Deconstructing the Triadic Relationship Between Elderly Residents, Family Caregivers and Health Care Workers in Long-term Residential Care in Hong Kong

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Abstract

A long-term residential care facility is a complex socio-political milieu where people from diverse backgrounds come to live, visit the residents and work together. Changes in the basic local support networks of the elderly suggest that there will be a growing number of elderly people seeking entry to long-term residential care facilities in Hong Kong. The quality of life for such residents has been shown to be related to the quality of the relationship they maintain with family members and with the staff. The purpose of this research is to provide empirical data and theoretical understanding of this “care triad” in the context of residential care facilities in Hong Kong. The study will describe and analyse the pattern and dynamics of the interaction between the elderly residents, their family and the staff with a view to informing professional practice and enhancing quality of care for residents.

The theoretical perspective guiding the study was informed by post-colonialism, post-colonial feminism, symbolic interactionism, intersectionalities and Foucauldian epistemology. The method of inquiry adopted was Charmaz’s strategy of grounded theory, which allowed for a constructionist inquiry of the taken-for-granted triadic relationship that exists between residents, family and staff.

Following eight months of observation conducted in a facility for 294 elderly residents with varying levels of dependency in Hong Kong, a purposive sample of seven triads was identified on one floor accommodating ambulant independent and frail aged residents. Field work consisted of approximately 218 hours of participant observation and 31 interviews with administrators, family members, residents and staff conducted by the researcher.

The findings from this study are discussed under three key themes. First, an empowered citizenship emerged in this setting that generated three distinctive care triads, namely the resident-driven triad, the family-driven triad and the staff-driven triad. In the resident-driven triad, the elderly residents expect family and staff to conform to their opinions and ways of doing things. In this type of triad, the residents struggle with their desire to retain acknowledgement of their identity and maintain their own independence in the face of institutional expectations of conformity and their own failing abilities. In the family-driven triad, family members reconstruct their sense of identity as a consequence of role changes and taking on new tasks formerly
not performed by them. In the staff-driven triad, the residents’ individual preferences and needs are subordinated to the rules of the institution. The residents appear to be willing participants, believing that the staff should be in charge and will help them to meet their needs. The residents are obedient and compliant, while the staff member enacts a traditional hierarchical relationship. Second, the impact of a tripartite engagement in care had important consequences for the relationships between residents, family and staff. Third, conscious alliances emerged in the relationship, fostering the development of a “third space” in the dynamic care triad. All of these themes were underscored in the situational reality by external factors, such as medicalisation of care, relations of power, and discourses being influenced by the perceived frailty and vulnerability of the elderly, which are ultimately played out in day-to-day interactions between those who live in the facility, visit the residents there and work there. The study recommends that a constructionist inquiry of the triadic relationship needs to be continued to further examine the issues raised in this research. Scholars in the field of gerontology, particularly modern gerontology, are positioned to continue to challenge the discourse of the ageing identity and the threat this constitutes for those who live, visit and work in long-term residential care settings and in society more generally. Fostering consciousness about this discourse requires fundamental changes in the way ageing is viewed. Furthermore, all stakeholders of the care triad need to reorient themselves towards relational care. In a setting such as long-term residential care, relational care occurs in the form of a conscious alliance. The development of the “third space” that is fostered in these triadic interactions provides opportunities for the development of participatory, inclusive communities for the diverse populations that live, visit and work in the long-term residential care facility.
Declaration of Authenticity/Originality

I certify that the work in this thesis has not previously been submitted for a degree, nor has it been submitted as part of requirements of any other degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work, and the preparation of the thesis itself, has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signed: .......................................................  

Date: ..........................................................
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Introduction

1.1 Background and significance

The aged population (65 years and older) of Hong Kong is predicted to reach 28% of the total population by the year 2039, double of the 13% in 2010, which means that one out of four Hong Kong people will be aged 65 or above (Census & Statistics Department, 2010). The common story we hear about ageing today is that humans are living longer and healthier lives. Clips on the health promotion news and The Government of Hong Kong Special Administrative Region’s policy address on healthy, independently living, socially active elders add colour to this optimistic picture of the local scene. Yet, this is only part of the story of ageing in Hong Kong. About 70% of the 880 thousand people in Hong Kong aged 65 and older live with at least one chronic, and potentially disabling, health condition, and about 50% of older adults live with at least two chronic illnesses (HKCSS, 2008). These individuals must navigate a system of long-term care that, historically, has been biased toward long-term residential care rather than home- or community-based care. When frail, older people can no longer be assisted to stay in their homes and the need for skilled care arises, seniors and their families are often forced to choose between the level of care needed to safely manage chronic illness and disability and leading a satisfactory, autonomous and independent life that is highly treasured in Hong Kong society.

Since the advent of the institutional care reform movement in the 1990s, long-term care providers, advocates for seniors and policy makers have grappled with the questions of how to establish a client-centred and sustainable long-term care system that helps to facilitate older people remaining productive and participating members of the community. Even when the older people’s chronic health conditions or functional dependency can not be reversed, there is room for optimising their functional abilities, and to help them regain self-esteem, a feeling of control and a sense of coherence. Given the constraints of institutional life, these initiatives often prove difficult. To a large extent, the structure of long-term care settings revolves around the clinical routines of frontline staff, leaving residents isolated and under-
stimulated. Yet, creating opportunities for involving all stakeholders in the “care triad”, that is, residents, family and staff, can have the unintended consequence of creating conflicts (Abrahamson, Suitor & Pillemer, 2009) and further restricting the residents’ limited chances for exercising autonomy and independence and also their own and their family’s involvement in the care process.

As outlined in the action paper by the Social Welfare Department (1991),

An elderly person who requires care on a long-term basis should be assisted to live with dignity and a spectrum of services should be provided in and by the authority to facilitate his continued participation in society both socially and, if he likes, economically for as long as possible. Opportunities should be made available for elderly persons to play an active role rather than treated in isolation as a class apart. (p. 1)

This policy aims at establishing an integrated, client-centred and sustainable long-term care system providing a sense of security, a sense of belonging and a feeling of health and worthiness (老有所養 老有所屬 老有所為). The belief is that there are always ways to facilitate seniors’ remaining productive and participating members of our community.

Concomitantly, expectations related to the psychosocial dimensions of health care have changed. There is a paradigm shift from focusing on medical- and/or task-oriented care to client-centred care. The rise of consumerism, lack of tolerance for paternalism and development of client-centred approaches have led to the growing acknowledgement that not only the clients (referred to as “residents” in this study), but also the family members are legitimate and indispensable stakeholders in the triadic relationship. While service delivery has evolved to a medical and/or task orientation towards the residents (McWilliam, Ward-Griffin, Sweetland, Sutherland & O’Halloran, 2001), service delivery has not always collaborated effectively with family (Ward-Griffin, 2001; Ward-Griffin & McKeever, 2000). Although health ideology encourages the formation of “partnerships” with family and advocates client-centred care, the experience for both the residents and the family continues to be fraught with problems, for example, residents’ involvement in their own care is limited and family involvement in caring for their relatives in the long-term care setting is far from either smooth or widespread (Anderson, Hobson, Steiner & Rodel 1992; May, Ellis-Hill & Payne, 2001; Norris, 2000).
These issues – demographic changes and a paradigm shift in the psychosocial dimension of health care – set the stage for the socio-political milieu where people from diverse backgrounds come to live, visit the residents and work together. We may identify four groups in Parkview; an independent group of residents struggle to have their identity acknowledged and to maintain their independence; a subordinate group of residents appear willingly to subordinate their preferences and needs to Parkview’s regime, and are thus willing participants in its regime; a dominant group is constituted by nursing staff and administrator; and a group of “subalterns” in Spivak’s terms as set out in her post-colonial theory (1988) comprise the nursing aides working in Parkview.

Historically, relations among these groups are structured as part of a hierarchical system, recognising and with respect for the dominant and the expert, which formally and informally shapes the pattern and dynamics of interaction between the elderly residents, their family and the staff (Brown-Wilson & Clissett, 2011; Reed, Weiner & Cook, 2004). In addition to those who live and work in the long-term residential facility, there are family members who interface with formal care providers, a process that entails negotiation and sharing of resident care tasks (Caron, Griffith & Arcand, 2005; Keating, Fast, Dosman & Eales, 2001; Ward-Griffin, Bol, Hay & Dashnay, 2003). The socio-political milieu is also underscored by a biomedical institutional context (Kayser-Jones, 2003) that has not been responsive to the increasingly complex relationship among those who live, visit the residents and work in a long-term residential facility (Berdes & Eckert, 2001), a situation which is ultimately evident in what a triadic relationship is and how it is shaped.

Research has shown, for instance, that quality of life for residents is associated both with aspects of the care provided by health workers and by their former primary family caregivers who continue to visit on a regular (sometimes daily) basis (Brubaker, 1987). Contact with family contributes to the overall wellbeing of the residents, reinforces the residents’ sense of self and helps them retain an individual identity, particularly during the initial period of residency (Gladstone, 1995; Greene & Monahan, 1982; Tobin, 1995). The establishment of a relationship is the foundation of any caring situation (Peplau, 1988). At the same time, studies have shown that the presence of relatives is not always viewed favourably by staff. Failing to value family
caregiving expertise and affective work in long-term care has been recognised as a source of conflict in the professional / family caregiver relationship (Bowers, 1988; Duncan & Morgan, 1994). In one study (Voutilainen, Backman, Isola & Kaukkala 2006) visits to the facilities were associated for relatives with feelings of frustration, resentment and anger as they were unsure how they fitted into the long-term care environment. Successful resident–staff relations (Hewison, 1995; Lotzkar & Bottorff, 2001) and family–staff relations (Dempsey & Pruchno, 1993; Schwartz & Vogel, 1990) are premised on the need for a shared understanding, with a potential coalition of all three stakeholders and a negotiation of care. There is an extensive body of (mainly Western) research into various aspects of residential aged care. An important subset of this research has investigated the factors associated with the quality of life and care in such facilities from the perspectives of the three main groups of stakeholders: elderly residents (e.g., Gubrium, 1975; Lee, 1997; Street, Burge, Quadagno & Barrett, 2007), family caregivers (e.g., Lee, 1999; Lundh, Sandberg & Nolan, 2000; Nolan & Dellasega, 2000) and health care workers (e.g., Pursey & Luker, 1995). To date, however, no study has investigated the care triad as an interactional, multi-perspectival whole.

The overall aim of this study was to provide better understanding of the care triad as a dynamic interaction between the three key stakeholders, ultimately providing insights that might be applicable to introducing an emerging conscious alliance of all stakeholders in the triadic relationship. Until a greater depth of understanding of these aspects of “institutionalised care” is attained, it will not be possible to establish a client-centred and sustainable long-term aged care system providing a sense of security, a sense of belonging and a feeling of health and worthiness for the elderly without a commitment to directions and initiatives, such as the development of participatory, inclusive communities for the diverse populations that live, visit and work in the long-term residential care facility, is needed to.

1.2 Phenomenon of interest

Relationship is not a new concept, and much has been written on how to establish relationships in various clinical settings (Cott, 1997; McCormack & McCance, 2006), for example, for hospitalised children (Berlin, Johansson & Tornkvist, 2006), for oncology patients (Radwin, Cabral & Wilkes, 2009), adult patients in the acute
hospital (Thompson & Ciechanowski, 2003), etc. However, while there is considerable rhetoric on how to establish and maintain these relationships, research explaining how the individuals interact and relate with each other in every day practice is minimal (McCallin, 2001). Further, relationships in long-term residential care facilities are embedded within a complex socio-political milieu, which to date has received little attention when examining how individuals and groups from diverse backgrounds who come together for living, visiting and working interact with one another in this setting.

A “grounded theory” approach to address gaps in the literature has been taken in this study, designed to understand what a triadic relationship in the long-term care setting is like, “to deconstruct” it. The process of deconstruction is to read a text in a particular kind of way that challenges its assumed meaning. Johnson (1988) noted:

Deconstruction is not synonymous with “destruction”, however. It is in fact much closer to the original meaning of the word “analysis” itself, which etymologically means “to undo”…. (p. 28)

The term “deconstructing” means to see ideas that rest under the surface of the material humans have produced – to peel away the layers that are in front but are often taken for granted until researchers investigate. The question of “why” may enter the arena of discussion. This question aroused my interest because giving attention to human interaction may benefit all the stakeholders in the care triad. Deconstructing the triadic relationship in long-term residential care aims to improve it, make it more effective, and enable the members involved to understand the interaction pattern and its dynamics. The triadic relationship can be deconstructed in various ways, by interview, by observation, etc. Many researchers have tried to quantify and compare the factors involved in building relationships between key participants in the nursing home – between residents and family, and between family and staff. However, this is not deconstruction. This study did not seek for any statistical correlation of variables (Higgins & Cadd, 1999), or the effects of nursing interventions designed to promote constructive staff–family relationships in long-term care settings (Farren, 2001). The intent of this study is to provide empirical data and theoretical understanding of the triadic relationship in the context of residential care facilities in Hong Kong. The data is grounded in data from my fieldwork, especially in the actions, interactions and social processes involving residents, family members and staff. As such, it is
grounded in the empirical world, and explains why a qualitative approach suits the process of deconstruction.

1.3 Research statement: aims, objectives and significance

The triadic relationship is approached in this study from the distinct perspectives of three individual stakeholders: the resident, the resident’s family member and the staff. Data are derived from field visits and in-depth, semi-structured interviews with all three stakeholder members of seven different care triads. Emphasis is placed on what the triadic relationship is and how it is shaped and patterned. Kathy Charmaz’s (2010) social constructionist version of grounded theory is employed to examine the thematic patterns of the interaction observed (and recorded in the field notes) and discussed in the interviews. Finally, the triadic relationship between resident, family and staff in the triad is examined in-depth to develop a theoretical perspective on the triadic relationship in the long-term residential care situation.

The study investigates the underlying premise that an interactive triad is a fundamental component of the quality of care for residents and their family members. The goals of this study are to promote a more thorough understanding of the specific themes inherent in the interaction in the triad and to identify the pivotal attributes that characterise and shape the type of the particular triad being investigated. This work has immediate and long-term implications for improving the quality of care for residents and their families, and for promoting a sense of wellbeing for staff by fostering a better understanding of a care triad’s interactive dynamics.

Most of the research on caregiving issues in the clinical setting has so far been at a less detailed and concrete level of analysis than the work on two-way relationships (Bergland & Kirkevold, 2005; Lawrence & Schiller-Schigelone, 2002; McGilton & Boscart, 2007). There is a practical reason for those researchers who are interested in the details of interaction having mainly confined themselves to two participants because of the enormous amount of data produced by groups, that is, the triad in this study. The case series approach of this study will enhance our understanding of the complexity of triadic relationships and allow for a synthesis of the diverse experiences and perspectives of all stakeholders. The synthesis will provide a more holistic
account than that which has been discovered in past research, albeit at a relatively macroscopic level (Morse, 1992).

The study also addresses the potential of conflict during interaction by linking the contributions and experiences of all stakeholders with negotiations taking place in some situations. To date, research on the interaction patterns in the care triad of the long-term residential setting is limited, failing to adequately address the interpersonal nature of the triadic relationship and the issues arising from the interpersonal dynamics at work when viewing the care triad as a multi-perspectival whole.

The purpose of the study is to describe and analyse the dynamics of the triadic caregiving relationship and interaction pattern between the older residents, their family caregivers and professional health care workers in the long-term residential care facility. The specific objectives associated with this purpose are:

- To describe the relationship and the pattern of interactions between the older residents, their family caregivers and health care workers in the context of a long-term residential care facility in Hong Kong;
- To examine the perspectives of each group regarding the meaning and significance of “care” and caregiving relationships;
- To explore the phenomenon of caregiving in a residential care facility as a dynamic, triadic relationship; and
- To develop a grounded theory of triadic relationship that can inform professional practice and service delivery in Hong Kong.

1.4 Overview of thesis

This thesis is written in eight chapters. Chapter 1 provides the background of the study, explains its significance and provides the purpose and objectives that guide the study. Chapter 2 locates this study in the field of gerontology, introduces the discourse of ageism and considers its influence on ageing and the perception of the ageing identity. This is followed by a review of the literature that includes perspectives and concepts about relationships in residential aged care. Chapter 3 presents the theoretical perspective of the study, which is informed by post-
colonialism, feminist post-colonialism, symbolic interactionism, intersectionalities and Foucauldian epistemology. The chapter concludes with a synthesis of the literature review and theoretical perspective, which leads to the research questions. Chapter 4 discusses the methods of inquiry used in the study, including Charmaz’s social constructionist version of grounded theory. Chapter 5 discusses the research site and agency dynamics, providing information on the physical environment of the residential facility and background information on the seven cases studied. Residents, families and staff are introduced via their socio-demographic characteristics. The account of the interconnectedness of informants and who they are emphasises relationships, roles and key attributes. Chapter 6 describes the findings of the pivotal attributes that characterise and shape the type of the particular triad being investigated. Chapter 7 discusses the three key themes that emerged from the data in terms of the overall “construct” of the care triad; these themes permeate all levels of analysis as being most salient to understanding the triadic relationship in the long-term residential care facility. The final chapter, Chapter 8, includes a summary of the study, conclusions and recommendations.
Chapter Two

Literature Review

This review of the selected literature provides a background to the multi-faceted issues that impact upon, and ultimately shape and influence, the triadic relationship that evolves in the long-term residential aged care setting. This study is situated within the field of gerontology, which is concerned with the study of ageing and ageing related issues. Similar to the Western world, the growth of gerontology is related to population ageing, a demographic phenomenon occurring in Chinese society. The discourse of ageism is also explored (Dobbs, Eckert, Rubinstein, Keimig & Clark, 2008). Population ageing is occurring because of a number of converging factors, including declining fertility rates and rising longevity (Leigh, 2006). At the same time that the populations are ageing, expectations related to the psychosocial dimensions of health care have triggered a paradigm shift from focusing on medical- and/or task-oriented care to client-centred care, ultimately influencing the triadic relationship in long-term residential care facility. This review of selected literature brings these issues together to illustrate the complexity of the triadic relationship in the long-term residential aged facility and the need to address the gap in knowledge that exists around the intersections of different attributes that existed in the triadic relationships. I bring these issues together to illustrate the complexity of the triadic relationship in the long-term residential aged facility and the need to address the gap in knowledge around the intersections of different attributes in the triadic relationships.

I begin this literature review with a description of the sources of the literature. Then I locate the study within the larger field of gerontology and review other perspectives in gerontology such as critical and feminist gerontology. This part also includes the discourse of ageism and its influence on how ageing is viewed and the ageing identity in Chinese society. This is then followed by an integration of the literature review which includes perspectives on and concepts of relationships in residential aged care.

Sources of the literature

An extensive literature search was performed using the following databases for the years 1990–2010: Ageline, CINAHL, Cochrane Library, Comprehensive Clinical
Psychology, Embase, Medline, PsycINFO, Pubmed, Social Science Citation Index, Embase, Dissertation and Theses@the Hong Kong Polytechnic University, and ProQuest Dissertation and Theses. The combined search terms of an initial search were “residential aged care”, “long-term care”, “institutionalised care”, and “provider–client–family relationship”, leading to one reference, “tri-focal model of care” in nursing homes (O’Connell, Ostaszkiewicz, Sukkar & Plymat, 2008). This study was excluded from this critical review as it was a general description of a framework for nursing practice with definitions of the core elements and principles that guide nursing actions in general. No other studies addressed the triadic relationship as an interactional, multi-perspectival whole in long-term residential aged care. This lack of scholarly attention to this area provides support for this study, especially in its use of a grounded theory approach.

There is much controversy about the use of literature reviews in qualitative research documentation. Glaser and Strauss (1967) suggest that in order to allow the theory to emerge from the data and not be contaminated by the theories of different areas, the researchers should “literally ignore the literature of theory and fact on the area. Similarities and convergences with the literature can be established after the analytic core of categories has emerged” (p. 37). Grounded theory research allowed me to admit that I did not know enough to pose a specific research question when writing the proposal – I did not know what the right research questions were until I had finished collecting and analysing the data. I also continued to refine the research questions after I had collected and analysed the data. Therefore, instead of reading the literature looking for a specific question or problem, I let the grounded theory approach instruct me to look for issues that were open and broad. What I started to search for as part of my literature review was a set of “sensitising concepts” (Glaser, 1978). This social constructionist approach to grounded theory led to the literature review being expanded as appropriate throughout the data analysis process. As data were analysed by comparing previous incidents in the same and different triads, diverse emergent categories provided connections between data and lower and higher levels of conceptual abstractions of categories and properties. A second literature review being conducted during the data analysis process was used to redefine current concepts, establish boundaries of concepts and discover new concepts that yielded meaningful pictures of phenomena (Charmaz, 1990).
A secondary search of the literature on residential aged care was performed, using the following search terms: “institutionalised care”, “quality of life”, “quality of care”, “autonomy”, “privacy”, “provider–client relationship” and “nurse–client relationship”. Papers examining the formation of provider–client relationships as well as the barriers to and facilitators of relationship building were reviewed. Most of the studies, in the fields of sociology, gerontology or anthropology, were conducted from a single person’s perspective, either from the professional or from the client (Gladstone & Wexler, 2001; Larsen, 1998). While psychologists have become increasingly aware of the fact that social interaction has interpersonal origins, it has specifically been dyadic situations which a range of disciplines have studied in great detail and which has added enormously to our understanding of social interaction patterns (Heller, Roccoforte & Cook, 1997). Nevertheless, some studies have been criticised for their failure to study actual interaction, some of them having been experiments of the artificial, laboratory kind, testing hypotheses, and thus lacking the essential features of real-life situations (Argyle, 2007).

The next search of the literature was done after the pivotal attributes influencing the triadic relationship had been categorised using the key terms “provider–family caregiver relationship”, and “nurse–family caregiver relationships”, searching the following databases: CINAHL, Ageline, Cochrane Library, Comprehensive Clinical Psychology, Embase, Medline, PsycINFO, Pubmed, Social Science Citation Index, Embase, Dissertation and Theses@the Hong Kong Polytechnic University. Finally, a search of the literature using the terms “team interactions”, “team relationships”, “dyadic interaction”, “teamwork” and “collaboration” found a total of seven studies which had examined the concept of team interaction.

Once the articles were retrieved, I reviewed them. Each paper was read thoroughly, assessed for its scientific quality and scholarship, according to the standards for the type of study. I then pooled papers that were similar in their substantive area and examined for similarities and common themes. Once this step was completed, I synthesised the findings across studies to arrive at the state of knowledge in that area. Where there were contradictions, I identified a potential gap in knowledge that could be further examined.
Locating the study in the current field of gerontology

The impending demographic shifts and demands for client-centred care specific to the ageing population have encouraged the development of the field of gerontology, the study of ageing. Research about ageing was conducted throughout the 20th century and gerontology continues to develop into a distinct academic discipline. This multidisciplinary field has many facets, including a concentration on the biological changes of ageing and a more sociological perspective on ageing (Wade, 2001).

The growth of gerontology as a field of inquiry has lead to the realisation that little is known about the importance of establishing a partnering relationship with residents, family and staff, and engaging them as stakeholders in the care triad by consciously attending to their health and care needs in the long-term residential aged care facility. This realisation exists despite researchers’ awareness that stakeholders’ interacting socially in day-to-day care is both basic to developing a participatory, inclusive community with all stakeholders and essential for the development and refinement of the triadic relationship.

The study fits within the area of inquiry known as social gerontology (McPherson, 1990). Theory development in social gerontology has focused on ageing at both the individual level and at the communal level as a group. This theorising about ageing has focused on the aged, on ageing as a social process and on being aged as a dimension of social structures (Chappell, Gee, McDonald & Stones, 2003). In the literature the importance of the individualised nature of the ageing process is acknowledged, which is biological, psychological and social in nature (Holland, 1977). It is influenced by the complex socio-political milieu in which the older person lives and has lived.

Critical perspectives in gerontological research

This study is further situated within critical gerontology, a theoretical perspective that has developed in response to the traditional, biomedically driven view of the elderly as passive and dependent (Baars, Dannefer, Phillipson & Walker, 2006; Gubrium, 1993b). This perspective inspires researchers not just to understand the social context of ageing, but to change it (Minkler, 1999). In its early development, critical gerontological studies focused on including the voices of the elderly in the dialogue about ageing and the aged. The aim was to make the diversity, agency and creativity
that exist in ageing explicit by bringing those voices that have previously been silenced to the fore (Gubrium, 1993b). Yet this particular approach to critical gerontology has been criticised for continuing to ignore the role of social context in ageing, in particular the dynamic interactions between the individual and their physical and social surroundings (Kontos, 1998). My study explores the pivotal attributes that characterise and shape the interaction pattern in the particular triad being investigated in the long-term residential facility. This will advance our understanding of the triadic relationship by examining stakeholders’ interactive needs in their triadic experience and triangulating the perspectives of all stakeholders of the triad.

**Discourse of ageism**

In keeping with the need to further examine the role of ageing in Western society, an examination of the discourse of ageism itself is needed. Butler (1975) was the first to define ageism as the systematic stereotyping of, and discrimination against, the elderly simply because of their age. The systematic social exclusion of anything related to ageing and caring for the aged has been connected with the exclusion of the elderly from participation in the “normal” social world. This exclusion has been cited as beginning with mandatory retirement and continuing as chronological age becomes enmeshed with notion of physical and cognitive decline, fragility, clinical needs and dependence (Simms, 2004). Ageism interacts with discourses that typify these images, in particular the idea that the elderly create intolerable pressure on health care, possibly making them a burden as they are no longer considered to be contributing to society (Wade, 2001).

Filial piety was a distinct Chinese cultural trait which lead the Chinese to accept “dependency” as the norm, being part of a system of reciprocity. Adults accepted dependency as an inevitable part of growing old and did not entertain the possibility of perpetual self-sufficiency and/or disengagement from the elderly. What adult children did for their aged parents was a natural way of making repayments for the support they received from their parents when they were young. The elderly also did not view their dependency as a fatal attack on their self-esteem and identity. This was in contrast to the West where the ideology of self-reliance and physical, social and economic independence of the elderly was fostered. As a result, growing old in a
Chinese community carries advantages for the frail or dependent elderly (Hu, 2009; Lee, 2010; Meng, Zhang & Jiang, 2011). Nonetheless, the discourse of ageism is also becoming more prevalent in Chinese society (Chen, Bond & Tang, 2007). There is a change taking place in how ageing is viewed in contemporary Chinese society. With industrialisation and urbanisation, the practicality of the traditional Chinese concept of having an extended family to care for the elderly appeared to be undergoing modification (Ng, Phillips & Lee, 2002). Phillips (1999) proposed that older people in the Chinese community have grown old, but are often without substantial personal resources. It is not uncommon to find that older people lack confidence in their abilities. Gerlock (2006) argued that because of the failing health and weakness, older people are not able to continue to work to the extent they did when they were younger. Of this has led to older people believing that they are a burden to their families and they are not productive. Ageism is characterized for older people by becoming more and more burden on their family and the community. (p. 4)

The stereotype of the elderly is gaining ground, as found in patronising language, and affects the elderly people’s self-esteem and identity. The discourse of ageism now serves to reaffirm the social identity of the elderly as “outsiders” or as undeserving of regular, “normal” treatment or service. An undercurrent to this change is how the discourse of ageing is viewed and how the stakeholders are reorienting themselves towards the development of triadic relationships in the long-term residential care facility.

As mentioned above, gerontology as a field of study has been proliferating over the past few decades. An important aspect of this growth has been the development of social and critical perspectives that situate ageing within broader social, economic and political contexts. These contexts are influenced by the discourse of ageism, which grow and persist despite the growing number of elderly people in our society.

In the next section, I review the literature touching on perspectives and concepts about the relationships between the three stakeholders in residential aged care. Investigating the triadic relationship benefits from considering it holistically, as it depends on an understanding of current and past experience that the elderly residents, their families and staff have had in the residential aged care facilities. The literature reviewed therefore reflects an empirical focus drawing on a wide array of pertinent perspectives.
and concepts about relationships in residential aged care. Such an inductive approach to studying the triadic relationship from a multi-perspectival whole contributes to the development of new insights that are useful both in practice and in researching residential aged care, with specific emphasis on the nature of the triadic relationship involving residents, family and staff in the long-term residential aged care facility, and which engages all members in consciously improving the quality of life and care for the elderly residents.

During the last few decades, the literature on residential care has frequently addressed concerns related to quality of life and care in the long-term residential aged care facility. The issues have been examined in various paradigms: the institutionalisation paradigm (Goffman, 1961), the social meaning paradigm (Gubrium, 1993a; Smithers, 1992), in which Gubrium investigated the meanings assigned by the residents on the basis of their experience of living in the facility; how they made sense of the transition to institutional life; and what strategies they used to maintain their social identities; the political economy paradigm (Diamond, 1992; Free, 1995), in which the concept of organisation culture has been central to improving the quality of care and life; and the humanistic paradigm (Bowker, 1982). Because the focus of this study is on institutionalisation and understanding the triad care relationships, the literature review will concentrate only on literature that addresses these issues.

2.1 Institutionalisation paradigm

Goffman (1961) defined the concept of institutionalisation by reference to “institutions established to care for the blind, the aged, the orphaned and the indigent” (p. 4). He described the central feature of these institutions as a breakdown of the barriers ordinarily separating the three spheres of human life: sleep, work and play. He asserted that this results in people being moved in blocks, and with staff performing surveillance to keep things running smoothly. In long-term residential aged care this creates a split between staff and residents and creates a situation in which social interaction is absent and social detachment is a normal phenomenon.

According to Goffman (1961), the resident transfers responsibility for care either from themselves or from their families to the staff upon admission to the facilities. All the components of everyday life are centred around the routine of the facility and the
assignation of staff. Administrators, nurses, nursing aides, social workers, kitchen staff, cleaners, physiotherapists and occupational therapists become the central figures in the facility to meet the residents’ needs. Goffman described these residents as “homogenous samples”, with no sense of personal identity, living and working in the facility.

The impact of institutionalisation on the elderly was the focus of several early studies (Beery, 1993; Nay, 1993). Nay (1993) examined the nursing home experience of the over-65 residents in his study, and raised concerns about their disempowerment. Beery (1993) focused more on how residents lost their locus of control after moving into a nursing home and the impact of this loss of control. It was beyond the residents’ capacity to preserve a sense of autonomy, and there was evidence of staff and administration making decisions on behalf of residents without getting their consent beforehand. This was problematic for those residents who were both physically and cognitively capable, had distinct personalities and made personal demands, as it created conflicts. They expected both family and staff to go along with their opinions and ways of doing things instead. Allowing residents increased control and to maintain a sense of self-identity in the long-term residential aged care facility was the focus of a study by Warner (1997) whose findings showed that lack of privacy and control arising from the demands of communal living and regimentation of activities of daily living were barriers to residential care quality.

