] See Folkman & Lazarus (1980); Drew (1987); Wrubel, Richards, Folkman & Acree (2001); Chia & Holt (2006).

[56] In terms of work ethics, some AINs are lazy, slow and incomplete tasks leaving them to committed AINs.

RN Helen perceives nursing home care as institutionalised care with all those connotations! Of significance is that RN Helen whispers this passage of interview as if this is a secret of her true beliefs, just between herself and me.

DON's problematic management style

For RN Helen there is a dilemma in being an insider and an outsider. RN Helen has known and worked with the DON for over ten years - the DON having asked RN Helen to come to Golden House to be 'her right hand person'. RN Helen has a very close relationship with the DON (Nancy) and although Helen believes the management at Golden House is poor, she remains very loyal to her friend.

RN Helen revealed the issue of the DON not handling complaints properly from her perspective. According to RN Helen the complaints were received repeatedly but they (DON and management) appeared to do nothing about them, allowing them to become major problems requiring the Department of Health and Ageing and ACSAA to come onsite. However, in common with the DON, RN Helen did not like receiving complaints that were really systemic problems but which, nevertheless affected her self-esteem.

RN Helen's criticism of the DON relates to the DON's inability to resolve systemic issues but RN Helen is unaware that the DON was restricted by the proprietor to not take action. If the DON was allowed to work some hours on the weekend she could have observed the weekend AINs, perhaps sacking some of them when their care delivery did not improve.

> The management style (DON's management style) wasn't that good! I just feel that the problems was not resolved. Ah, a lot of patients (residents) complained and I think because of the workload that the…administration, they couldn't respond appropriately to those problems. If they did resolve the problems it was not adequately resolved, because the feeling that was always left behind was that…the residents complain[t]. When [that's the case] what's the use of complaining because if take the complaints, they (management, DON and proprietor) don't do anything about it. And that was part of the common complaints I got! (RN Helen)

RN Continuity

RN Helen pointed out that there was no stable employment or commitment of RNs to report to the DON. RN Helen has a sense of commitment which is reflected in a tone of

guilt (she is a part timer herself) that creeps into her voice when describing the situation of a 'passing parade' of registered nurse part-timers who are mostly there for the extra money - like herself. Her valid point is that the poor management practice of not employing a stable group of committed, experienced RNs at Golden House has led to poor care provision. There is nobody at the 'helm' of Golden House who has enough continuity of exposure or commitment to understand all that goes on and to be able to develop problem solving strategies and then see them through.

> The staff didn't have regular meetings, you know, where they could bring all their … all their complaints together and then be able to talk, it was another problem as well. There's got a lot of problems. The same with the RNs as well…we didn't have any meetings and the problem there too was that we didn't have a continuing of staff. Like most of us (RNs) that worked there was we had jobs elsewhere, our full time job when then you (registered nurse) worked just to fill in work there as part timers.

> Just part timers, just few days here, few days there, that sort of thing. There was no continuity, no continuity…, a lot of RN coming in like they (RN) just want to come and work their eight hours, give out the medication, write their report up and off they go. (RN Helen)

Proprietor's Tight Budget

According to RN Helen the proprietor is extremely tight, a miser in trying to save every cent at the expense of safety and the quality of care provision to the residents. As the volunteer[57] Educator at Golden House, RN Helen was concerned that the proprietor refused to pay non-rostered staff to come in (in their own time) and attend compulsory education lectures[58]. At the same time there was no penalty[59] for the non-rostered staff who did not attend compulsory education lectures and since the proprietor had refused to pay

[57] The term 'volunteer' refers to the fact that RN Helen was not required by her position to take educator duties but instead took these responsibilities upon herself.

[58] The payment of non roster staff to be paid to attend educational program is a nursing home industry accepted practice and is well looked upon by accreditation assessors.

[59] Penalties could have involved non attending non rosters part time staff not been given extra work when it became available, instead this work was given to those off roster staff that did attend education programs.

staff, they chose not to attend. The consequent safety and quality of care is compromised by their non-attendance. Perhaps the proprietor believed the documentation relating to the training, for accreditation purposes, was of no consequence to him in maintaining his operational license. In fact, RN Helen was blamed by the operational manager[60] and the proprietor for the poor educational outcomes and subsequently resigned her unpaid position but maintained her registered nurse position.

Following the sanctions being applied to Golden House, the proprietor has loosened his purse strings and has spent some money on resources and staff. The following quotes illustrate his turnaround:

> Oh, before, he (the proprietor) doesn't pay the staff (non-roster staff) coming…not even a fire lecture, never used to pay the staff hour (hour paid to the staff for the hour lecture), they're (proprietors) supposed to, he got away with all that! That's why the staff don't need to come! (RN Helen)

> He (the proprietor) doesn't pay me the right rate for a start anyway (forty percent more per hour for being an educator/registered nurse), he doesn't even (pay for some hours for RN Helen being an educator/registered nurse) I mean I went there initially is for help Nancy. (RN Helen)

> I could not… get somebody from infection control, to come to give a lecture, because I remember Nancy (DON) always saying 'Oh, he won't pay for it Helen! (RN Helen)

> The only one that they (proprietor) used to pay, was the ah what's this the fire lecturer… now he has to pay whatever lecturer comes in, now he has to pay staff as well. (RN Helen)

> Now, of course they're forced to do all these things to spend a little more money on staff, equipment and building upgrades, if they don't, they could, they can't have the business. Of course they are forced to…if the proprietor won't buy the resources! But

[60] The operational manager was the replace DON for DON Nancy who was on sick leave.

> Mr. D (the proprietor) was getting away with it at the time. And even the lecture, who knows how to give the lectures. (RN Helen)

> Now he's got to pay them. Every lecture they come in now the proprietor got to pay them doesn't matter, whether this ah infection control, or manual handling, we just had recently, he's (proprietor, Mr. D.) got to pay that! And then we had ah behavioural management, he's got to pay that the proprietor was forced to do it! He was told he had to do it! (RN Helen)

Presence of relatives

RN Helen states that when AINs are aware of the presence of the relatives, they are more focused, kinder and spend more time with the resident. RN Helen is convinced that AINs change their attitudes towards the residents depending upon the presence of their relatives, but particularly in the presence of advocates like relative Max.

> I do believe that relative has a certain degree, I think, that happens…staff tend to be more kinder to the resident when the relative watching, I said more focused you know, spend more time talking to the resident. I think they [AIN] do it a way but not a large effect spend more time talking to residents and the trying to ah show the relatives…and…yeah, but it just gives an attitude changes when they're not there and when they're there, you know what I mean. I saw that, it was quite clearly, yeah. (RN Helen)

> When feeding, if they're a caring sort of person, they will make sure that the patient has been fed properly before they move onto the next one. Then the other ones, who are 'I don't care so much', umm… you know, they'll try to rush when they feed them, move on to the next one to try get their, their work umm workload you know…Ah… but if the relatives are there, there is a difference there oh yes, right in front of your eyes! I think they tend to be a little bit more…even more aware what they are doing, and ah…that's why they…own by themselves you see them changing the character, the nurses attention. (RN Helen)

RN Helen comes to the conclusion that overall what determines the quality of care give to the residents is dependent upon the individual care provider's personality more than

anything else. Therefore RN Helen believes in self accountability being the determinant of quality care provision, particularly when there is a lack of supervision and consequence for poor care provision.

> The good ones sort of their nature, the ones that are caring you know, they care. They care about residents welfare, but the ones that don't have that sort of caring attitude you know, they'll rush a bit more. Rush bit more and then they want to you know…have a rest! So we don't know whether the residents been properly fed or not, you know, so that's a problem. And you find that their works is done much more quicker. Well, I'm not being over critical, that's the way it is, that they just different. (RN Helen)

Finally RN Helen reflects upon herself stating that:

> I always been a caring sort of person. So to me, I mean, the main thing to me was their (resident's) diet, for these poor old people… So the ones that you have the difficult behavioural, physical, illness ones (residents), sort of ones you know, nurses have problems with, I always being making sure that you know they have been properly fed, even…as far as I can remember. Also to make sure that they (residents) are properly fed…that just …depends on the sort of the person I am. It's a personality thing. (RN Helen)

AIN Andrea[61]

AIN Andrea emigrated from Greece and has only ever worked in nursing homes as an AIN, now for more than 23 years. She was interviewed at the same time as RN Helen after Golden House had failed the accreditation investigation. From AIN Andrea's viewpoint,

[61] Andrea's life experience in Greece of hardship and being brought up by elderly relatives and mentors, may have contributed to her positive appreciation, and very grounded approach, to older people. With this respect for the elderly combined with both her cultural and religious worldviews this places Andrea in having a desire to service the needs of the elderly which give back to her rewards of following religious doctrine and cultural expectations. In terms of her cultural models, Andrea I believe highly values her standing in the local Greek community that she has embedded herself within by her religious practice which gives her back spiritual support and community recognition. This sense of her standing in the local Greek community is something that I believe Andrea is conscience to maintain by being an exemplary care provider and mentor to novice care providers.

nursing home care is about making the experience 'homelike' - their home away from home.

> You look after the people. Look after the people. Everything! It's to them, their home. I'm not call nursing home, I'm call home. Because the home for the residents. So we try to make, nice and comfortable, you know! For the food, for the sleeping, and for everything nice and happy. (AIN Andrea)

From Andrea's point of view, for residents who have difficulties in communicating, it is incumbent on the AINs to try something to engage with them because the residents don't talk or make their intentions[62] known without prompting.

> People (resident) is not talking…you have to try…something. If you people [residents] talking, you [AIN] have to sit down to talk. To walk a little bit. You know. To give the food, the shower, to walk, to talk and if you put the wheel chair out, because these people (resident) never go out, you know. You have to push them around. (AIN Andrea)

'Soft-hearted' Care Provider

Andrea herself acknowledges her own 'soft heart', together with her love of both her work and the residents in general. Her approach supports her ongoing struggle to maintain a quality of care at least where it is within her own sight, control, influence and accountability.

> I happy to go to work! because… I see the old people and I give the shower…I want to dress up nice, I give the food. But any time, I'm see old people I feel better! My heart is very umm, I can't say it (find the right words), 'very soft heart'. (AIN Andrea)

Andrea gives examples that show her compassion compared to other AINs who are quite happy to leave residents sitting in the same place/chair all day. Andrea will not rely on anybody else's opinion, she will investigate for herself and refer to an updated care plan or talk to the RN. According to Andrea the resident's ability to walk could be dependent upon

[62] Intentions in Andrea's sense include body language, gestures, facial expressions and proximity to objects.

their physical condition or motivation. Andrea will carry out her own investigation to assess whether the resident needs assistance to walk or can be motivated to walk more independently to improve their mobility. Andrea states the longer a resident remains not walking, the higher the chances that they will lose the motivation and ability to walk. Andrea is proactive (a critical thinker rather than a passive routine follower) in monitoring residents walking capabilities and in encouraging them to retain their mobility. At the same time Andrea works with the RNs to pass on and receive information regarding the current physical status of residents.

> …maybe this lady (resident) no walking (unable to walk), I can't leave her there in the chair all day. You have to I'm try myself. I'm see (resident) walking or no? If you [are] no walking anymore. I'm not touching any more! But if you walking…I'm try to walk a little bit everyday! But some girls not doing nothing needs of the residents! Not try nothing! (AIN Andrea)

> …the physio never coming to me and walking people, I'm try everything myself! I see (observe the residents) the people…I'm try to stand up!' (Andrea role-plays a request of a resident wanting help to stand up) I 'see you' (AIN Andrea)

Again Andrea emphasises the importance of the AINs in finding a means of communication and in understanding the context in which the communication has been attempted by the resident.

> You [resident] no talking (not talking clearly), I'll try to understand from the mouth (the communication by voice of resident who has had a stroke) or for…you know (gestures made by resident to communicate that they wish to attempt to walk), if you not talking just (role playing doing physical exercise for resident)…hit (touch care provider to gain their attention)! That's why I'm learn myself. (AIN Andrea)

Andrea's next example is of herself being proactive in encouraging a resident to walk and in mentoring an experienced AIN in her team to follow her example, encouraging him to spend the time to improve the resident's walking.

> One man coming from the hospital, one Chinese (resident) and the wife say, the hospital never move (him) from the bed… Now, I'm try and Roy (AIN), we just try to

> walk him (the resident), if you (resident) no walk (resident doesn't walk), no worries! And (we) try to walk to the room to the dining room. I'm walking… one time during the day... then good! (AIN Andrea)

Andrea believes the AINs need to try to understand the gestures and non verbal communications of residents who have had strokes and to learn to create a means of communication that is useful to both. To Andrea, a good AIN must be open to learning new things and believes that situated learning (learning that takes place in the working environment) is the best use of the opportunity to become a good AIN.

Again this approach highlights the limitations of 'isolated' care providers who steer away from empathy and social communication with the residents and their co-workers. Andrea acknowledges her ability to read social cueing within the communication between herself and the residents is a major distinction between herself and other AINs.

Criticism of Certificate III training

Andrea questions the value of the Certificate III[63] course as she has not seen changes in the people who have done the course. She believes she learned on the job, in terms of the course, she had difficulties writing and being taught in English. Andrea believes that the Certificate III was of no benefit to her because of her English [64] but even so, she believes situated learning is far better. Andrea was forced to undertake the Certificate III qualification after more than ten years of real world experience because it is now an industry wide pre-requisite for ongoing employment within nursing homes. Andrea saw doing the certificate as a waste of her time, why would she bother, except to be away from work (it's not her habit to be lazy). Andrea explains that despite gaining the Certificate III some AINs don't do what they should do.

I'm have [the] Certificate [III], but (shaking her head from right to left, shrugging her shoulder and gesturing by showing her opening palms). I'm not believe in the certificate.

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[63] Certificate III has 400hrs of classroom teaching and instruction, whilst also including ongoing clinical assessment.

[64] From my experience the majority of AINs have poor English ability which is at odds with the relatively high level dependency upon English comprehension within the instruction and materials within the Certificate III course. It has been my ongoing observation of AINs undertaking this course is that they are dependent upon RNs to help with the written assignments.

Because people is got the certificate…one year (on the job and part time study) and one year (one year experience) four months (full time study) and they doing nothing (pause) job, they not doing their job properly or working hard enough. (AIN Andrea)

> …do the same thing, for me…nobody help me because you have to write, you have to understand! But I do everything I learn myself! Some people doing certificate is gone to the school …for me… what for…because my English…is not very good. (AIN Andrea)

To Andrea, learning from day to day practice is more important than classroom learning. Andrea gives an example of being a pro-active critical thinking care provider who assesses the needs of the resident rather than just blindly following production-line routines.

> You have to shower… to feeding…to put in the toilet (toilet the resident)…to walking (give walking exercises for resident)… maybe this lady no walking (unable to walk), I can't leave her there in the chair all day (said with compassion; sitting in the same place/chair all day)! (AIN Andrea)

Doing a good day's work

From Andrea' point of view nursing home care is the same every day, a routine, a production-line of care, of segmented work. Andrea likes the predictability of the routine, she knows what to do, when a task occurs and how long it will take, giving her a sense of control and ability to successfully achieve her duties. In following her routine she gains a sense of satisfaction that she has done 'a good day's work'. Andrea likes working to a set task routine. Andrea maintains her own high standard disregarding other AINs around her, whose work standards may not be as high. Andrea explains: "All the days, my same days"; and while she likes this routine, Andrea also has a sense of praxis because she attempts to work in an ethical way, making sure that by the end of her shift all her tasks have been completed to the resident's and her satisfaction.

> Same day everyday! Because they all the same thing for me… talking to the people, shower the people, feeding, and just clean a little bit…and you know, a lot of work for myself. Oh, you have to do the same thing everyday! I want finish the same thing everyday. I'm going home, and I done all the work and think, oh yes, everybody right! (AIN Andrea)

A team player

Andrea believes that teamwork and altering the residents allocated to different AINs as required allows them to solve of the problems of personality conflicts between care providers and residents. The tasks become easier and the working together becomes more comfortable. As Andrea says:

> I think for the staff…I think staff, is the most important. Well, if you have a good staff…you can have a good care! If you work… good team with you, you have good staff. Umm. If you work good team together, um very nice! Oh! Yes. (AIN Andrea)

> But if you have a good partner…fine…doesn't matter from my hard work, work team will make it easier, if you work team. I do it for you, you do it for me. Some people say to me, oh, Andrea, I don't want to shower this lady, or this man, you do it for me, I do it for you another (resident) … fine! Oh, yeah! (AIN Andrea)

Work stress

As Andrea is a senior and hard working AIN, even she has admitted to the difficulty of dealing residents with dementia. Andrea experiences a lot of stress even thinking about this. Her afternoon shift workplace (second job after her shift at Golden House), is Wellington nursing home. It's a dementia specific unit, she describes the character of the residents with dementia and the stressful working conditions for the AINs.

> These people walking up and down (wandering residents with dementia at Wellington nursing home)…maybe hit, a little bit…of push (physical contact between residents and care providers) Or this that (conflicts between resident and care providers), the resident…Picking his jumper (dementia resident taking someone else's jumper)! Everywhere [residents with dementia wandering and causes issues throughout the nursing home]…you know, spill their water (knock drinks over) you know! a lot things (issues created by residents with dementia)! Some people sleep my bed or your bed… yeah! Some people going to the toilet, in the kitchen umm shitting you know! Is Golden house more quiet (Golden House is more quiet)? And then resident is more stable is not…mad (Golden House's residents are more stable, not mad)!

> In Wellington [nursing home], oh my God! (Residents) Sit down [on] the table and go (wandering all the time). I bring another dinner [to] these people (wandering dementia

> resident) will go, oh my God. I feel more dementia here; I am dementia there (in Wellington nursing home). I'm crazy there (Wellington nursing home)! (AIN Andrea)

In comparison, Golden House is a quiet place having few residents with dementia who have disruptive behaviours (for example, 'wanderers'). Golden House has a resident population of lower functional ability residents with high support needs that attract a higher RCS category, or residents without dementia with high functional ability. The character of the residents directly influences the stress levels that the AINs experience within the workplace.

Proprietor's Tight Budget

AIN Andrea describes the proprietor as being very tight with his money (budget). Andrea believes his miserly approach impacts directly and negatively on care outcomes.

> Oh, yes! He's, he's Altantian[65], always like this, (tight with his spending on Golden House)! Very bad! The Altantian people very… (Andrea screwing up her face & clenching her fist to illustrate and emphasis her point). Tight of the money! Tight, yeah! (AIN Andrea)

At the same time, Andrea believes if nobody makes a complaint there will be no improvement in care provision. AIN Andrea gives an example of the nursing home being too hot and the proprietor being too mean to turn on the air-conditioner.

> Well, if you don't use the air-condition…the people complain, the resident complain, no (not) the resident, the family complain. Too hot! Some people complain, you [the proprietor] have to do it, to fix it. (AIN Andrea)

Andrea believes the amount food provided to residents at Golden House is not enough. From my own experience the average meal size and nutrient value of the food is acceptable but is insufficient to satisfy bigger eaters. There are no guidelines in place or any requirement to engage a nutritionist to investigate the food nutrient values at Golden House.

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[65] The designation Altantian is a pseudonym for the proprietor's true cultural identity which is used for ethical considerations and to maintain anonymity of the nursing home.

Using food quality and service as a measure of the quality of care, it is clear that care is devalued in an effort to maximise profits.

> Well, the food all the same food! All the nursing home is the same in every nursing home! But want a little bit, a little bit, a little bit. Not enough! Because this is not enough, this is going for the pocket you know! He's (proprietor) not going to spend a lot of money for everything. (AIN Andrea)

Following the introduction of the operational sanctions[66] the proprietor was forced to purchase resources to benefit the residents. The new DON (who commenced after the operational sanctions were applied to Golden House) needed to start from scratch, the spending was needed to make up for the long-standing neglect and to 'rescue' the nursing home from further sanctions. The new resources provided were principally equipment and manchester.

> …now is Paula (the new DON) is spend a lot money…now we put the bowl for covers (covers for food bowls). Never glass bowls now. Never! Never use glass bowls for the dessert! Umm. Only Plastic bowls and cover the top. Oh, now's all different…Yeah, good for the residents, because keep nice and warm the food. Umm. No hurry to feed! Because (before the new food serving containers) if you feed these people this food is cold (other resident's food becomes cold as you feed resident before them), you know…but now is keep warmer. (AIN Andrea)

Glass food bowls without covers were replaced with thermal food bowls with covers [see Max's criticism of cold food], Now, according to Andrea, the food is kept warmer for serving to the residents.

Non-conformist care providers

Andrea is dedicated to finishing her job correctly while some of her colleagues either don't finish the job or don't do it properly. The issue is that a correctly finished job is one that has achieved its stated outcomes and to an acceptable standard of care. Andrea gave two examples to demonstrate the different type of care providers at Golden House.