Schmidt (1982) and Kaye, Caplan, Urv-Wong, Freeman, Aroskar and Finch (1997) echoed Goffman’s theory of institutionalisation in which the routine of the facility hindered the maintenance of individualism and a sense of personal self for the residents. They had no choice and control over some personal matters in their daily lives such as when to go to bed, when to get up, what to eat, who were to be their roommates, how much money to keep in their pocket, how and when to use their own money, the time for care routines, availability of public phones to call their relatives and friends, and so on. Russell (1996) advocated the need for residents taking an active role to navigate their control over the quality of care. She recommended a paradigm shift of the role from a passive, dependent care recipient to a resident taking the lead for his or her care on his or her own, learning the rules of relationships and at the same time striving to regain a sense of self and independence. Privacy was another
major concern for residents living in public places and trying to maintain their self-identity (Schwartz, 1992). These studies focussed on the personal demands of residents trying to maintain quality of life and care in the residential aged care facility.

2.2 Humanistic paradigm

Some researchers appreciated the importance of interpersonal aspects in maintaining quality of life in the aged care sector, arguing that the establishment of a relationship was the foundation of any caring situation (Majerovitz, Mollot & Rubber, 2009; Peplau, 1988; Suchman, 2006). Consistent with modern healthcare philosophy, which espouses the virtues of holistic care, Bowker (1982) and Hewison (1995) acknowledged that the nature and the quality of a relationship was an important framework for conceptualising health care.

Under the heading of a humanistic perspective, there was a vast amount of literature to be found on the provider–client relationship obtaining in residential care, the routines of such care facilities and the communication skills needed to manage the provider–client relationship (Cook & Brown-Wilson, 2010; Stewart, 1995), yet the process of how the provider–client relationship develops has thus far not been examined.

2.3 Staff–client relationship

Studies exploring relationship building among staff and clients were limited in their scope, with only two, Ramos (1992) and Artinian (1995), conducted from the perspective of staff in the residential aged care setting.

Ramos (1992) conducted an exploratory qualitative study in a tertiary health care centre with a purposeful sample of 15 health care staff of various disciplines, such as rehabilitative care and oncology care, to describe the situations in which the participants experienced a sense of connection with clients. The findings revealed that staff perceived relationship building to be an ongoing and cumulative process of attachment with varying degrees of involvement: instrumental, protective and reciprocal. Instrumental relationships were characterised by a brief, superficial interaction pattern, intentionally lacking any sense of connection and cohesiveness, and as being task-oriented. Protective relationships were characterised by having a
somewhat balanced emotional and cognitive connection with clients, while retaining control of the care process and actions based on the values, professional knowledge and competency of the staff rather than that of the clients. Thus, protective relationships were unilateral and staff-dominated. Reciprocal relationships were characterised by staff developing bonds with those in their care and being committed to spending time with clients and giving beyond that which was required for the task.

Artinian (1995) conducted a grounded theory study with 32 nurses in an oncology setting to describe how the staff affected the development of relationships with cancer patients. The findings revealed that while maintaining a professional perspective, the nurses viewed the patients first as a person and second as a patient. This was either because the patient and nurse have been interacting for long enough for the relationship to have evolved beyond the care task or the process was accelerated because of the patient’s extreme need. In this relationship, the patient chooses to trust the nurse and the nurse chooses to enter into and be committed to the relationship and to meeting the patient’s needs. When nurses were unwilling or unable to commit to the patient, a unilateral relationship developed.

Two studies, Fosbinder (1994) and Lotzkar and Bottorff (2001), examined staff–client relationships from the perspectives of both staff and adult patients. Fosbinder (1994) explored how patients and staff perceived the nurse–client relationship using in-depth interviews in a private teaching hospital in the United States. Four stages of relationship were found: “translating”, “getting to know each other”, “establishing trust” and “going the extra mile”. “Translating” involved an introductory stage of informing, explaining, instructing and teaching patients about aspects of their care. “Getting to know” included information exchange, using humour and being friendly. “Establishing trust” consisted of building confidence in nurses’ professional knowledge and skills. Lastly, if the patient believed that the nurse had “gone the extra mile”, he or she respected the nurse’s judgement and felt grateful, while the nurse believed that the care provided had made a difference to the patient.

In a qualitative observational study, Lotzkar and Bottorff (2001) explored the stages of developing the nurse–client relationship through dyadic interactions in an oncology setting. The patients and the nurses got to know each other at the beginning of the relationship. The patients strove to accept the nurses, but with some caution and
remaining vigilant, then subsequently by informing the nurses about their concerns and eventually becoming comfortable with the nurses. After resolving a problem and completing the task, the patients developed trust and stayed connected. The nurses’ behaviour included getting to know the patients, demonstrating competence of their knowledge, making therapeutic suggestions and sustaining a connection with the patient. Successful resident–staff relations, argue Lotzkar & Bottorff (2001), are premised on the need for a shared understanding, potentially entering into a coalition and negotiation of care.

Trojan and Yonge (1993) conducted a grounded theory study with nurses and their elderly clients to explore the development of trust in their relationship. The findings revealed that trusting relationships developed over four overlapping developmental stages: “initial trusting”, “connecting”, “negotiating” and “helping”. In the first stage, “initial trusting”, nurses became accepting of the elderly people, their culture and their ability to make decisions. In the second stage, “connecting”, nurses and their elderly clients developed mutual trust and got to know each other. In the third stage, “negotiation”, nurses and clients set goals and negotiated control within their relationship. In the final stage, “helping”, nurses assisted their elderly clients to meet their health goals. Building trust within nurse–client relationships intensified in strength when both the nurse and the client experienced each of the four stages in establishing the relationship. Two studies, by Lotzkar and Bottorff (2001) and Trojan and Yonge (1993), illuminated that both the nurses’ and the clients’ efforts and their commitment to building the dual relationship in the care process are crucial. In these cases of dyadic interaction, it was a matter of how much the two participants were committed to and involved in the relationship.

In an ethnographic study, Shattell (2002) interviewed mental health nurses and patients. The findings of the study reinforced the importance of mutual trust, empathy and the presence and the willingness of nurses to listen to the patient in facilitating their relationship. By contrast, the nurse’s unavailability, superficial contact and a sense of the nurse’s superiority constituted barriers to the growth of the relationship.

A substantial amount of literature on communication skills examined the facilitators of and barriers to relationship building in the dyads between staff and clients (Micevski & McCann, 2005; Moyle, 2003; Ribner & Knei-Paz, 2002). Rundqvist and
Severinsson (1999) used qualitative interviews with staff working in a hospital setting to identify factors facilitative of their relationship with elderly clients with dementia. Facilitators described included the use of touch, active listening, direct contact and the need to be caring, compassionate, supportive and authentic. These communication skills involve a range of emotions used to regulate the social interactions in the dyads of staff and clients – from affection and empathy to criticism and belittlement.

2.4 Staff–family relationship

Research has shown that quality of life for residents is associated both with aspects of the care provided by health workers and by their former primary family caregivers who continue to visit on a regular (sometimes daily) basis (Brubaker, 1987). Contact with family contributes to the overall wellbeing of residents, reinforces their sense of self and helps them retain an individual identity, particularly during the initial period of residency (Gladstone, 1995; Greene & Monahan, 1982; Tobin, 1995). However, studies have also shown that the presence of relatives is not always viewed favourably by staff. Failing to value family caregiving expertise and affective work in long-term care has been recognised as a source of conflict in the professional/family caregiver relationship (Bowers, 1988; Duncan & Morgan, 1994). In one study (Voutilainen, Backman, Isola & Kaukkala, 2006), family visits were associated with feelings of frustration, resentment and anger as the families were unsure how they fitted into the long-term care environment. Studies of family involvement within the aged care residential setting have identified a wide variety of roles played by the families, ranging from the provision of affective and psychosocial support (Bowers, 1988; Kellett, 1999) to physical care (Laitinen, 1994). In the aged care sector, the involvement of families has been acknowledged as one of the best guarantees of a resident’s quality of life and care (LaBrake, 1996). Family of older residents are important members within the caregiving process as they have often been the primary caregiver before admission to the facility (Bauer, Fitzgerald, Haesler & Manfrin, 2009).

Hertzberg and Ekman (2000) conducted a qualitative study to explore the relationships between staff and family caregivers of elderly residents in a nursing home. Participant observation was carried out and focus group interviews were conducted with the administrator, family caregivers and frontline staff. The results
revealed that staff–family relationships were facilitated by staff who were welcoming and who valued and recognised the contribution of the family in caring for the residents. Having opportunities to work together and to get to know each other over time also facilitated these relationships. Conversely, relationships were inhibited when staff and family caregivers were reluctant to have contact or to communicate with each other, or when staff failed to take caregivers’ contribution into account.

In a qualitative study, Gladstone and Wexler (2000) interviewed and observed family caregivers caring for elderly residents in two long-term care facilities to explore the staff–family relationships. The findings revealed that there were five types of staff–family relationship: collegial, professional, friendship, distant and tense, which varied for families interacting with different staff working in the facilities. Family caregivers developed a sense of trust in their relationships with staff by arriving at the facility at unexpected times, observing staff and engaging in conversation.

Gilmour (2002) used qualitative critical discourse analysis to explore the family caregivers’ experiences in establishing relationships with staff. The family acknowledged the benefit of relating to staff as they shared information about their relatives’ care, improved care coordination, made care delivery easier for providers and ensured that their relatives’ need were met. Staff–family relationships were facilitated when dyad members recognised each other’s sense of self and interacted in a friendly manner, and when staff appreciated the expertise possessed by family caregivers. Relationships were inhibited when staff disrespected and devalued the family’s input in the care process.

Ward-Griffin, Bol, Hay and Dashnay (2003) identified intrinsic and extrinsic factors affecting the development of four types of staff–family relationships: “conventional”, “competitive”, “collaborative” and “carative”, by interviewing 17 staff–family dyads. Intrinsic factors are related to the orientation of care and family members’ sense of obligation to continue providing care. However, the devaluation of the expertise of family members had a detrimental effect on the relationship. Extrinsic factors that facilitated its development included administrative influence and collegial support, whereas time constraints, organisation structure and limited support from colleagues inhibited relationship building.
Ward-Griffin (2001) used critical ethnography with a purposeful sample of 23 staff family dyads to explore the interconnectedness of the relationship. Four interconnected types of relationship were identified: nurse–helper, worker–worker, manager–worker and nurse–patient. In the nurse–helper relationship, nurses took time to coordinate and provide the majority of care, while family caregivers assumed more supportive roles. Family caregivers sought additional opportunities to take on more duties to remain in control of care and maintain a sense of identity. In the worker–worker relationship, nurse and family worked together as co-workers, with nurses establishing trust with the family members and delegating care tasks to them. In the manager–worker relationship, family members were considered as members of the health care team, but tension was created related to the sharing of caregiving tasks. In the nurse–patient relationship, family members had overwhelming demand from the staff. The findings highlight the ways in which unequal responsibility for caregiving among staff and family members created tension and power struggles in the relationships.

Promoting successful family–staff relationships (Dempsey & Pruchno, 1993; Schwartz & Vogel, 1990) holds promise for improving care for residents to a holistic level, with the family being involved in providing quality care and ensuring the wellbeing of the residents. Nonetheless, most of the research under review explored the dual relationship between staff–resident and staff–family respectively in long-term residential aged care (Lawrence & Schiller-Schigelone, 2002). Research on the triadic relationship between staff–resident–family has so far been at a less detailed and concrete level of analysis than the work on dyads. The practical reason for those interested in the details of interaction pattern having mainly confined themselves to dyads is because of the enormous amount of data produced by a triad (O’Connell, Ostaszkiewicz, Sukkar & Plymat, 2008).

2.5 Teams

Much has been written about how to set up healthcare teams (Cott, 1997). As organising structures, teams have been defined as consistent groups of people who commit to a relevant shared purpose, possess complementary and overlapping skills, use a common approach to their work and hold themselves mutually accountable for the team’s outcomes (Manion, Lorimer & Leander, 1996). In health care settings, a
team approach is most useful when clients’ issues, needs and problems are complex, chronic and their resolution requires the collective input from a variety of individuals (Heinemann, 2002). Empirical evidence also suggests that health care teams positively influence the care process and outcomes of elderly residents in residential care settings. However, the concept of the team tends to be limited to the professional and paraprofessional, including doctors, nurses, occupational therapists, physiotherapists, social workers, dieticians and family members (Bauer & Nay, 2003), without engaging the elderly residents in collaborative relationships and engaging them as partners in consciously attending to care management for themselves.

The conceptualisation of empowering clients to control their own health care experiences in clinical settings, sharing decisions with clients and family members, being open and transparent, and anticipating patients’ needs are not new (McWilliam, Coleman, Melito, Sweetland, Saidak & Smit, 2003). Informed by an empowerment philosophy, clients are located as the central partner in their own care, and opportunity should be provided for both clients and the family caregivers to determine the extent of their participation with staff, based on their individual abilities, motivations and care needs. In addition, the research evidence suggests that approaches of this nature have not been successfully implemented in practice in other clinical settings (Lambert, Glacken & McCarron, 2010). While there is considerable rhetoric on how to set up and maintain these teams (Burns, Nichols & Martindale-Adams, 2000; Cohen, Feussner, Weinberger, Carnes, Hamde & Hsieh, 2002; Strasser, Falconer, Herrin, Bowen, Stevens & Uomoto, 2005), to date no study has investigated the “care triad” in the residential aged care setting, neither as a team nor as an interactional, multi-perspectival whole. To date there appears to be no research explaining how the elderly residents should be regarded as members of the team and work together in everyday practice.

McCallin (1999) conducted a grounded theory study to develop a substantive theory of interdisciplinary teamwork among doctors, nurses, other health care professional and administrative personnel in two acute care hospitals. The findings revealed that participants expressed a concern for meeting service needs and resolved that concern through open dialogue, specifically discussing differences and constructing new ways of working together. The process of pluralistic dialogue was comprised of two
complementary phases: rethinking professional responsibilities and reframing team responsibilities. Rethinking professional responsibilities occurred when health care professionals were involved in breaking down stereotypical images of having medical dominance. This became possible when participants were willing to reconsider traditional ideas and assumptions that underpinned controversial ideas. It encompassed a collective learning experience in which the participants negotiated the provision of services by demonstrating a willingness to be open and to accept others’ input into the care process. While McCallin’s (1999) investigation illuminated the processes that health care professionals use in their day-to-day interactions as they negotiate new forms of practice, clients and family caregivers were not considered in the team and whether similar social interaction pattern occur among staff in the long-term residential facility is not known.

In a quantitative study, Cott (1997) used social network analysis to describe the structure of multi-disciplinary long-term care teams, specifically the pattern of relationships that develop among staff as they go about their work. In an analysis of data elicited in a self-administered survey of 93 health care workers on three teams in an aged care facility, Cott found that teams shared a common structure consisting of two subteams, multi-professional and nursing. Multi-professional teams were comprised of predominantly non-nursing staff such as doctors, social workers and therapists, who had distinctive expertise, worked in their own field in the team and had no supervisory responsibilities over each other. These professionals were mainly involved in decision making and problem solving. Nursing teams consisted of nursing personnel who worked day and night, focussing on task-oriented duties. Thus, while a collaborative relationship for the purposes of decision making and problem solving developed among the multi-professional teams, nursing teams collaborated to assist each other with work tasks. While these findings illuminate how the team operated by a division of labour, how the health care team enacted their relationship remains unknown, not to mention the role played by residents and their families.

In a qualitative evaluation study, Shaw, De Lusignan and Rowlands (2005) conducted 48 interviews with health care teams of different disciplines, comprising doctors and nurses, about their concept of team collaboration. The findings revealed that team functioning was poor due to the absence of shared goals and poor communication
skills. In keeping with traditional hierarchical practices, there was a dominance of the medical staff and only limited participation in planning and decision making by other staff, leading to reduced feelings of shared responsibility and undermining teamwork. How other professional team members, and residents and family caregivers, experienced team interaction was not investigated by this study.

Willumsen and Hallberg (2003) used grounded theory to investigate how the professionals of different disciplines collaborated with each other in residential aged care settings. The participants contributed their expertise and the residents’ problems and priorities of care provided direction for their care. The researchers further investigated how participants combined their individual contributions by building networks and developing trust with each other. Participants’ readiness to act to increase the wellbeing of their clients was identified as a unifying force that facilitated the integration of services when working for the residents living in the aged care facility. This point was consistent with the findings of Stewart et al. (1995) and Stewart (2001) in illuminating the importance of relationship-based care. It became apparent in these studies that understanding residents’ preferences and their sense of satisfaction and wellbeing were important parameters for judging the performance of the professional teams. The main finding of these studies was that each resident “has to be understood as a unique human being” in any interaction (Stewart, 2001, p. 445).

Ellingson (2003) carried out an ethnographic study of the communication patterns of a geriatric oncology team, comprising 49 health and social care personnel. The study found the presence of seven processes: informal impression and information sharing, checking clinical progress, relationship building, space management, training skills, handling interruptions and formal reporting. Ellingson addressed the communication process enacted by the professional team on a macroscopic level, without involving the residents and families in the interaction process. Interprofessional collaboration was found to be infrequent, tense, business-like and task-oriented, consisting of superficial, unstructured and opportunistic interactions. Team members worked in their own spheres and there was little evidence of a coherent approach to teamwork involving all members, including residents and families in the team.

Lastly, Gantert and McWilliam (2004) interviewed staff of various disciplines including nurses, physiotherapists, occupational therapists to explore staff interaction
in caring for older people living in the community. Three social processes were identified: networking, navigating and aligning. The social process of networking was found to be located on a continuum of interdisciplinary communication experience that ranged from isolation to connectedness. The social process of navigating captured how team members assigned levels of trust in one another in their team functioning, such that familiarity with each other’s roles and responsibilities and abilities of other team members created a continuum of experience that ranged from absence of trust to greater trust. The process of aligning was manifested as staff manoeuvred within the team hierarchy to achieve the goals, enacting varying executions of traditional hierarchical relationships, ranging from fixed roles and responsibilities in a traditional hierarchy to more flexible professional autonomous roles and relationships. Again, the involvement of residents and their families was excluded.

In summary, research to date has only begun to inform our understanding of the relationship building process among all those who are considered to constitute what is understood as a health care team (Charmel, 2010; Safran, Miller & Beckman, 2006; Taylor & Rutherford, 2010). In all the literature reviewed, such studies were conducted with a narrow range of health care staff (Tuckett, Hughes, Gilmour, Hegney, Huntington & Turner, 2009) and/or with the families (Bauer & Nay, 2003; Gladstone & Wexler, 2001). Therefore, teams did not automatically function well as research evidence, e.g., McWilliam et al. (2003), suggests, namely, that approaches involving residents and their families as the centre of the team have not been successfully implemented in practice. It is anticipated that new knowledge on how triad members interact, what the triadic relationship is like and what its dynamics of work are in my study will enhance our understanding of the significance of the triadic care relationship to the optimisation of the quality of care and life in the long-term residential facility.
Chapter Three
Theoretical Perspective

In this chapter I introduce the theoretical perspective for this study. I am drawing on a number of perspectives to create the theoretical scaffolding for the research. In keeping with Charmaz’s application of grounded theory, I examined my own epistemological premises (Charmaz, 1990). By following Charmaz’s strategy of having a strong theoretical perspective, my research questions are guided throughout the research and analytic process, sharpening the whole process and delineating the theory to which I subscribed. I begin with post-colonialism, including some of the key theorists in this area in the 20th century. Then I draw upon post-colonial feminism which introduces an emphasis on gender. Next I discuss symbolic interactionism, focusing on the construction of self and Tajfel’s work on identity. This is followed by my discussion of the emerging area of intersectionalities. Lastly I follow Foucault’s position on discourse, power and subjugated knowledge. I follow the discussion of each theoretical perspective with a summary to examine how it contributes to the aims of this study.

3.1 Post-colonialism

Post-colonialism grew out of political acts of resistance. Although there are multiple approaches to post-colonialism, central to my study is its critical analysis of the experience of colonialism and the historical construction of identity and culture (Anderson, Perry, Blue, Browne, Henderson & Khan, 2003). Post-colonialism recognises that there was resistance to authority, usually of the West (Sharp, 2008). This was an act of resistance decentring colonial legacies by questioning the coloniser’s hegemony and its silencing of colonised voices and subordinated knowledge (Gandhi, 1998). This resistance is practised by many, including the marginalised and the least powerful. As Foucault (1980) points out, all relations involve some forms of power and resistance. This is especially the case in some settings which by their very nature are designed to instil particular dominant codes of behaviour, values and beliefs, for example, for staff of a long-term residential aged care facility. Thus for staff who are supposed to be the authorities and the experts, it is inevitable that at some point the prevailing rules and routine will become a source of
conflict in the triadic relationship. However, it is unwarranted to assume that the residents of a long-term residential aged care facility and their family are subordinate and respond to power in certain ways, for example, by being obedient and compliant. It is a fact that the reaction of residents and family may vary widely from deference and submission to opposition, or from passivity and indifference to open confrontation. In this section, I focus on the political roots of the term post-colonialism and its plural nature and introduce writers and theorists whose perspectives fit well with the overarching aims of this study. Post-colonialism is not to be taken to simply deal with the period of time after colonialism; the period may also be seen as a continuation of colonialism, and to mean different or new relationships concerning power and the control and production of knowledge (Sharp, 2008).

A critical starting point in the development of post-colonialism was the actions and writings of anticolonialists. Franz Fanon (1963) was among a group of vocal anticolonialists challenging repressive colonial rule. He proposed a radical style of total resistance, suggesting that rejection of Western hegemony was a necessary part of overthrowing colonial rule and moving on towards a stage of decolonisation and re-establishing African national identity (Gandhi, 1998). As Bhabha (1994) suggests, Fanon was also aware of the importance of retrieving the repressed history and restoring the identity of people who had been subordinated and colonised. An important political aim of post-colonialism was reclaiming and restoring the self.

From this beginning in political resistance, writers began to produce texts that articulated the effects of colonialism. One of the major texts was Said’s (1978) *Orientalism*. This book clearly illustrated the West’s systematic approach to dominate and have authority over the Orient. Said argued that the Occident (the dominator), i.e., the West, could not exist without the “East” (the subordinate), and vice versa. In other words, they are mutually coexistent. Notably, the concept of the “Other” was created by the Occident, suppressing the ability of the “Other” to talk for themselves. Western depictions of the “East” as the “Other” construct an inferior world, a place with less power and irrationality. Following Foucault’s belief, Said introduced the idea of the dominator’s claim to have knowledge of the “Other” reassured the dominator of their superiority and identified themselves as superior with the power to control (Sharp, 2008).
Spivak’s (1988) main contribution to post-colonial theory came with her definition of the term subaltern (the subordinate). Spivak poses a series of questions about how the subaltern has been positioned and the consequence of this for representation and representability. Spivak illustrates how certain groups have been constructed. By articulating the position of these groups, Spivak brings focus to the systematic determination of relationships with the dominator and the subordinates (Gandhi, 1998). Spivak also introduced terms such as “essentialism” and “strategic essentialism” (1988). Essentialism refers to the dangers of reviving subaltern voices in ways that might simplify heterogeneous groups, creating stereotyped impressions of their diverse group. Spivak, however, believes that essentialism can sometimes be used strategically by these groups to make it easier for the subaltern to be heard and understood when a clear identity can be created. Both Said and Spivak’s writing, among many others, address common threads of domination, power, control, marginalisation and identity.

By writing about the homogenisation and essentialisation of groups, post-colonial theories have also challenged the view of culture as a fixed and static state. Homi Bhabha (1990) introduced the idea of the “third space”, a place of cultural hybridity where two forms of culture come together, resulting in the creation of new positions. Bhabha posits that culture is something negotiable, and that shifts occur as part of the colonising process and that “the spaces in which culture is constructed are not neutral, but have been fraught with relations of power, subjugation and domination between the coloniser and the colonised” (Anderson, 2002, p. 14). Bhabha states:

This third space displaces the histories that constitute it, and sets up new structures of authority, … the importance of hybridity is that it bears traces of those feelings and practices which inform it, just like a translation, so that hybridity puts together the traces of certain other meanings…. The process of culture hybridity gives rise to something different, something new and unrecognizable, a new area of negotiation of meaning and representation. (Bhabha, 1990, p. 211)

Bhabha then offers a different view of culture as an entity that is dynamic, rather than fixed, and exists within the global nature of post-colonial relationships.

From this perspective on culture, I move into another area in post-colonialism about race. Post-colonial theorists such as Stuart Hall (1996) and Paul Gilroy (2000) have
critiqued the notion of race as a fixed element of identity. Rather than viewing “race” and “culture” as fixed constructs, which are often subsumed into the same neutral category, post-colonialism frames them as socially constructed, through the social-political processes of colonialism. As Anderson et al. (2003) discuss, “race” comes to be seen as socially produced and “culture” is dynamic. Racialisation moves away from socially/politically defined concepts of race and culture and instead refers to a political and ideological process by which particular populations are identified by direct or indirect reference to their real or imagined phenotypical characteristics in such a way as to suggest that the population can only be understood as supposedly biological entity. (Cashmore, cited in Ahmad, 1993, p. 18)

Simply put, “racialization involves a process of investing skin colour with meaning, such that ‘black’ and ‘white’ come to function, not as descriptions of skin colour, but as racial identities” (Ahmed, 2002, p. 58). Importantly for healthcare research, the process of racial identification has implications for how people receive, or are restricted in receiving, health care services, and how relationships are constituted and constructed in the clinical setting (Anderson, 1998).

Although post-colonialism brings to the fore issues about struggling for identity, for example, history and politics, groups, race, culture and class, it does not include analysis of the voices of the marginal groups and what happened to them in reality. The following section discusses approaches to post-colonial feminism, which address this limitation.

### 3.2 Post-colonial feminism

Post-colonial feminism emerged from the gendered history of colonialism, where colonial powers often imposed Western norms on colonised regions. As a result the status of women in the developing world, their traditional practices and the roles taken up by them, sometimes seen as distasteful by Western standards, could be considered as inferior and they were discriminated against (Mohanty, 2002).

Post-colonial feminism has emerged with two main aims. The first aim was to racialise mainstream feminist theory, and the second was to insert women’s identity
into post-colonial theorising (Lewis & Mills, 2003). This section focuses on the second aim, reviewing how others saw the views of minorities.

In describing what happened to women in a post-colonial context, Quayson (2000) writes about “the conundrum of attaining citizenship whilst becoming alienated subjects” (p. 103). Mohanty (2006) further examines the identity of women in a post-colonial context. She points out that a simple gendered analysis ignores the historically situatedness of women’s existence. It also ignores the histories of racism and imperialism that are addressed in Western feminism. She criticises the tendency of constructing an analysis from a single category, here the colonised, thus ignoring the important issue of gender difference. She suggests that it is important to question the impact of colonialism on the lives of the colonial subjects who also happen to be female in a post-colonial feminist context. Post-colonial feminism has been taken up by a few nursing scholars. Anderson et al. (2003) describe this approach as a critical, gendered analysis that provides a framework for analysis that combines the broader political context with voices from the margins. This approach can be taken up to examine a broad variety of issues in health care. Salas (2005) has critiqued nursing theory development from a post-colonial feminist perspective. Similar to the critiques made by Mohanty, Salas criticizes the absence of a non-Western perspective in nursing theory development. Western nursing scholarship is seen to be superior and to be bringing theory to non-Western countries which in effect means colonising their nursing practices. I turn now to another area of theorising, i.e., symbolic interactionism.

### 3.3 Symbolic interactionism

Symbolic interactionism developed from the work of Mead and her students. It has two assumptions: first, that the self as an object (me) is a product and reflection of its social community, and second, that there is an aspect of self (I) which is an active process which is a prime determinant of behaviour. Therefore, the self is both socially determined and agentic. The active self is self-organising, proactive, and is able to make choices.

The concept of role identity was crucial to symbolic interactionism, for it seemed at the time that “no other single concept would seem to offer more possibility for
exploration of relationships…” (Holland, 1977, p. 81). It enabled theorists to conceptualise a mutual relationship between the self, the other and the social community, which was manifested in three aspects of self: content, structure and dynamics. They proposed that each social role performed bestows on the person an identity. A person’s set of social identity comprises the content of self, and therefore reflects social community. The structural aspect of self reflects the ways in which the set of role identities is organised in the community. For example, some researchers propose that role identities are hierarchically organised in terms of the value assigned to and the power possessed by each role which may reflect, albeit loosely, the identity of a person (McCall, 1987). Finally, the dynamic aspect of self embodies a different kind of reciprocity, i.e., the mutual shaping of self and the social community. This is seen, for example, in the ways in which we attempt to “live up to”, “cope with” or “adjust to” our roles and persuade others to accept them (McCall, 1987, p. 86). This core issue of identity shaping is striving to live up to one’s structured set of role identities and of managing the role conflict or strain during any negotiation process (McCall, 1987).

In summary, symbolic interactionism addresses the self as a product, and the concept of role identity positions a person within social relationships that make up the community. Identity produces particular kinds of action, or role performances which, in turn, are situated within a social milieu and presumably alter or shape the social context. The image of self is a dynamic, agentic one in which negotiation and “mutual shaping” between the self and the others who make up the community are central.

As a theoretical perspective, Tajfel’s concept of social identity further explores the structural aspect of the self. It addresses the relationship between the person and the others in social groups (Tajfel, 1981). Identity posits how a person becomes a social entity in a group and how this influences its self-definition and behaviour. The resolution of the individual–group relationship is thus sought through an understanding of the reality of the social group and the social identity that is derived from the group membership. Social identity theories conceptualise self-definition and behaviour as lying along a continuum which runs from a purely individual form to a group form. At one extreme, self-definition and behaviour are a purely individual matter; at the other extreme, these activities are determined by our social location in
social groups and the community. This individualism–group continuum enables us to think of the self as both unique and as comprised of social roles or identities, bearing in mind that this is a continuum, sometimes reflecting both individuality and social identity simultaneously. Similarly, our behaviour can be thought of as reflecting either our unique dispositions, or we may be acting in terms of social roles or as members of groups. Social identity theories also conceptualise groups as having a social reality. So society/social group comprises real categories (gender, race, culture, class and so on) which stand in power and status relations to one another. Consequently, they do not exist in isolation, but acquire their meaning and functional significance in relation to other categories. Society is therefore structured according to contrasting sets of social categories (and this is reflected in the structure of the self concept). This structure precedes individuals who belong to a particular social group. In this way, a social group bestows self-conception, and hence defines who we are. It is argued that belonging to a group confers social identity or a shared and collective representation of who one is and how one should behave (Hogg & Abrams, 1988). In other ways, real social categories are internalised as cognitive structures in the self-concept (Tajfel, 1981). Social identity is therefore “the individual’s knowledge that he or she belongs to certain social groups together with some emotional and value significance to him or her of the group membership” (Tajfel, 1976, p. 31). To summarise, through the concept of social identity, society/social group and social structure are utterly implicated in identity. I turn now to another area of theorising, i.e., intersectionalities, which examines how race, class and gender interrelate with each other.

3.4 Intersectionality

As a theoretical perspective, intersectionality extends beyond gender as a single axis for analysis and is inclusive of other categories that influence lives (McCall, 2005). It examines how individuals are simultaneously positioned across a number of axes, for example across race, class, gender and age (Brah & Phoenix, 2004). This approach supports the inseparability of the social categories of the social identity approach as discussed in the previous section. This allows rich and complex understandings as opposed to the perspectives that reduce people to one category at a time, for example according to gender (Phoenix, 2006). Although there are different approaches to
intersectionality research, in this study I situate this perspective within post-colonial feminism, as discussed above.