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[66] I interviewed Andrea after sanctions were place on Golden House, consequently the proprietor was forced to be seen to be amiable to change.

Example: weekend care providers not dressing resident properly

Before Andrea leaves for the weekend she prepares full sets of clothes for the residents to wear on Saturdays and Sundays. The weekend AINs however do not dress the residents properly, perhaps using only a singlet, rather than the proper complement of singlet, top and possible jumper. Andrea tries to encourage a teamwork approach by preparing her residents' weekend clothing, but the weekend care providers do not take advantage of this. They make the feeble excuse of 'I don't know!' It is more likely that they do know but do not like what they think of as Andrea's interference or simply can't be bothered to do the right thing.

> I'm put the clothing everything, singlet, underpants, everything there… (Andrea role-plays by using cushion as a prop) in the locker (wardrobe)…and tomorrow morning I am go there, I'm not have, I have different partner, use this one (use this selection of clothing for the resident when Andrea is not there). Is easy for these people (weekend care providers). I'm trying easy for another people (make it convenient for weekend care providers), all right! (AIN Andrea)

> And these people (weekend care providers)…I'm leaving there (the following weeks clothes selections for residents), Monday morning the bed in, in the top of bed, all right…and this (these) people (weekend care providers) not think about, I'm leave for, for yourself, you shower these people (residents), alright! And pick it up another clothing (set of clothing for the residents to wear, e.g. from undergarment [singlet, underpants] to dress, trousers and jumper), another (incomplete set of clothes). I'm saying (to weekend care provider) 'Listen, this one that's for Joanne (resident) (Andrea says, role-play by using cushion as prop again)' He (weekend care provider) said to me, 'Oh, I don't know! (Andrea role-playing the weekend care provider)' Look, why I'm bringing here (prepares sets of clothing for the resident), this more easy for you! (AIN Andrea)

> And dress up just singlet, long pants and something else, I'm saying, 'I'm checking, oh Joanne (resident) she have some, the singlet jacket (only wearing a singlet and a jacket, Andrea says to weekend care provider)…today is very cold, you have to dress up (dress the resident properly to keep them warm) (Andrea says)!' 'Oh, I don't know! (Andrea role-plays the weekend care provider responding to her)' 'Oh, what you mean I don't know! Don't wake up (when are you going to understand, wake up!)? You no

> (understand or can appreciate that) feel cold theses people they sit here (in their individual rooms) all day (Andrea says)! That's old people always feel cold. (AIN Andrea)

Andrea wants to maintain her residents to enjoy a high standard of care over the weekend and puts herself in the residents' position to understand their needs. Residents need to be warmly dressed, as their rooms are cold. Andrea role-plays her interaction with a weekend care provider to make them aware of the issue of keeping the resident well clothed and warm. It is the empathy and understanding that Andrea has for the residents that sets her apart from the other care providers who see residents as tasks that they have to do or worse, to give the appearance of having fulfilled their tasks.

Wandering Care providers

Andrea cannot stop working. She is always trying to find a job to do. Andrea says 'I feel cranky' when seeing other care providers not doing their job. She can't change the situation and believes that some care providers can't be trained. Andrea is responsible only for her section but her frustration is that she can see the problem, but cannot say too much because it is also important to avoid conflict among care providers. The sectional allocation of care providers allows for the sub-groups to have their own domains of power. This of course does not continue into the shared spaces like the dining room.

> If I see people not working, I say, come on, come with me, help, doesn't matter your resident or my residents, doesn't matter. Because I do the job properly and some people (care providers) doing nothing, I feel cranky! I try makes them working, but I'm feel cranky, because I can't help nothing. (AIN Andrea)

> I can't tell them (mean working in different team colleagues). No! no! no, no, no! If you work on another section. I can't say why these people no (not) working. Maybe these people say to me 'is not your business'…you go for your section!" Well maybe, if you say like this, maybe say to me 'You are not working here (this section), why you watching me! I do it, just my section. (AIN Andrea)

DON Nancy

DON Nancy is from a non Anglo-Saxon background having come to Australia as a teenager. In the 20 years since completing her degree training as a registered nurse she has worked in both hospitals and nursing homes. The DON is the key informant in any nursing home, managing its day to day running. DON Nancy's view is that a nursing home is a resident's home, their home away from home for the rest of their lives. This view is the ideal and the way it should be but in most cases, nursing homes are still less home-like and more institution-like.

> …because the nursing home like their home…so you have to make them feel at home… you have to make atmosphere homely like…so that they (residents) can adjust. (DON Nancy)

> Well…that's because I think it's my personality… Because I like everything to be spick 'n span as you know. And to make everything look nice and like I dress up myself…in a very professional way so I like my nursing home... to look. (DON Nancy)

Decorating Golden House as a homelike environment is Nancy's favourite activity:

> I like beautiful things…so that's why I like the surrounding…to be beautiful things and spray for my residents…and that brings a lot of good vibrations and good feelings to them and positive effects upon them (residents) that's why I have made all this like Golden House is beautiful… place as you know that it's very homely (emphasised). (DON Nancy)

It is important to create a social dynamic rather than simply contact in a routine of punctuated service provision. Care must be integrated into a milieu of a community and to do this properly there needs to be more resources for residents, e.g. weekend activities, more staff on hand, more entertainment. In fostering residents' social engagement DON Nancy says:

> We have to spend more time with them, have more resources for them. For example, like, giving them more physiotherapy. Like, if they have got problems with their limbs - any part of body - at least we have got physiotherapist - *trained* physiotherapist -

> who can encourage them [residents] to do excessive - like, exercises, and all - and like, movement in their limbs and body. That's a high quality care. And also, like, to give high - optimum, ah, care to the residents in the nursing home is - you have to encourage [residents]! (DON Nancy)

Quality of care

From DON Nancy's view quality care is giving residents encouragement to take their agency and being valued by AINs with compassion, empathy and love.

> Encourage (residents) is the main thing…within the nursing home…because to let them know, to show them that they are someone…of heed. A lot of residents in the nursing homes are qualified educated people. So by doing that at least they know that they've been loved (emphasised) (said with conviction and compassion)! These people (residents) are there, that they are still being loved by the staff…doing things for them (residents) and encourage them to do it…so they know they have got their independent still. They, they can feel and they can still understand that they got the value of life (said with strong emphasis and conviction) that is the value of life. (DON Nancy)

Optimum nursing care for the residents requires spending lots of time undertaking bedside nursing.

> …for the optimum nursing care as well for the residents, there's a lot of like time is spent bedside nursing…and extra time is spent with the residents overall and by that clinically you can see it. You can see that the residents are getting better, like you know, appetite increases…weight gain some residents they can walk with you know, like encouragement to work, walk with the walking frame…and a lot of residents has done that in the Golden House … emphasize that, like we give very good care to the residents in there because quite of few of them have got better and they have returned home. (DON Nancy)

DON Nancy's view is that care providers are rewarded by the satisfaction gained through seeing their residents happy. Again, like RN Helen and others, Nancy uses the word 'your' not 'the' to give the sense of belonging and responsibility to the residents. High quality of care is dependent upon the care providers being able to make the residents happy and at the

same time gain satisfaction in undertaking the service. Like anyone else the comfort and happiness of the residents is clear from their facial expression. Overall, the quality of care is very high.

> The quality is there like looking after residents, get the satisfaction as well as you can see that your residents are happy. That's a very high quality care…you can give it to them…to see someone happy You can see by their (residents) facial expression! (DON Nancy)
>
> They're joining with the activities make recreational activities, like Bingo! You can see them singing and dancing with the … other staff members and … you can see them you tell that they are happy like the facial expression. … All the time they are smiling … laughing, joking … singing! (DON Nancy)

Defined by clinical measures

A measure of quality care is the use of clinical indicators, such as pressure sore occurrence. This measure relates to Standard 2: *Health and Personal Care (2.11 Skin Care)*, which aims towards a continuous improvement within the accreditation process. DON Nancy emphasised that measurement of the quality of care is based upon clinical outcomes or indicators.

> Quality care in that sense like they (residents) have been given like second hourly pressure in their cares (bed-ridden resident's body moved at least every two hours to avoid pressure sores)…for residents those who can't mobilise…as they suppose to, ah due to their old age frailty…and like CVA (stroke) like strokes and everything and the best thing about Golden House nursing home I'm talking about…the high optimum care in there I from my point of view is that like there's a very good high quality care residents getting in there because we don't have any pressure sore at all…Nothing at all, and that shows that's umm staff is doing a marvellous job. (DON Nancy)
>
> Residents are well look after…and we don't have any like drastic like skin conditions, or anything like that, no pressure sores so I'm quite happy. (DON Nancy)

Quality of Care Determinants

DON Nancy pointed out that there are two main factors that negatively influence the quality of care provision at Golden House: a lack of supervision of weekend care providers and budget restrictions on staffing.

Supervision Embargo

Nancy pointed out that weekend care providers playing up at Golden House due to a lack of supervision.

> Supervision in maintaining a high quality care…it's usually during the weekends in Golden House, because the Director of Nursing and Deputy Director of Nursing is not there…and the management part is not there…and people tend to play up. That is why RNs are being educated…and good counselled and spoken to, that they (RNs on weekend) have to be very strict… with the staffing (AINs, care providers) and close supervision. (DON Nancy)

Proprietor's Tight Budget

Golden House is dependent on more casual staff than permanent staff, with frequent gaps in their roster due to fewer permanent casual positions being made available. The proprietor allows the shortage of staff to be a cost saving, ignoring the difficulties for the staff of operating an understaffed nursing home. The proprietor is opposed to employing agency staff[67] to address the shortage of RNs.

> He's [the proprietor] against that. He's not interested - he doesn't want any agency staff in his facility. (DON Nancy)

DON Nancy knowing the weekend's care providers are causing problems has come in on a number of occasions on her own time to supervise staff.

> Sometimes I used to go in the weekend to supervise them without telling them and without pay, I never used to get extra pay…and like people in the afternoon shift, where I heard a problem like with some staffing… (AINs) not doing the work properly, so I used to stay back…and without pay again. I think it works…they (AINs) scared. I mean not really scared, it is they aware you are there when they're (AINs) aware that I'm there. (DON Nancy)

[67] Agency staff are people supplied by human resource agencies which are more expensive than part timers or casual but fill gaps in roster when there are no one available.

> But I can't stand by twenty-four hours. So you have to rely on your trained staff like registered nurses…and in the weekend yes, I mean sometimes I used to drop in but I can not (do this all the time) and with the staff in there we have to educate our RNs and tell them to be more strict…with nursing staff (RNs and AINs) and to supervise them closely. (DON Nancy)

> And that's why I was harping on about…for the proprietor to increase…staffing in all, because not enough…funding for staffing, not enough hours for staff and staff those who I got hard working in there, they works their guts out… to do extra to make sure residents get their care.

> The percent of the budget goes to staffing? It's about sixty-five percent. But I think now, is about seventy-five percent or seventy?

DON Nancy noted that while the staffing budget at Golden House was previously 65 % of the total budget and is now 70-75% (65 residents with high category), the increase in the number of residents means in reality there has been no improvement in the resources available to properly staff Golden House.

Presence of the relatives

DON Nancy believes that when relatives participate in the care of their relative (resident) in the nursing home it promotes and sustains a more dynamic social life within the nursing home.

> The role of the relatives I suppose like, I have got some relatives they are very into it. I mean they try to help their loved ones, like for example I got few relatives, like Max come in every mealtime…to feed their loved ones. (DON Nancy)

DON Nancy sees that reassuring the relatives is another way of building a good relationship with them.

> When the relatives are comfortable, that their loved ones will be well looked after so I don't have any problem with the relatives. (DON Nancy)

Two types of care providers

DON Nancy described different attitudes exhibited by care providers making a good care provider someone with a good heart and willing in their work and others who exhibit laziness, lack of education and ignorance, bad care providers.

'Good-hearted' Care Providers

Good care providers in DON Nancy's view are those who have empathy for the resident, who can see the residents worldview and have an emotional engagement with the resident. Good care providers can give their heart to the residents, they do everything for resident with a full heart and are very willing workers.

> I suppose it's the staff who are very willing to work and who's happy to work with aged residents who is always willing to learn more. *And to do better things for the residents, they are the good staff* [*emphasised*]. Responsible people, I think those who feel that way and who can feel… residents, I mean treat residents like their own. They're the best nurses. Good nurses you, you can trust them. You don't need to really say 'Oh you have to do this !…you have to trust people…to do their job.
> And… like they can give their heart to the residents. Like Andrea she can give her heart [emphasised] to the residents. You can tell, and they very willing workers, they do everything for residents with the full heart. [DON Nancy]

Non-conformist care providers

On the other hand, her example of an AIN trying to feed a resident who is not in an upright position, is demonstrating a fundamental error (that is highlighted in basic training), one that should not happen as the resident is at risk of choking.

> I think it's sheer laziness, and lack of education and for example like one day I was in the afternoon working on the floor and I went into this room…to give medication to one of this resident and this staff member was feeding this resident…she [AIN], the resident wasn't even sitting upright…So that way I called her aside, straight away told her how to sit up the resident…in the Fowler's position [upright seated position] and then feed. Then I told her about the choking that…the resident could have choked… with that person [AIN]. [DON Nancy]

> Because, I don't like to go… after behind them with a whip in my hand …if their work is not done, then they'd been reprimanded, called in the office and spoken to…straight away there and then if someone has doing something drastic and not listening…or been after educating and all …then they're told to leave. I'm very, very particular with that…I'm very strict in that kind of situation it's a vast difference being a DDON and Deputy Director and Director of Nursing. (DON Nancy)

DON Nancy believes that novices who receive better training and orientation will give their best in providing quality care provision to the residents.

> I believe that people those who get better training…better orientation they give the best because that way at least you know that the, the quality of care they give to the residents…is much higher. The rate is much higher because they'd been orientated about…around the nursing home. They'd been orientated for the residents, by their (residents) names…what conditions (illnesses) they (residents) have and everything. So that way at least they know that what sought of care they have to provide for the residents. Very important. Education is very important! (DON Nancy)

DON's Experience of Accreditation

DON Nancy spoke about her own negative experience at Golden House in dealing with the process of accreditation when faced with the burden of accreditation assessment paperwork while undertaking her normal care duties.

> Accreditation is just nerve racking. It's very stressed (emphasised)…every staff member gets very stressed out…during accreditation because you have to make sure that everything is up to the standard and the like extra time is spent…in preparing everything. And it's just so much paper works, just unbelievable (emphasised) and I think is gonna get worse. I believe worst! It will get worse. Well, I think this accreditation system is just whole pack of pack of rubbish I suppose. Because you doing so much paper work…your spending so much time on paper work, instead of spending time with your residents. And we're in here we have to be spending more time, ninety percent time bedside nursing…not in paper work. (DON Nancy)

> And this accreditation is just making so hard for everyone… it makes life so hard…that's why a lot of Director of Nursing and nurses are leaving the

> positions…they're (DONs) going out of these jobs and I'm thinking of doing that as well…because I can't cope with that anymore… the expectation from that accreditation agency is just so high you can't…keep up with that.

> Because it just. And the more you do, the more expectation, the more they want. (DON Nancy)

> So, that way…I mean you don't have enough staffing and then you have to spend extra time…preparing all the paper work you know…what for I think is just, just load of…crap! (DON Nancy)

So they should be more like giving kind of…not like criticising all the time. They should appreciate that way at least they can promote better…care in the nursing home. (DON Nancy)

Summary

This chapter has presented data from the interviews with six key informants: resident Tim, relative Max, RN Lily, RN Helen, AIN Andrea and DON Nancy. In revealing their key understandings of conceptualisation of quality care and its delivery, I sought to develop themes that were recurrent in their thinking. These recurrent themes became headings within the presentation of this material for each of the informants. The core headings clustered around the following issues: factors impinging upon the delivery of quality care; the nursing home environment; the two types of care providers; supervision; the proprietor's tight budget; the effect of the presence of relatives upon care; the accreditation process; and personality and ethical traits of people.

Within these discourses of care, the issue of accreditation became a topic of discussion - and became particularly salient when Golden House became the subject of a complaint investigation. This serendipitous change in circumstances allowed me to consider the complaints process and its consequences, and, in due course, the validity of accreditation itself.

Each of the informants added their own window of understanding; in hermeneutic terms, their 'horizon' that is composed of forestructures based upon the influences of historical

consciousness, tradition and thrownness[68]. Within this sense of an individual horizon, each informant has developed different foci and key nodes of concern, even though they spoke, in essence, about the same issues. Resident Tim's key node of concern, for example, was his autonomy and his relationship to the staff at Golden House, two concerns which he saw as tied together. Relative Max's key of node of concern was his interaction with Golden House through which he sought to create and maintain a certain standard of care for his father and for the other residents. Relative Max saw himself as an advocate whose role included safeguarding Golden House's quality of care. It is my belief that Max was responsible for lodging the complaint that brought action against Golden House. RN Lily, RN Helen, AIN Andrea and DON Nancy all sought to reveal pieces of the 'blackbox' of Golden House from a care providers' horizon, but still reinforced the conceptualisation of care offered by Resident Tim and Relative Max.

In one sense, all of the informants sought to vindicate their positions with regard to quality care and their actions taken within Golden House; however, in essence, all of them could not help to express their frustration with the profit before care position of the proprietor and the façade of the validity and reliability of the accreditation process.

[68] The conceptual model of the nature of Being and Understanding is presented in Chapter 3.

CHAPTER SIX: DISCUSSION AND CONCLUSIONS

Introduction

This study explores the phenomenon of Australian nursing home care from both the perspective of those who provide the care and those who receive it. Drawing on a thorough review of the literature and personal observation, it is clear that the AINs are key frontline workers in the provision of care. Consequently, the AINs are key to the conceptualisation of 'quality care' in this study. A paradox arises, however, when we apply this conceptualisation to the idea of the existence of a *moral ecology* within nursing homes. The provision of 'quality care', understood through a focus on AINs, the processes employed in the provision of care and the consequent possible conceptualisation of 'quality care', can be viewed as the hidden and unacknowledged constituents of care provision – the 'blackbox' of quality care.

Unpacking the 'blackbox' of daily life in a nursing home provides new insights into the complex social phenomenon that is a nursing home. As a result of these new insights this study can build on current understandings of clinical and human resource management and nursing competencies. At the same time, it can assist in developing thinking tools that will allow registered nurses to better conceptualise quality care and to implement positive change within nursing homes. This research demonstrates that registered nurses, from the DON to the 'on the floor'[69] registered nurses, should be the chief stewards - in partnership with AINs - of a nursing home's quality of care.

Philosophical underpinnings – a moral ecology

In Chapter Two of this thesis, I laid out the philosophical underpinnings for this research, while in Chapter Three I described how these underpinnings informed this study's

[69] The nursing idiom 'on the floor' means the nurse is actively working directly where the care to the residents/patients is being provided that could be 'hands on' care or at the nurse's station rather than being in their office undertaking paperwork removed from observing care provision. The nurse's station is like an active command post where the 'on the floor' nurse can observe care provision whilst undertaking administrative tasks as a general relative telephone enquiries and general administration.

methodology. This research is located within a 'moral ecology' (Aroskar 1995; Brinkmann 2004); a system that functions as an ecology of interrelated people working upon care provision within a moral community of a nursing home. This echoes Heidegger's and Gadamer's philosophical hermeneutics and is underpinned by praxis. The hermeneutic notion of the 'middle way' that lies between objectivism and relativism is drawn upon in this discussion. The experience of residents and staff of Golden House nursing home is framed from their forestructures and interaction within the world – their 'Being-in-the-World' (Heidegger [1927] 1962); furthermore, my interpretation is also shaped by these processes. For this reason, I accept a 'critical realist' ontology (Bhaskar 1989), which reflects this perspective insofar as it is itself a 'middle way', in (ontologically) accepting a reality, but (epistemologically) asserting that our knowledge of it is mediated.

Interpretation (by me as well as by the people of Golden House nursing home) arises in the context of interaction and is a 'practical-moral' activity which arises from engaging in dialogue – 'being-in-the-game' (Schwandt 1999). The reader is invited to enter the hermeneutic circle of this thesis, including when working through the thinking tool diagrams. With my support of the 'middle way' position - that being a position midway between objectivism and relativism within the realm of Gadamer's play (2004), we can now consider the findings of this research.

The Findings

This chapter brings together findings from both participant observation and in-depth interview data collected during the two and half years of this study. Participant observation revealed that there are eight key interrelated factors in the production of care within the nursing home:

Factor	**Description**
Resident	Characteristic of residents: functional ability, ADLs, chronic illnesses, dementia
Frontline worker	The work/care provision styles of individual care provider – 'tortoise' & 'hare'
Advocate	Advocacy: whistleblower, relative, resident, academic
Economic	Considerations: nursing home as a business, government

	subsidies
Accountability	Internal and external accountability: the accreditation system, registered nursing supervision, self accountability/ethics
Management	management and training: AIN training, management strategy (flat or hierarchical)
Stress and coping	care providers work conditions and environmental stressors
Organisational culture	

These factors and clustering of interrelationships in relation to the processes of care production are illustrated in the Venn diagram in Figure 2:

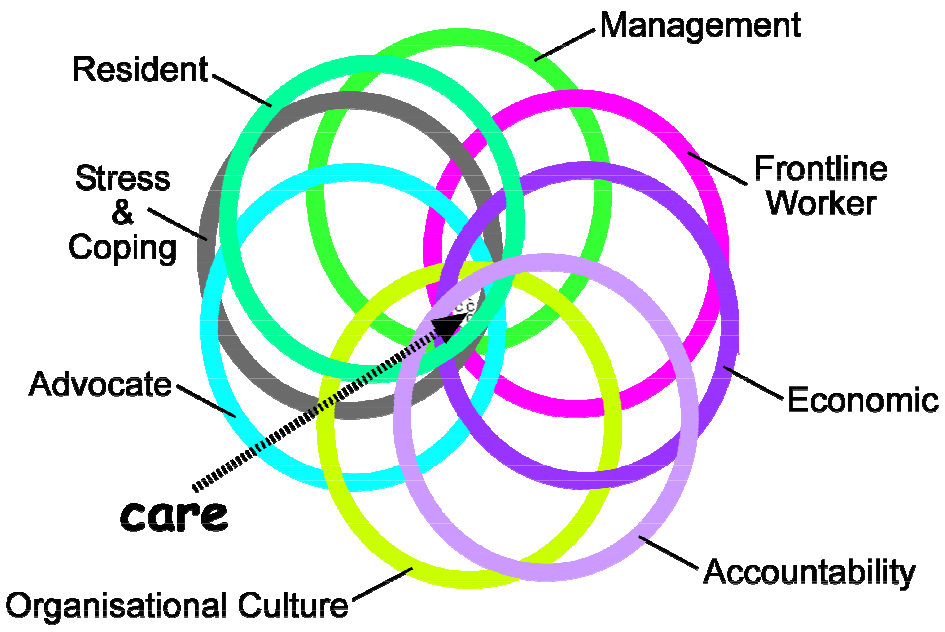

Figure 2: Eight interrelated factors in the production of care

Figure 2[70] illustrates a taxonomy of care that attempts to reflect all the inputs and outcomes of the production and conceptualisation of care. Care sits in the middle of the diagram as a 'blackbox' of the dynamic process of care production and conceptualisation (Dingwall 1992). Like Dingwall (1992) and Koch (1992), I seek to capture the dynamic, cyclic and holistic interactions within the nursing home, rather than a linear progression from one point to another. Failure to understand the dynamic nature of care production in a nursing home has serious consequences: it is apparent that Australia's accreditation system endeavours to log continuous improvement of outcomes using documentation of processes, such as relative's complaint resolution, without an evaluation or understanding of the nursing home in the real world. Exploring the 'why' question about the processor of care distinguishes this thesis from research based on an ethnographic approach. Such research seeks to answer the questions of 'when', 'how', 'who', 'where' and 'what', but not 'why'.

The Australian accreditation process and quality assurance system ignore the basic reality that nursing homes are businesses, and can be run by people whose main motivation is profit. Accreditation assessors are required to accept the desk audit as factual, a process which my research revealed to be open to flexibility with the truth. The desk audit that saw Golden House pass its second round accreditation - despite the unresolved and serious complaints of the relatives - ensured a situation where these relatives needed to seek other forms of action to have their voices heard. They chose to take their complaints to the Department of Health which led to action finally being taken.

In order to avoid the pitfalls of over-reliance on outcome measures and documentation of process (Dingwall 1992), it is necessary to capture the dynamic aspects of an organisation; the only way to do this is by situating myself within the organisation. To achieve this, I utilised a hermeneutic ethnographic methodology of watching and listening, aided by the study of the documents that the Golden House actors produced "to orchestrate or justify their activities" (Dingwall 1992 p. 163). These questions regarding an understanding of organisations are brought together by model of a quality assurance process which is composed of three interrelated components: *structure, process* and *outcome* (Donabedian 1976, 2003). In other words, Donabedian accepts a 'processor', a 'being-in-the-game'

[70] The diagram is a working thinking tool; a heuristic device to aid understanding and, as such, is open to modification. One such modification could have been to attempt to quantify the importance of each of the factors - the diagram illustrates each as having equal influence (by size). Further research on this issue would be interesting and useful but is beyond the scope if this project.

hermeneutic model for quality assurance which is a key underpinning of this thesis. This 'being-in-the-game' approach of orchestrating or justifying activities became a key observation window for my study; focussing in the way that Golden House management constructed its activities to present the organisation in the best possible light in an attempt to avoid criticism (Dingwall1992). What is missing is the functioning of the processes themselves – the 'blackbox'. In this lies the answer to the 'why' question, which is posed by Dingwall (1992 p. 162) as being whether there are "any influences intervening between individuals and the incentives and sanctions of the market or its proxy in the shape of the performance indicators imposed on them". This research revealed the eight key interrelated *blackbox* factors involved in the production and conceptualisation of care. This was initially developed based on my participant observation but went on to become a conceptual framework for the initial findings - a thinking tool to further my inquiry into the issue of care in nursing homes.

The Use of Metaphor

As illustrated in Figure 2 'Eight Interrelated Factors within the Production of Care', a factor is the 'frontline worker' whose work or care provision styles is being conceptualised using a 'tortoise and hare' metaphoric thinking tool. One needs to think of the metaphor of the 'tortoise' and 'hare' from the context of the 'middle way', where the notion of duality presents the 'tortoise' and 'hare' constructs as interdependent whilst being conceptually distinct. There is not a distinct dichotomy of 'tortoise' and 'hare' locale, but more of a constant flux and varying emphasis.

To aid in understanding the metaphor of a 'processor', two common examples are provided[71]. The first is a food processor where we want, for example, a glass of apple juice. We have the *input* of an apple, the 'blackbox' of the mechanism of the food processor that juices the apple and separates the juice from the apple; and finally the *output* of the apple juice. From another perspective (Donabedian 1988b), the apple and the processor merge together as the *structure* (that is, the availability of the apple and the processor machine) and the *process* (the use of the food processor). The apple juice is the *outcome*. The

[71] Authors that talk of the importance of metaphors within research: Goffman (1959); Gadamer (1976); Lakoff & Johnson (1980); Morgan & Smircich (1980);Tsoukas (1992); Richardson (1994); Capra (1996); Wurzbach (1999); Castells (2000); Dixon & Durrheim (2000); Church (2006) and Van Maanen (2008).

important thing about these metaphors is where they fail. What we are really saying is that what we have is a hermeneutic 'middle way' phenomenon and not a structuralist account of the passive 'apple' at the mercy of the 'food processor'. It is the 'being-in-the-game' aspects of simultaneously having both agency and structure operating together that is important. In such a metaphor, we would have to conceive the apple endowed with agency to bring the food processor to a grinding halt or the food processor's mechanism changing in response to the apple.

The metaphor allows us to think about how reality is different from a mechanical atomistic world perspective. For example, using the metaphor we can argue that we do not need to know, or be aware of, the workings of the 'blackbox' mechanism of the food processor for it to influence the outcome for the apple. At the same time, when the food processor does break down it mirrors Heidegger's *unready-to-hand* mode of experience insofar as this breaking down mirrors our experience when a problem arises and ruptures our unthinking experience. From an accreditation quality assurance perspective, it could be said that to document that we have a food processor at all is sufficient; how well it actually works is not assessed.

The second example of a 'processor' metaphor should be seen, again, as loosely conceived, but still holding some application. This second metaphor is that of a television, where the television station's signal is the *input* or *structure*, with the television's components being the 'blackbox', and, finally, the picture tube and speakers relaying the *output* of the television broadcast. Both these examples can be thought of as tracking the *trajectory* from inputs or structure through process ('blackbox') and finally to outputs or outcomes. The idea of trajectory has been incorporated into the second thinking tool or heuristic device, the schematic diagram entitled 'The Processor of the Production of Care (Figure 3). This new diagram creates one such trajectory from many others that could have been chosen, apart from that of the novice becoming a care provider, to illustrate the processual (grounded theory), 'being-in-the-game' (hermeneutic 'middle way'), moral ecology synergy, and the clustering of the interrelationships. The heuristic devices in Figure 2 and Figure 3 show the evolution of thinking in this thesis. The 'Processor of the Production of Care' model will now be described in more detail.

The Processor of the Production of Care

The Model

The 'Processor of the Production of Care' (Figure 3) takes one trajectory, that of a novice care provider moving through the processor of the production of care, and presents an array of outcomes and contingencies.

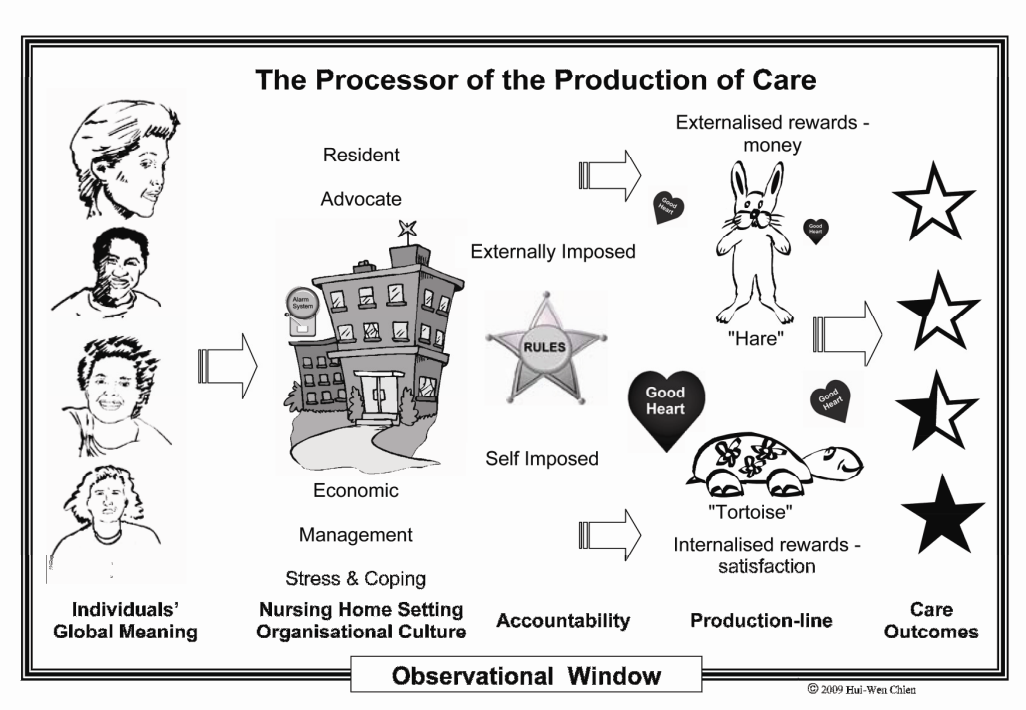

Figure 3: The Processor of the Production of Care

This thinking tool could have been used to represent trajectories of other nursing home phenomena such as the evaluation of the accreditation process, RCS outcomes, the Aged Care Act 1997 outcomes, or that of individual players such as the proprietor, registered nurses, relatives, the accreditation agency or government. It focuses, however, on the novice AIN as an example of the frontline worker who is key to quality care provision when all else fails. This study reveals the complex nature of the production of Australian nursing home care. The findings explain the individual components within the *processor* analogy, whilst emphasising that they are also in constant interaction with each other and influence one another in the production of the final care outcome. This is a process of juggling all the components at once, whilst being aware of their simultaneous interrelations.

It remained important to bear in mind the background or environmental factors (consistent with Bhaskar's 'critical realist' perspective), while being cognisant of the way in which all participants and observers are caught up in the processor of the production of care. The 'blackbox' of the process and the conceptualisation of care are the foci of this thesis and inform the notion of what it is to *become* a care provider, a stream of understanding embedded within that process. The *middle way* horizon of hermeneutics with its focus on *Dasein* is entwined with both *praxis* and *phronesis* in the act of becoming through actions, openness and reflection. These entwining actions are embedded in the blackbox thinking tool. Consequently, the process and conceptualisation of care is conceived as being multi-stranded, the care providers, in working through that process, demonstrate only one of many trajectories within the interrelated factors of the production of care. Care provision in nursing homes is complex and previously has been understood through a focus on single or, at best, multiple causal strands, rather than being understood as a networked phenomenon that mirrors the whole reality of the situation.

In undertaking this thesis, I attempt to use an individual-oriented, humanist nursing perspective, with a holist view of resident care delivery (Fawcett 1984). This approach is in-keeping with the 'interpretive turn' that has occurred in nursing research (Munhall 1989). Koch (1994a, 1996) have taken up the torch of philosophical hermeneutics to "embrace human understanding of experience [and] meaning in life worlds" in constructing a nursing research paradigm.

Before explaining the schematic diagram, I will consider a related and highly useful thinking tool (Church 2006) which will act as a stepping stone in understanding the rationale that underpins Figure 3. Church (2006) uses the metaphor of 'knots and threads' to represent networked organisations (Figure 4). The model is "very simple, and at the same time it captures a complexity that is very hard to define and put into words" (p.2). In the model, the triangles represent individuals or institutions that are connected through threads of communication which ties activities together as knots that in turn binds participants together in flexible web of activity.

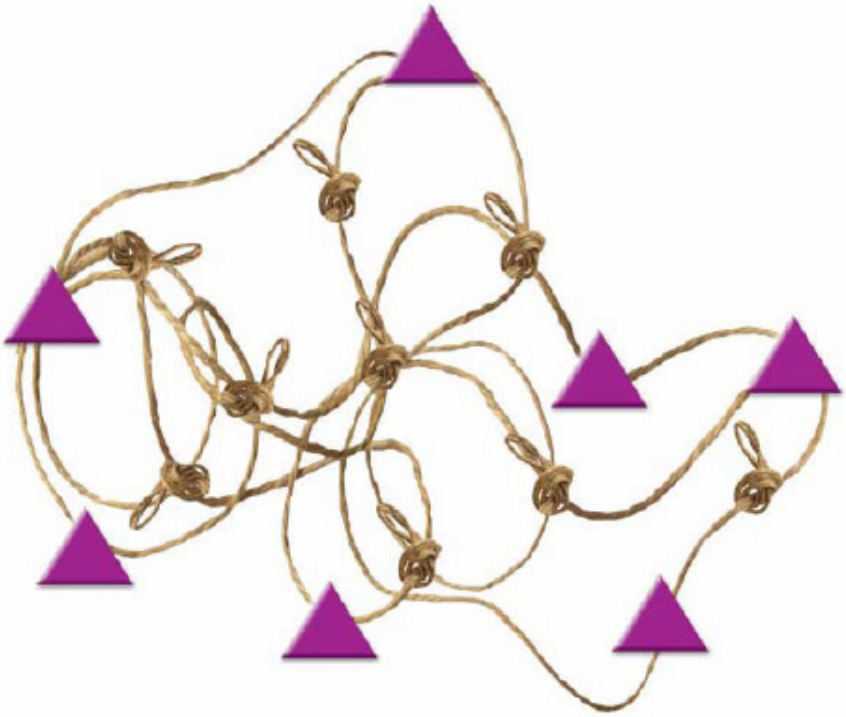

Figure 4: 'Knots and threads' model (Church 2006 p.2)

This metaphor represented by the 'knots and threads' model can be applied to the working of a nursing home, where care providers act autonomously while being loosely connect to the structure of a nursing home. At the same time, the model has an implicit hermeneutic underpinning in that it embeds the 'being-in-the-game' activity of a network. This idea relates well to dynamics of a nursing home, as illustrated within my observations and interviews, where care providers seek to create their own identity against the backdrop to the dynamics of the nursing home social environment.

The Stages

The Processor of the Production of Care diagram (Figure 3) illustrates the 'blackbox' process of the relationships, influences and outcomes which act upon different individuals entering the system of nursing home care. The diagram is composed of five stages that take into consideration Donabedian's (1966, 1976) quality assurance model which encompasses the components of structure, process and outcome. Although the stages are represented in a linear trajectory, in reality we have a recursive spiral effect of continuous movement through the stages, having gained hermeneutic fusions (of horizons) along the way. This is in keeping with hermeneutic tenet of the hermeneutic circle of moving from the whole to the parts and from the parts back to the whole (Paterson & Higgs 2005; Butler 1998).

Stage	Description
First stage	The individual's entering characteristics based upon their global meanings.
Second stage	Coming to terms with the nursing home setting as one develops a *Dasein*.
Third stage-	Working in the system and addressing the issues of external and self-imposed accountability as one develops an identity.
Fourth stage	Responding to the working environment and stress through the (final) selection of a sub-group entwined with resident coping strategies and subsequently becoming a 'tortoise' or a 'hare'.
Fifth stage	Care outcomes related to being a 'tortoise' or 'hare' (Brody 1992; Salmon & Polivka 1998).

The First Stage: Individual Care Provider

This stage of the processor is about the input of the novice care provider who enters the nursing home with pre-existing characteristics and life experiences, armed with an array of coping strategies based upon their worldview. This socialisation and orientation of the novice to the work and organisation culture of the nursing home creates both challenges and satisfaction. In focusing upon the frontline worker, I acknowledge the two worlds of care providers; that of inside and outside of their work (Tellis-Nayak & Tellis-Nayak 1989). I look at the influence of their personal life and inspirations against the value that they place upon their work and how this might impact upon their delivery of care. My focus here in the 'Processor of the Production of Care model' is on the global factors influencing or processing the production of care outcomes; that is, collectively, the Processor. It is necessary to imagine the care provider as the means to understanding the collective influences of the Processor producing the care outcomes of which the care provider is only one factor. It is through the window of the care provider that we can understand the 'why' of the Processor in action and the variation of care outcomes that can arise.

A simple explanation is that the care provider is like a ball of clay that the artist or processor uses to model a ceramic figure. The ball of clay in itself is important and is the

means of bringing the ceramic figure into reality, but there is more to making the figure than just the ball of clay. The artist or processor acts upon the ball of clay, altering it into another form through cognitive processes such as aesthetic decisions, construction techniques, cost considerations and, finally, glazing and firing to bring to life the ceramic figure. This metaphor fails in the same place as the 'food processor' metaphor, in that people are not passive malleable entities that readily hold the shape of the influence impacting upon them. Instead, they have their own agency and interact with and alter structures. In this way, agency and structure inter-relate within the construct of the *middle way*.

Litwak (1985) constructs a processor-like explanation for "our apparent inability to increase the quality of care provided by nurse's aides", which proposes that a nursing home is an 'empirical intersection' of primary and formal groups seeking to justify their activities (Bowers & Becker 1992 p. 361). He suggests that our expectation of nursing home care is unrealistic if we expect individualised, family-like care, since nursing homes are driven by institutionalised routines - consistent with my processor model. Within this processor-like environment, care providers are motivated more by finding ways to do their work as quickly as possible and, if need be, cut corners along the way thus reducing the quality of care provision to the residents.

The question now is: Is the nursing home processor the key influence in creating the difference between an economically and an affectively inclined care provider, or is this already set as a predisposition that the care provider carries into the nursing home? Alternatively, does it become a coping strategy directed towards the nursing home processor environment? My research has no answer to these questions but has instead focused on the underlying conviction that care providers should not be seen as "an amorphous mass of people who do what nobody else wants to do" (Wilner 2001 p. 6), but are, rather, moral agents with a range of motivations. Consequently, we need to know more about care providers and how they respond to the nursing home processor, since they are part of it, and not separate from it. Again the 'why' question about variations between economically and affectively inclined care providers drives this research.

Tortoise and Hares

From personal observations and interviews there exists a variety of understandings of what care means and these cluster around two categories of care providers, which I have called 'tortoises' and 'hares'. This is an archetypal description based on the Aesop fable and creates a simple dichotomy in care provider's characteristics. Aesop is not alone in providing archetypal personality traits through which to understand people. Thurstone (1934) proposed the 'Big Five' personality traits: 'openness', *conscientiousness, extraversion, agreeableness* and *neuroticism*. Keirsey and Bates (1984) proposed the 'four temperaments': *guardian, rational, idealist* and *artisan.* Berlin (1953) provided the hedgehog and fox analogies: "The fox knows many things, but the hedgehog knows one big thing" (Wolin 1954 p. 485). Like Berlin's fox and hedgehog analogy (or Litwak's economically, rather than affectively motivated, care providers), the 'tortoise and hare' analogy is of value as an investigative tool to frame the quality of care variation offered to residents within nursing homes. Tortoises and hares are not just fast or slow, they also differ in attitudes, values and characteristics.