As with post-colonialism, Black Feminist thought includes many voices and perspectives, therefore, the following is an introduction of writers who have informed this study. Black feminism has woven race and class together with gender, focusing on the intersectionalities of these categories and the complexities that result (Hill Collins, 2002). Importantly, some Black Feminists such as Hill Collins and Hooks, have included ageing and the aged as a social category that interplays in this intersectionality. In a key work that shifted perspectives in feminism beyond the single axis of gender, Hooks (1984) critiqued some theorists’ narrow presentation of women’s lives by focusing solely on class, and ignoring the struggles confronting Black women, in particular their struggles for economic survival, and against ethnic, ageist and racial discrimination. From this perspective, women of Colour are in a unique position to critique and decentre the dominant class, and introduce a new perspective “from the margins”. As Hill Collins (1989) states, “a subordinate group not only experiences a different reality than a group that rules, but a subordinate group may interpret that reality differently than a dominant group” (p. 748). Women of Colour are in a unique position of outsider, by being seen as members of society, yet from their marginalised space being able to look in as if from the outside (Hill Collins, 2004). Essential to this perspective is the importance of engaging in an active dialogue with members of the community to ensure participation by all those individuals who have been systematically excluded from the generation of knowledge through historical and social positioning (Harding, 2004; Hill Collins, 1989).

More recently, intersectionality theorists have extended their purview beyond race, class and gender to include a broad variety of categories that influence social positioning. Mahalingam and Reid (2007) used this approach to bring together groups of African American and Dalit Indian women to explore shared understandings and develop strategies for self-empowerment. Ringrose (2007) drew on an intersectionality perspective to examine race and racism in a school of women’s studies. The utility of intersectionality research is also expanding as scholars begin to articulate methodological approaches (McCall, 2005). Ludvig (2006) discussed concerns that intersectionality can encompass an endless list of differences to analyse.
how multiple axes of oppression operate simultaneously, reflecting the dynamic nature of the processes.

3.5 Foucault: discourse, subjugated knowledge and power

I introduce the Foucauldian notion of discourse, power/knowledge and subjugated knowledge as part of the theoretical perspective of this study. Foucault defines the role of discourse as a system of knowledge providing “a set of possible statements about a given area, and organizes and gives structure to the manner in which a particular topic, object, process is to be talked about” (Kress, 1985). Cheek (2000) extends this definition by stating “thus a discourse consists of a set of common assumptions which, although they may be so taken for granted as to be invisible, provide the basis for conscious knowledge” (p. 23).

In this sense, discourses help to frame how knowledge is produced and therefore, what is included and excluded from the way we construct reality. At any time, certain discourses may be more dominant than others, thereby marginalising certain knowledge (Cheek, 2000). In Chapter Two, I introduced the discourse of ageism that exists and some of its implications, for example, how ageing is viewed and how it may affect the elderly living in the long-term residential care setting. In studies of post-colonialism, many scholars have also used discourse in relation to race (Dua, 2007), while as part of symbolic interactionism, the discourse of the “self” was discussed (McCall, 1987).

Foucault also brought to light the ways in which a certain kind of knowledge, subjugated knowledge, has been silenced throughout history (Gordon, 1980). Similar to Bhabha’s (1994) concept of “those who have suffered the sentence of history”, this knowledge included “a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated… It is through the reappearance of this knowledge… that criticism performs its work” (Foucault in Gordon, 1980, p. 82). This construction of subjugated knowledge can provide insight into the ways in which residents and workers have been categorised into race, class and gender in long-term residential care (Jervis, 2002).

Power is also central to Foucault’s work. The way in which Foucault presented power represents a shift away from traditional views of power as belonging to specific
persons or groups (Martin, 1998). Power is viewed as a force which everyone can possess, which shifts depending on the situation and the context, “power must be analysed as something which circulates… it is never localized here or there, never in anybody’s hands… in other words, individuals are the vehicles of power, not its points of application” (Foucault in Gordon, 1980, p. 98). It is possible within this framework of power, therefore, for acts of resistance from those who have traditionally been viewed as subordinate and oppressed by those who possessed power. While Foucault has largely presented power as a neutral force, it has been noted by scholars that power is gendered, raced and classed (Diamond & Quinby, 1988) and embedded in the historical context of relations (Gandhi, 1998). Along with an intersectionality perspective, therefore, power relations can be influenced by the intersecting axes of control that are operating in an individual’s day-to-day life. I turn now to a summary of the epistemological premises that shape the theoretical perspective for this study.

### 3.6 Summary of theoretical perspective

For this study, I bring together the theoretical perspectives of post-colonialism, post-colonial feminism, symbolic interactionalism, Tajfel’s concept of identity, intersectionalities and Foucauldian epistemology to shape the theoretical perspectives of the study. As Alcoff (1998) has suggested, “when we move beyond a single axis framework of analysis, we can also begin to overcome the limitations of the superior/inferior binary…” (p. 484). This requires moving away from the traditional view of individuals as analysed in a rigid, monolithic perspective. For example: “Post-colonialism, with its roots in political action, allows for the examination of the micropolitics of power and macrodynamics of structural and historical nature” (Kirkham, 2003, p. 766). Post-colonial feminism introduces the element of gender into this historical and social construction of self. Symbolic interactionism and social identity involve the “self” from a sociological perspective. The intersectionality perspective prompts further examination of the complexities of the intersections of race, class, gender and age, an element of particular salience in this study. And lastly, discourse, subjugated knowledge and power from Foucauldian epistemology are interwoven with these other perspectives to shape the theoretical perspective for this research.
3.7 Synthesis of theoretical perspective

Joining together the literature review and the epistemological premises for this study bring to light issues in long-term residential care that invite further examination in this study. The review of the literature introduced critical perspectives in gerontological research. Yet there remains an opportunity to extend these perspectives further to address the triadic relationships that exist in the long-term residential setting. While previous research has at times acknowledged the discourses of power and control in the long-term residential setting, almost all of this research has been conducted from Western perspectives. Foucault (1980) reminds us that elements of control, power and resistance exist in all relations. In this study, the term “resistance” is perceived not simply as an attempt to demonstrate defiance or opposition occurring in the triadic relationship, though it may indeed be about that. It refers to strategies, consciously or otherwise, by residents, family and staff to “get by”, “get through”, “cope with” or “adjust to” the demands and roles imposed on them in order to cast out a sense of control and personal self.

This is especially the case in some long-term residential settings that by their very nature are designed to instil particular dominant codes of behaviour, values and beliefs in the staff. Thus for some staff who are supposed to be the authority and expert, it is inevitable that at some point the prevailing rules and routine will come in for direct challenge. However, it is unwarranted to assume that the residents and their family being considered as subordinates respond to power in the same sort of ways. For example, the reaction of the residents and family may vary widely from deference and submission to opposition, or from passivity and indifference to open confrontation. This theoretical framing is being introduced as a way of framing the complexities of the triadic relationship in the long-term residential setting and to acknowledge the existence and role of contextual issues in the process of relationship building.
Chapter Four
Method of Inquiry and Research Methods

The overall aim of this study is to provide empirical data and a theoretical understanding of the care triad in the context of residential care facilities in Hong Kong, ultimately providing insights that might be applicable to introducing the concept of tripartite engagement in care for residents and enhancing quality of care for residents and their families. To achieve this aim requires an in-depth understanding of the dynamics of the triadic relationship from the perspectives of older residents, families and staff, as well as increased insight into the interaction pattern among the triad members in the context of a long-term residential care facility. To gain in-depth understanding of the care triad as a dynamic interaction process of those involved in the triad, the methodology of grounded theory is used to construct what a triadic relationship in the long-term residential setting is like.

In this chapter, I describe the research methods that guided this study. I begin by discussing how this study looked at what a triad is actually like, and explain the relevance of its qualitative design, following which I discuss the method of inquiry, Charmaz’s social constructionist version of grounded theory inspired by the original work of Glaser and Strauss on grounded theory. Next, I describe the process of data collection, including negotiating access and entry to the study sites, participant recruitment and the methods of participant observation and in-depth interviewing. This is followed by a discussion of data analysis. Then I discuss how scientific rigor was addressed in this study, in particular, the areas of credibility, voice, reciprocity, reflexivity and praxis. Next I discuss ethical considerations germane to this study, and conclude with a discussion of the limitations of this study.

4.1 Putting research into focus

As noted in Chapter One, this study is effectively a series of case studies on institutional care. Drawing on scholarly work within gerontology, this study was fuelled by an ongoing interest in the human experience of the daily interactions of residents, their families and the staff. In this sense, the study stemmed from a basic curiosity about what a care triad is like and how the stakeholders of the triad
interacted with each other on a day-to-day basis. By conceptualising what is occurring in the field, this study immediately called for a qualitative emphasis.

4.2 Relevance of a qualitative design

Qualitative research is based on day-to-day interaction with informants in their own words and language and in their everyday environment (Kirk & Miller, 1986). Observations of the pattern of everyday interaction and personal accounts of the triadic relationship in the long-term residential setting were used to describe and explain what a care triad is like and how its stakeholders interact with each other in the long-term residential facility. It is anticipated that this new knowledge will increase our understanding of the interaction pattern in the care triad and has the potential to introduce the notion of tripartite engagement in long-term residential care so engagement does not just apply to the elderly residents, but encompasses family members and staff.

Knafi and Howard (1984) identified four general purposes of qualitative research: instrument development, illustration of qualitative data, sensitisation of others and conceptualisation of a process. They stated that the design of the methodology should be based on the purpose of the study. To date, no study has investigated the care triad in the long-term residential facility as an interactional, multi-perspectival whole. In addition, there is an absence of a substantial theory to describe and analyse the dynamics of the triadic relationship and the interaction pattern between the older residents, their family caregivers and the staff in the long-term residential care setting. For this reason, a greater understanding of how the triad works is essential to sensitise the community at large to this group of people.

4.3 Making methodological choices

Data collection and analysis were based on grounded theory. Gaining knowledge through “describing human experiences as it is in the real world and as it is defined by the actors themselves” is a premise of qualitative research (Polit & Hungler, 1991, p. 497). Grounded theory is a type of inquiry that begins with discovery and proceeds to a higher level by conceptualising the social processes discovered within the group being studied (Artinian, 1988).
The perspective underlying grounded theory research is the sociological theory of symbolic interactionism. Herbert Blumer (1969) further developed Mead’s (1934) approach of symbolic interactionism to study human behaviour.

Symbolic interactionists posit that human action depends on the meaning that people ascribe to their situations and that arise out of the process of interaction between people (Mead, 1934). These meanings derive from shared interactions, which turn on the pivotal role of voice. Symbolic interactionists assume that the indeterminacy of action rests on the human capacity to look at and objectify self and to give credit to its meanings. In this approach, knowledge originates from the raw data in the empirical world rather than the testing of concepts or hypotheses derived from existing theories. Symbolic interaction research is thus concerned with the discovery of what is going on in the real world, the nature of this reality, and how the human beings involved define and experience it in their world (Bowers, 1989).

4.4 General description of grounded theory

“Grounded theory research is aimed at understanding how a group of people define, via social interaction, their real life” (Hutchinson, 1993, p. 182). It is derived from a symbolic interactionist or social interaction framework premise that people construct meanings for phenomena based on an interpretation of the interactions they have with one another within a social context (Hutchinson, 1993). In other words, people construct their reality – their constructions are neither convenient fabrications nor idiosyncratic intervention. Rather their constructions reflect their understanding of their experiences as well as the diverse situations in which they have them. Further, the constructions lead others, for example, friends, family and researchers alike, to look closely at their interpretations of their actions and situations and understand it through their construction.

A grounded theory method has been frequently used to address gaps in the literature, or to clarify, introduce, develop or redirect research in content areas with considerable information. The original version of grounded theory described by Glaser and Strauss (1967) focuses on the process of generating theory rather than a particular theoretical content. The foundational question is “what theory emerges from systematic comparative analysis and is grounded in fieldwork so as to explain what has been and
Glaser and Strauss believed that the researcher’s choice of paradigm or paradigms of inquiry influenced the work since the researcher’s world view and accompanying assumptions guided how the researcher thinks and acts during the research process (Denzin & Lincoln, 2000).

4.5 Method of inquiry: Charmaz’s social constructionist version of grounded theory

The method of inquiry used in this study was Charmaz’s social constructionist version of grounded theory, underpinned by the theoretical perspective described in Chapter Three, drawing on post-colonialism, post-colonial feminism, symbolic interactionism, intersectionality and Foucauldian epistemology. Charmaz’s social constructionist version of grounded theory has grown out of the early work of Glaser & Straus that was itself grounded in empirical data. Grounded in the work of scholars such as Charmaz (1990) and Goldkuhl and Cronholm (2010), this social constructionist grounded theory has added theoretical grounding to the traditional approach grounded in empirical data only. Brown-Wilson and Clissett (2011) describe it as “part of a social construction, which hold different meanings for each person, in which people are active agents, make autonomous decisions” (p. 677). This style of research inquiry has been identified as suitable for health and social care professionals because of its assumption of an emergent reality fundamentally shaped by social interaction, facilitating the involvement of all stakeholders of the research. It offers an open-ended and flexible means of studying the fluid interactive research processes (Charmaz, 1990). Rather than focussing on creating a description that sensitises others as that of the early work of grounded theory, social constructionists take a step further by viewing the process of analytical categorisation as dialectical, processual and active (Goldkuhl & Cronholm, 2010). The emergent theoretical categories were used to further sensitise the researchers to look for themes and issues within the data. In my study, some residents seem to be “demanding” and displaying “resistance” in the resident-driven triad. But when viewed from these residents’ vantage point of desiring to realise identity goals and struggling to have a sense of self, the residents’ behaviour becomes understandable, rather than standing as evidence of “demanding” and “resistance”. Charmaz (1990) further elaborates that “the interaction between the researchers and the data result in ‘creating discovery’ by revising the research...
questions and by asking more questions on a generic level” (p. 1165). In my studies, for example, given my interests in some sociological concepts around power, control and self identity, I asked more questions such as: How do the stakeholders of the triad define their role? How do their definitions compare with the social values and larger cultural themes in the West? How do they feel about other stakeholders in the triad? Under which conditions do they have autonomy and control? Under which do they not? As I am also interested in the sociology of emotions, I often ask the stakeholders questions such as “What was time like for you living here, visiting here and working here?” When I studied my data, I continually raised questions such as: “How?”, “Why?”, “Under what conditions?”, “Under the conditions created by rules and routines, how do you think, feel and act?” The grounded nature of a social constructionist version of grounded theory in my study led me to attend closely to the data, ask questions about the data, and compare the themes and categories I identified with those discussed in the literature. Goldkuhl and Cronholm (2010) echo Charmaz’s version by agreeing that grounded theory should not only be grounded empirically, but also grounded in already existing concepts and theories. By making more systematic use of pre-existing theories in research, the social constructionist adds a critical dimension, namely, the distinction between what is usable and what should be refuted in the existing literature. Pre-existing theories may also contribute, through their explanatory power, to condensing the theory, which is one of the explicit aims and the main strengths of this social constructionist version of grounded theory (Goldkuhl & Cronholm, 2010). Using pre-existing theory reduces the risk of the overgeneralisation of findings from case studies, seven triads altogether in my study. Integrating or relating emergent themes and categories to other theories is one of the merits of my study when arguing the possibility of an appropriate generalisation of findings.

In addition, rather than focusing on creating a description of the “participants”, as in early work using grounded theory, Charmaz’s social constructionist version focuses on the development of a dialogical relationship between the researcher and participants with the ultimate aim of a social transformation of the sources of oppression. The term “oppression” is used in this study in the sense of the “silenced ones”, i.e., stakeholders being excluded from the research (Lincoln, 2001). The interaction of researcher and participants results in a shift in the distribution of power
through information sharing with and between stakeholders, designing intervention or activities as directed by stakeholders and creating conditions which foster action as the outcome of the inquiry. This is a move away from the traditional view of expertise to one of recognition and respect for the expertise and knowledge of the researchers (Reed et al. 2004). In this approach, I analysed a hidden agenda, “taken for granted” assumptions, and generated a sophisticated description or explanation of how the different triads worked in this long-term facility as a result of an interactive process between myself and the participants. This process included analysing the influence of socially and historically situated elements on the everyday (Thomas, 1993), elements such as medicalisation of care, relations of power, discourses being influenced by the perceived frailty and vulnerability of the elderly, and identity hierarchy, elements that often contribute to power imbalances leading to unequal power relations and, potentially, a sense of inferiority and subordination (Kincheloe & McLaren, 2005). A central aim of the social constructionist version of grounded theory is to enable the voices of all stakeholders involved in the research to be heard.

The theoretical perspective of the study had further implications for this study. It is framed through a political lens that critically examines relations by bringing together individual perspectives with group-based perspectives in order “to understand how individuals are active in producing and shaping relations and care approach and, in turn, shaped by these relations” (Kirkham & Anderson, 2002, p. 12). The social constructionist approach provides a means of enabling the inclusion of multiple perspectives in the research process (Rodwell, 1998). For example, equal access is ensured by giving all stakeholders the opportunity of sharing their perspectives in the research process (Nolan, Hanson, Magnusson & Anderson, 2003). There is also an enhanced awareness of the position of self and others, that is, as a result of participating in the social constructionist studies the participants understand their situation and have an improved understanding of the constructions of other, different, groups of stakeholders (Guba & Lincoln, 1989). Last, but not the least, the study was framed by encouraging action by providing an impetus for change and the means to achieve change.

In practice, the social constructionist grounded theory underpinning the theoretical perspective of this study is enacted in a dialectic relationship between the participants
and myself as researcher. This relationship reflects a number of elements: voice, reciprocity, reflexivity and praxis, which are enacted throughout the research process, from data collection to interpretation of the findings. The voices of participants are central to the analysis of intersectionalities, decentring dominant discourses and bringing to the fore worldviews and subjugated knowledge that have, in the past, sometimes been excluded in academic research (Kirkham & Anderson, 2002). The research process also reflects a high degree of reciprocity. Lather (1991) describes reciprocity as implying “give and take, a mutual negotiation of meaning and power” (p. 57). To achieve reciprocity, researchers must engage in ongoing reflection with regards to their social positioning in relations to the research participants (Reimer Kirkham & Anderson, 2002). Reflexivity refers to this ability of the researchers to reflect upon, explore and examine social processes and contextual factors influencing the research relationship as well as participants’ lives (Fonow & Cook, 1991). This critical approach to reflexivity brings a particular focus to the researchers’ own power and privilege, a position that can lead to tension when critiquing the power struggles of participants (Madison, 2005). Lastly, praxis relates to the political action orientation of this method of inquiry. Praxis has been described as the ability to link knowledge and theory development to practice-relevant social, political and ethical actions aimed at improving health, health care and social conditions (McCormick & Roussy, 1997). Later in this chapter, I discuss how the elements of voice, reciprocity, reflexivity and praxis were realised in the research process.

4.6 Research methods

4.6.1 Process of gathering data
Capturing the interaction pattern between the residents, family caregivers and professional caregivers is the central concern of the study. Grounded in the early work of Glaser and Strauss, Charmaz (2006) presented an overview of the philosophical foundations and new paradigms of grounded theory, and explained that grounded theory gives priority to the studied process, rather than to a pure description of the setting. From the beginning of the fieldwork, I studied what was happening in the triad by making a conceptual rendering of the observed actions. I then examined the seven different triads, and wrote about what they were like. Concentrating on a basic social process helped me to gain a more complete picture of the triad. Connection was
made between events in the triad to study the observed actions. It also increased my involvement in the study, dispelling the notion of the researcher as passive observer in other observational studies (Hertzberg, Ekman & Axelsson, 2001; Lotzkar & Bottorff, 2001). Later in this chapter, I discuss the nature of my social positioning in this study. In addition, I compared the data from the beginning of the research – not after all data had been collected – with emerging concepts and categories. This allowed me to maintain an open-ended approach and conduct checks on both data collection and analysis, going back to the data and forward to the analysis. I also returned to the field to gather further data and refined the emerging theoretical categories (Charmaz, 2006).

4.6.2 Research setting and negotiating access

Spradley (1980) suggested five criteria for selecting a social situation for doing field work and interview: “simplicity, accessibility, unobtrusiveness, permissibility and frequently recurring activities” (p. 52). This study was conducted in a long-term residential facility, hereafter referred to by the invented name “Parkview”, for 294 elderly residents with varying levels of dependency in Hong Kong. Data collection was carried out between December 2008 and August 2009 (see Table 1). A detailed description of Parkview to set the context for the analysis of the care triad is provided in Chapter Five.

Table 1: Overview of data collection

<table>
<thead>
<tr>
<th>Type of data</th>
<th>Purposive sample</th>
<th>Theoretical sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field Work (hours)</td>
<td>188</td>
<td>30</td>
</tr>
<tr>
<td>Interviews</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrators</td>
<td>2</td>
<td>NA</td>
</tr>
<tr>
<td>Residents</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Family</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Staff</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

In March 2008, I began looking for facilities to serve as sites for the study. Over the past years, I have been working as a volunteer on weekends and also have conducted several research projects in a number of long-term residential facilities. Because of this background, I was known to many of the staff working in long-term residential facilities. However, I found that gaining access was difficult through formal channels, such as the operational directors of residential care facilities at community-based social service organisations. Also, at some of the initial facilities that I approached staff expressed concerns that the aim of the study and the study methods would make
them feel as though they were being evaluated. When I was unable to secure a long-term residential care facility as research site by the summer of 2008, I began using my personal connections from the time of doing voluntary work, which proved to be much more fruitful. When I sent out an email request to a group of directors and superintendents of facilities, I immediately received one positive response, and so I began discussions with this respondent and it ultimately became the study site.

4.6.3 Negotiating entry

Negotiating entry and becoming one of the participants in the day-to-day milieu is a key to successfully engaging in data collection in field work. I spent the first month at the site introducing the study. Management was my contact and I was granted permission to attend a management committee meeting to request assistance with gaining access to likely participants. An overview of the research objectives, protocol and role of the prospective participants was presented by me at the meeting. The Director of the community organisation which runs Parkview expressed interest in the study was provided with a letter explaining the study and the criteria for participation. Subsequently, approval was obtained from the administration and the residents, their families and the staff of Parkview.

Before commencing fieldwork, I, in consultation with management, explained the project at meetings of staff, relatives and residents and answered any questions. A notice (Appendix 1) was pinned up at the reception desk and the nurse’s station, informing all residents, families and health care professionals of the research taking place and how they could obtain more detail.

Participant Information sheets (Appendix 1), a Consent Form (Appendix 2) and Request Not to Participate forms (Appendix 3) were also made available. It was emphasised that participation was entirely voluntary and that anyone who did not wish to be observed (or have their relative observed) could complete a Request Not to Participate form. No information about non-participants was recorded. An explanation of and invitation to participate in a private interview was also given at this time. With the permission of Parkview, the researcher placed a locked “post box” at a convenient location for the return of completed forms. Potential staff participants were asked to indicate (via the Consent Form) if they were willing to be approached by the researcher at a later date to arrange an interview. I was conscious of potential cultural
and practical limitations to such a recruitment strategy. Residents and relatives were to be recruited indirectly. Staff who were willing to do so were asked to approach residents and family members who had not submitted a Request Not to Participate form if they were willing to participate as it was assumed that residents and their family caregivers would feel more able to refuse the request if it did not come directly from the researcher. I then approached the residents, answered any questions and if the residents and their informal caregivers were in agreement, provided them with a Consent Form to sign. Whenever possible these explanations were made in advance of every visit. As it turned out, no one in Parkview had any negative feeling about this study or was unwilling to be involved.

4.6.4 Participants
Residents had to have had a minimum stay of one year in Parkview and be cognitively competent to participate in an individual interview and to give their informed consent. Relatives who visited at least once a week were also invited to participate. A sample of seven care triads (21 persons) were recruited and these were considered sufficient to achieve what Lincoln and Guba (1985) refer to as the “qualitative informational isomorph”, that is, data collection ceases when “saturation” (informational redundancy) has been achieved. Informants’ demographics are presented in Appendix 4.

4.6.5 Sample
The sample used in this study was a purposive one. In purposive sampling, individuals are recruited based on their ability to provide rich data (Coyne, 1997; Morse, 1986; Streubert & Carpenter, 1995). Suggested by the literature on research methods and prior experience of my supervisor, a small purposeful sample of five care triads (15 persons) was initially recruited to inform the researchers of their real-world experiences of the care triad. Analysis of the categories emergent from their experiences guided subsequent theoretical sampling for data collection to develop and refine emergent theory in keeping with grounded theory methods. This sampling method recognises that the composition and desired number of research participants can not be confirmed in advance and is, instead, determined during the course of the study (Glaser, 1978).
To arrive at the initial purposeful sample, participants compromising the care triad of approximately five residents were sampled. Initially five family members constituted a convenience sample of those involved in primary care. Similarly, the staff involved were those associated with selected residents. A total of 218 hours of participant observation was conducted. As conceptual categories emerged, theoretical sampling directed the sample process in order to elaborate and validate emerging concepts. Staff were asked to refer me to other residents and their families who manifested behaviour found in the emerging concepts. I tried to recruit two residents and their families for participant observation and interviews to achieve data saturation of the categories (Glaser & Strauss, 1967) to understand the social interaction processes in the care triad. Ultimately, the sample for this study was comprised of seven residents, seven family members and seven staff: one superintendent, three registered nurses, one social worker and two nursing aides. I spent 218 hours engaged in field work which included many conversations that were recorded in my field notes. A total of 31 interviews with administrators, family members, residents and staff were used to augment and expand upon the emergent themes.

4.7 Grounded theory strategies

4.7.1 Regarding data

“Grounded theory methods specify analytic strategies, not data collection methods” (Charmaz, 2006). In order to obtain both depth and breadth of understanding of the subtle nuances of interaction among members in the triad-rich data, the research “used a kaleidoscope to look at different view of people’s behaviour” (Silverman, 2005, p. 58). An extensive amount of data with thick description has been drawn from two sources, i.e., participant observation and interview. Five intact triads, comprised of a resident, family and staff, were interviewed individually and observed in action to gain insight into their shared enactment of caregiving in the triad. The main data collection technique for the study was observation. Participant observation allowed the detailing of what the key informants “do and say” in their everyday environment. Observations involving my unobtrusive (non-participant) presence for purposes of documenting in detail the full range of interactions that occur between residents, staff and visiting family members were made in the first six months. No observations were made of intimate activities, e.g., showering, engaging in personal care, etc.; I
respected any request for privacy by leaving the room. My “participation” was limited to innocuous activities such as helping with meals, arranging furniture, etc., and lasted on average 5–6 hours most mornings or afternoons. An initial six-month time frame was sufficient to provide opportunity to observe a wide variety of events, activities and participants in various context. There were opportunities for periods of my personal reflection away from the field to develop themes, while repeated visits offered an opportunity to discuss and confirm ideas and thoughts with the participants.

**Participant observation**
During the preliminary work, observation produced rich data about the activity patterns and interrelationships among the members of the triad. Gathering places such as day-room, lounge, television room, activity room and dining room were initial observation sites. As more data were collected, additional key field studies were identified. These included family–staff meetings, cooking classes, family fun days, festive celebrations and meal times. Field studies lasted a minimum of five to six hours per visit, twice a week. Data were collected until informational redundancy was obtained.

Participant observation allowed me to make observations from within a triad, for example of assumptions, roles and other aspects of the everyday life of the participants (Bogdewic, 1999). In this social construction version of grounded theory, participant observation was a constructive and reflexive act, with me, as a researcher, engaging with and reflecting on my participation in the study site (Tedlock, 2005). From the outset, I had to situate myself within the field. Because I am a nurse and had worked in Parkview as a volunteer previously, I had to explain my current role as researcher to participants. I explained that I was able to do similar tasks as a volunteer, but that I could not perform any nursing work as that was not my purpose of being on-site. Tasks I assisted with included delivering food or drinks to residents in the dining room as directed by staff, and retrieving items in the wards, such as clothing from the wardrobe or face towels, as directed by staff or residents. On three occasions, however, I was present when a resident had a fall. On one of those occasions, I was able to ensure that the resident was safe and then got a nurse as I did not know the resident’s medical and mobility history and did not want to put him at risk by moving him. On the other two occasions, staff were present and gave me directions on how to
assist them with supporting the residents back to bed. On one of these occasions, a
nursing aide wanted me to assess the resident rather than getting the nurse on duty;
however, I asked her to get a nurse so that she could do the assessment and document
the fall. Overall, I found that when I explained my role to participants they were
respectful of the limits to my activities in day-to-day routines.

At Parkview, I spent some time doing informal observations of the general milieu or
participating in group activities. I would sit in the common areas, such as the TV
room, the multi-use recreation room or the day lounge, so I would often sit among the
residents to pass the time. When the residents or visitors would inquire about what I
was doing, I would remind them about the study and explain. I also attended staff
meetings, family–staff meetings and resident–staff meetings, which gave me an
opportunity to observe their interactions and communication. I attended resident
activities such as the Chinese Opera singing group and the cooking class.

I also spent one-on-one time with staff, following them during their daily routines. I
did this mainly with nurses, nursing aides and activity staff. These sessions lasted
between one to three hours at a time. Throughout the session, I jotted down notes to
myself, which I later expanded into full field notes. I tried to have a flexible
observation schedule in order to avoid bias that may be introduced by restricting
myself to a limited portion of daily life in Parkview. So, for example, I conducted
observations on different days of the week and varied the time between day time and
early evening. I did not do observations during the evening and night shifts between 8
p.m. to 7 a.m., a time when residents are for the most part sleeping or staying in their
own rooms, and there are no visitors and only a small number of staff. Rather, I spent
time at Parkview most mornings or afternoons, my visits lasting on average 5–6 hours
when there were residents, family and staff interacting with each other in order to
capture the interaction pattern in this dynamic process.

In addition to these observations of daily routines, I also attended several formal
meetings to observe how individuals interact with each other in a more formal setting.
I attended meetings that were just between staff, such as staff meetings, committee
meetings, and resident–family–staff meetings. I also attended in-service or staff
education sessions, involving a guest speaker and staff, for example, on infection
control. Lastly, I attended care conferences, which are weekly meetings between the
director, staff, residents and family members where an individual resident’s plan of care is reviewed.

Observations were recorded by writing extensive, detailed field notes. Field notes provide a literal account of what happens during participant observation in the field (Bogdewic, 1999). In order to keep reflexivity central to the field work, I used subtitles in the field notes to delineate between the actual events and my reflections. I also wrote myself into the activities because I was often an active participant in what was happening. Writing field notes with this kind of texture, rather than using a neutral tone where the researcher is passive or absent, is reflective of the critical underpinnings of this study (Allen, 2004).

I wrote a field note for each observation. These field notes included data on where the observation took place, the participants’ physical appearance and my reflections on what had occurred. The field notes also provided a place to consider how the participant’s experience fit within some of the routines and policy that influenced their experiences. I used two steps to develop the field notes. The first step was to jot down key words and phrases to capture the essence of observation. I always had some paper and a pen in my pocket so that when there was a break in the action or I needed to take a break to capture something that seemed important, I could discreetly write down a few words. The second step was to expand these notes into detailed field notes with rich description. I was provided with a small desk in the reception office so I was able to write my complete fields notes immediately after each observation.

**In-depth interview**

Data were also collected through in-depth interviews with residents, family members and staff. Interviewing was the mode of inquiry with the researcher serving as the research instrument. Bertaux (1981) stated that since the subjects of inquiry in social sciences can talk and think, language is the appropriate tool. According to Seidman (1991), “at the heart of what it means to be human is the ability of people to symbolize their experience through language” (p. 4).

In grounded theory techniques (Glaser & Strauss, 1967), the interviews usually start with generalities and become more specific and focussed as basic social processes emerge through the use of the “constant comparison method”. The richness of the data
influenced the richness of the theory that was developed. According to Blumer (1978), in order to understand a group of people, the researcher must “lift the veils that obscure or hide what is going on” within the group. Semi-structured interviews that were adapted to the individual informants were conducted and focussed on answering the research questions. Interviews were conducted after at least one participant observation session and took place at a time of the key participants’ choosing in a private room away from the clinical area. Each interview was audiotaped with the participants’ permission.

The interview guide was constructed based on Charmaz’s (2003) method for developing questions for grounded theory research and the researcher’s preliminary work on observation. The interview questions were semi-structured around two broad topic areas, such as the description of an average day and what the caring and caregiving relationship looked like (Appendix 5). The first set of questions was intended to obtain data that would identify the social process associated with living in Parkview. The second set of questions was intended to yield information about the care triads. A total of 31 hours of in-depth interviews with 27 individuals representing residents, family members, staff and director were conducted. These in-depth interviews were characterised by an interpersonal dialogue between myself and the participants. As well, within the critical perspective that guided this study, interviews were characterised by their interactive nature, with myself and the participants often engaging in mutual self-disclosure (Lather, 1991). In describing these kinds of interviews, Heyl (2001) states:

… interviewing…in which researchers have established respectful, on-going relationships with their interviewees, including enough rapport for there to be a genuine exchange of views and enough time and openness in the interviews …(p. 369)

In this study, interviews were arranged at a time of the participants’ choosing. All interviews took place at Parkview. All of the staff interviews took place during a staff participant’s shift. These participants arranged coverage for their work so that the interviews largely went uninterrupted. Each interview started with some informal conversation about the participants, as a way of building rapport. Often I had already had several interactions with the participant before the interview began, so that it was more of a continuation of a conversation than an isolated event. This process of
building rapport is an important aspect of qualitative interviewing as it often leads to a richer dialogue between the participants and the researcher (Madison, 2005).

Interviews typically lasted an hour. Each interview was recorded and transcribed at a later time. Although I used an interview guide to provide some structure to the conversations, I generally asked the participant to tell me the story about their experience in the triad. This provided a springboard to explore further issues. Once the formal, recorded part of the interview was completed, there was often a period of “off the record” chatting that took place. Two residents who had been selected as participants perceived the study to be “too sensitive”, fearing that their loyalty to Parkview would be questioned. This was particularly noticeable with these two residents who often seemed to breathe a sigh of relief when the recorder was turned off and then told me “what they really thought”. This chatting after the interviews shed light on the participant’s interpretation of the interviewer and the interview process (Warren et al. 2003). These comments were recorded in my notes after each interview and were used to contextualise the interview during my interpretation of the data.

Interviews were tape recorded and transcribed verbatim. In order to keep the nuances of the conversation from tape to paper, ellipses (...) were included to indicate extended pauses, and expressions such as laughter were included in brackets. I checked each transcript by listening to the recording while reading the transcript, filling in any gaps where I was able to recall what was said. If I was not able to recall, then I would leave the gaps in place. This process of ensuring the accuracy of the transcripts contributes to the overall rigor of the research process (Tilley, 2003).

4.7.2 Keeping a personal diary

Becoming “theoretically sensitive” is also an important issue in conducting grounded theory research. Interpersonal preconceptions and values may result, at least initially, in a less than vigorous approach to data collection. Because the researcher is the research instrument, he or she must be aware of the personal factors that influence the data. Adler and Adler (1987) identified the following personal factors: identity, theoretical orientation, demographic characteristics and connectedness with the participants. This study was inspired by personal history. Ever since my grandmother had lived in a long-term care facility for ten years in the 1990s, I have been trying to
understand why living in an institution as a life event seems to devastate some older people and their family caregivers but was an enjoyable experience for others. This question has followed me over the years as I worked in general hospitals, community centres and nursing homes and, finally, my aunt moved into nursing homes. I worked with the residents as a co-researcher in investigating the residents’ nutritional status. I had the chance to talk to the residents, their family caregivers and the staff in a nursing home. One day, a staff member told a female resident that her daughter had brought her a meal with abalone. The resident was very excited as she was going to have something expensive for dinner. To her surprise, it was only noodles with a taste of abalone. I asked if the use of humour facilitated the building of the relationship and gained more interest in looking at what the triadic relationship among the residents was like, and how residents, family and staff interact with each other.

These accounts may influence the data collection and the relationship of the researcher to the participants, including the degree of secrecy involved and the participants’ ways of relating to me, as the researcher, in this study. I therefore kept a personal diary throughout the research process which served me as a good guide in writing this chapter on the research methods I followed.

As an outsider, the indexicality of these data can also only be seen as an approximation of the meanings and understanding of the real-life experience and the process involved in the care triad. Keeping a personal diary throughout the research process addressed these issues.

The reflexivity (Adler & Adler, 1987) of daily life influenced the indexical character of the situation and in turn reflected back onto my observations. This reflexiveness subtly constructed the situation through my interpretation. Using a personal diary was one way to increase my awareness of its reflexivity.

In the data collection process, I did not just concentrate on overt actions and statements in relation to the care triad, I also looked for implicit meanings and unstated assumptions. Then I asked myself how these assumptions and meanings relate to the conditions in which a category emerges. For example, a member of the resident-driven triad assumed that their personal autonomy was threatened. If their assumptions about a sense of personal self were affected, how did they react to these
situations? I developed a subcategory called “demand for conformity” when the residents in the resident-driven triad construed something as intruding on their privacy.

Allowing the data to speak was different. In keeping a personal diary, I was able to reflect and internalise the assumptions of the participants based on their accounts of the reality and my personal diary of these data. A diary was kept of every field visit regardless of its length, and it included sections of personal bias, responses to the field notes and transcripts, descriptive notes and reflective notes. As such, gaps, revisions of questions and the need for additional questions were identified.

**Recruiting theoretical samples**

As conceptual categories emerged, theoretical sampling was undertaken to elaborate and validate the emerging concepts. Staff were asked to refer other residents who manifested behaviours found in the emerging concepts. Also one more resident was identified through observation.

According to Chenitz and Swanson (1986), theoretical sampling is based on the need to collect data starting where the phenomenon is known to exist and continuing to collect data in order to examine categories and their relationships. In this study, theoretical redundancy of the emerging categories occurred at a point at which no new categories emerged in additional field visits and interviews. Saturation was reached after two more triads had been recruited, resulting in an eight-month period of field work that consisted of approximately 218 hours of participant observation, and with 321 interviews conducted.

**Review of relevant literature**

Following Charmaz’s social constructionist version of grounded theory, I actively shaped the research process and created the presentation of the data rather than discovering order within the data. This process consisted of discovering the ideas that I have about the data after interacting with it. For example, I did not intend to study self and the identity of the stakeholders, i.e., of residents, family and staff members of a given triad, nor did I have any particular interest in the topic of preserving identity, which appeared in the field notes and interviews around issues of conformity, attentiveness and resistance. The residents, family and staff attached great significance to these issues, which, in turn, caused me to look at them more
systematically and to raise new questions about them. I looked at my data first and then to the literature related to sociology concepts. I asked basic questions such as “What did the self mean to these people?”, “When were they concerned about it?” and “In what situation were they not concerned about the sense of self?”

I had conducted the literature review at the beginning of the study and read widely during the research process to make myself “theoretically sensitive” to the categories that emerged from the data. A review of selected literature was conducted in a constructive way throughout the research process. As such, the literature was also drawn on when doing the analysis (Goldkuhl & Cronholm, 2010).

Data management
Due to the scope and amount of data likely to be collected, I developed a systematic data management system to facilitate data analysis. Once data were in their final version, that is, field notes were completed, and transcripts had been checked, they were saved in files according to the type of data on a password protected computer. A file was also saved on a USB and a hard copy was printed and put in a locked filing cabinet in my office. Any materials containing identifiable information, such as consent forms, were stored in a separate, locked filing cabinet. The field notes and interview transcripts were entered into the qualitative software programme NVivo 8 for coding.

Data analysis
In grounded theory, analysis begins early. Data were coded as data collection continued. These are not discrete tasks in this qualitative design. Through coding, I started to define and categorise the data. As a result, data analysis began before data collection was completed and at the same time data collection was initiated. In addition, in the course of data collection, ideas about possible analysis began to occur. These ideas constituted the beginning of the analysis and became part of the field notes and research (Wright & Flemons, 2002). Therefore, analysis was interwoven throughout the course of the grounded theory coding, and codes were created as data were studied. I did not impose concepts on the data but interacted with the data and asked questions when coding them. For example, a demand for conformity was coded as a subcategory of the individual attributes in the resident-driven triad, leading to questions, such as: “Can a demand for conformity be applicable in all cases?” “Is it
affected by the resident’s personal trait?” “Is it true that residents can expect others to conform to their view all the time while living in a public place as a community?” “What happens if there is conflict?” Coding helped me to gain a new perspective on the data and on where further data collection should be focused.

The data analysis was guided by the theoretical perspective adopted in the study. Given the theoretical perspective that I was working within, guided by post-colonialism, post-colonial feminism, symbolic interactionism, intersectionalities and Foucauldian epistemology, I was critically examining themes such as ageing, power, control and identity, and analysing how they intersected with each other and with age, group, culture and class. This analysis, however, did not occur in isolation from the field. Once the data were in their final form, as described earlier, I began coding. The coding started immediately when data were ready, so that there was a back and forth between the data being collected and its coding. Through coding the data I gained insights into processes operating in the setting and this influenced the direction of the field work. For example, in the first few interviews, we discussed how the individual’s demand for conformity was reflecting his or her identity. This in turn influenced the questions that I asked in subsequent interviews, for example, how the individual’s identity was impacting upon the triadic relationships between residents, families and staff. This dynamic process continued throughout the simultaneous process of data collection and analysis to allow me to explore in depth into issues that were particularly important to the participants.

The review of relevant literature helped to inform the coding of interview data and field notes and I kept a personal diary about my interpretations of how different aspects of data influenced each other. Because data analysis was ongoing, I was also able to do ongoing member checking with participants, a process discussed in greater detail in Section 4.10 and 4.11. By taking my initial analysis back to participants, I was also able to ask questions about my interpretations of their experiences and they were able to reflect their insights back to me. When gaps in my understanding were identified, the staff helped me to identify participants who could provide more data or bring a particular perspective to the data. In this way, there was a dialectic between the theoretical perspective and the everyday realities of the participants.
By Charmaz’s process of data analysis (Charmaz, 1990), I also developed a codebook for the study. This allowed me to organise data that were similar. The coding categories included “demand for preserving self” and “demand to be involved” and covered a broad spectrum of issues that arose in the data. After I had coded a number of transcripts and field notes, I started to group common codes into themes. As Luborsky (1994) pointed out, “themes are emergent in the process of communication and of analyses and require a systematic approach that blends interpretation with explanation” (p. 207). These themes reflected areas such as “empowered citizenship” and “an emergent conscious alliance”, to name just two. These themes were grounded in both the empirical data and the literature. Relating the evolving concepts to other theories increases the possibilities for adequate generalisations (Charmaz, 1990; Goldkuhl & Cronholm, 2010).

4.8 Data interpretation

Data interpretation also occurred over the course of the study. After each field visit and interview, I wrote memos to myself. Often these memos helped to spark my thinking and encouraged me to look at the data in new ways. Memos were used to conceptualise how the codes were related to each other, and then integrated into categories of the theory. Often these memos related to issues that seemed to be “taken for granted” by participants and were issues that I could continue to examine during the course of data collection and analysis. For example, it was apparent that “orchestrating effort”, “ability to make decisions” and “sense of cohesiveness” described in the literature on relationship building existed in some of the triads.

During data analysis and interpretation, I cross-examined these categories and the implications for certain triads to form conscious alliances. This illustrates the potential for synergy in the social constructionist version of grounded theory between what is observed and heard (and coded), what is found in the literature, and the interactive and reflective process engaged in by the researcher, which is guided by the study’s theoretical framing. This dynamic process of data collection, analysis and interpretation occurred throughout the course of the study. The results of this process are reported in Chapter 6.
4.9 Qualitative rigor

Several scholars have articulated ways to ensure rigor, or scientific quality of qualitative research (Lincoln & Guba, 1985; Onwuegbuzie & Leech, 2007). As discussed above, a social constructionist version of grounded theory conducted within the theoretical perspective of this study reflects several elements, including voice, reciprocity, reflexivity and praxis, and to this list, I would add credibility and dependability (Lincoln & Guba, 1985). In addition, the criteria of fit, work, relevance and modifiability (Glaser, 1978) were used to evaluate the emergent theory.

4.10 Credibility

The techniques used to establish credibility included checking with my supervisor and the participants of the study. Member checking was the technique employed in this study whereby data, analytical categories, interpretations and/or conclusions were shared with the chief supervisor and participants in order to determine if their own realities had been adequately represented. After the completion of data collection and the first stage of the analysis, member checking was carried out by sharing emerging findings during informal interaction and through conversations with participants. Informal interactions during the course of data collection sometimes took place over lunch in the dining room with staff and the director, or in conversations with staff at the hallway as they went about their daily routines. With residents’ families, member checking was conducted during follow-up conversations when they were visiting the residents. With residents, member checking was carried out in informal conversation in the lounge or TV room. Member checking was also performed in a small group consisting of two residents and their families and one staff member.

The second technique used to establish credibility was peer debriefing (Lincoln & Guba, 1985). This involved exposing oneself and the research process to a “disinterested peer”. Peer debriefing allowed my personal bias and interpretations to be examined by others interested in this study. Peer debriefing was performed by three oral presentations at the annual postgraduate research conferences organised by the Faculty of Health Sciences of the University of Sydney and in one poster presentation at a nursing conference held in Suzhou, China. Verbatim transcripts of audiotaped interviews increased the credibility of the interview data. Regular contact
with my primary supervisor during the course of the study allowed me to gain
guidance, critique and mentoring to maintain the quality of the research findings and
its analysis.

In this study, I have used a number of ways (writing extensive field notes, in-depth
interviewing, further reviewing of the relevant literature) to gather multiple
viewpoints of the data. By having these multiple sources of data, I was able to
compare and contrast the different pieces of data when doing the analysis, hence
lending further credibility to the findings.

4.11 Dependability

Varied forms of data collection were used to assess the consistency or dependability
of the findings. This refers to whether “the findings would be consistent if the inquiry
was replicated with the same subject or in similar context” (Morse & Field, 1995, p.
144). Dependability expands the concept of consistency by factor instability by
including maximum variation in the selection of informants. Following Charmaz
(1990), the compare and contrast approach and emphasis on the process provide
strategies for making data dependable. I constructed a set of rich data by amassing
pertinent details.

Voice

Within the theoretical framework of this study, participants’ voices are the vehicles
for telling their experiences. In this study, voice relates to maintaining the integrity of
the experience of those participants, for example, the frailty of ageing, the
vulnerability of the elderly, relations of power and multiple intersections of
oppression. Therefore, the voices that were central to this study were those that have
been considered as “the subordinate”, “the silenced”, in particular, those residents that
appeared to be willing participants because they believed that the staff should be in
charge and will help them to meet their needs. In addition, other voices to be heard in
this study were those of residents who had been taking the lead in their own care.
They struggled with their desire to retain acknowledgement of their identity and
maintain their own independence. By relying on verbatim, unedited quotes in the
chapter 6, this study has the potential to become a source of resistance: “resistance
against silence, as resistance to not being engaged in care, as resistance to being
grouped or marginalisation” (Lincoln, 2002, p. 337). By employing direct quotations, I also hope to illustrate the linkages between data, interpretation and conclusion (Corden & Sainsbury, 2006).

**Reciprocity**

As described earlier in this chapter, reciprocity “implies give and take, a mutual negotiation of meaning and power” (Lather, 1991, p. 57). This aspect of the research was built into the relationships that were developed during the field work. Reciprocity was part of the member checking that took place to achieve credibility and will continue as I return to Parkview to share the findings of this study. During the course of data collection, reciprocity occurred as I talked with the participants about the data that I had already collected and was still in the process of collecting. They reflected back to me where they perceived gaps either in my interpretation of the data or in the data that was being collected. They said “you should really say …” and then they often directed to me what their actual meanings were. By sharing my emerging analysis with participants in the field, I was able to integrate their viewpoints into the analysis and interpretation of the data.

Over the course of the study it became apparent that reciprocity also occurred in the form of negotiation of power between the residents, families and staff, for example, when I performed member checking with a group of participants consisting of two residents and their family members and one staff. In one instance, a female resident had told a staff member, “No, if I were you I’d be going to speak up and negotiate…” They shared the information with me as if I were one of their members.

Over the course of the study, reciprocity was found between me and family members. They caught up with me on my way out of Parkview and walked with me to talk about new ideas they had related to the study. In this way, a small community was built around and between the study participants and also with me who provided ongoing insight into what I had discovered in the data and also in the literature.

**Reflexivity**

Reflexivity allows researchers to include their “own selves” in the research by making transparent their values and beliefs that might influence the research process (Etherington, 2007). As described in relation to the method of inquiry, a critical lens
of reflexivity brings a particular focus on the researchers’ own power and privilege, a position that can lead to tension with the participants in the research process. In this study I was challenged, therefore, to engage in the reflexive process, particularly around my social positioning and how it affected my position in the field and my interpretation of data.

As with the participants, I was located in this study at the intersection of roles. The nursing literature has discussed the insider/outsider binary. In essence, being an “outsider” means that the researcher has little knowledge of the setting prior to immersion in participant observation and, conversely, being an “insider” means the researcher already has some knowledge of the setting (Bonner & Tolhurst, 2002; Brayboy, 2000). In this study, this binary may be deceiving because I occupied multiple identities and social positions during the research process. I was known to some staff and had been working as a volunteer before beginning the fieldwork. I found myself being continually pulled to perform some of my other roles. For example, early on in the fieldwork, a nurse said to me “maybe you can give me some tips on what should be done”. It was difficult to respond to this in a way that would make her feel I was not the expert in that situation. As mentioned above, I was also asked to perform a nursing assessment by a nursing aide when I was present during a resident’s fall. Thus, negotiating my role and social positioning was another concern during this study. I recorded thoughts and issues related to the reflexive component in the field notes, memos and my personal diary and included these in the analysis. In addition, I also had ongoing discussions with my supervisor at the University of Sydney about the research process, issues arising in the fieldwork and themes arising from the analysis. Following Charmaz’s (1990) and Goldkuhl and Cronholm’s (2010) admonitions, these discussions were extremely important as they enabled me to step outside the field and avoid an isolated development of knowledge.

**Praxis**

As described above in this chapter, praxis is the ability to link knowledge and theory development to practice-relevant social, political and ethical actions aimed at improving health and health care conditions (McCormick & Roussy, 1997). In this study, praxis was closely linked to the notion of catalytic validity (Lather, 1991), which refers to the degree to which the research stimulates and promotes action as
part of the research process. In essence, praxis is linked with the knowledge generated in the study. To a certain extent, it is difficult to assess the extent to which this aspect occurs and how it occurs, but I attempted to address it in a number of ways. I communicated emerging findings to staff in some informal group gatherings, and encouraged dialogue about the potential implications of the findings for practice. In addition, a thick description of the findings can facilitate the data to be “transferable” to other contexts, such as the palliative care setting, or even to be used in the same context at some other time. Finally, while it is difficult to generalise to a larger population on the basis of a single study, this study lays the foundation for further research to address issues that have arisen in service delivery.

4.12 Ethical considerations

Ethical clearance was obtained from the Human Research Ethics Committee of the University of Sydney (Appendix 7). All participants received a letter informing them that they had the right to withdraw from the study at any time. Participants were informed that all information provided would be treated as strictly confidential and used only for the purposes of this study. Informants signed a Consent Form before data collection began. All the materials collected (including transcripts, field notes and audiotapes) will be retained under secure storage for a period of seven years following submission of the thesis. Paper files will then be shredded, tapes manually destroyed and computer files erased. A numerical code was assigned to each informant’s data, all names were removed from data files, and computer files were password protected and made only accessible to me. Participants and the participating facility are not identifiable in the thesis nor will they be in any publication or report resulting from the thesis. In addition, all the names of the participants used throughout the whole thesis are pseudonyms.

In addition, negotiating my role as a researcher was another ethical concern during the course of fieldwork. As discussed above, I found myself being continually pressured to perform some other roles at Parkview. I recorded thoughts and issues related to the reflexive component in field notes, memos and my personal diary, and included these in the analysis. Doing so also helped me to step outside the field.
Limitations of the study

This study was limited in a number of ways. First, the site was self-selected. Although there is some consistency among long-term residential care settings, they have each evolved separately and have developed, over time, a distinct culture of how the triadic relationship develops. Although the study findings are not generalisable in a quantitative sense, this study has implications on what the care triad is like in long-term care facilities that are similarly organised. Second, participants were self-selected. Again, this meant that certain perspectives were not captured in the interview data and participant observations. For some residents this was particularly significant, as some were unable to verbalise their views due to the disease process of dementia, stroke, etc. Further studies should have more inclusive participation to reflect the diversity of both participants and long-term care facilities, for example, residents in infirmaries and in palliative care settings, so that the diversity of care triads can be thoroughly analysed.

4.13 Summary

Due to the lack of current knowledge on what the triadic relationship in a long-term care facility is like, a social constructionist version of a grounded theory approach was used in the conduct of the study. Observations of daily life and personal accounts of interaction patterns between triad members were used to gain an in-depth understanding of the care triad as a dynamic interaction process of those involved in the triad. The methods described in this chapter demonstrate the relevance of the study design to the research aim of the study. Scientific rigor guided this study. The results of the analysis are presented in the following chapter.
Chapter Five

Description of Cases

This chapter describes the environment of Parkview. The physical environment is overviewed and the seven cases portrayed so as to set the context for the analysis of the care triad.

5.1 Overview of physical environment

Parkview is a not-for-profit facility, providing a “home” to 143 ambulant independent and frail aged residents. The facility is only a few years old, built after continuous efforts of a community-based social service organisation to better meet the long-term residential care needs of the elderly; to assist them in maintaining their general sense of wellbeing and quality of life; to uphold the elderly’s self respect; and to promote harmonious social relationships with families, staff and other residents while living in the facility. Parkview is located in a run-down residential area off a busy road with heavy traffic. On the blocks surrounding it are two other long-term care facilities, a hospital across the street, and a small park between the street and the main road that runs at the back of Parkview. Further down the street there are several private apartments.

Parkview is accommodated in a six-storey community services block built of limestone, with two care units each located on the first and second floors, an auditorium on the third floor, a physical therapy facility on the forth floor, and office and recreational spaces on the top floor. The ground floor provides access to the backyard, and there is an office on this level for the superintendent. There are also laundry and kitchen facilities and a few administrative offices located on the ground level, as well as an activity space for a recreational programme. The front yard resembles a small park, with benches and a walkway.

Inside the entrance of the care unit on the first floor is a small lobby with a small reception desk where during the time of my research a male resident often sat in his wheelchair and asked guests to sign in, having volunteered for this duty. A reception office is located down a long hallway adjacent to the entrance. During the time of my research the mission and vision statements of Parkview were displayed along the
walls of the hallways, along with snapshots of activities, artwork of the residents, and photographs of all the staff with their names engraved on a plaque. A monthly calendar of scheduled recreation activities was displayed on a bulletin board outside the reception area. On the back wall there was a decorative map made of colourful ceramic tiles depicting the Great Wall of China. Opposite the reception area was an entrance to the family room with a few chairs and a small sofa for families to have a quiet visit with their relatives or for other private conversations. Adjacent to the reception was a large television room with more seating, and larger windows on the outer wall. Residents frequently used this area for visiting family members.

Past the main lobby was a multi-use recreation room, with sliding partitions in one corner that sectioned off a temporary meeting room where tables could be moved into place to seat about 20 people for staff meetings or recreational activities. The far corner had two mah-jong tables while the rest of the room had folding tables and stacked-up chairs that were moved into place for different activities. Most of the time, the room was empty in the middle, with chairs and folding tables pushed together. On the wall nearest the entrance hung a colourful calendar of the month’s recreation schedule with several activities posted for each day. Along the same wall was a small open kitchen used for monthly cooking classes offered to the residents. Other cabinets lining that wall contained various craftwork made by the residents. Along the far end of the hallway was a small fish tank and two sofas.

A large dining area was located in the centre on this floor, with continuous, large windows overlooking the park. Opposite the nurses’ station was a large day lounge with television, which was often crowded with about 10 residents seated in chairs or wheelchairs facing the television. At one end of the L-shaped hallway there were one or two offices for social workers, the physiotherapist and the occupational therapist. Residents’ rooms and wards were some way down the hallway from the nurses’ station, with some located around the corner. The care unit selected as the principal site for this study consisted of two single rooms, four twin rooms and nine wards, each accommodating up to five people. The hallways of this care unit did not resemble the stereotypical image of a nursing home, with residents lining the hallways in geriatric chairs or wheelchairs, cries of suffering coming from the rooms, and an
overwhelming odour filling the air. In fact, the hallways of Parkview were clean, organised and fairly quiet. A sense of orderliness dominated the halls.

Parkview is operated by a non-governmental social service organisation, governed by the Department of Social Welfare. There is a set of minimum standards of quality of care and subsidised rates for its residents. The regulatory body conducts yearly inspections of all licensed local long-term care facilities in the area, producing reports on a range of quality measures for each facility. An investigation of the values and organisational culture of Parkview did not come within the scope of the current study; nonetheless, it is worth noting that these aspects, including its style of leadership and its approaches to care, reflect key elements that contribute to the emergence of different interaction patterns between the stakeholders of the care triads in this facility.

Parkview’s leadership emphasises both the residents and their family as clients and their physio-psychosocial needs. The Director, Lillian, highlighted the importance of her frontline staff, including nursing aides, experiencing work satisfaction. Joy and harmony and stakeholders’ solidarity are important to Parkview, contributing to its emphasis on all the stakeholders’ satisfaction with the services offered. This differs from a traditional institutional model focusing on medically-oriented care. Lillian stated that, “The goal of Parkview is to mitigate the negative effects of being institutionalised”. She added that among the priorities of care was responding to the psychological needs of residents and their families.

5.2 General description of cases

It would be impossible to fully understand the significance of the themes discussed and the emerging concept without some background information on the informants involved in this study. This part of the chapter provides a general overview of the seven cases examined. The residents, families and staff members are introduced through a triadic description of each individual case.

Each case is introduced to provide a greater understanding of the context underlying the informants’ experiences in the care triad. The strength of a case series approach is strongly dependent on the case examined. Therefore, providing an overview of each case will strengthen the thoroughness and creativity of the study in its search for patterns and relationships among the constituent elements of the care triad. A case
series approach focuses more on an aggregate analysis rather than on individual situations, with a particular focus on identifying patterns of similarity and differences within and across each care triad. In this way, a higher conceptual level of categories of the triadic relationship, grounded in data, will be developed.

**Case 1: Chan King**

**Case overview**: This case concerns an 83-year old woman, Chan King, who suffers from hypertension and the consequences of a minor stroke. She is a widow and has been living in Parkview for six years. Susan, her daughter, visits her mother 3–4 times a week. Helen is King’s primary nurse and a nursing aide, Bing, provides day-to-day care assistance, e.g., doing the laundry, etc. King, a quiet resident, projects a sense of self-esteem and belief in her competence by making a contribution to her own everyday activities. She disregards the routine and any reminders from staff. King views staff as intruders into her privacy, compromising her independence and control over aspects of her everyday life. She wishes to preserve her personal boundaries. Her daughter is identified as the primary family member, with her daughter-in-law assisting on a limited basis. Helen, the primary professional caregiver, is a registered nurse in her late forties.

King is a woman with a pear-shaped body. She has always been attentive to her personal appearance. She has strong likes and dislikes, particularly in matters pertaining to her personal life. For that matter, she maintains strong opinions about things that go on around her. Last Lunar New Year, when old, confused Wong Keung was costumed like the God of Wealth at the party, King complained to Lillian, the Superintendent, that it was not fair to make fun of poor Wong Keung like that. Lillian told King that Wong Keung was enjoying all that attention and no harm was done to him. King insisted that this act was disrespectful. Last Mother’s Day, King, with two other residents, Sum and Kam Chi, complained to Ling, the Associate Director, that they were not allowed to keep fresh flowers in their rooms. The flowers, though fresh, were thrown away by the cleaner. King did not accept the excuse that the water in the vase was a breeding ground for mosquitoes.

King did not like to follow Parkview’s routine, having always had a “personal routine”. She makes every effort to wear clothes and cosmetics that enhance her appearance. She tried to keep all her clothes in good condition. She preferred doing
her own laundry as she complained her clothes were damaged by drying in the tumble-dryer.

While not very talkative, King spoke up whenever she found her “privacy” being intruded on. Cool and unfriendly in demeanour, King was confined to her bedroom most of the time. Next to her bed was a locker filled with an artistic portrait she had done of each of her children when they were young. There were some Chinese hand-made knots hanging over King’s bed as decoration.

King had been a life-long housewife with some junior college education. She had two living adult children and two grandchildren. Her husband, a doctor, had died just shy of their 55th wedding anniversary. King focused her energies on the knotting artefacts and ran a Chinese knotting interest group for her neighbour when she lived at home. King is proud of her knotting skills. For example, she once gave Sum, her friend sitting at the same table for meals in Parkview, a Chinese knot as a Lunar New Year gift. She told Sum that a knot represents power and harmony. It brings the feeling of reunion and intimacy. She continued to say that the production of Chinese knots went through a process of “waving”, “pulling” and “correcting”. Each method is fixed but pulling, which requires special skills, decides its tightness, wing length and fluency and tidiness of ropes, thus showing her skills. In addition to the time and effort it takes to make knots, there is an underlying meaning of purity, nature and skilful hands which can not be replaced by a machine. She once joked that making knots might be a real thrill to Kam Chi, a fellow resident who suffered from Parkinson’s disease and who could not have done this due to her tremors. Having a strong sense of “self”, of her uniqueness, King insists on individualising her personal choices and characteristics. Continuity with the past, for example, by doing her own laundry on the wash board, contributes to her sense of integrity, preservation of identity and the wholeness of her life. She wants to ensure herself full autonomy over every tiny aspect over the course of her life.