This study's findings reveal a distinct separation in care provider characteristics. Such a separation was also described by Bowers and Becker (1992). As noted in Chapter Two, Bowers and Becker (1992) was one of three texts which I did not read initially in order to allow for the development of theory grounded in the data (Glaser 1978). In their study of nursing home staff, Bowers and Becker described three categories of care providers: 'good' workers, 'bad' workers, along with 'acceptable', 'good enough' 'not too bad' workers. 'Tortoises' and 'hares' either had, or did not have, 'a good heart', a description coined by one the participants in this study. However, the predominant trait of being a 'tortoise' or 'hare' could temporarily, if the circumstance demanded it, change, so that the care worker displayed elements of the other. Bowers and Becker found similar flexibility of moral values in the work style patterns among novice and experienced care providers. In the high demand, high workload setting of a nursing home, both novice and experienced care providers developed ways of coping; that is, they 'routinely cut corners'[72]. This was seen as a necessary survival strategy if one has to continue working in nursing home and

[72] This cutting of corners is not a new social phenomenon and, in the context of research on organisational culture, has been called 'patterned evasion' (Merton [1948] 1968, 1987; Zurcher, 1965; Jacobsen, 1979).

was routinely used by 'good' care providers as well as 'bad' care providers. Bowers and Becker (1992) found that 'bad' care providers resorted to the 'cutting corner strategy' on a daily basis, whereas good care providers used the strategy occasionally, such as, for example when staffing was inadequate and to respond to a 'desperate situation'.

When there is a mix of care providers , 'good' care providers ('tortoises') will continue to provide what they believe is good care and will attempt to make up for the 'bad', 'corner – cutting' care providers ('hares'). In fact, it is clear from this research that 'hares' depended upon tortoises to finish off tasks they had half finished or ignored. This feature of care provision was particularly evident as a difference between weekend and weekday care providers. Monday mornings were consistently the busiest times for weekday care providers as they attempted to get the nursing home back into shape after the predominantly hare weekend care providers. In fact the source of Golden House's problems was the 'untouchability' of weekends care providers and their poor care provision.

'Hares' demonstrate a belief they can get away with not sharing the work, as no one can blame them or single them out for their cutting corners. If 'hare' care providers were assigned to individual residents and made accountable for the state of the residents' care then the situation would change. By accessing 'tortoise's' goodwill, 'hares' reduce the risk of being held accountable for their poor care provision. In fact, there exists a symbiotic relationship between 'tortoises' and 'hares', as they are dependent upon each other to maintain and construct their *Dasein*. This relationship is another 'why' question answered by this research in the words of the care providers.

In Their Own Words

It is only relatively recently that the perspectives of frontline workers have been presented in their own words (see Lekan-Rutledge et al. 1998; Bowers et al. 2000; Leon et al.2001; Richardson & Martin 2004). In an effort to understand the issue of retention and turnover among care providers, research began to conceptualise care providers as 'frontline workers' (Kayser-Jones, Wiener & Barbaccia 1989; Bowers & Becker, 1992; and Richardson & Martin, 2004). This study has revealed that 'tortoises', such as AIN Andrea, exhibited an empathy and emotional intelligence in relating to residents. Empathy, or the giving of autonomy to residents, was a behaviour conspicuous among 'hares', whereas 'tortoises' acted more as enablers, ensuring dependence in the residents. 'Tortoise' care

providers have compassion towards the residents. That is, 'tortoises' sought social engagement as a means of gaining both personal satisfaction and successful outcomes for the residents and relatives, as well as for gaining peer respect. 'Tortoises' who engaged in social engagement became part of the extended family of the resident. AIN Andrea has conceptualised her construction of caring through her own worldview which embodied respect and desires autonomy for older people. The literature on care providers has, until recently, seen them as a homogeneous group that shared the same potential responses to working in nursing homes. This research has clearly demonstrated this not to be the case.

The Second Stage: Nursing Home Setting

On entering the nursing home, the care provider is confronted with the nursing home setting and its organisational cultures' influences. At the same time, the care provider faces up to the realities of the nursing home working environment; that of being forced to reappraise their everyday coping strategy to deal with stress (Park 2000). It is the variations between frontline workers and their relationships within the organisational culture of the nursing home, combined with their responses to the stress of their workplace, that raises the question of organisational 'fit' and the success of their coping strategy.

This study revealed, that a care provider entering the nursing home environment wished to feel comfortable and secure, whilst making new experiences more predictable. At the same time, novices are exposed to socialisation pressure to show their allegiances. Care providers become 'good' or 'not so good' care providers based upon the following characteristics of the care provider: temperament, coping strategy, character, life experience and predisposition based upon their global understanding of life. Other factors included the organisational culture and physical environment of the nursing home.

Care providers may have a predisposition for a particular set of coping strategies, but this is dependent upon the environment in which they are placed and the support, or lack of support, from those around them. If novice care providers are not given adequate orientation or induction into the realities of working in a nursing home, such as a designated role model or mentor, or just their initial working partners they associated with, they will develop their own strategies. Within this stage of orientation, novice care providers are influenced by their forestructures, tradition and historicity as they deal with new experiences. Prime among these new experiences is the *residents*.

Resident

The stereotype of the 'elderly' is that they should be compliant and appreciative of the services that are provided to them. This is not always the case, however, since many factors affect the relationship between frontline workers and the resident within the context of the nursing home environment. Eighty percent of Australian nursing home residents are affected by dementia (AIHW 2004), sixty percent suffer from psychosis (Brodaty, Draper, Saad, Low, Richards & Paton 2001) and sixty percent suffer from depression (Helmes, Pachana & Stokes 2004). The relationships between resident and resident, and resident and care provider, make nursing homes challenging environments (Nay & Closs 1999). In practice, some nursing home residents are abusive, racist and uncontrolled due to psychosis and dementia, resulting in attacks directed towards each other and towards care providers (White 1998; Shaw 1998; Foner 1994).

Although the issue of abuse between residents and care providers is a two-way occurrence, it the abuse of residents by carers, that is frontstage (Shaw 1998). In this study, for example, relative Max spoke of incidents of manhandling and abuse of residents during showering and the restraining of residents. He believed if a care provider was doing their job properly, then he or she should not be concerned about accidents or incidents being reported. Within the workplace, if there is an incident of abuse (verbal or manhandling), then the care provider should be made accountable. In reality, even if a care provider is shown to be abusive, they can easily move on to another nursing home without suffering any consequence, as there is no documentation of care providers performance record nor mechanism to regulate AINs continuance or discontinuance within the industry. Unfortunately, the lack of an industry- wide register of care providers would appear to be a major failing. Interacting with the residents does not become easier even as one gains experience. AIN Andrea, a senior and hard working care provider, admitted to her difficulty in dealing with residents with dementia.

In orienting oneself to the nursing home setting important questions are raised. What coping strategies do care providers use and how are they supported in this endeavour? Are some care providers more susceptible to stress because of their worldviews and are they therefore suited to working in a nursing home environment?

Coping Style Response to Residents

The primary coping strategy of 'hare' care providers is denial and avoidance, whereas 'tortoise' care providers seek social support in terms of teamwork and sharing the burden.

In general, moderate residents suffering dementia who have a higher functional ability (such as those who are capable of self-toileting, feeding and dressing), may also exhibit disruptive behaviours but attract a lower rating within the RCS system. This will not change until their dementia becomes more severe. This scenario of growing numbers of severe dementia places tremendous stress upon the care providers and negates much of the financial motivation for nursing homes to accept these residents as more care providers are normally required. This study revealed that in the case of AIN Andrea's other nursing home employer , 'Wellington', which is a 'not for profit' nursing home, they had a mission to provide care for more severe residents suffering dementia. The DON told me that she prefers to admit 'quiet residents' with high care needs resulting from physical disability or illnesses rather than people with dementia who also had behavioural problems.

Functional Ability and Social Death

Resident's characteristics (dementia and functional abilities) influenced the value the care providers place on the resident and in turn their selection of the quality of care provision. In such circumstances, a person cannot answer back, cannot complain about the care provided, or the care that was not provided. Related to the resident's functional ability is the concept of 'social death', where having a low functional ability leads to residents not being regarded as a person, but as a set of tasks (Sweeting & Gihooly 1997). At the other end of the spectrum is resident Tim. Tim's main point in his interview was that he does everything for himself and sees himself as living in a hotel that he pays for, rather than a nursing home. Tim emphasised that he is left alone in his shared room most of the day and that is the way he likes it.

Within this context, another set of concepts becomes relevant in terms of Tim's perception of himself and his fellow residents; that of functional ability. Hyyppa (1986 p. 4) defined functional ability as the "ability to provide for ones needs. It is ability to act and participate in the society as a full active member of society and fulfil ones roles" (cited in Hyppönen 1997 p.1). To be able to make judgments in relation to the quality of care offered to residents, it is necessary to understand clearly the needs of the residents. The following models of 'functional ability' gives insight into factors that influence the type

and quality of care that is required and offered to residents. It also reflects Tim's perception of the other residents around him, particularly his roommate Mr P.[73].

From resident Tim's point of view he was given due acknowledgment or rewarded for the fact that he has higher functional abilities and is more autonomous than his fellow residents. On the other hand, because he has higher functional ability he is accepted by the care providers and as a consequence receives better care and wider choices than other residents. It is Tim's physical disability that meant he required the support of a nursing home but it is his physical disability that he uses to define his own level of autonomy and self-esteem. The more Tim does, the more he is left to do. For example, on weekends, Tim walks himself to the showers and, unaided, showers himself for twenty minutes. There is an advantage to this, as he would only get a ten minute shower if he had to rely on the care providers. However, to take his own shower, Tim has to remove the appliances left in the shower bay by the care providers and is unsupervised while he is having his shower. This suits Tim in that he maintains his autonomy and agency. However, he is at risk of having a fall when moving appliances (or even having a stroke whilst having his shower) and nobody would know.

Tim however, does not have enough agency to influence the meals that are served on the weekends, instead he uses his self-efficacy to formalise a strategy to deal with the issue by having a hidden supply of fruit given to him by AIN Andrea on weekdays and by eating sandwiches over the weekend.

Autonomy, Agency and Dependency

The concepts of 'autonomy', 'agency' and 'dependency' are explored as they relate to the quality care in a nursing home. These issues have to be resolved by the novice care provider at an individual level and are contrasted with those with whom they work closely and also with the organisational culture of the nursing home. Resident Tim's interview revealed that Golden House conceived care as a set of processes, where all the residents are serviced or left to look after themselves; there is nothing in between. Either the resident fits the model of the standardised resident or does not, and is left to look after him- or herself.

[73] Mr P. shares the room with Tim but is not in the room during the daytime. He is totally dependent upon care providers to assist him in his daily activities.

This insight supports Litwak's (1985) theory of nursing homes as institutional (formal group) settings.

Of interest here is that some care providers appeared satisfied to have tried, although always falling short of the expected level of care, as long as they can be seen to have attempted the expected. For example, a care provider will start feeding a resident at an appropriate feeding speed but when they are faced with difficulties or non-compliance from this resident, the care provider then gives up and moves on the next resident (for example, resident Alma, and resident Nina who struggle for 25 minutes to drink). This situation was observed and became a cycle of behaviour on the part of both the care provider and resident, with little acknowledgment that there is a problem that has to be remedied on the part of the care provider. In these cases the resident is blamed for being non-compliant rather than the care provider not finding an alternative feeding technique or strategy.

One Size Fits All Mentality

It appears that in a nursing home, there is little acknowledgment of the individual differences of functional ability among residents. It is far more convenient to standardise the residents into a single category that is less demanding in time and responsiveness. This issue of responsiveness on the part of the care provider to be constantly accommodating to the individual differences in residents is not incorporated into care routines. It is easier to remain removed from contact with the residents by pretending they have a lower level of functional ability. At the same time this allows for some care providers to remain removed from emotional engagement - 'not being fully there' with the resident (Kahn 1992) - and conceive the provision of care as being process/task oriented rather than a social interaction seeking to support the resident's level of functional ability. Attree (2001) used the criterion of 'Good Quality Care', which was characterised as being humanistic as reflected by the care provider's personalised care that reflected an involvement, commitment and concern for the resident.

This model of the standardised resident is also in part driven by the variables of staffing levels, time restraints and budgets. If one has concerns for a resident, a care provider may become an advocate from them, such as AIN Andrea for resident Tim. The next question to arise for the novice is whether to become an advocate for the residents when they see poor care provision being given to the resident?

In advocating[74] for patients, care providers may be putting their jobs at risk. Being an advocate, and being seen as a 'whistleblower', creates a moral dilemma for care providers when confronted with poor care provision. *Dasein,* according to Heidegger ([1927] 1962), is embedded with our concern for caring for others, and that it is an issue for us as it relates to our construction of identity, since what we do reflects upon what we are and what we have become. The connection between the actions of care providers (such as being a 'whistleblower') and the construction of identity is also considered by Gadamer (2004), who says that a person "becomes what he is through what he does and how he behaves; i.e., he behaves in a certain way because of what he has become" (p. 311).

It's only through frustration with systemic issues having not been resolved over a long period of time that advocates turned whistleblowers are forced into action, and even then those solutions may only be superficial, pasting up the façade again, rather than making deeper changes. The strategy of Golden House management in dealing with 'accidents' (for example, incontinent residents remaining unchanged) was to rationalise them as unavoidable; when they knew it had more to do with 'hare' care providers' reluctance to change residents. Other rationalisations included organisational culture casting - Italian relatives being 'too fussy'. Such rationalisations led advocates to become whistleblowers, as a last resort. This became inevitable after Golden House had passed their second round accreditation crushing the hopes of advocates that the accreditation process would reveal the inadequate care provision.

This moral dilemma for advocates – whether or not to turn 'whistleblower' -becomes even more poignant when the care providers are faced with the choice of placing their own interests behind the interests of the residents. Complicating the issue is the reality of resident violence and abuse induced by dementia, mental illness and cultural or communication clashes that is directed towards the care providers on a daily basis. The experience of this violence created conflicting feelings in care providers while deciding whether to advocate for those patients.

In this study, relative Max believed that relatives' presence is the only way to ensure that proper care is given to the residents. Max appears at a loss as to why the 'hare' care

[74] I used the term 'advocate' in the sense of a person who openly seeks to support a resident with a legitimate request, whereas a 'whistleblower', discussed in the next section, is a person who makes a legitimate complaint that will have repercussions upon the nursing home.

providers behave in the way they do. The only solution is for 'tortoises' to make 'hares' accountable, or to weed 'hares' out of industry altogether ('three strikes and you're out of the industry'). As Max says of the importance of advocates, "If nobody is here, how can you know they feed or give them a drink?". Relative Max took on the role of an advocate and then whistleblower to look after the interests and well-being of his father and the other residents. Max makes himself visible to the care providers as a signal to inform them that he is there to monitor their behaviour towards the residents and provide quality care. In contrast to Max's strategy of visibility, the carers used the opposite strategy in that they make themselves invisible. They may wander aimlessly or spend more time than is necessary on a task that avoids contact with residents. Being an advocate comes at a cost as they are seen as 'whingers' and trouble -makers who have unrealistic expectations on the one hand and legitimate concerns on the other. This probes the moral integrity of the care providers (Carper 1979).

Resident Tim is also an advocate, but on his own behalf; he speaks up for himself. In his interview, Tim brings up his concern about a lack of supervision by weekend care providers. He reminds me that the DON is effectively unable to work on the weekends thus removing her from her supervisory role. As a consequence the weekend care providers feel untouchable. Tim indicates that he is reminded 'five days a week' of the contrast between weekday and weekend care provision. Tim feels secure in getting reasonable care as he can speak up for himself by reporting back to his mate, the DON, during the weekdays.

Whistle-blowing and the whistleblower

In recent years, incidents of whistle-blowing in the healthcare area have been increasingly reported in the Australian media and academic literature. There is an official 'complaint' channel through which relatives and staff in nursing homes may raise their concerns in relation to the care or workplace issues. The 'complaint' channel is an hierarchical structure with most of the cases in fact being solved internally. However, when the internal channels are closed, perhaps due to low ethical standards or poor attitudes among management personnel, it becomes much more likely that whistle-blowing will occur. The issue of whistle-blowing becomes a practical and ethical dilemma for nurses (Wilmot 2000), as well as, I contend, relatives and residents. The act of whistle-blowing has to be taken within the moral context of attempting to achieve positive change and of fulfilling one's duty which relates back to the development of one's *Dasein.*

The fact that whistle-blowing occurs within an organisation is an indication of an "ethical failure at the organisational level" (Fletcher, Sorrell & Silva 1998 p. 1). With the whistleblower fulfilling their duty in an attempt to stop unethical practice in their organisation they face the likelihood of being punished for it. They may have to live through many harrowing experiences, for instance leaving the job, and for many being involved in the difficult process of court proceedings in seeking justice for themselves (Fletcher et al. 1998; Illiffe 2002; Armstrong 2002; Firtko & Jackson 2005). The novice care provider must add this ethical consideration to their conceptualisation of the quality of care they will provide to the resident.

Economic Imperatives

The economic imperatives of 'a nursing home as a business for profit' impacts on the novice care provider within the Processor trajectory. As governments reduce their responsibilities and privatise services, the economic viability of nursing homes becomes a major new focus in understanding the trade-off between profit and quality of care. The conservative Coalition government in 1997 brought in major aged care reforms that reflected its preferred market forces economic model. In the USA, For-Profit ownership of nursing homes has been found to be related directly to poor care outcomes (Aaronson, Zinn & Rosko1994; Spector, Selden & Cohen 1998; Binstock & Spector 1997; Harrington 2001; Bowers et al. 2003). Conversely, Not-for-Profit nursing homes have been found to "reduce adverse outcomes substantially relative to for-profit homes" (Spector et al. 1998 p. 650). This may be a result of the reliance on unskilled nursing personnel as a way to saving money by reducing salaries (Munroe 1990).

Invisible proprietor: a puppet master

Within the Australian aged care industry, there is no charter of moral obligation to which individual proprietors must comply, rather proprietors are free to attempt 'to squeeze the golden goose', in order to receive as much profit as possible. This appeared to be the case within the Golden House nursing home. Unethical or morally corrupt practices such as perpetuating ongoing under-staffing; under-rostering; poor quality food with no variation in menus; scarce entertainment or social interaction; inadequate lighting heating and air-conditioning continue in order to minimise costs and maximise profits. While such practices are not illegal, proprietors will not change their operations.

The prime objective of accreditation asserted by the Federal government is to uphold a standard of care that is represented within the four major standards and 44 expected

outcomes. From the proprietor's point of view, accreditation is the process required to obtain and maintain the licence required to operate. Between the expected outcomes of the proprietor and the government lies a grey area where government, through sanction, seeks to make accountable proprietors who seek profits ahead of quality of care. Caught in the middle is our novice care provider who observes the way the government subsidies are spent. This study revealed that the proprietor of Golden House exerted significant pressure on the DON to achieve financial goals by cutting corners on quality care provision, and also to bear the brunt of any criticism. The more efficient the DON became whilst attempting to maintain quality, the greater the profits to the proprietor.

The proprietor controlled the nursing home through the budget and management policies but remained essentially unseen. I was only able to find three Australian articles (Kendig & Duckett 2001); Braithwaite 2001; Lohr & Head 2000), that addressed the issue of For-Profit compared to Not-For-Profit nursing home and related care outcomes, as directly as the American literature. At best, the reports that were available addressed specific issues such as mealtime, and only as it relates to For-Profit nursing home ownership (Pearson et al. 1997). One of the biggest myths that persists in Australia is that all nursing homes exist for the benefit of the resident, even at the expense of profit. Despite the money that they make, For-Profit nursing homes continue to behave as if they were charity-based nursing homes, running raffles to the staff and holding fetes to raise monies to buy entertainment equipment and extras for the residents to improve their quality of life in the nursing home. For-Profit nursing homes seek out donations from local businesses. For example, Golden House received donations from food manufacturers and attempted to win reductions in the price of equipment, abusing the 'goodwill' of the community. For-Profit nursing homes seek out mutually beneficial relationships with other businesses to turn a profit. For example, free recreational bus trips to an entertainment venue or outings provided by a funeral company to get exposure to advertising.