King identifies her daughter, Susan, as her primary family member. Susan is married with a newborn, Rachel, and a school-age child, Anny. Susan is most involved in King’s day-to-day care, but due to Susan’s own family responsibilities, King also receives some assistance from her daughter-in-law, Yee. King is fairly close to her daughter. As noted by me, Susan is a filial daughter especially attentive to care
instructions and visits her frequently. Susan shows love, respect and complete obedience to King. She also takes the best possible care of her. Susan’s “no question” approach suggests her dedication to King’s care. As a primary family member Susan describes her biggest responsibility as being the mediator of the resident–staff relationship. There is some evidence showing that King is emotionally detached from the staff looking after her, seeing them as looking after her as a stranger would, not appreciating what they are doing for her. She views the staff as intruders into her privacy, breaking her independence and establishing control over aspects of her everyday life. Although Susan is assumed to be the mediating link between King and the professional caregivers, the resident–staff relationship has already been influenced by King’s desire to protect and preserve her own identity.

Helen, her primary professional caregiver, is acquiescent to and respectful of King’s wishes, choices and actions. Helen makes most of her judgments when dealing with King not only in light of moral issues but also in relation to her interpretations of King’s situation, acting as she feels King would like her to act. Unfortunately, Helen recognises that her relationship with King is not always seen as positive or welcome. Helen did note that the relational connection she has with King’s daughter, Susan, plays a significant role in maintaining and preserving the physical and emotional bond when caring for King.

The triadic relationship seen in King’s case has distinct elements that influence the pattern of interaction between its members. With King’s individual traits and beliefs, and her demand that her carers act in compliance with her wishes, she can not see or hear the other stakeholders in the triad, but only sees what she perceives to be judgements made by others. This innate quality leads to a series of mundane but pragmatic activities in which King is in control of the triad.

**Case 2: Kam Chi**

**Case overview:** This case concerns a 73-year old woman, Kam Chi, suffering from end-stage Parkinson’s. She has been living in Parkview for six years. Her primary symptoms include tremors, unsteady gait and constipation. The primary concerns expressed by her are being a financial burden and her social life being affected by Parkinson’s. She acknowledged some concerns regarding family relations with an emphasis on her husband, two living adult children, one of whom, Beth, lived with
Kam Chi before she moved into Parkview. Beth is identified as the primary family member, with her father Chong, Kam Chi’s husband, assisting on a limited basis due to his condition of early-stage Parkinson’s. Amy is Kam Chi’s primary nurse and Bing, the nursing aide, provides day-to-day care assistance.

Kam Chi, a 73-year old, small-frame woman, is visibly fighting her body. She suffers uncontrollable tremors. Kam Chi initially agreed to meet with the researcher despite expressing reservations regarding what she had to share. Ultimately she turned out to be one of the most insightful residents I met. At the onset of the disease, Kam Chi was very ashamed of her trembling hand, with people often looking curiously at her hand in restaurants. This hurt her self-esteem. She tried to hide her shaking hand, but this did not work as it is her dominant hand, being right-handed. Going out was a heavy burden to her. She even refused to go to a restaurant to celebrate her birthday. Upon receiving balance and muscle control training by Tsang, the physiotherapist, Kam Chi’s coordination, muscle tone and strength have improved. She regained her confidence, and so she went out for yum cha with other residents. Today, this genuinely humble yet energetic woman is honest about the physical challenges caused by Parkinson’s. Aware of her physical decline, she shares exceptional wit about her condition. For example, she once joked that it was so easy for her to prepare scrambled egg because due to her tremors she could mix 20 eggs in one minute. Extremely meticulous and preoccupied with social activities in Parkview, Kam Chi is actively engaged in planning her social activities inside and outside Parkview. She openly and repeatedly discusses with the staff how they can get her engaged in the social activities, in planning, organising and participating. Kam Chi wants to ensure herself a certain level of control that is often lost with institutionalisation. This seemed to be a distinctive theme after re-establishing her physical wellbeing during her residency, whether out of necessity or preference. She proudly notes, “I’ve always been one to handle my own affairs”. Though old, Kam Chi has a strong presence in her social group through her extensive involvement in Parkview and her church and other community organisations. Members of her church family seem to play a prominent role in her support network, visiting, going out for yum cha and shopping.

1 Quotations attributed to any of the stakeholders of Parkview (residents, family, staff) are italicised, both in-text and in block quotations, thus distinguishing them from quotations from literature.
The primary family member most active in Kam Chi’s care is identified as Beth, the oldest daughter. In fact, Beth and her family moved into her parents’ home to assist her mother and family before her mother entered Parkview. Beth has made adjustments to her work schedule to maintain her role as the primary family member at home. The care she provided was supplemented or substituted as needed by her father, but Beth remained predominantly responsible for primary care duties such as attending medical visits and communicating with health care professionals regarding Kam Chi’s condition at that time. The closeness of family members seems a part of the family culture. Although Beth was clearly the primary family member most involved in her mother’s care, her three younger brothers, sisters and in-laws regularly called, visited and participated in Kam Chi’s care. Kam Chi discusses her health status, her condition and needs, and her social involvements openly with her husband, Beth and her other children. The extended family as defined by Kam Chi also includes her church family. She values the support received from the Buddhist Master and other church members.

Beth, Kam Chi’s oldest daughter, discloses some knowledge regarding looking after others with chronic illness, having cared for her mother-in-law and her parents during their respective decline in health. Beth is extremely committed to caring for her mother. Having worked as a full-time accountant in the past, Beth’s sense of dedication began with information gathering and questioning of the Parkview staff about Kam Chi, particularly of Tsang, the physiotherapist. Beth was frequently present during Kam Chi’s physiotherapy training sessions. Beth asks questions, often if needed, and indicated that Tsang generally addresses both Kam Chi’s and Beth’s concerns and questions. Beth also kept a diary to document Kam Chi’s gait pattern, for example, of a swaying gait that tilts the body from side to side or an unsteady, uneven gait. This diary proved to be a useful communicative tool between Beth and Tsang. Tsang appreciated Beth’s work as the diary helped her to do gait analysis in identifying any posture-related and movement-related problems in Kam Chi. Beth did note that the relational connection she had with the mother’s professional caregiver plays a significant role in her ability to look after her father Chong at home, who has early-stage Parkinson’s, and to communicate with her siblings, who visit often, regarding Kam Chi’s condition and to keep them informed.
Amy Kam Chi’s primary nurse is fairly new to Parkview, having only been working here for approximately a year. A young nurse in her early thirties, Amy seems quite personable. As Amy once told the researcher, “due to time constraints, it is quite difficult to address every immediate concern from Kam Chi and her family, as we do have other residents here. Frustration sets in when I don’t have the time, which is often the case”. Nonetheless, based on the researcher’s observations, Amy insightfully dealt with Kam Chi’s and Beth’s concerns and sensitivities associated with her care. For instance, she asked Beth to record updates of Kam Chi’s condition and treatment, and questions relating to her care. She once asked Beth to write down her concern about the menu, then discussed it in the next resident–family–staff meeting. Amy associates with Kam Chi and her family whenever she is free so as to maintain the care relationship. She told Beth that the staff and the management would welcome any suggestions serving as a second opinion and a source for improvements. Their triadic care relationship is distinctly shaped and influenced by the strong involvement of the family.

Case 3: Yuk Fan

Case overview: This case concerns a 91-year old woman, Yuk Fan, suffering from the early stage of senile dementia. She has been living in Parkview for a year. Her primary symptoms include mild memory loss and painful fingers. The primary concerns expressed by her are being able to leave Parkview and spend most of her time with her children and grandchildren prior to dying. She also has concerns about the financial situations of her two daughters. She has one son, two daughters, eight grandchildren and two great-grandchildren. Yuk Fan has a domestic Filipino maid, Anna, who visits her every day during lunch and provides minimal day-to-day care assistance. Yuk Fan identifies her son Kwan and her daughter-in-law as her primary family members despite Kwan’s infrequent visits, noting that he is the only male heir. Nonetheless, Amy, Yuk Fan’s primary nurse, indicates that Anna, the maid, is actually the person who is taking care of Yuk Fan. There seem to be some issues, some tension, associated with Yuk Fan’s daughters. For example, one daughter is struggling with a husband’s serious and unexpected illness. The other daughter is having serious financial difficulties and, as Anna tells the cleaner working in Parkview, “she has always been the one in the family to be in the most need and I think she’s very inconsiderate of her mother’s condition”.

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Yuk Fan notes that Amy, her primary nurse, is an invaluable resource for the provision of care to her and that the services she provides are “wonderful”. Among all the staff involved in Yuk Fan’s care, Amy seems to be the one with the strongest ties with her. Yuk Fan always holds Amy’s hand when they are talking to each other. Amy possesses a good “bedside manner that Yuk Fan loves”. For instance, she often helps her to make phone calls, remembers which grandchild’s or great-grandchild’s birthday is approaching, which family member Yuk Fan wants to see, which Chinese opera is her favourite, and what happened during her last home leave.

Amy is quite aware of the important status of Kwan and the family tension influencing Yuk Fan’s care and her support network, and fully realises the dysfunction and stress caused by one of her daughters who often solicits money from Yuk Fan. Additionally, she notes the limited interaction between the staff, Kwan and his other family members, for example, his wife and two sisters.

Kwan, Yuk Fan’s only son, who is in his late fifties, and the researcher met a few times during the observation period. As mentioned above, his visits were not enjoyable and the lack of mutual satisfaction in some instances was actually upsetting. During one visit Kwan told Yuk Fan that he did not know what to say or talk about during a visit. He became more upset when the nursing home staff phoned him to report Yuk Fan’s problem behaviour. For instance, Yuk Fan once got up at three o’clock in the morning, broke into the room next door and searched another resident’s bed-side locker for her granddaughter’s baby photo.

One day Kwan was called with a report about Yuk Fan’s behaviour that caused him some unease. The nursing aide heard screaming and shouting emanating from the day room. The researcher and the nursing aide rushed in to see what the trouble was and saw Yuk Fan was sitting in an armchair just next to the television and quarrelling with Fong. Fong, a heavy-set woman, considers herself to be the leader of the residents. Fong always sits in this armchair in the dayroom. Other residents usually leave the armchair for her and they also let Fong decide what television channel to watch. Fong was protesting loudly and making menacing gestures at Yuk Fan. Yuk Fan ignored Fong, stating that this chair did not belong to her only, that “it belongs to all of us”. The aide made peace as best she could, explaining to Yuk Fan that Fong usually sat in
the big armchair and pleading with Fong to make allowances for Yuk Fan. Yuk Fan further questioned Fong’s behaviour by asking “who owns this place?”

Yuk Fan does not like living at Parkview. She did not want to be there, and she keeps reminding Kwan on every visit that he had said, it would be only “temporary”. Her adjustment has not proceeded very well from the staff’s point of view. Yuk Fan telephones Kwan and each of her eight grandchildren at least once daily to discuss how things have gone that day, to give Kwan a list of things to bring on his next visit, and to continue expressing her eagerness to get out of Parkview. She makes these calls from the public phone near the entrance of the television room. She may need help from the nurses or the cleaners to dial the numbers, because she sometimes forgets their telephone numbers and her fingers are painful. Kwan went to see Lillian, the Director, requesting that staff not help his mother make the calls. Her family think their mother and grandmother is too bored and her calls are almost the same, a nuisance. These calls upset some of their routines during the day. The calls are also somewhat upsetting to two great-grandchildren. One 5-year old girl has started having bad dreams about her great-grandmother being locked away.

Lillian met with Amy about Kwan’s concerns and said they are caught in a dilemma. They are not sure if they are being unethical if they were to “cut off” Yuk Fan’s communication with Kwan and her grandchildren. Meanwhile, Lillian suggests it is the business of Yuk Fan’s family to deal with the issue and she recommended that her son list their phone numbers on a piece of paper and fix it above Yuk Fan’s bedside cabinet or just ask Anna to help her make the calls during her visit.

The triadic relationship seen in Yuk Fan’s case has distinct elements of one-sidedness that influences the pattern of interaction in some situations. Primarily focussed on her own interest, Yuk Fan was manipulative in the resident-driven triad.

**Case 4: Wai Woon**

**Case overview**: This case concerns a 68-year old woman, Wai Woon, suffering from lung cancer. She has been living in Parkview for eight months. Her primary symptoms include mild dyspnoea and fatigue. The primary concerns expressed by her relate to the uncertain duration of a recently identified “remission” or unstable state of illness progression. She expressed a reluctance to burden her son and the family with
Wai Woon is married and has three adult children and four grandchildren. Recently the birth of another grandchild occurred. Her second son, Shun, is the primary family member involved in her care, with her daughter Barbara assisting when needed. Helen is identified as her primary professional caregiver. Her support network includes immediate family and former neighbourhood friends.

Wai Woon is a busy mother of three adult children. After retiring as an elementary school aide, Wai Woon helped her second son Shun to look after his two children at home. Barbara, the eldest granddaughter, aged 19, is a first year university nursing student, and May, aged 10, is attending primary school. Wai Woon’s symptoms began with just a minor cough. Being a lifelong smoker, she really was not too concerned about the cough. After about four weeks the cough was accompanied by an unusual discomfort and difficulty with breathing. She reports a conversation with an ex-neighbourhood friend during her visit:

“I never really felt sick, it was just that the darn cough got so bad. At first, it didn’t bother me, you know being a smoker you always cough a little bit, but I talked with Shun (her son) and Barbara (her granddaughter) and they thought I should go in. So I went to see the doctor. (Wai Woon)”

Wai Woon’s visit to the doctor resulted in a diagnosis of terminal lung cancer. For an old lady who can only rarely remember being sick, the diagnosis was extremely shocking. The thought of “being sick” and having to rely on others is identified as a part of the devastation of her terminal prognosis. Despite the difficulty and with the support of her beloved granddaughter Barbara, Wai Woon has felt a strong need to identify herself as “fighter”. Wai Woon has had targeted therapy as she had no other treatment choices, neither surgery nor chemotherapy. She moved into Parkview following an inexplicable remission in the progression of her condition. Wai Woon expressed a reluctance to burden Shun and his family any more. She wishes to be independent and be able to make decisions as she is still cognitively and physically competent. She tried to avoid interfering with the family’s life whenever possible.

Wai Woon attributes her remission to her prayers to Guanyin, the Goddess of Mercy, and the support received from Barbara. Although not a member of the congregation of any particular Guanyin Temple, and not having taken part in formal religious
activities since moving into Parkview, she still adamantly makes prayer a part of her care regimen. Wai Woon refers to herself as a quiet lady and says, “I don’t like to make trouble”.

Helen is her primary professional caregiver. Assisted by Au, the social worker, Wai Woon takes part in many activities organised in Parkview. Barbara, with Helen’s and Au’s support, encouraged Woon to try and help make the activities of Parkview a success, seeing that she was living there.

Wai Woon started to become “active” during last May’s Tuen Ng Festival. Woon told her ex-neighbour during a visit that,

> Participating in an activity can create a sense of control that will be lost with institutionalisation. This may be one of the reasons why Barbara would like me to find an “interest”, to be engaged socially, and to make friends. (Wai Woon)

When Au asked Wai Woon to invite her son to be the musician, to play the Chinese violin, at the Tuen Ng Festival, there was a sense in which she became a co-hostess of the activities, something that increased Wai Woon’s sense of personal responsibility. However, Shun refused, saying,

> I don’t understand why the staff are always assigning my mum to do this or that. I refused to help out with the Tuen Ng Festival celebrations. I don’t think it is quite fair. The staff are paid to serve the residents and to do these kinds of things, and with the “high fees” charged here, residents should not have to do any work. I think all residents, including my mum, should get what we pay for. (Shun)

Woon also helps out in the co-operative grocer’s twice a week. This co-operative grocer, called “Old Friend Shop”, receives products such as boxed dry goods, including snacks, desserts, drinks and some personal hygiene products, donated by not-for-profit agencies. The Old Friend Shop operates a food stamp programme where residents and their families can deposit a small amount of money monthly into their own account with the programme. If a resident wants to purchase a can of milk, say, a
volunteer with the co-operative grocer’s will stamp the resident’s card, which means that the volunteers do not need to deal with money.

With Barbara’s encouragement, Wai Woon serves as a go-between for staff and family in the care triad. Barbara serves as an advocate of greater family involvement, encouraging her father to become engaged in the Parkview activities. A spirit of joint responsibility has Helen, Wai Woon and Barbara trying to get Shun to change his ideas about Parkview, specifically that residency in Parkview ought to mean that “residents have no duty to help out as ‘high fees’ are being charged”. A change has been observed in this triad, with its members, for example, now expecting residents and their family to adopt new attitudes and behaviours, and abandoning ideas reflecting traditional hierarchical structures. As if singing in a chorus, Helen echoed these new views by saying,

Yes, it is not a good sign if the family is becoming almost like strangers. Doing things together is good for building enthusiasm and momentum for the family having time together. (Helen)

The triadic relationship comprising Wai Woon, Barbara and Helen has been developing and becoming fairly strong. Helen recognises and accepts the important role of the family as Wai Woon’s advocate. As a result, this triad exhibits a sense of cohesiveness.

Case 5: Po Chun

Case overview: This case concerns Po Chun, a 70-year old widow with one daughter, Man. Po Chun has lived at Parkview for almost six years. She had a left mastectomy three years ago and she has tremors in her right hand. Immediately after the surgery, Po Chun’s self-image was hurt. Similar to Chan King, Po Chun has always been attentive to her personal appearance. She has strong likes and dislikes, particularly in matters pertaining to her appearance. Immediately after the surgery, Po Chun’s self-image was damaged. She did not really want to look in the mirror. Helen, her primary nurse, and Man, her daughter, co-operated to teach her how to work at getting back a positive view of herself. Now Po Chun can openly share her experience of how to make herself presentable with another resident who has just had this surgery. Man, Po Chun’s only daughter, is identified as the primary family caregiver.
Similar to Chan King, Po Chun also has her own “routine”. She prides herself on her attractiveness and has lots of fancy lingerie and nightwear. She indulges herself. Every morning, Po Chun will spend more than half an hour getting dressed. She told the resident having the same surgery that she studies herself in a mirror for 15 minutes and chooses three things that she really likes about herself every morning. She also said that having a good prosthesis is much better than have a reconstructed breast. It has the bounce, the weight and the resilience of a natural breast. She also showed her a list of shops where this old lady can get an excellent variety of prostheses fitted into underwear and swimsuits. Formerly a business woman, Po Chun is quite demanding regarding what she expects of her care, according to her own description of her preferences to the nursing aide in Parkview.

Widowed less than two years, Po Chun and her husband had owned a small toy manufacturing factory in Shenzhen, China. Her husband died of chronic obstructive airway diseases while living in another local nursing home, and Po Chun viewed his experience as a negative and difficult time, as she told Helen during one conversation. According to Po Chun, he was not well cared for and they had to make economies in their lives to get him the care he needed. In contrast to her husband’s nursing home experience, Po Chun views her experience in a completely different light. She considers herself lucky to receive such good care, but worries about the financial strain. She jokes that she may, potentially, spend all of her money and leave nothing behind for her daughter and grandchildren. Unlike King, who keeps to herself, Po Chun is actively involved in and attends most of the activities and functions organised in this small community. She also invites her daughter to join these functions, for example, Man was responsible for wrapping the Chinese dumplings for the Tuen Ng Festival.

Man is extremely active in Po Chun’s care despite her other family and work responsibilities. She visits Po Chun regularly, contacts the doctor and Helen, the nurse supervising her mother’s care, for information and updates. She often takes Po Chun to yum cha on weekends and spends most weekends at Parkview with her mother after lunch. Sometimes, they spend the afternoon together, saying nothing to each other and watching television. Both Po Chun and Man have experienced individual and collective losses that seem to have increased their closeness and interdependence.
For example, Man copes with her divorce while also mourning the death of her father. These losses have prompted Man and Po Chun to appreciate and support each other tremendously.

Man is not only a primary caregiver to her mother, but she also cares for her son as a single parent. Man’s numerous caregiving responsibilities are apparently stressful and difficult according to Po Chun. But Man feels that she is able to manage without much difficulty and finds every visit enjoyable and rewarding. Man sometimes worries about her mother “living in the past”. Po Chun loves playing mah-jong and Man is concerned that Po Chun’s life in Parkview is boring. Man bought her a gameboy that she can play on her own. However, Po Chun does not like playing against her computer opponents on the screen, preferring to play with her usual friends.

Helen, the primary nurse, and some other staff in Parkview also remind Man that the quality of her visit to Po Chun generally has little to do with how often she comes and how long she stays. Visits can be too long and too short. As I have personally observed, Man understands the value of her deliberately incorporating elements of Po Chan’s past life into her present one. For example, she takes her mother to the restaurant where the family often went when Man was small to enjoy its signature dish of Swiss chicken wings. Man appreciated Helen’s actions as they created quality visits. For example, Man likes to massage Po Chun’s shoulder while she plays mah-jong but Mr Cheung, another registered nurse, said to her, “Po Chun, I think you are the loser as it is poor etiquette to touch the shoulders of someone during the mah-jong game as this is said to bring you bad luck”. Po Chun replied, “Bullshit, it does the opposite for me. It brings me good luck”.

The staff are usually perceived as having the knowledge and power to get things done. However, the conversations of the members of this triad are not characterised by authority and guardedness but by a sense of mutuality and cohesiveness, shown, for example, by teasing each other for fun. Their relationship appears to be co-operative and harmonious in nature. The triadic care relationship in this case is distinctly shaped by the strong presence of family, and the communicative complexity of the triadic care relationship is regulated by active involvement, compromise and negotiation of all stakeholders.
Case 6: Uncle Kwai

Case overview: This case concerns Uncle Kwai, who at 67 is younger than most residents. He has been at Parkview for a year. He has been diagnosed with diabetes mellitus. A community social worker referred him, saying Kwai was incapable of living on his own. Kwai divorced his wife when his two children were babies, and during his career as a mariner they almost never heard from Kwai. His adult children did not visit him often, though they have a little interest in his welfare. Kwai likes to talk about his great history as a mariner, and he is not demanding. “He keeps pretty much his own company” is the way Mr Cheung, his primary nurse, describes Kwai. Kwai is a favourite with all the nurses and aides because he is always willing to lend a hand or ear to fellow residents with problems.

Kwai notes that Mr Cheung is an invaluable resource in his care and the services he provides are “wonderful”. Mr Cheung is a handsome, personable man with a quick wit, a health care professional who seems to respect the quality of his relationships with the residents. Ever since his admission, Kwai has liked to take a daily walk for yum cha. Over the years, Kwai has become generally more frail. He walks extremely slowly. Lately, his eyesight has begun to fail, too. He has major problems with his peripheral and depth vision. Watching him from the nursing home widow, Mr Cheung has noticed that Kwai sometimes has trouble at the traffic lights in front of Parkview. Either he starts out when they are red, or they turn red before he gets across. Mr Cheung has begun to worry about Kwai’s safety when going out on his own. Parkview can not spare any personnel to escort him to the restaurant and he wonders if an order is needed to restrict his ability to leave Parkview on his own. Yet Mr Cheung hates to deprive him of the daily excursions that give Kwai so much pleasure.

Mr Cheung is unhappy with Kwai’s youngest son, William, as primary family caregiver. As Kwai did not want to have to cope with managing his financial affairs, he indicated that he preferred to have his youngest son handle his money. A difficult part of Mr Cheung’s job is having to ask Kwai’s son to release more funds, as Mr Cheung has to plead with him before he will spend a cent of his father’s money on things that will give him pleasure, for example, attending Chinese opera or even getting the new glasses that he needs. William also refuses to pay for physical therapy for his father because, he says, “The nursing home is getting $7800 a month; it should
provide physical therapy”. But William’s attitude makes Mr Cheung think he is more worried about conserving the money than about his father’s wellbeing. Mr Cheung always finds himself helpless in these situations, particularly when William makes a decision that may not be in his father’s best interest. Unlike in Wai Woon’s case where Barbara, Woon’s granddaughter, serves as go-between in the staff–family relationship in caring for Woon, there is no one functioning as go-between and as someone advocating the development of a functional staff–family relationship.

Lillian, the Superintendent, Mr Cheung, the nurse, and Au, the social worker, are becoming concerned that Parkview will be held liable if Kwai should be hit by a car and therefore want to keep him safe. Mr Cheung initiated a meeting with William to discuss the matter and explore other alternatives. After listening to Mr Cheung, William appeared impatient and said,

*Then what? Your responsibilities include providing services that might be required for the health, safety and wellbeing of my dad; you have an obligation to keep him safe. If you think there is a danger to him, then you should not let him leave Parkview on his own. It is so simple and logical.* (William)

Then William turned to Kwai and said,

*As long as you are living here, you are bound to follow a set of rules and customs. There are meals provided here, why do you want to go out every day for yum cha?* (William)

Mr Cheung disagreed with William, saying that,

*Entering a nursing home may strip your dad of his personal autonomy, but he is entitled to maximum self-determination and dignity as far as this is possible. Confining him to Parkview is only an extreme option.* (Mr Cheung)

Mr Cheung showed his goodwill by inviting William to take part in the discussion and incorporating family care as one of his goals in caring for Kwai. He insisted that it was his responsibility to clearly and convincingly communicate to William that “being there” for residents was crucial. Mr Cheung further emphasised that it was equally vital for William to recognise his advocacy role. Parkview expects William to
have concerns about his father. In fact, Parkview wants him to actively participate in Kwai’s care and act on Kwai’s behalf, voicing his concerns and working with Parkview to have any deficiency or mistreatment addressed and corrected.

Contact with family contributes to the overall wellbeing of the residents, reinforces their sense of self and helps them retain an individual identity. Establishing a care relationship is premised on the need for all involved to understand each other, with a potential coalition of resident, staff and family being involved in a negotiation of care. The staff highlighted the importance of involving the family in caring for Kwai in this care triad.

**Case 7: Sum and her husband (Ming)**

**Case overview:** This case involves Sum and her husband Lee Ming, who have been married for 50 years. Lee Ming was admitted to Parkview with paraplegia of his left side. Sum is herself not very well. She visits her husband every day. Given her multiple ailments, the difficulty she has in maintaining her household, and her desire to be near her husband, she began considering entering Parkview as a minimal-care resident two years ago. Her plan was accelerated when she broke her hip a few months later. After having a hip replacement, she was admitted to Parkview. She is now walking with the assistance of a walking frame.

Sum, a 73-year old, small-framed woman, speaks with great passion about her choice and privilege to be involved in her husband’s care. She expresses the difficulty of separating from her husband, and also understands the importance of her valuing the time and opportunity to show her love by caring for him. Sum and Ming were married while in their twenties and Sum clearly has a very strong bond and affection for her husband. She works to nurture him, while he worked to nurture, comfort and care for her when they were young. Their relationship reflects a sense of reciprocity associated with intimacy.

Before breaking her hip and admitting herself to Parkview, Sum was identified as Ming’s primary family member. Sum is most actively involved in his day-to-day care and care decisions. Their grandson, Alex, a Canadian migrant, had returned for a holiday for a week when the study was being conducted at Parkview. He visited his grandparents daily during that week. This additional care seemed invaluable to Sum.
and she expressed her appreciation for Alex’s efforts. Sum notes that women care in a different way from young men. There are times when she humorously notes that “with a woman you don’t always have to say what you need, we would just know. Alex is learning, but... both Ming and I need a woman to care for us.”

There were no rooms suitable for couples immediately available. Sum maintained her usual pattern of visiting Ming in his room for most of the day. They spent the time talking together and simply being in each other’s presence. Sometimes, they held hands while Ming was sitting in his wheelchair for the whole afternoon and in the evenings Sum would hold Ming’s hands watching television.

Lately, Mr Lee, the primary nurse for Ming, is worried about the changes in his condition. Ming got a little confused and wet the bed every night. Mr Lee decided to put him on adult sanitary napkins. Ming had his napkin round every four hours. It also became safer to restrain Ming in a geriatric chair in the morning. Mr Lee’s reason was that, “The nursing aides can’t be watching him 24 hours a day, we can’t rely on you (Sum, his wife) to keep an eye on Lee Ming”. Ming is usually restrained at night. He wears mitts so that he will not scratch himself, and he is tied into the bed. Sum is upset at the thought of Lee Ming but agreed to go along with Parkview’s decision. She feels it is wrong but does not know what choices she may have. She thinks may be Parkview knows best. Alex accompanied his grandmother to see Mr Lee and explore other, less restrictive alternatives. In the end, Parkview made several environmental changes, for instance, it lowered Ming’s bed, installed a nightlight and placed a commode by the bed. A call bell was provided in case Ming and Sum needed prompt attention, having to use the bathroom, or getting in and out of bed unattended. However, a physical restraint may be imposed if Parkview is understaffed on a particular day.

The staff regarded Ming’s health to be “going downhill”. They now frequently made decisions for him, which set the stage for staff taking the lead in imposing controls. Instead of being a person to care for, Ming was treated as a body that needed physical maintenance, with him becoming a means to the end of staff performing their professional duties and providing caregiving routines, thus illustrating a staff-driven triad.
Chapter Six
Examining the Pivotal Attributes in the Care Triad

Detailed descriptions of the seven care triads were presented in Chapter Five to provide the necessary background for Chapters Six and Seven. The primary purpose of this chapter is to describe the pivotal attributes of the triad members as part of an overall “construct” of the care triad which permeated all levels of analysis. However, the construct does not adequately capture the features of the triadic relationship at every level of analysis. To this end, the pivotal attributes are considered “features” of the stakeholders that imply the characteristics / dynamics / motivations of the three stakeholders in the care triad, i.e., the resident, the family and the staff, that shape the triadic relationship.

Throughout the data analysis process, three pivotal attributes, namely, individual, communal and external forces, were identified. The term “attributes” refers to the driving forces of each stakeholder that steer the triadic relationship. These attributes are concerned with what influence the stakeholders have, with what they do and with what they say, that is, an attribute which causes a stakeholder to engage in certain behaviour in certain situations. The attributes shape, to some extent, a variety of related issues at both the individual and the communal level in different situations involving the triads. In addition, some external and internal factors are largely or partly beyond the direct, personal control of the stakeholders in the institutional environment.

While a discussion of each attribute is presented and illustrated with anecdotal evidence in this chapter, a more in-depth discussion of each theme used to explicate the relationship pattern of the care triad is provided in Chapter Seven.

Different individuals have different mundane activities to carry out in their everyday lives, and they have vastly different things to say about a given topic. One’s values, beliefs and perceptions are implicated in how one behaves and in what one says. This point occurred to me as researcher while observing, recording and coding many hours of field work and interviews throughout this study. Intuitively I felt that the differences between the individual events and interviews I was observing seemed connected with all-pervasive underlying forces that shaped the triadic relationship.
For example, by focusing on the stakeholders’ individual traits and behaviours, I uncovered their distinct personalities with their individual attributes, and began to understand the personal demands they made and how these shaped the triadic relationship. Conversely, communal attributes such as a sense of cohesiveness led to the stakeholders orchestrating group efforts and negotiating a triadic identity, with an emphasis on compromise, negotiation, shared power and cooperation. In addition to individual and communal attributes, I noticed there was a tendency for external forces, for example, situational reality and institutional influence that are beyond the direct personal control of the stakeholders, to emerge in the context of the institutional environment impinging on the care triad. It was theoretically impossible to focus exclusively on the account of a single stakeholder in the triad because there was a natural mixture of feelings, attitudes, behaviours and values of the different stakeholders revealed in the field notes and interviews in different situations. One would expect that this entanglement probably is the essence of the dynamic triadic relationship, involving every single stakeholder in the care triad.