Max's interview revealed that Golden House, in general, used all consumables (linen, furniture, and equipment) to the point of that they were no longer functional. This is as much a reflection of the worldview of the proprietor, as it is a need to be mindful of the bottom line of the business. Expenditure on such consumables would be a normal claimable expense of running a nursing home.

Subsidy for Service

This study confirmed that one of the key influences upon the quality of care of a nursing home is whether or not it is a 'for profit business.' Proprietors receive government subsidies to provide services to the residents based on the resident's category, but actually achieving those services is left to the discretion of the proprietor. There is little mention of the percentage of profit, estimated at 12 percent (Gray 2001) or the building subsidies they receive, yet the public profile they maintain in the media always calls for increased government funding.

The proprietor's margin of profit is increased by the difference between what he claims (and hence receives0 from the government and what he actually provides to the resident. This is his profit. With a capable DON in place, the proprietor was able to generate greater profits. Adding to this his tight budget, which impacted directly on staffing levels and running costs (quality of food, use of electricity, replacement of equipment, and so on), he was able to make a profit above the industry average, according to the DON. The proprietor was reluctant to take any action to resolve the poor provision of care of which the DON had made him aware. This inaction led to complaints being made which led to a re-accreditation assessment. Golden House failed this re-accreditation in thirty-three of the forty-four outcomes and received sanctions that remained in place until it could demonstrate improvement.

In order to demonstrate the required improvements, the proprietor authorised the purchase of a new mechanical patient lifter, linen laundry bag racks, replacement curtains in the renovated section of Golden House (they were taken, second-hand, from another nursing home) and the introduction of the thermal food serving dispensers. The proprietor resisted making these improvements despite years of pressure from the DONs until it was no longer possible to achieve accreditation without them. This points to accreditation being a 'toothless tiger', as twelve months prior to Golden House being sanctioned, the proprietor did not feel obligated to make such changes, and still passed receiving accreditation without any non-compliance, passing 44 of the 44 outcomes. Working within the environment where the proprietor under-staffs, turns off lighting that needs to be turned on and pretends that the air-conditioning is broken so as to save money, leaves a novice care provider bewildered by the ethics of the proprietor and in turn by those who accept his mandates.

Management

Management exerts influence on organisational cultures, and this can be for the betterment of quality care outcomes in nursing homes. The dynamics of subgroups within nursing homes, especially those whose behaviours seek to establish autonomy for particular groups or individuals, has rarely been the focus of research. This is most particularly true for frontline workers who have hitherto been seen as a homogeneous group affected equally by global influences. Evidence for the USA appears to suggest that where quality of care issues have been addressed by management (ostensibly to improve outcomes for residents) the actual underlying motivation has been the need to resolve retention and turnover issues. Teamwork, mentoring, frontline worker autonomy and decision making input and peer support, when embedded in the organisational structure by management, are successful strategies for improving care provider job-satisfaction, but still have little to do with improving care outcomes. These strategies may, in fact, have more to do with supporting coping styles than anything else (Stone, Dawson & Harahan 2004; Health Service Union 2004).

Key amongst the literature is the idea that training will resolve most issues of poor care provision in nursing homes. This research challenges this notion and suggests that care providers in fact know what is expected of them and how to carry out their duties, but may choose not to.

Training

Some of the literature suggests that giving more recognition to the frontline workers has a flow-on effect in terms of positive outcomes. A number of studies indicate that when adequate training is combined with orientation and appropriate supervision, there is a positive impact on the quality care provision. However, high workloads and staff training did not lead to the decrease high turnover of nurse aides in the USA. Rather, training increased care providers' work autonomy, job satisfaction and career opportunity (Banaszak-Holl & Hines 1996).

This study revealed that education or in-service training does not influence care providers to do 'the right thing'. Instead, after training, the care provider would set up their own criteria with regard to finishing tasks. For example, instead of using a mechanical lifter, even 'tortoise' care providers like AIN Andrea, preferred to lift residents themselves, placing themselves at risk of injury. In AIN Andrea's case, despite already having a back injury from manually lifting patients, her preference is to do what is most comfortable for

the resident. She explained that "the lifter hurts the resident and that the old manual way is quicker and better for the resident if you know what you are doing!". Consequently, even the 'tortoises' are open to 'cutting corners' (Bowers & Becker 1992), and set their own criteria of how tasks should be done, taking it upon themselves to do the task their own way.

Why is this the case? The answer lies, at least partly, in the organisation culture where there is an understood need to do everything as quickly as possible. In addition, the answer lies in the shortage of time in which to undertake the required tasks that make up their routines. Although staff training is beneficial for staff members themselves (increasing job satisfaction and so on), there is some debate whether training alone can improve quality of care for residents. Adequate training is certainly necessary (Wilner 2001), yet it is not sufficient (Smyer et al. 1992; Adams & Bond 2003a). Wilner concedes that the knowledge, preparation, support and supervision necessary for frontline workers to do their jobs properly is also "vitally important to the delivery of good care" (Ch.7-1). This is borne out by my study in that, although the care providers had been well-trained and had been certified, they did not put that training into practice. Culture change is needed if significant improvements in quality of care are to be made (Smyer et al. 1992), as is change in the "prevailing ethos of care" (Adams & Bond 2003b p. 293).

This position is confirmed in my study by the proprietor's reluctance to dismiss poor care providers and provider adequate staffing levels. Staff stability is important for quality care (Adams & Bond 2003b), and, from my perspective, this relates to care workers' commitment and satisfaction in their work. The key aspect is one of ethics and attitudes that counter even inadequate numbers of staff. In Golden House's case, those care providers with ethical commitment made up for those reluctant to offer quality care. Organisational culture, attitudes and care providers' willingness to use their competence, outweighed aspects of organisational systems such as training and staffing levels (Adams & Bond 2003b). Therefore, the culture and ethos of the care provider had a more profound effect upon the quality of care than did staff satisfaction, workload or training - this is the position of this study.

Stress and Coping within Organisational Culture

This research shows that organisational culture affects care workers' stress and coping strategies. This is revealed when research has explored frontline worker's autonomy in the decision making process, as well as empowering them to have a greater control of their workplace domain. Having a level of personal control within the workplace allows the frontline worker to implement coping strategies that best fit their temperament and existing worldview (Braithwaite 2004). This issue of frontline worker autonomy has been underestimated, as it goes against the traditional view of management authority and control of the frontline worker in hierarchical vertical management structures (Pennsylvania Intra-Governmental Council on Long Term Care 2001; Richardson & Martin 2004). However, this research has shown that frontline worker exercise autonomy despite constraints posed by their organisation. This is evidenced by 'cutting corners', as discussed earlier (Weiner & Kayser-Jones 1989; Bowers & Becker 1992). A solution is proposed by Bowers and Becker (1992) which involves encouraging care providers to view residents as members of their "primary group" to whom people are generally most willing to provide nonstandardised, nonroutinised, nonfragmented care (Litwak 1985). Within this 'primary groups' horizon, care providers would regard cutting corners as violating their perceptions of acceptable care. Another solution is proposed by Weiner & Kayser-Jones (1989) who suggests that the accreditation inspectors should change from being adversarial to encouraging and offering constructive criticism in movement towards informed improvement.

Coping strategies are related to characteristics of care workers. This study suggests that 'hareness' and 'tortoiseness' qualities are derived from the person's personality, life experience, disposition, temperament, and also determines their chosen coping strategy. 'Tortoises' will adopt a problem solving social strategy, while 'hares' will adopt an avoidance coping strategy. Stress is a major determinant of quality of care provision, because coping with stress brings into play the social structures and practices within nursing homes that care providers use for self preservation, and these have consequences for care provision. 'Hares' and 'tortoises' are 'hares' and 'tortoises' in nursing home jobs, but also in their outside lives. The stressful nature of the work distills these characteristics and makes them more obvious. In addition to the stressful nature of the tasks themselves, care providers are constantly reminded of their own mortality and have to deal daily with

language difficulties, racism, hierarchical management structures, cultural and sub-cultural clashes.

Coping strategies differ according to the particular sub-culture. 'Hares' enjoy a high level of autonomy through avoidance, being able to wander, not engaging with residents, working in isolation, not being accountable for their actions and being reliant upon 'tortoises' to pick up their uncompleted tasks; 'tortoises' similarly enjoy a high level of autonomy, but their's is achieved through socialising, problem-solving and working in a team. It is also necessary to consider whether 'hares' are 'hares' by choice, or whether this is their only protective survival measure. This issue will be covered in greater depth in the discussion of accountability below; however it is worth highlighting some key points that lay the groundwork for that discussion. These involve the important issue of the care provider's organisational fit which relates to job satisfaction and the dynamics of a subculture (Moyle et al. 2003). People will search for an "environment that will allow them to exercise their skills and abilities, express their attitudes and values, and take on agreeable problems and roles" (Man 1983, p. 41).

This research revealed that organisational culture chooses and supports those that fit within the band of acceptance. It is clear that it is the responsibility of organisational culture to remain flexible to the differences that exist to avoid creating subcultures of marginalised outsiders, an underclass of wanderers. It is also possible to see that these wanderers can perceive themselves as autonomous and not concerned by the acceptance or rejection of others.

Nursing home care has traditionally been perceived as a linear 'production line' that needed to be updated and modified to adapt to new outcomes for the residents. The operating culture is the actual performance of players within the organisational culture, their choices or the impositions of their co-workers. The climate and organisational culture produce the potential choices made by the subcultures, whereas the operating culture is where those dynamics are played out (Weick & Sutcliffe 2003). Members of the dominant culture can operate without thinking about how to interact with that culture; outsiders, on the other hand, need to think about how to interact with the culture.

Stress and coping have their own domain and autonomy. The care provider does not have control over the external stressors but can manage stress according to their predisposition, that is, their control of stress is done according to their nature. Stress and coping strategies

must be given equal prominence in terms of the care provider and the production of care, since ignoring these variables limits our comprehension of the production of care.

The third stage: Accountability

Once the novice care provider has come to terms with the realities of the residents and the day-to-day work of the nursing home, and having determined what their ethical position is (whether to become an advocate or not), they must take a position on their own accountability. The issue of accountability arises for all care givers, and is not solely dependent on external or internal drivers. Much of the literature suggests that ethical values are rule-based and are the primary gatekeepers of care provider behaviour. This research however, hypothesises that it is through the influence of differing operating cultures, the care provider's global understandings and their search for *Dasein* that determines whether to adopt or reject self- or externally-imposed rules. It is this flux of imperatives that eventually guides individuals to align themselves with an operating subculture in the fourth stage.

Self-Imposed Accountability

Awareness of accountability starts well before a novice care provider undertakes formal training; we have a sense of accountability before we even know what it means. From a hermeneutic perspective, accountability and the consequences of actions merge in the development of understanding and *Dasein*. *Dasein* is not 'pieced together', but is rather "primordially and constantly a whole" (Heidegger [1927] 1962 p. 65; also Winnicott 1971; Vygotsky 1978). In the Golden House context, accountability for AINs is largely to themselves. This is despite the fact that AINs, in Australia, are generally certified through a formal qualification system.

Good Heart

'Tortoises' such as the DON, relative Max and AIN Andrea in this study were described by the participants themselves as having the quality of a 'good heart'. Analogous to having a good heart is being a 'true believer', of doing the 'right thing' from which such people as the DON, relative Max and AIN Andrea gain satisfaction. It is part of their personal need to live up to their global understandings and worldview. Being 'a true believer' for the DON has meant that, to some extent, it is necessary to be a little naïve about the machinations of the For Profit nursing home proprietors. DON Nancy, like AIN Andrea, has a strong sense of self-accountability that comes from their global understandings and

worldviews. It requires them to ensure that those residents, for whom they are directly responsible, have received quality care provision from them. DON Nancy, like AIN Andrea, acknowledges that 'hare' co-workers are beyond their influence and that of even the external accountabilities of Golden House management are ignored by the 'hares'. She says she cannot walk around, "with a whip in her hand", in an effort to make care providers accountable.

The interview with AIN Andrea focused on the level of autonomy and the level of isolation from external accountability that operates within Golden House. Andrea's perception is that she is left to be self-accountable, but that her self-accountability creates a façade that Golden House is externally accountable. Andrea revealed that what drives her to maintain a high level of self-accountability in a vacuum of external accountability are her own global understandings, supported at some level of organisational culture, by normal expectations of quality care in a nursing home.

This study discovered that individuals may have a 'tortoise' 'good heart' in terms of making themselves self-accountable for the own work at a very high ethical level, but are 'hare managers' in relation to being accountable to those around them. For example, the RN Au who is the only weekend RN at Golden House is very similar to AIN Andrea in that on an individual level - she has a 'tortoise heart'. However, RN Au had been forced by a lack of authority to become a 'hare manager'. She does not make herself accountable to and for the care provision of those around her. It is easier for her to 'turn a blind eye' when there are no options available to her to change the situation. This is preferable to becoming a whistleblower about the provision of care over the weekends. This is a serious issue for RN Au as such accountability is part of her statement of duties and embedded into the organisational culture in which she is accountable for the AIN work practices.

The best explanation for this situation may be found in theories of organisational culture and its failure, rather than focusing on individual behavior. For example, Hall's (2003) paper on spacecraft accidents observes that problems which persist despite changes in staffing, reflect a systematic problem within the work place. Golden House demonstrates systemic problems that were known but remained unresolved simply because the proprietor was more focused on profit margins than the quality care and believed he could guard himself against any lasting accountability that was a threat to him. Sadly, this is what

he managed to do by scapegoating the DON and quickly returning to prior practices without too much change or cost to him.

This research reveals that quality of care outcomes are far more dependent on the self-accountability of the frontline AINs who act in isolation and fear of any retribution or reward. My findings suggest that for AINs, the meaning of work is embedded within their global understanding, and what they personally receive from that work is as significant in influencing quality care outcomes as the organisational culture of the nursing home of which supervision and accountability are components.

Accreditation Accountability

Within the nursing home setting, the process of accreditation is an externally imposed accountability which filters through the setting and organisational culture of the nursing home to, it is intended, impact on both self-imposed and externally imposed rule adherence in individuals. This study revealed that there is little correlation between the benchmark indicators within the documentation process and concrete, on-the-ground everyday care outcomes for the residents. Accreditation may at best pick up the symptoms of poor care, but is unable to identify the systemic underlying problems. At worst, accreditation has questionable reliability and validity (Illiffe 2000; Braithwaite 2001; Gray 2001; Hogan 2004).

Golden House initially passed all 44 outcomes of accreditation but within six to eight months, the Health Department had enough complaints to require action being taken to reassess Golden House. As a result of this process, Golden House failed a majority of the 44 outcomes and received a period of two months of sanctions. The ACSAA was only triggered to review its original assessment of granting a three year accreditation when the Health Department received complaints from relatives about the poor standards persisting after the accreditation. During the sanction period, Golden House was not allowed to take on any new residents; but, as it was already operating at full capacity and continued to receive full subsidies from the government and payments from residents, this prohibition had no effect.

In failing to achieve accreditation, Golden House was required by ACSAA to take certain steps. I have viewed the ACSAA report and can relay two of its recommendations:

- Implement planned improvements to staffing levels at the Service to ensure there are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service's philosophy and objectives.

- Monitor the effectiveness of these improvements on an ongoing basis to ensure that services are delivered in accordance with these Standards (Accreditation), and the residential aged care service's philosophy and objectives.

It is necessary therefore to conclude that ACSAA neither addressed, nor were aware of, systemic problems as would be revealed by a processor-like thinking tool. In particular, ACSAA was primarily focused upon a paper trail of documentation, rather than assessing the operating culture, leadership and management of Golden House. It was fortunate that the Department of Health and Ageing undertook inspections of Golden House on the weekends, revealing a level of care not observed by the ACSAA assessors who visited on weekdays. The only positive outcome from failing the accreditation was that the proprietor was forced to spend money on improving quality outcomes which were not identified from Golden Houses formal accreditation some 12 months prior. Instead of DONs being supported by regulatory bodies, Golden House's DON was scapegoated, for not being able 'to wave a magic wand' to make up for systemic problems such as budget restrictions at the expense of quality care outcomes and a lack of a system of accountability of care providers working within nursing homes.

This research argues that the notion that ACSAA has 'standards' is false. For example, what is the level of appropriately skilled and qualified staff, sufficient to ensure that services are delivered in accordance with these standards and the residential care service's philosophy and objectives? It is not a ratio of care providers to residents' RCS categories (as was the case under CAMs), as this would mandate staffing levels. Additionally, the standards in accreditation in fact do not pin proprietors down to any real standard but instead give them room to manoeuvre, ultimately making them unaccountable. Apart from sanctions, there is no real accountability, because most of the sanctions are temporary, and, I contend, too lenient. In practice, accreditation accepts the process of the production of care and tries to identify the 'bugs' in the production line process (for instance, bed sores, falls, lost of weight). This is as opposed to perceiving care as a holistic entity. This conception of care as a production line conceives the care providers as robots that may

need adjustment. However, care is more than a collection of piecemeal tasks, it is a community of people – a 'moral ecology- interacting positively with each other to realise their goals.

The quality assessors' belief is that the audit paper trail substantiates that change has taken place and is ongoing. This study, however, revealed that this belief has little validity in reality. There is a disjunction between what that documentation purports to reveal and the reality of what is happening in the nursing home. Overall, although accreditation may be a contributing factor in improving care outcomes, it fails to identify or understand the structural issues of subcultures as real foci of change and stability for positive care outcomes. Accreditation, therefore, misses the most important factor, that of human behavior; particularly the acknowledgement of the importance of the division of care providers into 'hares' and 'tortoises' and how to respond to this reality in the objective of improving or stabilising the quality of care provision. Governments like to appear to be responsible because ultimately they are accountable to the electorate through the ballot box. In reality, however, they remain aloof. The creation of the Agency gives the appearance of them being proactive.

The Fourth Stage – Production Line

Care providers operationalise their approaches to work in how they perceive the tasks they undertake and their relationships with residents. Traditionally, the work tasks that care providers undertake are conceptualised in most cases as routinised, segmented work within the production line of care (Litwak 1985; Koch 1994a, 1994b, 1996; Bowers & Becker 1992). This is reflected in a preference for successful completion of the tasks based upon speed ('hares'), rather than outcome ('tortoise'). Completing tasks in a manner that suits one approach and not another is a potential for friction in staff relations.

Mealtime as a snapshot window the processor in action

This study revealed that at Golden House everything had to be done in a rush. There are two imperatives operating here: the proprietor does not pay staff overtime and some staff like to maximise their free time. The problem is that there is no reflection on the purpose of the activity of mealtime in the minds of care providers. It is driven by the time and pay imperatives. Consequently there is little understanding regarding what reflects a standard of quality, what indicates the mealtime has been a success. This study suggests that if Golden House had a better staffing system (more staff available or a longer time to carry out tasks) and timetable for activities such as mealtime (extended timeslot) the situation

may change. There is a mindset operating in some nursing homes that keeps them chronically under-staffed at the cost of quality care and this is why residents of nursing homes, unlike as the rest of us (including hospitals and even some prisons) have their main meal in the middle of day and sandwiches at night. Why is it that our elderly have less of a normalised lifestyle than prisoners?

This study found that "getting through the work" was the major goal of these case staff. Pearson et al. (2005, p. 47) links this approach to an inappropriate emphasis on a biomedical model, rather than a patient-centred approach to care. A consequence is routinised care. Routines structure the way people work and gives them a way in which to process their work. Routine supports dealing with stress and gives care providers a sense of control. Routines set the work pattern during the day, developing a timeframe and milestones of activities. It details what tasks have to be done by what time. Achieving milestones by finishing tasks ahead of time allows care providers to have extra rest periods. Therefore, a culture where speed of completion is valued ahead of quality makes the act of completion the determining criteria for success.

The idea of routine is to make sure that all the care (individual 'parts') are delivered - and nothing left out -before handing over to the next group of workers in the production line. However, when the speed of completing tasks is the main criterion, care providers use this as an 'outpoint', where they can walk away from the activity when time is up. This allows them to accept the excuse of having tried and failed but having got the work partially finished nevertheless. These outpoints, or shortcuts to early finishes, allow the 'hares' to rest rather than fulfilling the criteria of quality individualised care (Mortimer, Queen & Patrick 1958; Zurcher 1965; Jacobsen 1979; Bowers & Becker 1994). The assumption within an outpoint acceptance is that the care provider will come back to the resident, but this is not the case for 'hares'; instead they leave the unfinished work for the 'tortoise' to complete. Interestingly, if relatives are present, there is a variation in the behaviour of 'hares', in that they will articulate their rationale for outpointing; clearly 'hares' are aware that what they are doing may not be accepted by an outsider.

RN Helen described 'hare' care provision in her interview as, there being "a lot of gaps there in their work!". This observation of partial care provision was also reported by relative Max who said that his father has not been shaved properly. Personal observation and interview data revealed that during mealtime that 'hare' care providers were shovelling

food into the mouths of residents, taking plates away before residents had actually finished their meals and always pushing to partially complete their tasks. RN Helen characterises 'hares' as those that "play up and (are) not so enthusiastic" and are "just there for the money!". She believes that these AINs exhibit no emotional engagement, commitment or work ethic, being, in the end, a liability. She suggested that they would eventually need to be fired, yet this is difficult to do under Australia's industrial relations laws.

This then is the basis of conflict for relative Max who is caught between his personal beliefs about how residents should be cared for, and the realities of 'hares' conceptualising care provision as "my job is just a way to earn money!" Relative Max concluded that 'hares' should not be working in nursing homes, but instead "they should work in a fruit shop!"

A Deeper Understanding of Hares and Tortoises

As mentioned earlier, the difference in practice between 'tortoises' and 'hares' is deeper and has much to do with their orientation to socialisation and interaction with people. 'Hares' are 'isolates', in that they do not want to be emotionally or socially engaged at work, whereas tortoises are 'consociates' who revel in the opportunity for social engagement at work. On another level, 'hares' are basically 'out for themselves', whereas tortoises want to share common values and rewards with those around them. 'Hares' are aware of the maxim 'everyone gets paid the same, whether I do a good job or not', whereas a 'tortoise' would think of 'a fair day's work for a fair day's pay'. It may be that 'hares' have difficulties with staying on task, a short concentration span, together with the issue of social interaction. The fundamental differences in the characteristics of 'hares' and 'tortoises' may be magnified in the nursing home environment. 'Hares' may be unsuccessful in most of their working life apart from working in a nursing home where they are just tolerated. 'Hares' may have no option left to them but to work in a nursing home because of their skills and personal characteristics; whereas 'tortoises' may have a wider range of options but choose to work in a nursing home.

In summary, 'hares' focus upon task completion and routines work for them. For the 'hare', the resident is seen as a set of tasks rather than an individual. 'Tortoises', on the other hand, see the resident as a person and attempt to build a rapport with them as they develop and maintain their own ethical identity through their work.

Conclusion

Overall, the Processor of the Production of Care model is presented in Figure 3 this schematic diagram in order to demonstrate the process by which individuals enter and move through the nursing home. The model tracks their evolution of becoming care providers and the choices they make. The model highlights the reality that care providers are not a homogeneous monoculture but people with varying characteristics, predispositions, personalities, temperament and life experiences. The driving force influencing the choice of becoming either a 'tortoise' or a 'hare' is bound up with coping style and the worldview of individuals, as they deal with the reality of working within the stressful environment of nursing home. Foner (1994) quite correctly suggests that the quality of the care provider's work life has a great impact upon the quality of the care they were able to provide but the greatest impact comes from the care provider's ethical values contained in their identity, their *Dasein*.

This identity is made up the care provider's horizon which has been constructed from their experiences, and from forestructures interrelated to their personality as they work their way through everyday experiences. As Heidegger ([1927] 1962) reminds us, *Dasein* is dependent upon two key aspects, these being 'practical coping', and that we care within a context of *praxis* (ethical practice). In a similar vein, Bourdieu, Giddens and Weick highlight that we are constantly constructing and reconstructing ourselves as we seek to maintain and augment our sense of identity. In this context, care providers seek out opportunities to become who they wish to be within an ethical horizon of their work as they justify their actions and rebuke those around them that challenge their positions.

Implications

This research has generated both an original conceptual model of eight interrelated elements in the production of care within a nursing home and a theoretical framework that identifies the "work-care style" of care providers as the central factor in the "quality" of that care. My findings thus constitute an original contribution to knowledge in the field and also have implications for aged care policy and service delivery. To improve care outcomes, managers must acknowledge the reality of the 'hare' and 'tortoise' subcultures as being the norm in any nursing home, and move away from the notion of a homogenous monoculture of staff that can be changed through training strategies. Managers need to

adopt an operating culture dominated by 'tortoises' that improves the climate of the nursing home to engender a less confronting and stressful working environment, and to bring out the best of the 'hares' and 'tortoises'. To bring out the best in 'hares', managers need to identify 'hare' characteristics, and create cognitive and social interaction supports that encourage engagement with 'tortoises'.

The issues of staff retention and turnover can be addressed by improving job satisfaction. It could be that we do not even need additional staff, but instead need to have more staff who are on-task and productive. We need to get the best out of all staff, not simply rely upon the 'tortoises' to keep the sinking nursing home ship afloat. It might be argued that it is advisable to 'match' care providers to the particular nursing home in order to obtain the right person for that particular organisation. This assumes stability in both care providers and organisational culture, and this is not a valid assumption. The novice care provider is modified by the processor of the production of care, as much as by the organisational culture itself. Neither aspect within the processor can be viewed in isolation, and we are therefore left with the 'juggling' scenario – a 'middle way'.

The strategy to improve nursing home outcomes will become unsustainable, inconsistent or fail, if there is a lack of awareness of the production of care processor which highlights the complexity and synergy of the eight interrelated factors that must be acknowledged to have enduring successful outcomes. This study revealed that care providers are not all the same and that sub-cultures exist; namely 'hares' and tortoises', and that these have an influence upon the production of care outcomes. There must also be an acknowledgement that the nursing home working (and living) environment is stressful and that coping strategies to deal with those stressors are a major hidden factor influencing care provision outcomes. The issue of external- as opposed to self-accountability, is of prime importance when seeking to make the government, proprietors and individual care providers accountable for care outcomes. Accreditation and quality indicators in themselves have too narrow a focus and can therefore only pick up the symptoms of quality of care problems, rather than underlying systemic issues. There is a need to develop supportive evaluation tools, such as observational vignettes, that identify the processor of the production of care in action.

A new theoretical framework is required in order to design a new approach for strategies of care outcome improvement which will also support improved policy decision-making. A

conceptual processor model based upon a hermeneutic underpinning of the *middle way* may also be a valuable tool to evaluate care provision in contexts outside of nursing homes.

Recommendations and Future Research

On the basis of these findings, I am making four recommendations that assist in improving the quality of care for nursing home residents.

1. The proprietor to be held accountable

The proprietor needs to be held personally accountable for putting profits ahead of good care provision in matters that are under their control. As in the case of Golden House, this particularly included the issue of adequate staffing and pay. The question is, then, what actions, whether 'carrot or stick', need to be considered to engender better outcomes into the future? One possible strategy may be to expand the present rating system for nursing homes' accreditation ('pass', 'commendable', 'with merit') to include prominent signage next to the accreditation certificate that gives notice of infringements, much like OH&S signage that states so many days without accident within a factory. However, the issue of the proprietor purposefully not suppling heating and cooling for the residents, I believe, is a form of assault and should demand some form of personal punishment, perhaps restricting him from being a board member of the nursing home company for a period of time or civil action resulting in community service.

Within the area of general nursing home accountability, I suggest that prior to accreditation, a random spot check is undertaken on the weekend and on different shifts during the week. Similarly, DONs should be allowed exchange time so that they can at last be paid to observe weekend care providers directly, and pass judgement on their care provision. They should also be able to take direct action to penalise poor care provision, independently of proprietors. This would relate directly to my next recommendation of licensing AINs.

2. The licensing AINs is recommended

In the Australian aged care industry, people are not held adequately accountable for their actions. Licensing of AINs, as well as a method of basic tracking of their performance record, is required. This process of licensing AINs should be computer-based, with the AIN having a 'smart card' license that is a record of the working life that they carry with them, and is required when they seek new employment, and it required to be maintained by their employers. This would mean that an AIN would have their performance tagged to

them for prospective employer to access their true performance. With this maintained record of performance, an AIN could be reviewed by a licensing boarding every three years to evaluation their continuance within the industry and could be awarded for outstanding performance. Rewarding good care provision should also form part of this strategy and could lead to both community recognition and perhaps increased salaries.

3. The creation of a quality coordinators position and a mealtime observational tool

To support the present accreditation system, the creation of a designated position of a 'quality coordinator' to support the work of the DON would be greatly beneficial. Both this proposed position and that of the DON need to be given specific training in order to become more focused on the quality of their documentation. Part of this training should include the findings of research that focuses upon a hermeneutic *middle way* perspective to understanding the operation of a nursing home.

Flowing from this acceptance of a new conceptual model of the phenomenon of nursing homes is the adoption of a mealtime observational tool to screen and evaluate the quality of care providers within each workplace. Developing an observation matrix or protocol of mealtimes would assist in safely predicting the quality of care across nursing homes, and align it to other indicators such as bed sores, urinary tract infections, food poisoning, falls and incidents or accidents. The vignette of mealtime is a highly useful observational window that has embedded within it all the aspects of the processor of the production of care which would support the work already done on mealtimes by Pearson et al., (1997) and Simmons, Babineau, Garcia & Schnelle (2002). An observational vignette of the overall nursing home could be designed that captures the main dimension of quality of care. These include care, communication, staff, environment family involvement and home. Such a tool could be used during a relatively short walk-through of a nursing home (Rantz, Jensdóttir, Hjaltadóttir, Gudmundsdóttir, Sigurveig Gudjonsdóttir, Brunto & Rook, 2002).

4. The design of an AIN personality profiler

Implementing an AIN personality profiler to assist nursing homes selecting care providers would be most useful. This strategy is not unfamiliar to an American context and is gaining slow acceptance within Australia. A profiler would be the outcome of research based upon observations of AIN characteristics such as in this ethnographic study, and gained from personality questionnaires from both general research and employer AIN selection

campaigns. Both culling potential poor AINs before entering the industry, and those already in the industry, would hopefully improve the quality of the AIN workforce.

Limitations of the study

There are a number of limitations to this study, most of which are typical of qualitative studies more generally. I will consider these as I address the generalisability of the findings of this study. I will note firstly, however, that although I, as the researcher/author, have been visible in the research/thesis (a reflexivity that assists in elucidating my role in the construction of meaning) there are alternative ways of framing and interpreting this research (Gergen 2001). This is to be expected given that individual nursing homes are fuzzy, in that they are both simultaneously within a moral ecological flux, whilst still maintaining a consistent component that reflects the nature of people in organisations.

The question arises to what extent the findings of this study can be generalised to other settings? The social theorist, Max Weber, held that interpretation is fundamentally different in the social sciences from in the natural sciences. The latter looks for 'nomothetic', or rule governed, explanations, while the former (particularly in interpretive approaches) looks for 'ideographic' descriptions that interpret the meaning of individuals within particular social contexts. Empirical generalisation, appropriate in quantitative research, is based on statistical representativeness. An alternative conception of generalisability applicable to qualitative research is 'theoretical generalisation' (Mason 2002). This type of generalisation "does not represent one uniform method of generalizing, but instead encompasses a range of strategies based on differing logics" (Mason 2002 p.195). I will consider the limitations of this research by addressing the extent to which the study permits 'theoretical generalisation'.

'Ideographic' explanations in social sciences replace the 'nomothetic' explanations of quantitative research. The ideographic nature of this study is both the main limitation of this study and its strength. The particular social context that is Golden House is unique, and the myriad permutations of social processes therein cannot be replicated in other settings. However, the research has identified processes (particularly as described in Figure 2 and Figure 3) which might be expected to play out in other settings. Below I will compare Golden House to other settings, for this purpose. The relevance of this for 'theoretical generalisation' can be explained this way:

> By establishing what is possible (this can happen) and having an explanation of how and why it happened in this setting (key explanatory factors) the researcher can try to widen the resonance of explanations by asking questions about the lessons for other settings (Mason, 2002 p. 154)

A limitation that arises from the ideographic nature of this study is akin to a reliability issue. Golden House is in a state of flux, just as is any other organisation. My data collection took place over two and a half years, but one-off events occurred in that time, and they altered the nursing home. New events, staff and the regulatory environment will continue to occur after I left the setting. The 'middle way' approach to this research acknowledges that we are both changing, whilst attempting to maintain our identity on an individual level and at an organisational level. Consequently, both individuals and nursing homes are in constant change and cycle through change modes of identity depending of the variables in play. This was evident in the collapse the Golden House through the process of seeking accreditation, gaining accreditation and then being sanctioned after complaints had been made. In the case of Golden House it will never be as it was, whilst I undertook my study, but the thinking tools that I have developed in the processor of the production of care point to how one might start to understand nursing homes.

Another basis for 'theoretical generalisation' is the rigour of the research methods (data collection and analysis). I have already discussed the use of data and methods triangulation in this study. The process by which my interpretations were developed is explained in both the methodology chapter and in the process of describing my interpretations in the data chapters of this thesis. One obvious limitation is the 'opportunistic' choice of Golden House as the research site, described in Chapter Three.

I have tried to provide sufficient detail about Golden House for the reader to assess for themselves the extent to which it is similar or different from other settings – an aid to assessing generalisability of the findings. I will now try to be explicit about some of the possible similarities and differences to other contexts. The nursing home sector in Australia includes a wide range of nursing home types and providers. Golden House was owned and operated by a private provider, which can be contrasted with nursing homes owned and operated by church-based proprietors, and other not-for-profits. This may affect the generalisability of the findings regarding cost-cutting and so on. Golden House is likely to be atypical also in the quality of care it provided. This can be simply inferred

from the fact that it ran into accreditation difficulties, which is not true of the majority of nursing homes. There are, no doubt, other significant ways in which Golden House was atypical, and I now leave it to the reader to assess the applicability of these findings to their particular context.

Further research

The key question is why AINs make the choices they make in regards of becoming a 'tortoise' or a 'hare'? Why do they switch from one to another? Is the decision based solely of personality and life experiences or more to do with those variables with the addition of coping strategies in response to their changing workplaces?. Are 'hare' care providers not servicing the needs of residents because they are oblivious to their needs, or consciously choosing to ignore them in a callous attitude? Is it their coping strategy that encompasses denial and isolation or simply a reflection of their predisposition to isolation from social engagement?

More research is needed to these questions about hares. More research is needed to these questions about 'hares' in particular, but also about why some people becomes a self-sacrificing 'tortoise'. I hypothesise that there is a set of more refined gradations that describe people's position upon a continuum towards and away from autism than we wish to openly acknowledge. As Kron (2008) says the social world is not black and white but shades of grey. It would appear fruitful to explore the phenomenon of 'tortoises' and 'hares' in other cultures to determine the degree of similarity or variance from an Australian context.

> Pity arises when we are sorry for someone. Compassion is when we understand and help wisely (Buddha, 2003).

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APPENDICES

APPENDIX A: Accreditation Standards Overview

Standard 1: Management Systems, Staffing and Organisational Development	Standard 2: Health and Personal Care	Standard 3 Resident Lifestyle	Standard 4 Physical Environment and Safe Systems
1.1 Continuous Improvement	2.1 Continuous Improvement	3.1 Continuous Improvement	4.1. Continuous Improvement
1.2 Regulatory Compliance	2.2 Regulatory Compliance	3.2 Regulatory Compliance	4.2 Regulatory Compliance
1.3 Education and Staff Development	2.3 Education and Staff Development	3.3 Education and Staff Development	4.3 Education and Staff Development
1.4 Comments and Complaints	2.4 Clinical Care	3.4 Emotion and Staff Development	4.4 Living Environment
1.5 Planning and Leadership	2.5 Specialised Nursing Care Needs	3.5 Independence	4.5 Occupational Health and Safety
1.6 Human Resource Management	2.6 Other Health and Related Services	3.6 Privacy and Dignity	4.6 Fire, Security and Other Emergency
1.7 Inventory and Equipment	2.7 Medication Management	3.7 Leisure Interests and Activities	4.7 Infection Control
1.8 Information Systems	2.8 Pain Management	3.8 Cultural and Spiritual Life	4.8 Catering, Cleaning and Laundry Services.
1.9External Services	2.9 Palliative Care	3.9 Choice and Decision-Making	
	2.10 Nutrition and Hydration	3.10 Resident Security of Tenure and Responsibilities	
	2.11 Skin care		
	2.12 Continence Management		
	2.13 Behavioural Management		
	2.14 Mobility, Dexterity and Rehabilitation		
	2.15 Oral and Dental Care		
	2.16 Sensory Loss		
	2.17 Sleep		

Standard 1: Management Systems, Staffing and Organisational Development

Principle:

Within the philosophy and level of care offered in the residential care service, management system are responsive to the needs of residents, their representatives, staff and stakeholders, and the changing environment in which the service operates.

Purpose:

This standard is intended to enhance the quality of performance under all accreditation standards, and should not be regarded as an end in itself. It provides opportunities for improvement in all aspects of service delivery and is pivotal to the achievement of overall quality.

Number	Title	Expected Outcomes
1.1	Continuous improvement	The organisation actively pursues continuous improvement
1.2	Regulatory compliance	The organisation's management has system in place it to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines.
1.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively
1.4	Comments and complaints	Each resident (or his or her representative) and other interest parties have access to internal and external complaints mechanisms.
1.5	Planning and leadership	The organisation has documented the residential care service's and commitment to quality throughout the service.
1.6	Human resource management	There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service's philosophy and objectives.
1.7	Inventory and equipment	Stocks of appropriate goods and equipment for quality service delivery are available.
1.8	Information systems	Effective information management systems are in place
1.9	External services	All externally sourced services are provided in a way that meets the residential care service's needs and service quality goals.

Standard 2: Health and Personal Care

Principle:

Residents' physical and mental health will be promoted and achieved at the optimum level in partnership between each resident (or his or her representative) and the health care team.

Number	Title	Expected Outcome
2.1	Continuous improvement	The organisation actively pursues continuous improvement
2.2	Regulatory compliance	The organisation's management has system in place it to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines.
2.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively
2.4	Clinical care	Residents receive appropriate clinical care
2.5	Specialised nursing care needs	Residents' specialised nursing care needs are identified and met by appropriately qualified nursing staff.
2.6	Other health and related services	Residents are referred to appropriate health specialists in accordance with the residents' needs and preferences
2.7	Medication management	Residents' medication is managed safely and correctly.
2.8	Pain management	All residents are as free as possible from pain.
2.9	Palliative care	The comfort and dignity of terminally ill residents is maintained.
2.10	Nutrition and hydration	Residents receive adequate nourishment and hydration
2.11	Skin care	Residents' skin integrity is consistent with their general health
2.12	Continence management	Residents' continence is managed effectively
2.13	Behavioural management	The needs of residents with challenges behaviours are managed effectively
2.14	Mobility, dexterity and rehabilitation	Optimum levels of mobility and dexterity are achieved for all residents.
2.15	Oral and dental care	Residents' oral and dental health is maintained
2.16	Sensory loss	Residents' sensory losses are identified and managed effectively
2.17	Sleep	Residents are able to achieve natural sleep patterns.

Standard 3: Resident Lifestyle

Principle:

Residents retain their personal, civic, legal and consumer rights, and are assisted to achieve active control of their own lives within the residential care service and in the community.

Number	Title	Expected outcome
3.1	Continuous improvement	The organisation actively pursues continuous improvement
3.2	Regulatory compliance	The organisation's management has system in place it to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines.
3.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively
3.4	Emotional support	Each resident receives support in adjusting to life in the new environment and on an ongoing basis
3.5	Independence	Residents are assisted to achieve maximum independence, maintain friendships and participate in the life of the community within and outside the residential care service.
3.6	Privacy and dignity	Each resident's right to privacy, dignity and confidentiality is recognised and respected
3.7	Leisure interests and activities	Residents are encouraged and supported to participate in a wide range if interests and activities of interest to them
3.8	Cultural and spiritual life	Individual interests, customs, beliefs and cultural and ethnic backgrounds are valued and fostered.
3.9	Choice and decision-making	Each resident (or his or her representative) participates in decision about the services the resident receives, and is enable to exercise choice and control over his or her lifestyle while not infringing on the rights of other people.
3.10	Resident security of tenure and responsibilities	Residents have secure tenure within the residential care service, and understand their rights and responsibilities.

Standard 4: Physical environment and safety systems

Principle:

Residents live in a safe and comfortable environment that ensures the quality of life and welfare of residents, staff and visitors.

Number	Title	Expected outcomes
4.1	Continuous improvement	The organisation actively pursues continuous improvement
4.2	Regulatory compliance	The organisation's management has system in place it to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines.
4.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively
4.4	Living environment	Management of the residential care service is actively working to provide a safe and comfortable environment consistent with residents' care needs.
4.5	Occupational health and safety	Management is actively working to provide a safe working environment that meets regulatory requirements
4.6	Fire, security and other emergencies	Management and staff are actively working to provide an environment and safe systems of work that minimise fire, security and emergency risks.
4.7	Infection control	An effective infection control program
4.8	Catering, cleaning and laundry services	Hospitality services are provided in a way that enhances residents' quality of life and the staff's working environment.