### 6.1 Individual attributes

Individualism is a term commonly used in social psychology and family research to capture the relative degree to which an individual’s attitudes, beliefs and behaviour reflect independence or interdependence, separation or attachment, and individual autonomy or group solidarity (Harding, 1981). Reviews of some related studies by Clyne (1994), Gudykunst and Matsumoto (1996) and Scollon and Scollon (1995) have painted a picture of individualism which emphasises the self over the group and personal independence over social interdependence. Individualists share important traits of self-expression and self-reliance, speaking one’s mind freely, emphasising individual interests and personal goals. The prominent individual sub-themes identified at the level of the resident are related to demands for conformity and reactance, cries for attention and a recognition of their identity, while the individual attributes of the residents’ families are related to demands for being involved and parenting-style caring. The sub-themes related to individual staff are task-oriented care, perceived frailty of ageing and making surrogate decisions.
6.1.1 Demand for conformity

A recurring feature of individual attributes at the level of resident was that there was no room for difference. Residents like Chan King did not accept any deviation from her personal care habits, not even a suggestion from her daughter or the staff, for example, regarding her diet or how her laundry was to be done, for she construed any changes to be at odds with her will and as intrusions on her privacy. She rejected their ways of doing things for her.

*I have to fit into my role exactly how mum would like me to. I should agree with all her thoughts and I should be more like her. She always affirms, “I am mum, not you”.* (Susan, King’s daughter)

*It is sometimes difficult because you know residents don’t live exactly the same way as they usually did before moving into the facility.... Whenever we, especially those nursing aides, do something which is different from what she expected or that is against her will, she goes directly her own way – no point for discussion; that’s when we get into strife. It’s still true – she thinks that we are not grateful at all.* (Helen, the nurse)

Consequently, the residents who expected conformity to their needs and desires were reluctant to talk about their likes and dislikes. In order to avoid direct confrontation, these residents tried to stay away from the others and mask the difference. For example, rather than being considered uncooperative, King usually gives those “intruders” a wide berth and stays aloof from them.

*She always stays in her own room. She doesn’t come to the public places such as the television room or the lounge much. She doesn’t like our garden. “It’s not a proper garden.” You see, we usually get a broom and sweep all the leaves up and shovel all the leaves back there on top. When King comes to the garden, she moves all those leaves back – she likes it to look natural (a native garden).... The professional gardener said that summer is never the best time to move or transplant garden plants. The sun is too intense. But King did the opposite; she liked to water the plants and then dig them in at night when others were sleeping. She left all the soil on the ground so as to let them have some sunshine in the morning.* (Bing, the cleaner)
Kam Chi does not like the way the lounge area is painted – the stains on the window frames. She told our professional painters, “you shouldn’t have that colour on the window frames. It is too shiny.” Some of the nursing aides find them demanding. They hate it when they make any criticisms. You know King would look to see if there was any dust. She wrote her name on the dust – that’s what creates the tension. (Helen, the nurse)

The same thing happened with conversation. Residents who expected conformity did not like to open up or get connected. King always presented as cool and unfriendly in demeanour. Staff and families were reluctant to discuss their care with the residents as it was considered “too risky”. Sometimes they were made to feel negative and disheartened by criticism and unwanted advice from the residents which, if rejected, made things more difficult.

In King’s eyes, everything we ever did was not good. We don’t talk about anything with her because she always criticises. It’s always, “I wouldn’t do it in this way if I were you”. (Bing, the cleaner)

I don’t even bother to join them. I don’t open myself up. I have my own kingdom here. (King)

Some families used one of the three strategies for coping with residents going their own way. Some families and staff adopted a “no question approach”; they showed complete obedience to the residents and acted in accordance with their wishes and demands. Susan mentioned she was willing to do whatever King told her. These families were clearly dedicated to giving them the best possible care.

Some family and staff managed the “deviance” of residents by trying to get them to realise that they simply had to follow rules, to change and to do the right thing. They did this through criticism.

When King left all the soil on the ground overnight, I told her that she is not living at home now. It is our duty to keep the floor clean, both for safety and for sanitary reasons. Whenever there is water, mud, not to mention the occasional spills and scuffs on the floor, it is dangerous. One resident was recently knocked
out when he slipped on the dirty floor plates. When the floors are dirty, the room feels and looks dirty. I told King that her action was not acceptable and was hazardous to other residents, I have to let her know that she was wrong. (Lillian, the Director)

A third approach was to minimise the residents’ awareness of differences between their desires and preferences and what was possible at Parkview to minimise any frustration they might experience. Both family and staff limited their conversations to what they saw as trivialities, changed the subject or diverted the resident’s attention.

When there was tension or uneasiness, King shifted the attention and changed the topic of discussion. She did not want to talk about herself. She talked about the weather, her grandchildren, etc. Helen left King alone whenever there was “something” straining the relationship.

Demands for conformity often tainted the triadic relationship for residents, who were often held responsible for driving the relationship. The residents expected both family and staff to agree with their opinions and conform to their ways of doing things; deviation from residents’ established ways led to them becoming uncooperative and isolated.

6.1.2 Demand for attentiveness
Residents who did not stress conformity demanded attention, and often they sought both. They were seen as self-centred and demanding, and expected a great deal of attention from the family.

She wants some sort of devotion to her – for me to take the responsibility for meeting her needs, maintaining filial piety and family relations. (Kwan, Yuk Fan’s son)

However, some family members thought differently as they generally did not enjoy contact with the resident and might visit and then leave. I wrote in my field notes:

Visiting was not enjoyable to Kwan and in fact there was a mutual lack of satisfaction, and in some instances, visiting was actually upsetting. Kwan once said to Yuk Fan during a visit that he didn’t know what to say or talk about during a visit. He became
more upset when the nursing home staff phoned him with a report of Yuk Fan’s problematic behaviour. Kwan usually dropped in very late at night so that he had to leave as soon as Yuk Fan had to go to bed. (field note)

She (mother-in-law) won’t eat this and she won’t eat that…. She’s trying to reassert control. I must do as she wants. It’s quite traumatic. She likes to be the centre of everything and if we come into her room and the grandchildren don’t rush up and greet her, then she is insulted… she is not keen to organise things but wants us to run after her and listen to her complaints about how she is feeling… (Yee, King’s daughter in law)

Some residents’ one-sided demand for attention was most evident in the conversations with their families. Talk centred on their life and interests, intensifying the family’s feeling of being neglected in the relationship.

She monopolises the conversation... It will always turn to what she has done, how she did, what she thinks. It’s about herself. (Kwan, Yuk Fan’s son)

She thinks that the things that are happening to her are fascinating – even if they’re trivial – and she tends to repeat every little thing that’s happening, so a lot of it is listening. Occasionally, I’ll think, “Mum, you know, something happened to me yesterday, too, but you showed no interest in listening at all”. (Susan, King’s daughter)

She is proud of her knotting skills. Sometimes only her unique timbre was heard. She could spend hours talking about how she did a Chinese knot and did not let anyone interrupt. She continued saying the production of Chinese knots went through the process of “waving”, “pulling”, “correcting...” (Yee, King’s daughter in law)

Families also contributed to this one-sidedness. They were reluctant to open up much to the residents for fear of being embarrassed and criticised. If they tried to talk about themselves and the residents showed no interest, this put further pressure on the relationship.
When I try to tell her about the things I am doing I always get the brush-off. Whenever I talk about the kids, my mother-in-law will immediately start talking over the top of me and every time it is just personal stuff. Her face just pinches up tight and she turns away and if her daughter, Susan, is there she will just get involved in something with her. (Yee, King’s daughter-in-law)

All I get is criticism and talk about her stay here. It’s always something about herself: her own little world. I don’t talk about my husband’s cancer, she won’t be interested. So I shut up and don’t say anything. (Mei Ling, Yuk Fan’s elder daughter)

Those residents who demanded attention always expected to be looked after without any reciprocating.

When Mei Ling’s husband (Yuk Fan’s son-in law) was diagnosed with cancer, he received neither sympathy nor offers of help. This non-reciprocal situation intensified the sense of control in the resident-driven relationship.

She wants full attention. She wants all the positive things that her daughters give without being able to give anything in return. When my children were small and sick, she lived in a flat next to mine, she did not bother to come and babysit as both my husband and I worked full time. I’ve got really lucky friends whose mothers offered help whenever needed. It’s never occurred to her to help. I didn’t bother to ask either. (Mei Ling, Yuk Fan’s daughter)

I brought her a bottle of home-made salted fish. She said, “It was far below standard. You didn’t follow what I told you to do. Throw it away and don’t bring in any more in the future.” (Yee, King’s daughter-in-law)

Apart from providing opportunities for negative criticism, Yee feared that any help from King could be used to create a sense of obligation to make her more attentive.

There is always a catch. She’ll remind me of what she has done and wants a lot of credit and praise for it. It is better to leave it to her daughter. (Yee)
As well as having a strained relationship with the family, the residents who demanded attention usually did not get on well with the staff either. The residents expected the staff would care for them without any delay.

*Their attitude is that we are there to do things for them. They see it as our duty to meet their needy behaviours.* (Bing, the cleaner)

*King stays in her bed most of the day.... She appeared not to be interested in participating in any activities offered in Parkview. We don’t bother to invite her to join as it provided opportunities for criticism.* (Helen, the nurse)

*Amy shouted to Yuk Fan: “We are all busy in the morning. We can’t give you the drugs in this way. You are pretty sure it is the rule. If you know you would like to have the drugs at this time, you should give us prior notice. You are disturbing our routine work as everybody is busy. You are not the only one. We don’t look after you only, there are over a hundred residents here. I shall administer the drug one by one according to my own work schedule”.* (Amy, the nurse of Yuk Fan)

One trait that doubtless contributed to the residents’ demands for attention was that they were alone in their social world. King had no success in mixing with other residents in Parkview. She has been a life-long housewife, with some junior college education. She has two children and two grandchildren. Her husband, a doctor, died just short of their 55th wedding anniversary. King focused her energies on the knotting craftwork on her own. She had no friends, was not readily accepted and was treated as an outsider by the social community of Parkview. Her social marginality made her rely mostly either on herself or on her daughter, Susan – a personal trait that others found extremely demanding and attention seeking.

*She doesn’t get anyone to visit her or ring her. She has little interest beyond her own self and her grandchildren. She wasn’t interested in her brothers and sisters and anyone. Just doing the knotting craftwork on her own.* (Helen, the nurse)
She has no interest outside. So she makes little things big and she repeats what and how she did it and this becomes extremely irritating. She calls me and each of her eight grandchildren at least once daily to discuss how things have gone that day, to give me a list of things to bring on my next visit, and to continue expressing her eagerness to get out of the facility. She is too bored and her calls are almost the same, a nuisance. These calls upset some of our usual work during the day. Each call is just the same old thing. I think if she had something a bit more to do so her attention would move elsewhere. (Kwan, Yuk Fan’s son)

She doesn’t have friends, except Sum (her friend sitting at the same table for meals). She just is involved in her Chinese knotting skills but she always is judgmental, uses negative words. She doesn’t seem to have very much joy in her life here. (Helen, the nurse)

In a resident-driven triad the residents can be manipulative, which is inappropriate or incongruous in some situations in Parkview. Their demand for attention soured the triadic relationship. The residents may feel inadequate unless they are constantly at the centre of things. Their behaviours are geared toward attracting the attention of other members of the triadic relationship.

6.1.3 Reactance to constraints of freedom

According to psychological reactance theory, individuals have a basic need for freedom and independence (Brehm & Brehm, 1981). When an individual perceives that a third party is trying to constrain his or her behaviour, reactance is aroused, triggering a drive to reassert his or her freedom.

The residents were not allowed to keep the fresh flowers in their room. The Associate Director asked the cleaners to throw away all the fresh flowers that the volunteers gave to the residents on the Mother’s Day. The Superintendent excused that by saying if there was an accumulation of stagnant water that would be a breeding ground for mosquitos. All the flowers were thrown away without informing the residents beforehand. Kam Chi and King, together with a few other residents, appealed against the decision made by the management, with King saying,
They are fresh flowers, not leftover food. I just did the watering and trimming this morning. I learned from TV that changing water for plants at least once a week and leaving no water in the saucers underneath the flower pots will prevent mosquitos from breeding. They are all fresh. Ms Wong, why can’t we keep those roses, they are fresh flowers, and the volunteers gave us for the Mother’s Day yesterday? (Kam Chi)

Yes, explain. (King)

The residents believed that they had behavioural freedom when they lived in Parkview. This freedom could pertain to what one does and how one does it. The residents acquired a general expectation that they were free to keep fresh flowers in their own room. They now felt that their freedom of action was threatened, and reacted negatively against management’s decision to protect a right which they believed they should possess. A few residents crowded together outside the office; they mumbled and apparently they made “silent complaints”.

Reactance is a form of resistance. The residents were motivated to restore their lost or threatened freedom. The most likely consequence of reactance was a continuation of behaving in their chosen way, a tendency to complain or express their opinion and a refusal to compromise. King said, “It is the order. Nonsense.”

The staff used the residents’ families as the source of a persuasive message being given by staff to minimise reactance as the family was seen as a part of the residents’ network (Dunbar & Burgoon, 2002). Therefore, family should likewise induce less reactance. It is common practice for staff to involve family in the negotiation process when the resident is likely to react to constraints on his/her freedom.

An example of a resident’s reactance is provided by Uncle Kwai. He liked to take a daily walk to yum cha. Over the years, he had become generally frailer. He walked extremely slowly and lately, his eyesight had begun to fail too, creating major problems with his peripheral and depth vision. Watching him from the window of the nursing home, Mr Cheung, the nurse, had noticed that Kwai sometimes had trouble at the traffic lights in front of Parkview. Either he started out when they were red, or they turned red before he had reached the other side. Mr Cheung had begun to worry
whether it was safe for Kwai to go out on his own. Parkview could not spare any personnel to escort him to the restaurant and so he wondered if an order was needed to stop Kwai from leaving Parkview. Mr Cheung initiated a meeting with William, Uncle Kwai’s son, to discuss the matter and explore alternatives. Mr Cheung showed his goodwill by getting William to become involved and showing that caring for the family’s views was one of his goals in caring for Kwai.

Living in a residential care facility brings the feeling of a loss of freedom. Loss of self may occur if the residents accord the other stakeholders in the triad no recognition of their freedom of behaviour and the relationships demands that they obey and do not react. The capacity to react is recognised as an important individual sub-theme in a resident-driven triad. In this type of triad, residents struggle with their desire to retain acknowledgement of their self, and strive to receive care on their own terms and be independent in the face of institutional expectations of order and co-operation.

6.1.4 Perceived self-efficacy

Originating with Bandura’s (1986) construct of self-efficacy or “people’s beliefs in their capacities to organize and execute the course of action required to manage prospective situation” (Bandura, 1995, p. 2), personal efficacy beliefs have been shown to affect an individual’s motivation in a wide variety of studies in educational psychology (Maimon, 2002; Taylor, 2008), clinical psychology (Weiss, 2008) and care of elderly nursing home residents (Chang, Fang & Chang, 2010).

Perceived self-efficacy can significantly influence how residents think, feel, motivate themselves and act. The stronger a resident’s perception of how far he or she can manage his or her self, the higher the confidence level, the firmer the motivation to carry out actions under the resident’s control. King did not like to follow the routine of the facility.

*If you are scheduled to have a bath in the morning, everyone has to finish bathing before 10 a.m. They collect all the dirty clothes for laundry. If you miss the time, then you have to wash the clothes yourself. I can manage to do the washing myself. I am not so old. I also don’t want my clothes put into the tumble-dryer. The heat damages my clothes, they will come in a smaller size if*
those people dry the clothes with high heat. It’s easy, I just hang the clothes to dry outside. (King)

How residents feel, including their likes or dislikes, are influenced by their self-efficacy beliefs. These beliefs determine their motivation to act (Chang, Fang & Chang, 2010). There is evidence that perceived self-manageability enhances performance directly and indirectly through its effects on personal goals and self-reactions. It is believed that residents’ judgment of “what they could manage” was key to successfully performing an action in a given situation.

Wai Woon helped out in the cooperative grocer called Old Friend Shop. Wai Woon ran her “business” twice a week. The shop is operated by the food stamp programme. Residents and their families deposit money into their own account in the programme. If a resident wants to buy a tin of milk, Wai Woon would put a stamp on their card for the transaction. The shop receives some of its goods, such as boxed dry goods, including snacks and dessert items, beverages and some personal hygiene products, as donations by not-for-profit charitable agencies while others are ordered by the staff at Parkview. (field note)

Wai Woon’s success in running the shop reinforced her perceptions of her abilities as manager. With a strong belief in her own efficiency, Wai Woon tended to believe “I can do it” and exhibit great persistence in meeting the expectations she had of herself. (field note)

This seemed to be a distinguishing feature after re-establishing her physical wellbeing during her residency at Parkview, whether out of necessity or preference. As Kam Chi proudly notes, “I’ve always been one to handle my own affairs”. (field note)

Residents’ perceived self-efficacy positively mediates their ability and subsequent performance. They formed beliefs about their abilities, what they could do, and the importance and appeal of any task at hand. Residents followed their own path in Parkview by choosing the types of activity and environment they wanted to engage in the care triad.

6.1.5 Demand for preserving self
People experience many roles throughout the course of their lives. These roles are often associated with a distinct identity. Roles guide people in their behaviour and
serve as a source of personal self. In essence, people construct self within roles, structured by a sequence of chronological events and changes within their self-image (Kammerman, 1988). Sequenced elements such as coping with life in Parkview, abandonment of many previous roles after moving there, a gradual decline in functional ability and an increase in frailty result in a role change in the life of residents. Residents need to have satisfying roles in their daily lives in order to feel meaningful and useful (Smyntek, 1997). Without this role identification, residents lose their personal self. Living in residential care thus brings additional threats to self (Bickerstaff & McCabe, 2003).

The desire for preservation of self is obvious in residents’ conversations. King emphasised that,

*it is important to state my feelings out loud, and to say how I feel, to say, “I am angry”. I am stating that the feeling is who I am. By stating the feeling out loud, I am affirming that I have a right to feelings and to my own voice. I own my right to speak up.* (King)

As written in my case notes about Chan King:

King had strong likes and dislikes, particularly in matters pertaining to her personal life. She maintains strong opinions about things that go on around her. King has a strong sense of self. When Susan, her daughter, asked her reason for purchasing a wash board, King asked her to stop asking, saying it was not her business. “I am the mum, not you.” Susan said that King was quite assertive and always insisted on behaving in her own way. (field note)

King projected a sense of self-esteem and belief in her competence by making a contribution to her own everyday activity. She disregarded the routine and health reminders from the staff. Having a strong sense of “self” as a whole, King insisted on individuating her personal choice and characteristics. Maintaining her past habits, King wanted to ensure full autonomy over every tiny aspect of her life. (field note)

Most of the residents participating in the study had been relatively independent before moving into Parkview, and therefore they experienced not only a sense of being institutionalised but also “a loss of self”. Maintaining past habits and an individual routine is associated with strong preservation of self. These residents discussed their
loss of control, abandonment of previous roles, sense of powerlessness and difficulty in preserving their “self”. The residents struggled with asserting their personal preferences, maintaining their self-care independence and their roles as parents, grandparents and residents in Parkview. For instance, King notes:

*I can never accept something like this. I am not so old and have always been pretty healthy. I don’t like to follow their routine. I can manage to do the things on my own. I am not so old. I like to take a bath before going to bed, I have my personal routine.* (King)

As King and some other residents suggested, the idea of being strong and independent, protecting the self and their independence, was characteristic of a distinct personality trait for them. This identity is unavoidably transformed by moving into a facility and the need to follow its routine (Anderberg & Berglund, 2010). Life in a residential facility thus creates a sense of loss of self that stands in extreme opposition to their former independent identity. Being self-reliant, the residents in the resident-driven triad readily identified with being involved in their own daily life and their own care rather than being cared for and following rules.

Another profound characteristic of the preservation of self is the creation of a life story or parts of it, often associated with residents’ life events. Through recounting their stories about their life, past and present, residents presented who they are, based on their selective memories, their life events and factual accounts of their past, linking them together sensibly and then placed in relation to the present context of living in a residential facility. For King this means the following:

*I ran a Chinese knotting interest group in the past, making Chinese knots. And er... that was interesting, ‘cos the production of Chinese knots went through the process of “waving”, “pulling”, “correcting”. Each method is fixed but pulling decides its tightness, wing length, and fluency and tidiness of ropes, which shows my skill. Behind the time and effort it takes, its underlying meaning is purity, nature and skilful hands that cannot be replaced by machine... . I began to teach Sum and Kam Chi and continue with the workshop here.* (King)
King had a very strong notion of being someone who carried on with her past hobby and routine in the present. Running the workshop allowed King to lead a group and align herself with the staff supporting her, such as Helen, to feel respect, useful and needed.

The relationship with their children provided recognition, attachment and positive regard, which the theoretical literature suggests are vital for the preservation of self (Branaman, 1997; Goffman, 1997). Being a parent and grandparent and taking great pride and pleasure in the successes of their children was important, as they frequently recounted stories of their children’s successes in life.

Kam Chi discussed how she saw herself as occupying a central role as a loved and cherished member of her family. Being a wife, a mother and a grandmother and taking great pride and pleasure in the successes of her children and grandchildren, she frequently recounted stories of her children’s successes in life.

Mm. They’re good, good girls, you know, my daughters, and my sons-in-law. Well, I suppose I don’t…. I’m not boasting about them at all, but it’s partly the way I bring them up, isn’t it? Do you agree? (Kam Chi)

These stories provided the basis for preserving the self. A heightened consciousness of self is obvious in the resident-driven care triad in which the residents take responsibility for protecting and taking care of themselves. King notes:

I need to tell them (my daughter and staff) when they are acting in ways that are not acceptable to me. A first step is them starting to know that I have a right to protect and defend myself. That I not only have the right, but a duty to take responsibility for how I allow them to treat me. (King)

The residents focused on the way in which they carried themselves, moved and acted on their own terms, while appreciating their life-long habits of going about their everyday practices and activities. Buber (1970) asserted that the preservation of self is significantly related to the recognition of status and quality of interpersonal relationships. Kitwood and Bredin (1992) and Kitwood (1997) also argued that the concept of self was not a property of a person, but a status that was bestowed upon
one person by others in a relationship. The resident’s individual attributes dominate the resident-driven triad.

A heightened consciousness of self and identity is not just limited to the residents, but extends to family members as well. While for the resident such self-consciousness is mostly dependent on an individual possessing certain personality traits, for family members it is initiated by a change in how the family view themselves and new identity formations based on a change of roles. Many families do not lose their sense of commitment and demand to be involved in providing support and care to their relatives in a way that impinges on the family-driven triad.

6.1.6 Demand for participation

These families are concerned about the conditions in Parkview and the care that residents receive. Often families do not know what is happening to the resident, except for what they can see for themselves. Forming a new role in caring for their relatives in Parkview, families shifted their sense of responsibility and looked for ways to continue to function as families.

Beth (Kam Chi’s daughter) was frequently present during Kam Chi’s physiotherapy training session. Beth asked questions often if needed, and indicated that Tsang, the physiotherapist, generally addressed both Kam Chi’s and Beth’s concerns and questions. Beth also kept a diary to document Kam Chi’s gait pattern, for example, a swaying gait that tilts the body from side to side or an unsteady, uneven gait. This diary proved to be a useful communicative tool between Beth and Tsang, the physiotherapist. Beth did note that the relational connection with the staff played a significant role in her ability to look after her mother and her father at home, too (Chong with early-stage of Parkinson), to communicate with her other siblings who visited often regarding Kam Chi’s condition and to keep them informed. (field note)

Several family caregivers expressed the belief that it was important to promote closer contact with other family members, and, in turn, that family had a responsibility to help maintain the residents as part of the family. Some family caregivers reduced their hours of paid work or quit their jobs altogether to provide care for their older relatives.

Working as a full time accountant in the past, Beth (Kam Chi’s daughter) sacrificed her job and came in every day and her children spent an afternoon with Kam Chi every week. In spite of recognising that caregiving was not possible at home, Beth expressed
Contrary to the common belief that families “dump” their relatives once placed in Parkview, Beth did not abandon her mother; rather, she attempted in every way to make the situation the best possible one for Kam Chi. She visited her every day. Some family caregivers believed that the older person needed to remain active and so they needed to become involved in their care.

*Mum was very ashamed of her trembling hand, people often looked at her hand curiously in the restaurant. It hurt her self-esteem. She tried to hide her shaking hand, but it didn’t work. Going out to public places was a heavy burden to her. She even refused to go to the restaurant to celebrate her birthday. I finally decided I had to be mean in order to get her to do what she needed to do.* (Beth, Kam Chi’s daughter)

Families still found themselves engaged in care after the admission of their older family members to Parkview and developed strategies for controlling their care. Families monitored staff behaviour and the treatment of other residents during their visits to get insights into what things might be like when they were not present. It was a common view among some nursing aides that families interfered and made life more difficult for them. Nursing aides with many ever-present families in their wards considered unlucky themselves. Families sometimes overwhelmed aides with other priorities to attend to a resident’s needs.

Too often, the myth of abandonment or dumping has stemmed from the assumption that families cease to play a major caregiving role once the move to a facility has occurred. This assumption is now being challenged, for example, by myself documenting the continuing involvement of families in the family-driven triad in the current study. The members of such a family assigned responsibility for the performance of certain professional tasks to the staff but held themselves responsible for monitoring and evaluating the effectiveness and quality of care. They voiced a strong desire for staff to treat the residents professionally and to ensure quality of care. These families expressed the view that if they had to come in every day to monitor...
and observe whether the older people were being cared for properly, then this is what they would do.

6.1.7 Parenting-style caring

Expectations of a supportive role of the family may seem to come to nothing when the elderly are placed in a facility (Kellett, 1999). But families having adapted to having become a parenting figure in caring for the elderly in Parkview characterised the family-driven triad in this study. Families become the emotional anchor and a source of support and guidance for their ageing kin. Just like the attributes that characterise parents, there are some attributes that are characteristic of a parenting style of care giving in the triad. Such a style of care giving was realised through the acceptance of filial responsibility and a sense of reciprocal obligation. Families often believed or stated that they had a special obligation to take care of their elderly family members’ basic needs. They had to ensure that their elderly family members were fed and clothed and that their other needs were met, so they had to check if they were cared for properly, that they were clean and got a bath. These families expressed the view that it was the children’s responsibility and obligation to care for their elderly family members. However, such an obligation is not simply the product of family ties, affection, feelings of closeness and interconnectedness but is also explained by kinship reciprocity:

that has just been instilled in me since childhood. I should care out of compassion. I have always been responsible for her. (Barbara, Wai Woon’s granddaughter)

I may not keep her here if she is not happy. I have to feel good about the place. I can’t just leave her with anyone, just like you wouldn’t leave your kids with any babysitter. (Beth, Kam Chi’s daughter)

When my mum was told that she had Parkinson and breast cancer and would only live six months, I hired a series of domestic helpers to come in and help care for my mum at home. Some turned out not to be well trained, or not very sensitive, and the good ones moved on. So it was not just expensive, it was so unreliable. There was the constant aggravation of looking and interviewing, and the hiring, the firing and the quitting. My son and I moved into her place to live with her. I also made adjustments to my work schedule in order to maintain
my role as the primary family member… Moving mum here was something that was against all my principles. It was a very difficult decision for me. I decided to search out the best nursing home that I could find, knowing full well that it wouldn’t be as good as it was supposed to be. And then I made sure that I would go each and every day and supervise what was being done to mum... If I don’t get some answers and feel she is getting good care, I may just move her to find the “best place”. (Man, Po Chun’s daughter)

The concept of role reversal has been employed extensively in the family relations literature and describes a situation in which a child assumes parental responsibilities, effectively to parent the parent (Mayseless, Bartholomew, Henderson & Trinke, 2004). Adult children are called upon to provide the elderly with protection, support and care.

*Mum’s situation calls out to me to maintain recognition of her dignity as the person I have known, now grown frail in old age. Where her wilful ability seems reduced, I am called upon to compensate for and supply support to her process of being a person through my own personhood.* (Man, Po Chun’s daughter)

She described herself as her mother’s “right hand”, saying she “never left her side”, and “I was more her mum than she was mine”.

Families tended to become more protective of their parents, as if they were taking care of children. They had a duty to protect the elderly from all manner of injuries, including psychic injury, and “take care not to inflict themselves by abuse or denying affection” (Jackson-Newsom, Buchanan & McDonald, 2008).

*Immediately after the surgery, Po Chun’s self-image was hurt. She didn’t really want to look into the mirror. It’s Man, her daughter who helped her how to work at getting back a positive view of herself.* (Helen, Po Chun’s nurse)

In parenting-style caring, it was not uncommon for families to make decisions for the elderly. They appeared to be controlling areas related to the older people’s sense of wellbeing, learning skills to deal with people in Parkview and developing serviceable habits for enriching their lives and making life meaningful in Parkview. Barbara (Wai
Woon’s granddaughter) serves as an advocate for Wai Woon to find something interesting:

*Participating in the activities can help Mama to develop a sense of being part of Parkview, and being able to communicate with other residents and with staff keeps her busy and enjoying the group atmosphere.* (Barbara, Wai Woon’s granddaughter)

According to Brock (1996), parents may become controlling when motivated by parental affection and concerns for a child’s successful adjustment and development. This also resembled the parenting behaviour in the family-driven triad. The families maintaining a parental figure tended to uphold authority and control by using explanation in the family-driven triad.

### 6.1.8 Sense of vulnerability

A sense of vulnerability is inevitably experienced by someone entering a long-term care facility. Being institutionalised was a major life event for both Po Chun and her daughter, Man. It took a long, long time for Man to eventually accept the nursing home placement of her mother. And the pain would come back to her:

*Even now sometimes I dream about it. I’m back there in time, arguing – in the dream of my dad. “How can I do this to mum?” I cry to her. My face is in her lap but she is not saying anything. I’m afraid to look up. I’m afraid of how she’ll judge me and then I wake up.* (Man, Po Chun’s daughter).

In my field notes, I have written:

In the process, Man became more vulnerable to stress and strain as she cared for her son as a single parent. Po Chun and Man have experienced individual losses that seem to increase their closeness and interdependence. Man copes with her divorce while also mourning the death of her father. (field note)

The concept of vulnerability relates to the susceptibility of a person to risk, harm or injury (Conroy & Marks, 2003; Palmer, 2005). Families themselves were considered a vulnerable group and responded to lack of resources and stressors presented by the multiple roles that they occupy both at their own home and when caring for their
elderly family members in a facility. According to Kellett (1999), some families experience considerable emotional stress such as feelings of guilt, loss and self-doubt. Families were uncertain about the boundaries and how to form an appropriate role in caring for the elderly in a residential setting. They had mixed feelings about being excluded from care, and experienced strain resulting from unclear or conflicting expectations of family participation in care.