Reference: Department of Health and Family Services. (1998). *Standards and Guidelines for Residential Aged Care Services Manual*. Canberra: Aged and Community Care Division, Commonwealth Department of Health and Family Services.

APPENDIX B: Application form for accreditation

[self-assessment/desk audit]

ACSA Application for Accreditation

RACS ID:

Service Name:

Part 3: Self-assessment Report

Standard 2 Health and Personal Care

2.9 Palliative care

The comfort and dignity of terminally ill residents is maintained

What do we SAY we do to achieve this Expected Outcome? This means outline what information the service has in place to provide guidance about this Expected Outcome. This could include structures, roles, policies, procedures, protocols, plans, written directions or other ways of providing guidance.	
What do we DO to achieve this Expected Outcome? This means outline what practices the service carries out for this Expected Outcome. Include what actually happens and how it is monitored.	

What are our RESULTS? This means explain what the results are and how the service knows that it is compliant. Include the details of what measures have been used and the results achieved. It also means outline what the service will show the assessors to demonstrate its performance and that it is complying with this Expected Outcome. This may include particular people the assessors could talk to, physical aspects of the service, observations of practice assessors will see, documents such as records and survey results, data showing improvement in this Expected Outcome since the last self-assessment.	Does our service comply with Expected Outcome? **Yes** ☐ **No** ☐
What will we do to IMPROVE our PERFORMANCE? If YES, list the issues or opportunities for improvement. Then prioritise them and record them on the Plan for Continuous Improvement.	As a result of this self-assessment do we plan to make improvements in our performance in this Expected Outcome? **Yes** ☐ **No** ☐

Reference: Aged Care Standards and Accreditation Agency Ltd. (2001b December). *Submission for high ratings award for residential aged care services (Issue 2).* Parramatta: Aged Care Standards and Accreditation Agency Ltd.

APPENDIX C: RCS Weightings

The weightings that apply to each on the RCS are:				
Question	**Response Weighting**			
	A	**B**	**C**	**D**
1. Communication	0.00	0.28	0.36	0.83
2. Mobility	0.00	1.19	1.54	1.82
3. Meals and Drinks	0.00	0.67	0.75	2.65
4. Personal Hygiene	0.00	5.34	14.17	14.61
5. Toileting	0.00	5.98	10.65	13.70
6. Bladder Management	0.00	2.22	3.82	4.19
7. Bowel Management	0.00	3.32	5.72	6.30
8. Understanding and Undertaking Living Activities	0.00	0.79	1.11	3.40
9. Problem Wandering or Intrusive Behaviour	0.00	0.80	1.58	4.00
10. Verbally Disruptive or Noisy	0.00	1.19	1.75	4.60
11. Physically Aggressive	0.00	2.34	2.69	3.05
12. Emotional Dependence	0.00	0.28	1.50	3.84
13. Danger to Self or Others	0.00	1.11	1.54	1.98
14. Other Behaviour	0.00	0.91	1.82	2.61
15. Social and Human Needs – Resident	0.00	0.95	1.98	3.01
16. Social and Human Needs – Families and Friends	0.00	0.28	0.55	0.91
17. Medication	0.00	0.79	8.55	11.40
18. Technical & Complex Nursing Procedures	0.00	1.54	5.54	11.16
19. Therapy	0.00	3.64	6.10	7.01
20. Other Services	0.00	0.71	1.46	2.93

Resource: Commonwealth of Australia. (2002a). Residential Care Manual. P.5–9

APPENDIX D: RCS Daily Subsidy Rate

Classification Level	The basic subsidy amounts States							
	NSW	**VIC**	**QLD**	**SA**	**WA**	**TAS**	**ACT**	**NT**
RCS 1	$109.97	$113.83	$103.78	$106.55	$107.80	$115	$107.72	$111.46
RCS 2	$99.46	$102.87	$93.96	$96.57	$97.60	$104.12	$97.63	$100.86
RCS 3	$85.64	$88.54	$80.89	$83.25	$84/04	$89.87	$84.23	$86.81
RCS 4	$60.81	$62.75	$57.22	$59.14	$59.47	$64.21	$59.91	$61.54
RCS 5								
RCS 6								
RCS 7								

Resource: Commonwealth of Australia. (2002a). The Residential Care Manual (No. 2677). ACT: Aged and Community Care Division, Commonwealth Department of Health and Ageing. .6-29.

APPENDIX E: Subject Information Sheet

The University of Sydney
School of Behavioural & Community Health Sciences

Faculty of Health Sciences, Cumberland Campus

East Street, PO Box 170 Lidcombe NSW 1825 Tel: +61 2 9351 9576 Fax:+61 2 9351 9540

Subject Information Statement

Research study into 'Care in a Nursing Home '

You are invited to take part in a research study which is seeking to gain a better understanding of the delivery of care within a nursing home setting. We are particularly interested in learning more about the views and experiences of the staff who provide that care. The study is being conducted by myself, Hui-Wen Chien, a Doctor of Health Science student from the School of Behavioural and Community Health Sciences, University of Sydney. I will be supervised by Associate Professor Cherry Russell for this study which will form the basis of my thesis for the degree of Doctor of Health Science.

If you agree to participate, I would like to interview you at a time and place that is convenient for you. The interview will be recorded on audio tape, again **with your permission,** otherwise shorthand notes will be taken. The focus of the interview will be your own past and present experiences of working in residential aged care.

The interview is expected to last about 60-90 minutes. If necessary, a follow-up interview may be requested. You will be free to stop the interview at any time. You can also ask for the tape recorder to be turned off at any time and can request all or sections of the taped interview to be erased in your presence. If you wish you may invite someone else to be present at interview.

All aspects of the study, including results, will be strictly confidential and only myself and my supervisor will have access to information on participants. A final report of the study will be submitted as my thesis and some findings may be published in journals or presented at conferences, but neither the facility nor individual participants will be identifiable.

Your participation in this study is completely voluntary. You are in no way obliged to participate and if you do not want to participate, you can withdraw at any time. Whatever your decision, it will not affect your relationship with your employer.

When you have read this information, I will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact me, or my supervisor, Associate Professor Cherry Russell.

This information sheet is for you to keep.

Please return the attached Expression of Interest form in the stamped addressed envelope if you wish to participate.

This study has been approved by the Ethics Committee of the University of Sydney. If you have any concerns or complaints about the conduct of research you can contact the Manager of Ethics and Biosafety Administration, University of Sydney, on (02) 9351 4811.

Thanks again for your interest.

Hui-Wen Chien

Doctor of Health Science student

Associate Professor Cherry Russell
Chief Investigator
School of Behavioural &
Community Health Sciences
East Street PO Box 170
Lidcombe NSW 1825
Tel: (02) 9351 9129

Mrs. Hui-Wen Chien
Co-investigator (Researcher)
Doctor of Health Science Student
School of Behavioural &
Community Health Sciences
East Street PO Box 170
Lidcombe NSW 1825
Tel: (H) 02-97875251

Any person with concerns or complaints about the conduct of a research stu can contact the Manager of Ethics and Biosafety Administration, University Sydney, on (02) 9351 4811.

APPENDIX F: Informant Consent Form

The University of Sydney
School of Behavioural & Community Health Sciences

Faculty of Health Sciences, Cumberland Campus
East Street, PO Box 170 Lidcombe NSW 1825 Tel: +61 2 9351 9576
Fax:+61 2 9351 9540

Consent Form

I, _____, give consent to my participation in the research project

Title : Care in a Nursing Home

In giving my consent I acknowledge that:

1. The procedures required for the project have been explained to me, and any questions I have about the project have been answered to my satisfaction;
2. I have read the Subject Information Statement and have been given the opportunity to discuss the information and my involvement in the project with family and/or friends;
3. I am aware of the risks and inconveniences associated with the project;
4. I understand that I can withdraw from the study at any time, without affecting my relationship with the researchers now or in the future;
5. I understand that my involvement is strictly confidential and no information about me will be used in any way which reveals my identity

Participant Signature …… Signature……

Date…….

Name of investigator ……Signature ……..……

Date ……

Any person with concerns or complaints about the conduct of a resear study can contact the Manager of Ethics and Biosafety Administratio University of Sydney, on (02) 9351 4811.

APPENDIX G: Interview Follows Up Questions

The core questions and common elements for all the informants are as following:

For resident Tim

1 Tell me about your life style when you were able bodied and looked after yourself?
2 Can you tell me what it's like to live here?
3 What do you think 'care' in a NH is all about? And how would you describe it?
4 Can you tell me about the staff in this nursing home and how they provide care to the residents?
5 If you could change anything in the way that care is provided to you, what would it be?
6 Do you believe that you have receive a quality care in this nursing home? why / why not?
7 Talk about accreditation?

For relative Max

1 Why did your father move to a nursing home?
2 Who choose to come to this nursing home and why?
3 What are your father's care needs?
4 Tell me about your involvement in nursing home (i.e. carer meeting)
5 What have been your observation from coming to this nursing home throughout the whole week?
6 What do you think 'care' in a NH is all about? And how would you describe it?
7 What do you think 'quality care" in a NH is all about? And how would you describe it?
8 Do you believe that your father has received a quality care in this nursing home? Why / why not?
9 Can you tell me about the staff in Golden House?
10 Is there any staff member in particular who stands out as offering quality care? what do they do that distinguishes them from other staff?
11 What do you know about the accreditation process? Were you involved by been asked questions?
12 If you could change anything in the way that care is provided to your father, what would it be?

For care providers:

1 Can you describe in your own word about what is 'care in nursing home?'

2 What do you see as 'quality of care?

3 Do you believe the residents in Golden House receive quality care? Why/Why not?

4 Can you tell me about yourself and your work (life) experience before you come here?

5 Can you describe what your work details? Is there a typical day? What is it like?

6 Can you tell me something about the residents? What is it like for you to work with elderly people?

7 What are the most/least satisfying aspects of your work here?

8 Can you tell me something about the staff in Golden House?

9 Can you describe the management style in Golden House?

10 Can you tell me about your involvement in the accreditation process?

11 If you could change anything about the way care is provided to residents, what would it be?

An example from RN Helen interview

No	Core questions to ask	The questions to follow up
8	Can you tell me something about the staff in Golden House?	□ What is your relationship with staff □ Do you see any general distinctions/difference between staff in this nursing home? □ How would you categories staff into similar group? Or are staff generally all the same? □ How would you describe the major difference between the groups? □ How would you describe group way of working in nursing home, can you give me some examples? □ What sort of thing have you notice that different group do? □ What do you see as the main difference between group of workers or individual in this nursing home? □ Are there any common thing (behaviours) that each of the group do? □ What do you believe you can changes staff's behaviour to one that encourage quality care service? What strategies would you or do you use to achieve this? (role model, peer mentoring, supervision, accountability) □ What would you recommend as a positive role model for staff entering this nursing home to develop quality care procedures?

APPENDIX H: Personal Correspondence with Supervisor

An example of the email (personally correspondence) I wrote to my supervisor in regards to the confusion of using different methodologies in analyse the data:

Dear Cherry,
When I started to analyse Lily's interview transcript I realised that there was "something missing", I have identified all the individual parts, but the glue that joined them together was not clear to me. I revisited my observations, transcripts and methodology texts for help in dealing with this issue and discovered through Silverman "Doing Qualitative Research" a way forward that of looking at puzzles (Jennifer Mason). The puzzle I wanted to understand was the behaviour of care providers wandering. After working through this puzzle I came up the idea that wanderer is a coping strategy to stress and that coping strategy styles were the missing glue in my research so far. Coping strategies also applied to my other interviews of Tim and Max, giving me some confidence that I am now onto something to further explain the variation of the quality of care given in nursing homes

In the course of my rereading I became concerned about my understanding of both the Ethnography and grounded theory methodology in regards to an accepted set of steps that are recognised academically. It appears to me that the more I read, the more variation in the steps and rigour that authors use for both methodologies. It seems to me to be more like all the authors stating that they have the only right way to the truth, can you help?

From my rereading Silverman and Grbrich, they appears to be more generalist in their approaches to research, being less specific in process to as say James. P. Spradley "The Ethnographic Interview" & "Participant Observation, Minichiello "In-depth Interviewing" or the series on Ethnography by Schesul et al "Essential Ethnographic Methods" etc.

The latter authors of Spradley, Minichiello and Schesul et al, all have step staged processes in varying amounts of detail and complexity, which one would you recommend as the most accepted academically and suited to my project.
At the same time I have also became aware of the controversy surrounding both the definition, use and variety of Grounded Theory. I am happy with the distinction of Ethnograpy being focused upon the explanation of phenomenon through culture and that Grounded Theory is the process to build theory but they appears confusion in the academic world of these two methodologies.

Initially I understood Grounded Theory in its narrow usage (Grbich) at a tool to assist you while you undertook your Ethnographic study, a constant review of your conceptual framework that helped you

sensitize your unfolding comprehension of the phenomenon with theory. But now I know that there exists a far more elaborate standalone research version of Grounded Theory devised and fought about by both Glaser and Strauss & Corbin. This version of Ground Theory is ridiculed by Silverman, particularly the newer version devised by Strauss & Corbin (1990). I have become attracted to the original ideas of Grounded Theory by Barney Glaser which are far more applicable and helpful to my project. Can you tell me what you think about academics review of Grounded Theory and what would be acceptable to use in my project?

To summarise, I am at the stage where I now need to analyse my data more thoroughly, constructing a rigourous coding/analysis process of categories, symbols, labels, etc, to allow me to create more searching questions to investigate my hypotheses within ongoing interviews.
Therefore would you comment of the following choices:
** using Spradley as the basis for my Ethnographic work in both participant observation and interview*
** using Glaser as the basis for my Grounded Theory work and*
** marrying both together (that of Grounded Theory and Ethnographic), with a content analysis of the Ethnographic data, then representing the combined approaches in a narrative format*

As my supervisor responds to my letter, she said:
This is all very exciting! You are exactly where you should be and doing great! The 'coping strategies' sounds like a useful emergent theme. As for the methodology question, everything you have written here makes good sense - don't trash the email because you can use this reasoning in your write up. There is NO SINGLE 'RIGHT' WAY of doing it. Remember Denzin and Lincoln talk about the qualitative researcher as a 'bricoleur' - you put together your techniques from what is available in the way that best suits YOUR project. The important thing is that you will be able (later in the write up) to DESCRIBE what you did, how you went about the analysis, etc. Gadamer's concept of the 'hermeneutic circle' might be useful here as a way of understanding the process that you are going through (see Koch's article in the Qual Research Methods Reader). Personally I don't find Spradley all that useful - I don't think it works in neat 'stages' (hence I prefer the idea of the circle). But if he works for you, use him. There are all kinds of definitions of ethnography, grounded theory etc., as you know. The words are not important - as long as you use them systematically you can adopt the approach that you find most useful (and put them together in ways you find most appropriate for your particular task and data). Have a read of Koch and see if the 'circle' idea helps.
~ End of e-mail ~

APPENDIX I: The Standards & Guideline

Standard 1: Management Systems, Staffing and Development

Principle
Within the philosophy and level of care offered in the residential care service, management systems are responsive to the needs of residents, their representatives, staff and stakeholders, and the changing environment in which the service operates.

Purpose
This standard is intended to enhance the quality of performance under all accreditation standards, and should not be regarded as an end in itself. It provides opportunities for improvement in all aspects of service delivery and is pivotal to the achievement of overall quality.

1.4 Comments and Complaints
Expected Outcome
Each resident (or his or her representative) and other interested parties have access to internal and external complaints mechanisms.

Criteria
Policies and practices provide:

a. that the organisation's management actively seeks feedback from each resident (or his or her representative) and staff on all aspects of the services provided by the service;
b. that issues raised by a resident (or his or her representative) relating to the services provided by the service are dealt with fairly, promptly, confidentially and without retribution;
c. that a simple and easy-to-use comments and complaints resolution mechanism is in place;
d. that all comments and complaints are recorded, monitored and acted upon in order to achieve a satisfactory resolution;
e. that information relating to internal and external complaints mechanisms is available to each resident (or his or her representative); and
f. for the referral of complaints that are unable to be resolved internally, to the appropriate external agencies for resolution.

The Guideline for 1.4 Comments and Complaints

Expected Outcome

Each resident (or his or her representative) and other interested parties have access to internal and external complaints mechanisms.

Preamble

An effective comments and complaints handling system provides invaluable information for continuous quality improvement. Dealing with comments and complaints supportively, and receptively, creates clear opportunities for improvement. The absence of complaints and comments does not necessarily indicate resident satisfaction.

Complainants must have access to external mechanisms and be assisted to access external complaints mechanisms when the complaint cannot be resolved at the local level.

Residents or their representatives should be provided with information about the availability of assistance from advocacy services. Complaints should be seen as an integral part of the quality management system.

Considerations

- Management has a clear policy on handling comments and complaints within the service that encourages feedback from each resident or their representative
- Comments and complaints policy is documented, communicated to residents, relatives and staff, and is available at all times
- Resident and staff information outlining the benefits for consumers and providers in relation to feedback on all areas is developed
- Management ensures all staff, residents or their representatives have information on the philosophy and process of the comments and complaints system including how to make a comment or complaint, who to make it to, and the process for resolution (for example, through resident/relative handbooks, newsletters and minutes of meetings)
- Residents or their representatives, and staff, are encouraged to comment or complain
- Staff awareness that comments and complaints represent opportunities for service improvement and can be resolved in a number of ways including:
- informal -- for simple, straightforward comments or feedback. Staff have authority to resolve such issues as fully as possible
- formal -- for more complex or serious matters that need to be referred to a designated complaints person and
- external review -- when complaints cannot be resolved internally, they are referred to an independent external complaints mechanism
- Processes ensure that complaints are handled fairly, promptly and confidentially
- Comments and complaints policy statement provides that complainants and other people who provide information are protected from any repercussions, reprisals or victimisation
- The comments and complaints system is accessible and transparent
- Comments and complaints are recorded, action monitored and the information used to identify and address service delivery problems
- Comments and complaints system includes:
- positive conflict resolution strategies
- sound policies and procedures
- ongoing staff education and training
- consumer information and education
- recording and monitoring of comments and complaints and
- timely action on comments and complaints to improve service delivery
- Complainants are regularly informed of progress in relation to their complaints
- Development of a complaint mechanism that also records the nature of the complaint, possible solutions, and the outcome and resolution
- Information about internal and external complaints mechanisms and access to advocacy services available to each resident or their representative
- When a complaint cannot be resolved internally or it raises issues that need to be investigated by another agency, the complainant is referred to that agency. Such agencies could include professional bodies, police or the Commonwealth

Standard 2: Health and Personal Care

Principle

Residents' physical and mental health will be promoted and achieved at the optimum level, in partnership between each resident (or his or her representative) and the health care team. [According to the Standards and Guideline for 2.10 Nutrition and Hydration that the principle is set up for resident's health and mental wellbeing need to be promoted and achieved to an optimum level. All the residents are expected to receive adequate nourishment and hydration.]

2.10 Nutrition and Hydration

Expected Outcome

Residents receive adequate nourishment and hydration

Criteria

Policies and practices provide:

a. that residents' nutrition and hydration needs are assessed, documented, regularly reviewed and acted upon;
b. that residents are offered a varied, healthy and well-balanced diet that takes individual preferences into account;
c. that residents receive sufficient food and fluid to meet their nutritional requirements;
d. that residents are assessed for and are provided with assistive devices that enhance the resident's ability to meet their nutrition and hydration needs;
e. that residents are assisted to maintain their dietary customs according to their religious and cultural beliefs; and
f. that residents' swallowing is regularly assessed, documented and reviewed, and that food and fluids of appropriate texture are provided.

The Guideline for 2.10 Nutrition and Hydration

Expected Outcome

Residents receive adequate nourishment and hydration.

Preamble

This Expected Outcome addresses the food and fluid requirements of residents. Consideration should be given to the physical and mental abilities of each resident and their nutritional requirements. A variety of food and fluids should be available to meet the health needs of the resident as well as any specific cultural or religious requirements.

Considerations

- Procedures for identifying, assessing, documenting, managing and reviewing each resident's nutrition and hydration requirements and deficits that may affect eating and drinking
- Consultation with each resident or their representative in the development and review of the care plan

- Resident care plan details the resident's individual needs and how these will be managed
- Outcomes are regularly reviewed, documented and acted upon
- Staff awareness of the care needs of residents and documentation that identifies action taken
- Resident information indicates the types of foods (including all meals and snacks) and fluids that are available to residents, and the choices that are offered
- Availability of dietary information for the development and review of menus to ensure residents' needs are met
- Procedures for developing and reviewing menus
- Identification of the physical, psychological and behavioural deficits in the ability to initiate eating and drinking
- Identification of services and health professionals available to assist in meeting residents' nutrition and hydration requirements
- Identification of the assistive devices that are available for residents to use
- Documentation identifies residents who have an eating or drinking deficit and any special devices to be used
- Information on assistance and meals the service can offer to help residents maintain their cultural and religious dietary requirements
- Procedures for assessing residents' swallowing ability
- Identification of the services and health professionals available to assess and review a resident's swallowing ability
- Resident care plan addresses residents' swallowing ability
- Menu planning includes a variety of food and fluid textures that are appropriate to residents' needs.

2.13 Behavioural Management

Expected Outcome

The needs of residents with challenging behaviours are managed effectively.

Criteria

Policies and practices provide:

a. programs that are designed to promote and enhance the resident's quality of life;
b. for the implementation of appropriate programs relating to behavioural management in accordance with contemporary practice;
c. effective communication with each resident (or his or her representative);
d. that each resident (or his or her representative) is invited to be involved in care planning;
e. for any necessary specialist assessment and treatment to be sensitive to residents' cultural and linguistic needs;
f. for the development of an individual resident care plan that identifies needs/problems/strategies and details goals and/or expected outcomes; and
g. for the regular review of the care plan and assessment of program outcomes.

The Guideline for 2.13 Behavioural Management

Expected Outcome

The needs of residents with challenging behaviours are managed effectively.

Preamble

Each resident with challenging behaviour should be individually assessed to develop a plan for the effective management of their behaviour in accordance with contemporary practice. In addition to the resident or their representative, it may be necessary to consult with health care specialists, such as psycho-geriatricians, clinical nurse consultants or other appropriate therapists, when developing and reviewing the plan.

Meeting the quality of life needs of such residents may require additional consideration, and staff need to remember that assisting them to maintain their dignity and self respect is as important as it is for any other resident.

The use of restraint is a sensitive issue. Management and staff should be aware of all methods for managing residents with challenging behaviours and should refer to best practice guidelines in this area. Each service should have a documented policy on the use of restraint which is available to staff and residents and their representatives.

See also Expected Outcome 4.4 Living Environment in this manual, as well as the Documentation and Accountability Manual.

Considerations

- Procedures for assessing, documenting, managing and reviewing each resident's behavioural management needs
- Consultation with each resident or their representative in developing and reviewing the care plan
- Residents' choices respected and accommodated, where possible. Documentation of discussion with and explanation to the resident or their representative
- Identification of quality of life issues including assessing the potential or underlying causes of the behaviour
- Development of individual behavioural management plans that take account of the safety and security of all residents, as necessary
- Resident care plan details the resident's individual needs and how they will be managed
- Outcomes are regularly reviewed, documented and acted upon
- Resource material for development of programs (for example, research and literature, conference proceedings etc.)
- Evidence-based best practice principles (for example, contemporary practice with restraint, dementia, disease processes)
- Development of networks with specialist centres or health professionals
- Formalised resident assessment tool
- Appropriately qualified and skilled health professionals, as required
- Equity of access to relevant health services for residents with challenging behaviours
- Current resource material and information is available
- Treatment management options identified and provided, as appropriate.

Standard 3: Resident Lifestyle

Principle

Residents retain their personal, civic, legal and consumer rights, and are assisted to achieve active control of their own lives within the residential care service and in the community.

3.5 Independence

Expected Outcome

Residents are assisted to achieve maximum independence, maintain friendships and participate in the life of the community within and outside the residential care service.

Criteria

Policies and practices provide:

h. identification of each resident's individual interests and preferences;
i. for consultation with each resident (or his or her representative) to provide a balance between the ways residents' rights are exercised and effective management of the service;
j. strategies to maximise community involvement that are reviewed regularly with residents, their families and community members;
k. strategies to foster family, friendship and social networks;
l. for the development of a resident care plan that takes account of and supports a resident's social independence; and
m. that residents are enabled and encouraged to maintain control of their financial affairs.

The Guideline for 3.5 Independence

Expected Outcome

Residents are assisted to achieve maximum independence, maintain friendships and participate in the life of the community within and outside the residential care service.

Preamble

This Expected Outcome is concerned with autonomy and the encouragement and support necessary for residents' reasonable expectations of self-determination and individuality within a residential setting.

Education and staff development programs should include issues such as the impact of cultural stereotypes, the risk of staff directing residents' options, and the effect of residents' beliefs about appropriate roles and behaviour relating to social independence.

Staff should actively work to overcome any loss of independence arising from inappropriate acceptance of control by other people (staff or families) or withdrawal from social participation.

The physical and social environment supports the expectation that residents will be able to maintain and develop interests in ways that they regard as appropriate.

Considerations

- Procedures for assessing, on admission, documenting and regularly reviewing each resident's interests, preferences and opportunities to participate in community life both within and outside the service (for example, church, ethnic or social groups, shopping, entertainment, hobbies, activities with family and friends)
- Regular consultation with each resident or their representative to ensure staff are fully aware of their interests and preferences
- A system to ensure that outcomes of regular consultation are acted upon and documented
- Residents encouraged to express their individual cultural identity, including language and religion
- Residents encouraged to re-establish interests curtailed during illness or lack of support services prior to admission
- Residents' preferences regarding services provided are respected and acted upon
- Open, reciprocal relations between residents or their representatives and management and staff of the service
- Residents encouraged to exercise their rights in ways that do not impinge on the rights of others
- Programs to support community involvement both within and external to the service
- Strategies developed, monitored and reviewed to encourage individual and group contact and involvement with the community
- Identification of options, other than staff, to assist a resident to have contact with life outside the service
- Strategies to create opportunities for the development of family and friendship relationships in appropriate settings
- Encouragement and facilitation of resident-directed social activity
- Support of community development activities
- Provision of care services that support residents' autonomy and participation in activities
- Encouragement for residents to extend their expectations of independence with the support of appropriate care, which is reflected in the resident care plan
- Consultation with, and assistance for, each resident or their representative to identify the resident's preferences in managing their financial affairs
- Procedures to protect residents' interests when a resident is not able to manage their financial affairs.

3.6 Privacy and Dignity

Expected Outcome

Each resident's right to privacy, dignity and confidentiality is recognised and respected.

Criteria

Policies and practices provide:

a. that each resident's right to privacy to maintain intimate relationships with families and friends is recognised and respected;
b. that residents are enabled to undertake personal activities, including bathing, toileting and dressing in private;
c. that residents are supported to die with dignity;
d. confidentiality of resident records and personal information; and
e. professional and respectful relationships between staff, residents and family that are fostered and maintained.

The Guideline for 3.6 Privacy and Dignity

Expected Outcome

Each resident's right to privacy, dignity and confidentiality is recognised and respected.

Preamble

This Expected Outcome addresses the issues of a resident's right to be treated with dignity and privacy and that information regarding their care and personal details is kept confidential. Professional relationships between residents and staff are enhanced by respecting each person's right to dignity and privacy.

Considerations

- Staff awareness and procedures that support residents to maintain personal relationships and carry out personal activities in private
- Regular review of residents' ability to carry out personal activities in private
- Procedures to support residents' right to die with dignity
- Resident care plan identifies the resident's wishes in respect to cultural, religious and other aspects of their terminal care
- Procedures to ensure each resident's or their representative's wishes are respected after death, including ensuring that all members of the health care team are informed of these wishes
- Procedures for securely storing residents' records and personal information
- Staff and the health care team aware of, and comply with, confidentiality procedures
- Residents are addressed according to their wishes
- Fostering professional relationships between staff and residents and their families or their representatives.

3.9 Choice and Decision-Making

Expected Outcome

Each resident (or his or her representative) participates in decisions about the services the resident receives, and is enabled to exercise choice and control over his or her lifestyle while not infringing on the rights of other people.

Criteria

Policies and practices provide:

a. an effective forum for each resident (or his or her representative) that takes account of residents' views in service planning and evaluation;
b. procedures that respect residents' rights to advocacy that are clear and known to all staff and each resident (or his or her representative);
c. that issues raised by each resident (or his or her representative) relating to the services provided by the residential care service are dealt with fairly, promptly, confidentially and without retribution;
d. that a simple and easy-to-use comments and complaints resolution mechanism is in place and that all comments and complaints are recorded, monitored and acted upon in order to achieve a satisfactory resolution;
e. that information relating to internal and external complaints mechanisms is available to each resident (or his or her representative);
f. for the referral of complaints that are unable to be resolved internally to the appropriate external agencies for resolution;
g. that information relating to individual resident care, lifestyle, services and internal and external complaints mechanisms is communicated to each resident (or his or her representative) in a language they can understand;
h. the assessment and documentation of residents' needs and preferences regarding their individual choices;
i. consultation with each resident (or his or her representative) regarding their care and choices; and
j. for a resident's right to refuse treatment.

The Guideline for 3.9 Choice and Decision-Making

Expected Outcome

Each resident (or his or her representative) participates in decisions about the services the resident receives, and is enabled to exercise choice and control over his or her lifestyle while not infringing on the rights of other people.

Preamble

Each resident's wishes and preferences in relation to their lifestyle are important and must be considered when planning and providing services. Residents should be encouraged to participate in decisions about the services they receive.

The exercise of choice requires a partnership between residents, management and staff, in which choices can be negotiated and agreed.

In communal living arrangements it may be necessary for residents to be assisted to have more control over their lives. Residents and their representatives should be provided with information about the availability of assistance from advocacy services. Management styles and practices should encourage residents to exercise control over their lives.

Considerations

- Mechanisms to enable each resident or their representative to express their views about the service's policies and practices that affect the resident's lifestyle (for example, a resident's committee, informal meetings etc.)
- Residents encouraged to discuss and communicate their views
- Resident information identifies advocacy services available
- Staff awareness of advocacy services and residents' right to access them
- Residents or their representatives are assisted to access advocacy services, as required
- Management has a clear policy on the handling of comments and complaints within the service
- Comments and complaints policy encourages feedback from each resident or their representative
- Comments and complaints policy is documented, communicated to residents, relatives and staff, and is available at all times
- Management ensures that all staff and residents or their representatives have information on the philosophy and process of the comments and complaints system including how to make a comment or complaint, who to make it to and the process for resolution (for example, through resident/relative handbooks, newsletters and minutes of meetings)
- Residents or their representatives and staff are encouraged to comment or complain
- Staff are aware that comments and complaints represent opportunities for service improvement and can be resolved in a number of ways including:
- informal - for simple, straightforward comments or feedback. Staff have authority to resolve such issues as fully as possible
- formal - for more complex and serious matters which need to be referred to a designated complaints person and
- external review - when complaints cannot be resolved internally, they are referred to an independent external complaints mechanism.
- Processes ensure that complaints are handled fairly, promptly and confidentially
- Comments and complaints policy statement provides that complainants and other people who provide information are protected from any repercussions, reprisals or victimisation
- The comments and complaints system is accessible and transparent
- Comments and complaints are recorded, action monitored and the information used to identify and address service delivery problems
- Comments and complaints system includes:
- positive conflict resolution strategies
- sound policies and procedures
- ongoing staff education and training
- consumer information and education
- recording and monitoring of comments and complaints and
- timely action on comments and complaints to improve service delivery
- Complainants are regularly informed of progress in relation to their complaints
- Development of a complaint mechanism that also records the nature of the complaint, possible solutions, the outcome and resolution
- Information about internal and external complaints mechanisms and access to advocacy services available to each resident or their representative

- When a complaint cannot be resolved internally or it raises issues that need to be investigated by another agency, the complainant is referred to that agency. Such agencies could include professional bodies, police or the Commonwealth Department of Health and Aged Care Complaints Resolution Scheme
- Identification, on admission, of each resident's preferred language
- Provision of relevant resident information is facilitated through the involvement of appropriate bilingual staff or trained interpreters
- Procedures for consulting with residents and assessing and documenting their needs and preferences
- Residents or their representatives informed, in a language they understand, of the implications of refusing treatment
- Documentation reflects a resident's decision to refuse treatment
- Procedures to ensure each resident's wishes are respected
- Staff education and training cover issues relating to assessing and documenting residents' needs and preferences.

Standards 4: Physical Environment and Safe Systems

Principle

Residents live in a safe and comfortable environment that ensures the quality of life and welfare of residents, staff and visitors.

4.4 Living Environment

Expected Outcome

Management of the residential care service is actively working to provide a safe and comfortable environment consistent with residents' care needs.

Criteria

Policies and practices provide:

a. for the identification of residents' needs and preferences to create a safe and comfortable environment;
b. for negotiation and agreement on residents' environmental requirements;
c. that the grounds of the service are safe, well-maintained and easily accessible to residents, staff and visitors;
d. for consideration of resident and staff needs in the management of environmental risks and the development of safe work procedures;
e. a restraint-free environment whenever possible;
f. that any restraint be the least restrictive type possible and only used after all reasonable alternatives have been explored; and
g. that a decision to restrain is made in partnership between the resident (or his or her representative) and the health care team.

The Guideline for 4.4 Living Environment

Expected Outcome

Management of the residential care service is actively working to provide a safe and comfortable environment consistent with residents' care needs.

Preamble

The environment in which residents live must be safe, comfortable and consistent with their care needs. Management of the service should actively encourage residents to personalise their individual space and communal living areas should be aesthetically pleasing.

The intent of this Expected Outcome is also to minimise environmental risks for the residents and staff and to ensure safe work practices.

In order to maintain a safe and comfortable environment, the service should consult with residents or their representatives and relevant members of the health care team.

Considerations

- Consultation with each resident or their representative, on or prior to admission, regarding the resident's needs and preferences, and identification of communication channels for ongoing feedback
- Encouragement of respect for residents' private property
- Regular review of temperature control, lighting, ventilation and noise levels to support the comfort of resident
- Security of residents' belongings
- Resident information identifies the service's policies with regard to meeting residents' environmental requirements
- Management and staff encourage residents to personalise their individual space and keep personal mementos and items, when practical
- Regular review of each individual's requirements
- Access for residents to telephones, television etc
- Provision of safe areas with appropriate furniture
- Identification of safe areas of the service for residents, staff and visitors
- Documented program for planned, preventive and corrective maintenance
- Regular environmental inspections conducted to ensure that safety issues are addressed
- A system for hazard and risk reporting
- Procedures that support safe work practices
- Staff education in the use of equipment (for example, lighting equipment)
- Assessment and identification of potential areas of risk and personnel authorised to access these areas
- Strategies to avoid the restraint of residents
- Consultation between relevant members of the health care team and the resident or their representative in relation to restraint
- Resident care plan identifies each resident's mental and emotional state, cultural backgrounds, past experiences and the strategies to avoid restraint

- Documentation of the reason for authorised restraint, type of restraint used, time restraint applied, length of time and how frequently released from restraint for ambulation, toileting etc
- Comfort and safety of the resident, when a form of restraint is necessary
- Legal and regulatory requirements
- Regular consultative review of decisions to restrain.

4.5 Occupational Health and Safety

Expected Outcome

Management is actively working to provide a safe working environment that meets regulatory requirements.

Criteria

Policies and practices provide:

- for the management of hazards identified in the workplace in line with current standards and occupational health and safety practice;
- management and staff involvement in identifying and resolving occupational health and safety issues;
- that incident reporting mechanisms are present, functional and acted upon;
- that equipment used is fit for the purpose intended and well maintained, and that staff are trained in its use.

The Guideline for 4.5 Occupational Health & Safety

Expected Outcome

Management is actively working to provide a safe working environment that meets regulatory requirements.

Preamble

Aged care services have a legal responsibility to manage their occupational health and safety. This responsibility applies to the service as an organisation and also to individuals who have the ability to influence the way work is done. This Expected Outcome is intended to reinforce legislative requirements in each State and ensure systems are in place to provide a safe working environment for all staff and a safe living environment for residents. In particular, management and staff should consider the information contained in A Practical Guide to Implementing Occupational Health and Safety in Residential Aged Care (see list of Resources for information on how to obtain a copy).

Considerations

- Identification and assessment of risks associated with specific hazards within each major hazard group, including:
- manual handling

- hazardous substances
- equipment
- electricity
- buildings
- resident aggression
- security and
- infection control.
- Mechanisms for cost-effective risk control measures (aimed at eliminating or minimising risks)
- Staff education and training are provided when there are changes to the workplace, equipment, work practices etc. that may affect the health and safety of staff
- Induction of new staff includes education and training in the management of hazards (for example, manual handling)
- Procedures for effective staff consultation that set out responsibility for the identification and resolution of occupational health and safety issues
- A system to encourage and facilitate the identification of occupational health and safety issues by staff
- Procedures for the timely resolution of occupational health and safety issues
- Feedback provided to staff regarding the resolution of occupational health and safety issues
- Staff awareness of incident and hazard reporting requirements and systems
- Availability of workplace incident and hazard reports to all staff
- Investigation of all incidents and hazards by the appropriately designated personnel, with documentation for quality improvement activities
- Incident and hazard investigation outcomes reported to management, the occupational health and safety committee or designated person(s)
- Analysis of incident and hazard investigation data for appropriate action and documentation
- An equipment maintenance system to ensure routine and preventive maintenance is recorded and undertaken
- Staff trained in equipment hazard identification, risk assessment and risk control.

4.8 Catering, Cleaning and Laundry Services

Expected Outcome

Hospitality services are provided in a way that enhances residents' quality of life and the staff's working environment.

Criteria

Policies and practices provide:
Catering services

a. for catering and menu planning to ensure that quality and variety of food is maintained and is regularly reviewed;
b. resident participation in menu planning and food presentation;
c. that expert dietary advice is sought when necessary;
d. assessment and action on an individual resident's preferences;
e. for safe and correct food purchasing, storage, handling, preparation and serving;

f. safe and sanitary disposal of unused food and other waste;
g. that equipment used is fit for the purpose intended and well maintained, and that staff are trained in its use;
h. that the dining environment is conducive to the relaxed, pleasant and social enjoyment of food.

The Guideline for 4.8 Catering, Cleaning and Laundry Services

Expected Outcome

Hospitality services are provided in a way that enhances residents' quality of life and the staff's working environment.

Preamble

Hospitality services have a major impact on a resident's quality of life within a service. In catering services, there are two main issues:

- the relaxed enjoyment of a variety of appropriate food that meets residents' nutritional requirements and food preferences and
- adherence to good hygiene practice.

Cleaning and laundry services focus on systems that efficiently and reliably deliver clean linen as required and maintain general cleanliness, with an emphasis on infection control.

Considerations

Catering Services

- Documented procedures and guidelines for catering and menu planning
- Regular review of catering and menu planning with input from residents and staff
- Expert dietary advice obtained, when appropriate (for example, through staff or visiting dietician, public hospitals, phone or fax communication)
- Menu rotation to ensure variety in accordance with relevant guidelines
- Main meals served at appropriate times
- Refreshments and snacks available
- Resident information includes meal times
- Menu updated regularly
- Regular communication and consultation between residents and catering staff on menu planning, food presentation and individual preferences, including where the resident prefers to eat (for example, through resident feedback, individual resident assessments, meetings, surveys etc.)
- Residents with special needs are identified and consulted on how those needs are to be met
- Assessment, on admission, of each resident's dietary preferences for menu planning
- A system for monitoring, documenting and reviewing each resident's dietary preferences (for example, diet card)
- Staff education covers hygiene and food handling, including infection control issues such as wearing gloves, wearing appropriate head gear by staff, safe pest control etc

- Food prepared by appropriately trained staff, and served in a visually pleasing manner and in appropriate quantities
- Adequate facilities and equipment for hygiene
- Procedures for food storage in accordance with relevant legislative requirements and guidelines
- Availability of testing equipment to ensure correct temperature for storage
- A food stock control system that ensures rotation of stock
- Procedures for managing and storing perishable stock
- Access to expert advice and reference material, as needed
- Procedures for disposing of food scraps and packaging
- Appropriate waste containers and regular removal and cleaning of waste containers
- A system for identifying, reducing and recycling waste
- Procedures for disposing of contaminated waste in accordance with relevant legislative requirements and guidelines
- A documented program for planned, preventive and corrective maintenance of catering equipment
- Staff trained in equipment hazard identification, risk assessment and risk control
- Appropriate equipment is used
- Dining room promotes and encourages a social environment
- Residents are encouraged to contribute ideas and feedback, and are consulted in relation to seating arrangements
- Minimisation of disruptive noise
- Availability of appropriate staff at meal times for assistance and supervision
- When residents choose to remain in their bedroom for meals, the room is prepared prior to serving the meal.

Reference: Department o f Health and Family Services. (1998). *Standards and Guidelines for Residential Care Service Manual*. Canberra: Aged and Community Care Division, Department of Health and Family Services.

An electronic full version of the Standards and Expected Outcomes is available from http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-manuals-sgr-sgrindex.htm