Living in Parkview was a stressful and frightening experience for some residents, too. Po Chun notes that, “it meant a change in who was in control and the need for me to adapt to a new environment”.

Man (Po Chun’s daughter) does recognise the existence of this shared vulnerability and will at times attempt to control its influence. Man did not abandon her mother when she moved to Parkview; rather she attempted in every way to make the situation as best as possible for Po Chun. She visited her daily and she also visited other residents who had no relatives. Her enthusiasm and involvement created a fruitful ground for an interactive relationship. As time went by, she also found herself at home in Parkview.

*I am not so stressed and don’t feel so guilty about it. Maybe that is because I still take the lead and am involved not just with my mum’s care but with many of the others here. What it amounts to is that I don’t feel like an alien and feel helpless now. Both mum and I are individuals and I preserve the value of caring for her in Parkview.* (Man, Po Chun’s daughter)

A sense of vulnerability is not so much negative in the family-driven triad, it is an experience that can be avoided or resisted. Man’s involvement and presence thus steered the triadic relationship and led to Po Chun and herself gaining both greater visibility and more attentive care in the triad.

Not only are both residents and families considered to be vulnerable in the family-driven triad, the residents are considered as frail elderly people when moved to Parkview. This is a pivotal attribute that characterised the staff-driven triad. In this type, the resident appears to be a willing participant, believing that the staff should be in charge and will help them to meet their needs.
6.1.9 Frailty of ageing
Taking care of the elderly at home was portrayed as a family crisis that was shaped by
dependence, burden, obligation, exhaustion and conflict (Pruchno & Rose, 2000).
Placement in a long-term facility was frequently seen as a last resort resulting from
the supportive role of the family at home failing (Montgomery, 1983). The likelihood
of placing the elderly in a facility was closely associated with a sense of frailty
involving a loss in different domains of functioning, both physical and cognitive, a
high risk of chronic conditions, a high level of impairment and a lack of family care
resources (Lee, 1997, 1999; Reschovsky, 1998; Schuurmans, Steverink, Lindenberg,
Frieswijk & Slaets, 2004). With their failing abilities, the elderly are depicted to be
unable to manage their own decline and to sustain their sense of wellbeing following
the onset of dependency.

Lee Ming, a resident who had had a stroke which had resulted in left paraplegia, was
very respectful of Parkview’s rules and appreciated that the staff were usually able to
help him meet his needs. Nevertheless, he felt there was a constant tension that came
from living with groups of people in a public place.

My two gripes about living in Parkview were “the shared rooms”, which is
supposed to be a ward environment rather than a “home”. Each resident
should have his or her own private area and the staff working here ... not
because they are not experienced, but most of the time it is the nursing aide’s
way and my way as to accept how my care should be done. (Lee Ming, Sum’s
husband)

The work of the staff working in the facility is considered unique. Most staff focus
their efforts on maintenance of functional status, management of chronic illness and
assistance with activities of daily living such as bathing, toileting and feeding. Facility
staff are characterised as providing technical and specialised tasks, implementing
regulations and hierarchical authority (Diamond, 1992; Wellin & Jaffe, 2004). Staff,
including nurses, nursing aides, social workers, physiotherapists, occupational
therapists and cleaners, are attempting to manage a large workload with limited time
and inadequate manpower. They are expected by their employers to deliver on this
“system of care” which demands efficient, uniform and documentable care within a
specific time frame.
Showers are scheduled by day and shift. For example, my shower is scheduled as an afternoon shower and if I want a day shower, I have to have a reason for requesting the change and have to apply one day before. My schedule may be changed if they can accommodate you. Each nursing aide has a set number of showers to give per shift. If residents want to change the time of their shower to a different shift they usually have to wait until all scheduled residents have finished or a scheduled resident has refused a shower. (Lee Ming)

*I was told I take too long in the shower, that everyone has to finish it within twenty minutes as someone who needs help in the shower is waiting.* (King)

As staff are experts in the care of the elderly, input from family members is usually considered secondary to that of the professional staff in Parkview. This example was noted down in my field notes:

Lee Ming had a stroke. He is not able to control food and saliva in his mouth and has difficulty swallowing solid food. Sum, his wife, was not allowed to assist in feeding for fear of having food or liquids going the wrong way and into his lungs. Neither can Lee Ming try to feed on his own as he usually takes hours to finish his meal and creates a mess on both his face and clothing. (field note)

Parkview’s staff are engaged in a number of tasks and have to manage completing the mandated tasks within time limitations.

*My husband takes more time than other residents to get ready in the morning because he is dependent on the staff to use the mechanical lift because of his limited mobility. Staff feel it is easier to complete the care of residents who can be done quickly, so that they don’t feel rushed in providing care to my husband who takes longer. Therefore, my husband usually has to wait longer for their care in the morning. But he will also stay up later in the evening as the staff said it would decrease the chance of sores on his back. Both my husband and I have little to say about this decision for wake-up and going to bed time.* (Sum, Lee Ming’s wife)

*When I go to bed, I am turned every four hours. I am put back in my bed at seven o’clock in the evening. They skip the turning at 8 p.m., and then I have my*
midnight and 4 a.m. turns and then usually have to wait until all the other residents are seated in the dining room for breakfast. I am wheeled to the dining room and join them. Can you image being confined to that schedule for the rest of your life? (Lee Ming)

Goffman (1961) presented a view that “being institutionalized for the blind, the aged, the orphaned and the indigent” was a simple breakdown of the three spheres of life into sleep, work and play (p. 2). This resulted in residents being treated as a single, homogenous group, with staff performing, controlling and gate keeping to keep things running smoothly in this system.

Conflicts never go away. I noticed that if you have a problem... it doesn’t go away when you bring it up... or it creates further tension so I would rather not bring it up. I would rather keep it to myself and not allow my wife and myself to show the tension ‘cos they are the professionals who know best. (Lee Ming)

Being considered frail is closely related to the stigma of dependency. In the staff-driven triad, the resident appears to be a willing participant, believing that the staff should be in charge and will help them to meet their basic needs. The resident is obedient and compliant, while the staff enacts a traditional hierarchical relationship in which professionals know best. This is a pivotal attribute that characterises the routinisation of care as priority, ranging from highly specific tasks to everyday and mundane activities in Parkview.

6.1.10 Task-oriented care

It is widely acknowledged that the orientation of care plays a pivotal role in shaping how staff practise and interact with residents and families in a long-term care setting (Gubrium, 1997; Vesperi, 1995). Previous ethnographic studies of nursing homes have illustrated the effects of the medical model on the orientation of care (Baumbusch, 2008; Diamond, 1990; Gubrium, 1975). The work life of staff is focused on the to-do list and things staff need to accomplish. They are concerned with productivity and efficiency. While everyday life is reduced to matters of physical health, disease and cure, physical care takes precedent over residents’ social, emotional and spiritual wellbeing.
They say to me “well, you’re not the only person here” or “you need a private duty aide”. What can I do? (Kwan, Yuk Fan’s son)

Sum’s concern is her grandson:

Once my grandson, Alex, was back from Canada and he was going to have a buffet at his hotel. My husband and I cancelled our lunch and applied for Lee Ming for an afternoon shower. When Alex called to tell us he was sick, he knew the buffet lunch would be postponed to the next day. I was busy for the whole morning as a result of trying to obtain a lunch from the kitchen people. They kept telling me that I shouldn’t have cancelled lunch because having to make it in the morning interfered with their schedule to prepare lunch. (Sum)

Residents who need assistance with meals usually find that their trays come later than for those who can feed themselves. This is done so that the nursing aides can set up those residents who are more independent and then be free to assist those who need help. On some occasions, some residents might have had an appointment to keep and so arrived early for meals; however, they had to wait until everyone else was set up before they could eat.

The nurse would like to send trays at the time for those who required assistance in feeding to sit together. I am assigned to sit with King, so even if I would like to have meals with my husband, that is not possible as I could eat on my own but my husband can’t. We can’t say anything as this is organised by staff rather than by us. (Sum, Lee Ming’s wife)

Doing the laundry provides an example of task-focused care. King notes:

The heat damages my clothes. No matter whether it is made of cotton, wool or silk, they dry them under high heat in the tumble-dryer and they will come back in a smaller size. The aides just want to have the job done. (King)

Task-oriented focus was observed in some residents’ situation. One resident suffered from chronic pain, so she asked for her seat to be tilted so that it would decrease the pressure on her side. Since this did not help reduce the pain, she
requested that the seat be repositioned a second time. When this still did not help, she was told that it would all be the same. She asked if she could have her old seat cushion while she waited. Although the staff persisted in trying to find the most appropriate pain relief, this took forty-five minutes. She mumbled that staff perceived her as demanding and difficult to satisfy while she perceived herself as having to identify her problems herself and what she wanted. A further example of a task-oriented focus was in the case of Kwai.

Kwai enjoyed his role as volunteer receptionist after his daily walk in the park. He would ask visitors to write down their names and the times they arrived and departed in a log book. Until he was diagnosed with senile dementia, he enjoyed making this contribution to Parkview.

The doctor recommended a 24-hour tracking bracelet for Kwai to keep an eye on his movements, and thus on his safety. Kwai has to wear an infrared bracelet on his arm so he would not get lost. He was not consulted on the decision to order the bracelet nor was it discussed with his family. He became profoundly depressed and was not eating due to suffering a lack of dignity and lack of meaningful activity, despite a scheduled friendly visitor. However, once he was allowed to take off the bracelet and be the voluntary receptionist, his good spirits returned. While care routine is frequently decided by the management team with the resident or family present, Kwai does not always have the chance to make or even comment on the decisions made. The task of keeping an eye on Kwai’s movement for fear of him getting lost is seen as a priority and so his needs are sometimes taken for granted. (field note)

The work history of the staff of a facility, their position in a hierarchy of staff and their personal traits can affect their orientation to caring practices. Nurses are often assigned tasks which are technical, require medical knowledge or are administrative in nature. These tasks are less frequently performed, they are less personal and they have the nurses being less involved with the residents and families. Nursing aides, on the other hand, who are responsible for bathing residents, taking residents to the toilet, changing bedpans and soiled clothes, are more conscious of the accomplishment of a task in the limited time available. They are unlikely to do much beyond providing “basic physical care” as a staff-driven triad is governed by the decisions of the staff in a culture of surveillance and control and with an expectation of passivity by residents and family.
6.1.11 Making decisions on the resident’s behalf

When a resident lacks adequate capacity to make decisions for him or herself it naturally follows that someone else must make the decisions or at least assist in the decision-making process (High & Rowles, 1995). The need for decision making for demented residents is acknowledged in ageing research, comprising decisions on treatment and health care, as well as about daily living and residents’ social environment (Black, Fogarty, Phillips, Finucane, Loreck, Baker & Babins, 2009; High & Rowles, 1995; Maust, Blass, Black & Rabins, 2008). It was typical that most of the staff in these studies tended to have preconceived ideas about a positive association between residents’ increased functional impairment or their declining state of health and “going downhill” and decisional incapacity. In Hing and Bloom’s study, 94% of the nursing home residents had at least one functional dependency (Hing & Bloom, 1990); nonetheless, it was argued that “ageing is not a disease” (Forbes & Hirdes, 1993) and that many of the elderly residents of a facility were still able to make decisions about the own daily lives and not just about quality of treatment and health care.

I wrote the following in my field notes to illustrate how staff made decisions on the residents’ behalf without getting their agreement:

Lee Ming states that he had been taking a shower in his wheelchair since he had been looked after by Sum, his wife, at home since 2003. Recently, the doctor came in and wrote an order for him to have a stretcher shower instead, due to the development of an ulcer on his buttock. Lee Ming said that although he was willing to have skin care and to adjust his shower to clean his private area better, he was not consulted. Showering in the wheelchair allowed Lee Ming some privacy during his shower and allowed him to clean his own face. Now he has to wait for someone to shower him, and strangers have control not only over the length of his shower but also where to wash and when to wash. Sum, his wife, is currently trying to talk to the staff for a return of wheelchair shower privileges. Both Lee Ming and Sum feel that his shower is a personal decision not a medical one. According to Lee Ming, “if the facility is my home, I should be able to make decisions regarding my own preferences. There may be other ways to deal with my torn buttock.” (field note)
Decisions about having a hair cut, clothing and bathing schedules, dining arrangement (who to sit with during meals), choice of room mates and what products are to be sold in the grocery store were all made by the staff.

Playing mah-jong is also an example that involves the staff in making a decision. The winner counts the points won, with a monetary value agreed upon by players. However, instead of the players making the decision, the staff decided to use a button for counting the points. (field note)

Weight management is another area that involves a staff decision. Uncle Kwai was obese on admission. The staff decided that he needed to be placed on a diet. He was never consulted about whether he wanted to lose weight. “The staff won’t let me win chocolate at playing chess; they substitute a pack of biscuit or a handkerchief” (Kwai). This is done without his input into the decision. (field note)

During a team meeting that the researcher attended as part of the study, the team discussed a resident’s situation which resulted in what seemed to be an extreme case of staff making a surrogate decision. A female resident with end stage dementia loved to eat even though she had great difficulty swallowing and was in danger of choking. It would take her an unreasonable amount of time (over an hour and a half) to complete her meal. For the sake of preventing aspiration, it was decided that a nasal gastric tube (a tube inserted through the nose, directly into the stomach) would be used for providing nutrition. Initially, this resident was no longer brought to the dining room for meals since she was receiving gastric feedings. The staff reported, after several meetings with her daughter and the psychiatric specialist, that the woman was depressed as no food was given to her and she continued to pull the tube out. It was then agreed by the staff that she would be permitted to continue eating for pleasure and to allow her to enjoy the food she liked by trying to use “thickened liquids” to help her swallow.

Decisions about aspects of daily life, including the clothes Lee Ming was to wear, had to be made by staff. Instead of having the aides choose the clothes for Lee Ming, Sum suggested to the staff the clothes she thought her husband liked best.

The surrogate decisions observed being made during the course of this study suggest that beyond the predominant treatment and health care decisions, decisions concerning the daily lives of residents, including social aspects, are also frequently
made. Depending on the nature of the decision, sometimes families might be involved in the process of decision making in a sequence of interactions. It was not surprising that staff tended to view the decisions as “task specific” in a fragmentary way and to become involved according to their professional roles and assignments. The staff did not always know about the full range of decisions made that often mirrored what would most likely have been the residents’ own preference in the staff-driven triad.

6.2 Communal attributing themes

So far, the typology of the care triad has been depicted as driven by a single stakeholder, i.e., resident, family or staff, in which the individual attributes dominate. Lying at the interface of the private and the public, the stakeholders who live as residents, visit as families or work as staff in Parkview as a microcosm of a community are not isolated. All stakeholders interact with others, with a great deal of interaction taking place in small groups. Each stakeholder is simultaneously trying to interact with and influence the others. If a stakeholder places more emphasis on the collective aspects of the group, he or she works out a pattern of interaction in which all stakeholders are related as members of the group. The care triad is viewed as a co-produced effort of the stakeholders in which three communal attributes are identified: group orchestration, sense of cohesiveness, and negotiation for identity.

6.2.1 Group orchestration

Different kinds of group come together in different ways: leisure and interest groups through common interests and some degree of mutual compatibility; and work and co-operative groups mainly to work and be engaged, and others which are organised by the staff. Various types of group have been formed in Parkview, for example, groups playing chess or mah-jong, a class learning how to make Chinese knots, a bakery class, a cooking class, a group organising community services, an art therapy group, a tai chi group, a Chinese opera appreciation group, a singing group, etc. Members of each group come together to pursue common interests. A member new to a group is concerned with the satisfaction of his or her personal needs and with carrying out the tasks that define the group.

Wai Woon became “active” in the last Tuen Ng Festival. Woon expressed the view that active involvement in a group activity facilitated the building of a sense of control that
seemed to be lost with institutionalisation. “This may be one of the reasons why Barbara (Wai Woon’s granddaughter) would like me to find an interest and to be engaged socially in the facility” (Wai Woon). Wai Woon was anxious when she attended the first meeting. She found out what the meeting was about, what behaviour was expected and what was acceptable in the group. (field note)

King focused her energies on the knotting art work and ran a Chinese knotting interest group in Parkview. Continuity with past habits and activities contributes to her sense of integrity, preservation of identity and wholeness of life. She wants to ensure full autonomy over every tiny aspect over the course of her life. (field note)

Extremely meticulous and preoccupied with social activities, Kam Chi is actively involved in the task of planning her social involvement in Parkview. She openly and repetitively discusses with the staff how they can get her and her family involved in the social activities, in planning, organising or participating. Kam Chi wants to ensure a certain level of control that is often lost with institutionalisation. This seemed to be a distinctive theme after re-establishing her physical wellbeing throughout her residency, whether out of necessity or preference, and she proudly notes, “I’ve always been one to handle my own affairs”. (field note)

Although Man (Po Chun’s daughter) has bought her a computer online game on which she could play mah-jong on her own, Po Chun continued to take part in the mah-jong group. “I like to talk, I have no one to talk to when playing mah-jong on the computer, and I like staying with them, talking, shuffling and stacking the row of tiles... I can’t hear the shuffling sound of the tiles when playing it alone on the computer.” (field note)

Shun (Wai Woon’s son) was invited to play Erhu (Chinese violin) together with other residents and staff singing Chinese opera in a fund raising concert for Sichuan. Shun rejected the invitation at the beginning as he thought it was beyond the duty of the family. With encouragement from his daughter and the staff, he accepted this task as a musician. (field note)

The staff and family were invited to join the mah-jong group. To invite a person to play mah-jong is an indication of friendliness in Chinese culture. Lin (the cleaner) and Man (Po Chun’s daughter) were considered as friends by the mah-jong group. An open exchange of views and development of feelings were observed in the mah-jong group. (field note)
Both Po Chun and her daughter (Man) are active members of the dumpling wrapping group for the Tuen Ng Festival. Man is extremely active in Po Chun’s care. She visits Po Chun regularly, makes contact with the doctor and Helen, the nurse supervising her mother’s care, for information and updates. She often takes Po Chun to yum cha on weekends and spends most weekends at Parkview after finishing lunch. (field note)

This interaction can encompass a variety of exchanges among the stakeholders in the triad, and may include discussion of the resident’s life and health, and of lifestyle options and preferences. In fact, the exchange of information about a resident’s condition can provoke collective action involving mutual understanding in the care triad. Such mutual understanding and engagement may foster the development of quality interaction and a quality relationship.

King is an active member of her Chinese knotting group, serving as coach, but a different type of relationship existed in other situations. Having a working relationship appeared to be the most common way in which King related to others in the triad. In this style the caring activities of the family and the staff in fact ran parallel to each other most of the time, without much apparent overlap. King emphasised the self over the group and personal independence over social interdependence. Her daughter, Susan, placed the main emphasis on physical companionship with King so as to manifest her concern for her mother, while bringing about some diversion or relief from the everyday routine. The importance of bodily care, i.e., whether residents were presentable or not, was a staff concern. The interaction between the members of King’s care triad in these situations was relatively brief and simple: the staff made an assessment and performed the required care activities, and the resident and family were satisfied with the task done. These types of working relationship were typical when the resident and the family had no expectation of the staff beyond the care requested and received. Task completion was considered the major concern. Staff met needs quickly and efficiently as professionals. The interaction in the care triad was superficial, courteous and by rote.

The dining department had recently converted the entire dining system into “restaurant style” dining, where meals were brought to the dining room on a buffet-style cart and served to each resident from the heated cart, rather than on trays. The food provided was prepared by a professional chef dressed in white with a tall hat, necktie, apron and checked trousers. King always criticised and had no interest in the
food provided in Parkview. “The food here is bland and tasteless, you guys always said it is good for my health, but even though it is not tasty, at least it should look attractive.” King put a mouthful of the food into her mouth, saying, “not surprised, no taste, no smell”. (field note)

The staff took these remarks as a cue to improve their caring activities and appreciated the acknowledgement of a demanding part of their work that was often taken for granted. Nonetheless, when King was in her Chinese knotting group, conversations were not characterised by authority and guardedness as in the work situations but instead by a sense of mutuality. Teasing each other for fun was observed in the triad. Given the stakeholders’ intimacy, they often created a social attachment with each other which could be likened to kinship or friendship. They also made an effort to provide one-to-one attention, talking with the residents about their families and their life histories or finding particular ways of attending to each other’s needs. One-on-one conversation provided an important opportunity for attending to individuals’ needs and creating intimate bonds. The stakeholders offered affection, both physical and verbal, such as giving a hug to the winner of the mah-jong game, approaching a resident with a gentle touch and holding hands, sharing a home-made dish, going to yum cha with staff and the family of other residents, sharing an orange or an apple with each other, or verbally expressing love and warmth toward each other. At the same time, however, staff and family members worked to manage tension and maintain some emotional distance from residents and families. The intimacy came with conflict, especially with residents such as King, who resisted Parkview’s regime, or Shun (Wai Woon’s son), who complained to the staff for delaying to administer a drug to his mother.

Humour was another resource that the stakeholders used to orchestrate a sense of common purpose in the groups. I wrote in my field notes:

One afternoon, Tsang, the physiotherapist, asked Kam Chi to stand upright and walk back and forth along the parallel bars at her usual comfortable speed. He made a joke, telling Beth (Kam Chi’s daughter) that her mother’s coordination, muscle tone and strength will have improved sooner or later and that Kam Chi will be able to dance ballet. Everyone laughed. (field note)
Meal times were a key opportunity for some humour, as several nursing assistants were typically present in the dining room. It was routine for Fong (a nursing assistant) to tell funny stories, at times flailing her arms and gesturing wildly, until her co-workers, some residents and families laughed. (field note)

At times, some staff and families relied on humour to gain compliance and shift the focus of a situation to avoid confrontation. Kam Chi became frustrated after learning that the Associate Director had thrown her Mothers’ Day flowers away without asking her agreement. This might have led to a verbal conflict if Beth had not used humour to cheer Kam Chi up by saying if Kam Chi were angry, she would like to Lucky (Beth’s dog, a Chinese Shar Pei with lots of wrinkles), as Beth understood Kam Chi didn’t want to have wrinkles on her face (field note)

Analysis of these triads shows that a relationship is situation-specific and changes over time. These ever-changing situations result in a kind of orchestration, as of a musical ensemble. The stakeholders in triads framed their interactions differently, particularly in the context of group recreational activities. In some of the triads, a mutually satisfactory pattern did not exist at the beginning, but “orchestration” of individual likes and dislikes took place which averted negative responses and worked towards a more harmonious triadic relationship.

6.2.2 Sense of cohesiveness
A group can hardly be regarded as a group, as opposed to a collection of individuals, unless there is some sense of cohesiveness. Cohesiveness refers to members working together towards a common goal, constructively engaging in common activities and events (Cartwright & Zander, 1959).

Every Saturday morning, a Chinese musical band consisting of three family members visited Parkview, offering live performances of Chinese musical instruments such as erhu, guqin, guzheng, xiao and pipa that lasted about forty-five minutes each. Both staff and families organised the performance to motivate residents to join in and generate a sense of togetherness, joyfulness and common purpose. One of the residents, Kwai, was the “Sheng” (the male vocal in the opera). Sum was the “Dan” (playing the female role). One of two female residents, who were room mates and close friends, had been a student of Pear Garden (the first known opera troupe in China) when she was young, sang the Peony Pavilion that the musicians played every week. Although one of the women, Ling, used a walker, she usually left the walker next to
her seat, moved to the centre of the group and sang. One morning, she hesitated before getting up to sing when the musician began playing the melodies. Helen, the nurse, said from across the room, “Get up! It’s your show!” Ling shook her head and said, “I can’t. I’ll fall.” Barbara, Wai Woon’s granddaughter, went over to Ling, pushed the walker aside, and held out her hand, urging Ling to move to the centre and sing. Finally, Ling got up and sang. (field note)

People present may be encouraged to join in by group members, for example, when the conditions for making friends are present. Compatibility of group members, making for a smooth integration of new members and socially isolated residents, is obviously important to smoothing over and resolving conflicts, and to trying to create friendship since that enhances cohesion. Sum is interested in the Chinese knotting group where she was valued and treated as a friend.

Shared power and shared success in group tasks, especially if this leads to an increase of status or other rewards, also produce cohesion. There was greater cohesiveness if a division of labour was created where members performed complementary roles.

At times, staff members’ efforts to create a sense of cohesiveness and set an energetic tone fell flat. This was the case during the “cooking group”, a weekly activity in which Man (Po Chun’s daughter) and Beth (Kam Chi’s daughter) cooked a special dish, usually a Poon Choi (Big Bowel Feast), which is traditional Hakka cuisine, for a small group of residents, families and staff. Some of the residents and staff did the cleaning afterwards. (field note)

Holiday celebrations and birthday celebrations were two important occasions in Parkview when a sense of togetherness was cultivated by recruiting residents and families to join in a common activity, resulting in a sense of cohesiveness. Although Parkview celebrated birthdays in a group once a month, staff members also held birthday parties for individual residents when possible. Nursing assistants, nurses and families were also invited.

On one occasion, Alex (Sum and Ming’s grandson, a Canadian migrant) ordered a large birthday cake over the internet to be delivered to his grandfather and shared with the residents and staff in Parkview. When Helen, the nurse, asked Sum to get in front of the camera with her husband, Sum hesitated and looked around the room. Her eyes welling up with tears, she said that she and her husband wanted everyone in the
picture, that “everyone is so wonderful here”. Although Alex could not attend the party, the staff videotaped the party and sent the video compact discs to Alex who is now living in Vancouver. Helen made a point of making both Sum and Ming feel that they were surrounded by family, by giving Ming a hug and Sum a kiss on the cheek. Residents, staff and other families also had a chance to mingle, eat birthday cake and catch up with each other. (field note)

Making an effort to be joyful and together was not limited to holidays and birthdays. Both staff and families routinely joined with the residents in everyday activities. They formed social ties with residents that they considered similar to kinship and friendship ties.

6.2.3 Negotiation for identity
At times an individual stakeholder actively worked to preserve his or her own identity when it was inadvertently being threatened, for example, when staff infantilised residents or objectified them by categorising them into groups. Identity work consists of practices in which a stakeholder in the triad worked to integrate the others’ daily life, support the residents’ and families’ social memberships and allow room for choice. The concept of identity preservation refers to the effort to acknowledge life experiences and provide opportunities for a person to continue with the activities that are important to him or her and to the family throughout the life in the facility (Coeling, Biordi & Theis, 2003). A resident is allowed to have the choice to act on his or her preferences or to fulfil a social role in which they find meaning, such as friend or community member. Families and staff also supported residents’ connection to their ethnic or religious identities through traditional foods, rituals and language whenever possible. But residents were not always allowed to act on their own choices. Families participating in this study usually looked upon their regular visit as being of great importance to the residents. The family’s input was welcome at Parkview. Family members were encouraged to turn to the director or the nurses on duty to address any matters at hand and to inform staff of any problems, concerns or special wishes. Furthermore, families were invited at random for a meeting with the administration, staff and representatives for residents to discuss any care giving issues in Parkview. This strategy of encouraging a family’s involvement and family visits appeared to be successful as a widespread family presence in Parkview was observed. However, the presence of relatives was not always viewed favourably by staff and
visits to Parkview were sometimes associated for relatives with feelings of frustration, resentment and anger.

The staff tended to be very respectful of family visits and gatherings and it is tacitly assumed that each family has its own mode of being together and relating to others in Parkview. The staff expect each family to set the tone in the triadic relationship. Failing to value family caregiving expertise and affective work has also been recognised as a source of conflict.

During lunch, a registered nurse came into the dining room to ask a nursing aide about Lee Ming, whom she took care of, as he had complained of discomfort in his buttock. A second nursing aide, who had been responsible for bathing Lee Ming, joined in the conversation. The nursing aides were in the middle of serving lunch to several residents. They explained Lee Ming’s symptoms to the nurse in public, and the conversation was audible from several feet away. Lee Ming was named during the conversation, seemingly without concern for his privacy. The emphasis of the nursing staff on the “body” dimension dominated in this context. This reinforced the medical model of care and the retention of the “patient” role as an instrument for fulfilling their professional responsibilities. (field note)

Po Chun has always been attentive to her personal appearance. She prides herself on her attractiveness and has lots of fancy lingerie and nightwear. She indulges herself. At one point, Mei Ling (the nursing aide) entered the dining room, sat next to Po Chun and greeted her warmly. Chatting quietly with Po Chun, Mei Ling pulled out a make-up bag from Po Chun’s purse and took out a compact, some blush, lipstick and eye shadow. She began applying make-up slowly and carefully, starting with the powder, then blush, then lipstick. Mei Ling said that Po Chun liked to have make-up put on everyday, but it depended on who was on duty – some nursing aides would do it for her, others would not. Sometimes, Mei Ling would call Man (Po Chun’s daughter) to buy lipstick in some new trendy colour. (field note)

Mei Ling’s interactions with Po Chun and other residents represented an effort to attend to the residents’ individual needs in an environment that allowed Mei Ling to help Po Chun maintain a presentation of self that preserved her sense of beauty and identity. It was a mutually agreed identity accepted by all stakeholders in the care triad.
These descriptions portray the ways in which the stakeholders negotiate the triadic roles that influence how their experience “fits into the lives” of the residents in Parkview.

6.3 External forces

In the words of the sociologist Jaber Gubrium (1993), the residential facility intrinsically intertwines the characteristics of home and hospital so that it becomes more complex than either one. The subtle influence of two external forces that were at work in Parkview constitute an important, friendly yet overlooked aspect of a triadic relationship. These external forces are institutional influence and situational reality.

6.3.1 Institutional influence

Parkview’s philosophy emphasised residents’ individual life histories, family input and roles, and interrelatedness between the stakeholders. Parkview’s orientation towards the development of relationships between stakeholders rested on emotional warmth, the feeling of being with family or kin, and a sense of togetherness and belonging. The family-like atmosphere created opportunities for integrating residents and families into Parkview’s daily life. The Director, Lillian, articulated a feature of relationship development that closely reflected the mission statement’s focus on family or kinship-like relationships. Lillian stated that among her priorities were promoting solidarity and harmony between the stakeholders in Parkview, promoting “resident-centred care”, responding to the needs of families and advocating a sense of collaboration. “Well, there is a concept that I have adopted, ‘solidarity among all’.”

She also tried to provide ample training to help staff members learn how to “put the resident first”. Lillian’s key strategy for cultivating the kind of triadic relationship she hoped to achieve was to have a mediating role and to encourage residents, family members and staff to speak with her directly about their concerns.

Lillian’s approach to staff relations was part of her mediating role. She reported that she got involved in conflicts between staff and residents’ families, which are fairly common in long-term care facilities, and she attempted to mediate in a way that cultivated mutual exchange, respect and solidarity in the triadic relationship. She said, “I’m the person that the residents, families and staff come to (when there is a concern)”. She continued:
The residents and families throw a lot of accusations around. They don’t understand that it’s not one-on-one service here... I listened to what Shun (Wai Woon’ son) said. He got frustrated when the nurse refused to administer the drug to his mum before the medication round, so I tell him that staff have to follow the routine. I believe what you’re telling me, and I understand what you’re saying, now let’s go and talk to the staff and try to work it out. And I try to mediate and make peace. (Lillian, the Director)

Lillian reported that she tried to find out directly from staff what they had encountered when conflicts arose. At times, staff felt a lack of mutual respect and appreciation from the residents and their families; Lillian responded to this by placing signs directly on the wall of the lounge, asking them to be respectful toward staff who cared for the elderly residents by co-creating a harmonious atmosphere in Parkview. Lillian related to each person, resident, his or her family and staff on a social basis in keeping with the institutional vision as a place where every effort at working out of a sense of solidarity was appreciated. Lillian’s style of interaction contrasted with the quality often expected of the role of Director, particularly efficiency and authoritativeness. It was not uncommon to find that the triadic relationships of residents, family and staff were influenced by the mediating role of the administration.

6.3.2 Situational reality
The medicalised approach to care in some situations set the stage for treating the residents as objects or instruments for performing professional duties, where residents become a means to an end in caregiving routines. The strict division of labour allowed frontline staff, particularly nursing aides, to attend to the routine physical needs of residents while maintaining noticeable, unconnected relationships. At times, nursing aides patiently fed residents until their plates were empty, with hardly any words exchanged with them. The lack of verbal exchange between the nursing aides and residents contributed to the conception of residents as bodies that needed to be fixed rather than people to be treated as a whole person. In addition, it was observed that residents were treated as children through language, and age-inappropriate activities.

Because of Lee Ming’s physical deterioration, he was put on adult sanitary napkins. His napkin is changed every four hours. It would have been safer to restrain Ming in a geriatric chair in the morning. Mr Lee’s reason is that, “The nursing aides can’t be
watching him 24 hours a day, we can’t rely on you (Sum, his wife) to look after him”. (Mr Lee, Lee Ming’s nurse) (field note)

Mr Cheung (Kwai’s nurse) initiated a meeting with William (Kwai’s son) to discuss his father’s failing vision and explore if there were any other alternatives as Kwai had a habit of going for yum cha every day. After listening to what Mr Cheung’s said, William appeared impatient and said, “Then what? Your responsibilities include providing services that might be required for the health, safety and wellbeing of my dad; you have the obligation to keep him safe. If you think it is a danger to him, then you should not let him leave the facility on his own. It is so simple and logical.” Then William turned to Kwai, saying, “as long as you are living here, you are bound to follow a set of rules and customs. There are meals provided here, why do you want to go out everyday for yum cha?” (field note)

At times, staff members actively worked with the residents and their families in their care process, while inadvertently infantilising or objectifying the residents in some situations. These external forces indirectly influenced the triadic relationship.

In this chapter, three pivotal attributes have been described as separate features of each stakeholder. The connectedness across these attributes that shapes the triadic relationship will be illustrated in the next chapter.
Chapter Seven
Discussion

In taking a social constructionist approach to grounded theory, I was challenged to observe and listen to all stakeholders of the care triad being investigated in Parkview. Building on the information provided in Chapter Six, this chapter may present some level of overlap or repetition. However, this chapter is designed to provide a more in-depth understanding of connectedness across the three pivotal attributes (individual, communal, external) and of issues not addressed in the previous chapter. The connectedness across these attributes helps to illustrate the dynamics that emerged between the three triad members in the care triad, the resident, the family and the staff.

The sections of this chapter are organised according to the three key themes that arose in the study. These themes reflect the complexity of relationship in the long-term residential care setting, particularly the interface between power, control and external factors, which ultimately shape the triadic interaction pattern. The first theme is an empowered citizenship for those who live, visit and work in Parkview. The second theme is the impact of a tripartite engagement in care with important consequences for the relationship between residents, family and staff. The third theme is about the conscious alliance that emerged in Parkview. These themes are discussed in relation to the literature reviewed in Chapter Two and the theoretical perspective that guided the research, which drew on post-colonialism, post-colonial feminism, symbolic interactionism, intersectionalities and Foucauldian epistemology.

7.1 Empowered citizenship

For the residents, families and staff, there was an empowered citizenship that was deeply connected to their association with Parkview. When an individual enters a long-term care facility to live, visit relatives or work, they cross a border and become invisible to the many people who are not part of this microcosm within our broader society. The findings from this study raised issues that intersect identity, power, participation, difference and, ultimately, citizenship for those who live, visit and work in Parkview. This section is organised into three subsections relating to residents, families and staff. The theme empowered citizenship that emerged in Parkview generated three distinctive care triads, namely the resident-driven triad, the family-
driven triad and the staff-driven triad. In the resident-driven triad, the elderly residents expect family and staff to conform to their opinions and ways of doing things. In this type of triad, the residents struggle with their desire to retain acknowledgement of their identity and maintain their own independence in the face of institutional expectations of conformity and their own failing abilities. In the family-driven triad, family members reconstruct their sense of identity as a consequence of role changes and taking on new tasks formerly not performed by them. In the staff-driven triad, the residents’ individual preferences and needs are subordinated to the rules of the institution. The residents appear to be willing participants, believing that the staff should be in charge and will help them to meet their needs. The residents are obedient and compliant, while the staff member enacts a traditional hierarchical relationship.

7.1.1 Empowered citizenship of the residents

For residents, the border between living “at home” and living in a long-term care facility represents important elements of Hong Kong society – the perception of going from being part of the “productive” world to being a dependent member. Placing the elderly in institutions is no longer solely the Western approach to dealing with the needs of the elderly who require ongoing care (Lee, 1997, 1999). There are more and more frail, older people who can no longer be assisted to stay in their homes and for whom the need for skilled care arises, and they must thus navigate a system of long-term care to safely manage chronic illness and disability. Stafford (2003) compared living in residential care to a “double burial” in which the institutionalised elderly residents experience a social death upon admission to the long-term residential care facility, and are consequently isolated from the world of living. Beginning with Gubrium (1975) and his work at “Murray Manor”, an institutional scene has been portrayed to describe the residential space and the elderly residents who live there. Residents had a limited amount of space, which was often furnished with institutional beds and dressers to facilitate care; they were expected to eat in common areas with little choice about the kind of food that was prepared by staff; and they were often medicalised and pathologised by staff rather than being viewed and cared for as individuals. As asserted by Savishinsky (1991), we live in a society that institutionalises the dependent, not just because of illness but also for social reasons. He states, “we are, in a medical, social, and political sense, an institutional society” (p. 238) with a history of creating spaces outside of the common social space for those
deemed marginal – the criminals, orphans, infected, intellectually disabled and of course, the frail elderly. Foucault also provided insight into the heavy reliance on surveillance and discipline as methods for controlling those in institutional setting (Foucault, 1977). Over time, there have been evolutions and revolutions within the marginalised space of the institution, with some of these groups becoming “deinstitutionalised”, while others continue to be excluded from the broader society (Savishinsky, 1991).

In this study, Parkview is structured as a home place: both a space which facilitates independent daily living, and a local construction that is negotiated and contested in the practice of its use. It is a home setting that shapes and maintains personal identity by maximising a sense of personal competence and control; it is also a “place” in that it is a shifting social space maintained through resistance, negotiations and collective social life. The experience of staying at home plays a critical role in maintaining a sense of personal identity (Rowles, 1983; Rubinstein, 1989). This is because home, unlike many institutional care facilities available to frail older people, does not compromise their independence. Home is a place where control over one’s own life can be freely exercised (Fogel 1992; Groger, 1995; Hauge & Heggen, 2008; Rutman & Freedman, 1988).

In this study, pivotal attributes of the residents in the resident-driven triads illustrated the concept of citizenship. The image of passive recipients of assistance living in an institution is replaced by the active, self-sustaining individuals living at home. Activity is seen as volunteering in Parkview and in the community. On a personal level, activity is understood as the self-management of health and life, albeit as an “expert patient”. Residents in resident-driven triads act as independent agents and are empowered through choice and voice while living in Parkview. One important choice has been depicted as control over food. For the Chinese, food is important. “To the ruler, the people are heaven; to the people, food is heaven” (ancient Chinese proverb). For the residents, food was seen to represent sociability, pleasure, power and control as well as important aspects of identity. Citizen voice is portrayed in terms of consultation and participation. Power and participation have been seen as two of the central elements in the concept of citizenship. At times, when staff tended to medicalise food on the basis of a diagnosis (such as diabetes and hypertension) rather
than treat it as a basic need, they did not allow residents to choose whatever they wanted to eat. For example, the staff decided Uncle Kwai had to be placed on a diet because he was considered to be overweight. Uncle Kwai was not allowed to win chocolate at playing chess, staff substituted a pack of biscuits or handkerchief instead. Uncle Kwai was not happy with this being decided without getting his prior agreement. Residents in the resident-driven triad intentionally refused to eat as a means of having some measure of power and control over their own body. Beyond medicalising food, it has also been noted that staff sometimes tended to pathologise residents. For example, it was common for some staff to view residents such as Lee Ming as one of a homogenous group of paraplegic persons. Labels used to refer to residents included “morning showers group”, “feeders”, “bed-bound”. Residents in the resident-driven triad struggled to maintain a sense of identity, despite being perceived as time-consuming and troublesome by staff. Efforts to maintain identity took the form of reviewing their life stories and engaging staff in predictable conversations and activities, such as playing mah-jong.

Apart from the concept of power and identity addressed in the previous paragraph, the notion of difference and how they were being perceived was challenging for residents in the resident-driven triad. As described above, residents were categorised in groups by staff into “morning showers group”, “feeders”, “bed-bound”, etc. Residents such as Chan King who expressed their dissatisfaction directly to management or the director were labelled trouble makers for being different from the “typical” residents who were silent and willing to follow rules and routines. These groupings resulted in individual differences being erased and identity being wiped away. These residents were problematic and required greater care attention. Some staff commented during field work and interviews that they felt these residents were manipulative. The result of these comments was that staff might withdraw their services, such as room cleaning or personal care. The consequences of being labelled a trouble maker included isolation and marginalisation of individuals and groups.

Post-colonial theorising helps to inform this problem of difference. Historically, concepts of race, ethnicity and culture were signifiers of difference (Kirkham & Anderson, 2002). In keeping with Charmaz’s social constructionist version of grounded theory, the analysis was enriched by clarifying my epistemological premises
and by reaching back into extant theory of the post-colonial era for example. It provided me and future researchers with sources of conceptual, explanatory and predictive comparison.

Empowered citizens’ participation in the resident-driven triad aimed at upholding independence, rights and choices. They added voices to the interaction process and engaged in their own care (Zeitz et al. 2010). Post-colonial feminism helps to inform the movements of Black women who were increasingly dissatisfied with their position of being marginalised in the society (Mohanty, 2006).

An overview of the resident-driven triad is given in the following section. The resident-driven triad is triggered by a situation in which the residents seek to make the decisions in the care process. The resident has a strong desire to retain acknowledgement of their personal identity and maintain their independence in the face of institutional expectations of conformity and rule following. The resident expects family and staff to conform to his or her opinion and ways of doing things. In this type of triad, the resident emphasises the maintenance of the self over the group and personal independence over social interdependence. The resident has important traits of self-expression and self-reliance, speaks his or her mind freely, and emphasises his or her individual attributes and personal interests.

Ms Au, the social worker, told a story about King, in the rehabilitation unit after a stroke and who was soon to return to Parkview. As part of the discharge planning process, Ms Au was responsible for ordering residents’ home equipment as needed, such as walkers, wheelchairs and other assistive devices. As Ms Au and other nursing staff attested to, this was only one component of a cumbersome and time-consuming discharge process that constituted a large part of the social worker’s workload. The physiotherapist working with King recommended that she use a walker with a small seat attached, allowing her both mobility and the safety of a place to rest. As Ms Au began to make special inquiries to make sure the particular type of walker was covered by King’s insurance, King insisted having the walker in red instead of the usual black. King refused to use the new walker unless Ms Au asked the supplier to change it to her preferred colour. King said: “Why don’t you ask my preference before ordering? I don’t think you are generous enough to pay for me; if that were the case, then I would have no choice but to accept your gift, but I don’t think that was the case!” Given King’s self-centred personality, Ms Au took the time, despite her heavy workload, to make special phone calls to the
supplier to see if she could place the order in King’s preferred colour again, and ultimately it took King two months to get her walker in red. (field note)

In this type of triad, residents maintained and adopted roles they perceived as desirable.

As long as Kwan could remember, his mother, Yuk Fan, had been intensely involved in his life and highly protective of him. His life had been her life. Throughout his years at school she had insisted on her involvement in all his school work and always collected him from school. She had maintained an unwavering interest in all that he did at work and remained involved in his social life. She prided herself on knowing his friends, was anxious for them to become her friends and expected them to visit her. Kwan went to considerable lengths to meet his mother’s longing to be involved in his life. He visited frequently, notwithstanding his wife’s resistance, but did not enjoy his visits. Kwan nevertheless tried to establish a distance between himself and his mother.

*She complains that I should tell her more about what I’m doing. I don’t share the mundane day-to-day things which she’d like and I must say I’m not overly interested in the things she talks about. She phones me and her eight grandchildren at least once daily to discuss how things have gone that day, to give me a list of things to bring on my next visit. I’m careful not to talk about my worries or personal feelings with her. If I felt depressed I wouldn’t talk to her about it. I keep a lot of things from her. I can predict her reaction to some things so I avoid the reaction by not telling her. But half the time this backfires because she finds out some other way and then I get into trouble – “why didn’t you tell me that?”* (Kwan)

There was ongoing tension between Yuk Fan’s craving for a sense of self as a mother and intimacy with her son.

*We go in cycles. If we have good times and are friendly and see her three times in three days, she tends to assume greater intimacy and greater rights to know things and expects to be able to tell us what to do as a mum. She starts to expect more than we’re prepared to let her have, so we withdraw a bit. So she gets offended and we don’t see her as much and she just gives “yes” or “no”*
answers. When we get closer she tries to get too close and too involved, so I have to draw back. (Kwan, Yuk Fan’s son)

In this type of triad, residents who find a great deal of satisfaction in their past identity tend to see it as highly salient to their lives. This implies that the residents successfully retained the role identity tied to their past lives regardless of their current role in Parkview. Yuk Fan has focussed on maintaining her personal self-identity to the exclusion of working with others in the care triad. Kwan said, “when she is with me, I have no life. She got all mime. I hate it. I resent her for that.”

Po Chun also illustrates the highly salient sense of self in her life by constantly grappling with who she is, who she was and what roles she can manage or maintain. These issues shape a sense of self deeply embedded in situations where she acts unilaterally without recourse to her care triad. Symbolically, her ability to mobilise her own financial resources signifies her independence and identity. Formally a business woman and stay-at-home mother, Po Chun has grasped every opportunity to make decisions, which has shaped her identity and life course, based on self-reliance. For instance, Po Chun even made decisions independently of her husband when he was alive. She elaborates:

I had to do things on my own. My husband stayed in Shenzhen all the time and I was the one left to take care of the house. I was left to budget, make decisions and raise my daughter, Man. I had no choice but to do it on my own (she laughs)... I got used to it, so when the doctor told me about my problem and the surgery, I didn’t tell anybody, I didn’t ask my daughter to help making a decision. I just told her what I had decided. (Po Chun)

In this resident-driven triad, the residents wanted to maintain their personal identity but the other triad members might not accept them doing so. The resident may continue to commit to the triadic relationship, yet other members may prevent the development of an involved relationship, or do not want or are not allowed to enter into a close relationship through negotiation.
7.1.2 Empowered citizenship of the family

For families who visit residents living in Parkview, identity, self and participation were also important elements in the process of empowering citizenship. Instead of the prevailing concept of maintenance of personal self in the resident-driven triad, the family-driven triad is triggered by the family’s consideration of role maintenance in the face of institutional expectations of conformity and the failing abilities of their relatives. Family members do, however, reconstruct their sense of identity as a consequence of role changes and taking on new tasks formerly not performed by them.

Upon admission to a long-term care facility, the role of family members can go from intense, hands-on care to one of outsider, a visitor who watches and monitors the “experts” provide care. This can be a tremendous change for families who have been providing day-to-day care at home.

Barbara, whose grandmother suffers from terminal cancer, views her assessment of her grandmother’s situation and the redistribution of roles as directly linked with the caring process for her grandmother. For example, her grandmother’s prognosis presented a need to assess what needed to be done while simultaneously mobilising resources and taking action. In a take-charge manner indicative of her personality, Barbara “assembled” the support of her father, Shun, and other family members in an effort to enact the proper resources and balance the load of care for her grandmother, a process she described as follows:

*I didn’t really think about it nor discuss it with anybody. I got the call from the nurse that grandma was sick, and we were all with her during the doctor’s next visit, and we heard what the doctor had to say. After that it was like, okay, grandma was sick, what do we need to do and what does she need…. I don’t even think I really discussed it with our family members or the staff here, even though they offered professional support. I just acted. (Barbara)*

Barbara’s comment suggests that in some situations there was asynchrony between the family members, with one member unwilling or unable to develop the relationship to the level desired by another family member.
I never did this in the past. It was my usual practice to ask grandma for her preference and discussed it with my dad, but now I could not...... I really didn’t know what to do once I knew that grandma had cancer, it was a shock to me and to my family..... I was the one who decided we had to fight, though she was at the end stage. I could not let grandma just waiting to die. Then I discussed with the doctor what grandma needed and who could do what in the family. I knew I would be the only commander in this battle because grandma no longer could decide and maintain her role and independence. (Barbara)

Some family members claimed the residents were mistreated and described their initiatives to protest against the staff so as to protect the personal self of the residents. They consistently positioned themselves as the monitor of the residents’ identity through maintaining the self. Before Sum, Lee Ming’s wife, moved into Parkview together with her husband, one of the nursing aides told her she did not need to visit him everyday, and she responded with “I’d need to go every day. That is my thing.”

The analysis revealed that some family members in the family-driven triad would assess the situations grounded in their implicit or explicit opinion that the residents’ identity and habits were maintained while living in Parkview. Parkview’s routines were commonly considered as problematic, included bedtimes and the arrangements for meals. Some families described how things used to be, for example, “my husband always used to...”, “I know that mum never liked to...”. Some of these comments from the families were built upon comparisons; between here and there: “at home he used to stay in bed until nine o’clock, but in Parkview, he has to get up at seven in the morning”, and between family and staff: “I know from experience that there is no point putting my dad on a diet, but the staff here think he has to lose weight. I brought him some home-made food at meal times. I think there is no point in following what the staff say....” This family-driven triad is also characterised by carrying out some actions that directly contradict the staff’s professional knowledge and competency. Blind faith in the staff’s technical competency was absent. For instance, Man discovered that Po Chun suffered from an in-grown toenail, which is easily treated by removing the offending nail wedge. After consulting the in-house doctor, Po Chun was prescribed a course of antibiotics. Nonetheless, Man disagreed with the staff’s way of managing her condition and just told them to discontinue the drugs and instead took Po Chun for a podiatrist’s consultation instead.
Some family members expressed dissatisfaction with the change in the appearance of the residents. They revealed the importance of maintaining the way the resident used to be and opposed to how he or she was dressed in Parkview:

*He has never worn a T-shirt... they dress him in a T-shirt and a pair of tracksuit pants and he has never worn those. A T-shirt is almost like a pair of underclothes and not something you walk around in... So eventually I took these clothes away. He can’t sit there in tracksuit pants, just because the staff think they are easy to put on, it is ridiculous.* (Sum)

Another family explained the importance of maintaining her brother’s shaving routine.

“My brother used to have wet shaving with foam lathering applied, not an electric razor, and he had always shaved twice a week.” After describing how the staff neglected his brother’s past habits, she concluded “sometimes they don’t ask him and just use an electric razor at their convenience... I think that is a bit of an insult.” This family member said that she had spoken to the staff about her brother’s shaving preference and was told, “I know”.

When a family is dissatisfied with the nursing it inhibits a relationship from developing and maintaining their sense of identity. The situations described above also illustrate how conflicts in the care triad arise. The staff believed that the daughter exaggerated the importance of her father’s clothing, but from the daughter’s point of view, her concern might not have been at the root of the issue of what to wear but rather a matter of the resident’s sense of self. In this sense, staff may question whether family are actively participating in care. Some of the families under investigation in this study felt that the structural and organisational conditions in Parkview hampered power-sharing and limited participation in the sense of citizen power.

### 7.1.3 Empowered citizenship of staff-driven triad

In this type of triad, the resident appears to be a willing participant, believing that the staff should be in charge and will help him or her meet his or her needs. The resident is obedient and compliant, while the staff enact a traditional hierarchical relationship. As discussed in Chapter Six, some caregiving practices in the facility, for example, in task-oriented care making decisions on behalf of residents, shaped their opportunities for maintaining a sense of identity. Disregarding the residents’ sense of self often
manifests in the some situations, for example, around issues of medicalisation in the staff-driven triad.

The medicalised approach to care set the stage for treating the residents as instruments for performing professional duties, where residents become a means to an end of the caregiving routines. The strict division of labour allowed frontline staff, particularly nursing aides, to attend to the routine of physical needs of residents while maintaining a noticeable detachment, not engaging in any social interaction with the residents. For example, there was little informal conversation between nursing aides and residents as part of the daily routines. This was especially noticeable during mealtimes, where nursing aides were responsible for spoon-feeding residents who were unable to feed themselves. Nursing aides usually approached residents without verbally acknowledging that the meals were ready, what to eat, when to eat (e.g., whether the residents would like to eat when their families visit), what was about to happen, etc. They usually stood next to the residents when feeding them, rather than sitting in a chair and facing them. Often nursing aides would engage in conversation with each other while they fed the residents, either about their personal lives, events in the news, or information about the residents themselves. Nursing aides patiently fed the residents until their trays were empty, with hardly any words exchanged with them, for example, to inquire whether their hunger was satisfied or whether they would like to have a spoonful of soup between helpings of solid food. What was particularly striking about these task-based routines was that they created barriers to social interaction between residents and staff. Staff were typically focussed on gaining compliance, evaluating the residents based on their cooperation or on whether they had finished with the food. For example, after feeding Lee Ming, a nursing aide commented to her co-workers, “he is very good, he finished his tray without spilling any food from the plate”. One afternoon, Bing, a nursing aide, gave Lee Ming a nutritional supplement. The nurse on duty, Ling, had prepared the medication for Lee Ming, and she added the medication into Lee Ming’s cup without getting his consent, then left. Lee Ming and his wife were aware of a white layer of medication at the top of his cup with the pink nutritional milk-shake. They had no choice in this situation but to accept.
Field notes also recorded the instrumental treatment of residents which threaten the residents’ sense of self, e.g., “one aide was a little rough with moving furniture and residents”. This observation was recorded to reflect a nursing aide’s effort to rearrange the dining table to prepare it for serving lunch. The tables and chairs needed to be set up according to the usual seating arrangements. As was often the routine, nursing aides had limited time to complete the task of rearranging the tables and getting everyone seated at the same time. Residents who needed help were often pushed to the spot and sat still in a chair. In these situations, residents were moved as if part of arranging the furniture. This “ordering” of residents particularly destroyed the sense of self.

Some staff-resident interactions during group activities often mimicked a leader-follower relationship. Staff took the role of manager and disciplinarian instead of serving as a facilitator for an activity geared to adults. The leader and followers lack interaction, but guidance occurs. During a mah-jong game, residents use buttons to instead of money as prize. Lin, the nursing aide, prompted Uncle Kwai which tiles to discard, “Don’t discard this one or you’ll lose. Use your brain and think first.” Kwai disregarded Lin’s advice which Lin interpreted to mean that he was not taking the activity seriously, saying, “you are so stupid, I told you what to throw out, but you don’t listen”.

On another occasion, in preparation for the Tuen Ng Festival celebration, Carol, who worked in recreation, felt the need to intervene between Kam Chi and Shun, Wai Woon’s son, when they disagreed with each other over how the melody of a Chinese Opera was played. Carol addressed Kam Chi as a child and told her to “be nice and don’t argue”. The infantilisation of the residents took their identity away. The staff took the role of controlling the interactions in the triad without getting the other members’ consent.

Any triadic relationship is the result of interplay among residents, families and staff until a mutually satisfying relationship is reached as argued by McGilton et al. (2011). If one triad member is unwilling or unable to commit to the other members, a unilateral relationship focussed on a single one stakeholder will dominate. Lack of negotiation in these situations can be a barrier affecting the pattern and dynamics of the interaction between the elderly residents, their family and the staff.
In summary, the concept of citizenship in the long-term care facility is something that must evolve. While past research has discussed the loss of identity for residents, as Davies (1989) put it in her historical study of a long-term residential facility, “in exchange for shelter, food and care in their ageing years, residents gave up the basic tenants of citizenship – the personal dignity and the right to determine where and how they would live” (p. 78), in Parkview empowered citizenship was connected to residents, family and staff. The concept of citizenship stands in a cyclical relationship with identity and dignity (Craigs, 2004). When these elements are considered together – the preservation of identity, its consequences for personal dignity and their meaning in relation to citizenship – the theme of empowered citizenship is important in the development of a participatory, inclusive community for citizens who live, visit and work in a long-term residential care facility.

7.2 Impact of tripartite engagement in care

It was within the day-to-day milieu of living, visiting relatives and working in Parkview that these three diverse stakeholders – residents, family members and staff – converged and interacted. In Chapter Five, I presented findings that relate to each stakeholder’s attributes and, to an extent, their motivations in establishing and maintaining the triadic relationship with each stakeholder perceiving their identity and participating in the three distinctive care triads that emerged in Parkview. In chapter 5, the theme empowered citizenship was shown to contribute to the relationship and how the residents, family members and staff uphold their identity and get involved in the care triad. In this section, I discuss how the three stakeholders related to each other and were engaged in their care at the interface of hierarchies, power relations and acts of resistance.

The ability of residents to be engaged in their care and have input into their daily routines was largely dependent on their abilities to express their needs and their physical ability to make changes for themselves. When daily routines were changed for staff and impacted on residents’ daily lives, there appeared to be negotiation around these changes. In this study, it was found that when triad members interacted with other triad members, either acting on their own behalf or as members of the care triad, imperfect alignment of preferences was inevitable, so all interaction involved some degree of conflict. This echoes Foucault’s (1980) argument that all relations
involve some forms of power and resistance. Negotiation is the process to be engaged in where the rift in connectedness gets restored and conflict is resolved. Some members are likely to seek out interaction differently from those with whom they feel a positive bond (Harmer & Orrell, 2008; Pillemer, Suitor, Henderson, Meador, Schultz, Robison & Hegeman, 2003). Negotiating parties voluntarily commit themselves to the course of action they agree upon (Øien, Steihaug, Iversen & Raheim 2011). I have written in my field notes:

A number of residents talked to me about the changes in the dining room seating arrangement at Parkview. I had been told that, From the staff’s perspective, the change was to place residents who lived in the same room at the same table in the hope that this would foster relationships. From the residents’ perspective, though, this change was made for the convenience of the staff. Susan, King’s daughter, explained how it impacted her mother: They just restructured the table, all the tables, and moved everybody around, and she said it was for the nurses’ benefit so that I guess the residents of the same room would be sitting in one place so that the medication could be given out easier and faster. Mum was not as comfortable with the new people at the table. I think it’s really odd with someone sitting next to you taking their teeth out. (field note)

She went on to explain how her mother dealt with the situation:

She finally moved herself, “no, I’m sitting here, not there”. Again, Helen probably would have backed her up but as I say she’s very independent, she is not shy to air her views, her beliefs, you know. This is my mum. (Susan)

In this situation, King was able to move to her preferred spot because she was physically able to get there and was able to negotiate and articulate her point of view. She successfully resisted and was engaged in the action of moving. Negotiation in this situation required physical and cognitive abilities for the residents to act and react, and if necessary, mobilise their family members and other staff to speak on their behalf.

Even residents who were not able to verbalise their complaints sometimes engaged in quiet acts of negotiation and resistance. On a day I was following Bing, the nursing aide, during her shift, Lee Ming was asked to have a shower while he was waiting for Alex’s, his grandson’s, visit. In this excerpt from my field notes, I describe how the
resident attempts to control his own actions, and resist those imposed on him by others, and speak up despite his physical limitations:

He (the resident) is sitting in a wheelchair with his back to us watching a show on television. One of the nursing aides starts to move him out of the room and he starts to yell and says: “I am not going to have a shower now”. The nursing aide stops moving him and says, “OK, we’ll wait until after you’ve finished watching the show and let you be the last one to have a shower”. (field note)

In this example, the resident resisted the action of the nursing aides and become engaged in making his own decision to take the shower or not in the only way his body was able to express his preference. In this singular act, the resident was able to speak up and be involved in his own care despite his physical limitations.

At the interface of power and resistance, the staff were another group who were part of the dynamic, actively engaged to assert their identities and desires (Hogg & Abrams, 1988). A nursing aide, Leung, related his experience to me when caring for Lee Ming:

\[\text{Sometimes when I think about it, I realise it’s kind of, when you put yourself to them, it is hard. Have lost the self, someone to tell them what to do, what not to do, when to do, when not to do, how to do, what to eat and what not to eat etc. and etc. So for me, it is something what to do with them is to respect what they want. I ask them what they want to be done and, how they like to be done and which one they like to be. So I just say, “OK, I respect what they want and so that’s what I do with them”. But still, it is difficult to have a couple of residents here, three or four of them to take care of at a time. One time, I forced Ah Keung, a resident with stroke, he doesn’t want to have shower while he and his wife were waiting for his daughter’s visit. And he is wet and everything, he has to be washed. Ah Keung doesn’t want to stand up, he doesn’t want to do anything, he is just sitting and waiting. You know what I did to him? I told Yee (his wife) “Ah Keung’s now wet, if he didn’t have shower now, it’s easy for him to get buttock sore”. So what I did to him, I take off his shirt, and he doesn’t want to stand up. So I said to his wife, “help me, at least he has to have his napkin changed”. His wife told Ah Keung that their daughter and grandson were going to have yum cha with them. He could not go if he was wet. His wife} \]
told me to shower him with his pants and with his chair, it’s wet. Then I washed him and he said, “Both of you’re bitch”. He goes like that to me. I said, “well, we’re bitches, but we’re just trying to help you. We want you to be clean.” I said like that. “You’re wet already, your grandson’s not going to come to you because you’re wet. And he just went on saying, “bitch, bitch” . But then, after I have washed him and everything, and all of a sudden he said, “thank you bitch!” then he laughed. (Leung, a nursing aid)

For the nursing aide, this was a story of success, as she had used her physical strength with the help of Ah Keung’s wife to make sure that Ah Keung was clean before going out with his wife and family and left satisfied with Ah Keung’s “thank you”. Ah Keung, through his attempt to resist, and his wife became engaged in his own care, leaving his pride intact.

Lopez (2007) discussed the work in the long-term care facility, describing how limited resources fosters a situation where staff must break rules in order to get the task done and complete their work within the time allocated. He further described how this mismatch between staff/time and task/residents’ and families’ desire for service fosters a culture in which tension and conflicts are created in the triadic relationships. In this study, conflicts were evident during the interactions between stakeholders. For example, during observations and interviews, staff talked about negotiating with the residents to get them to shower and to finish their meals. Sometimes staff sought help from family members in order to complete the care with the least amount of conflict. At other times staff negotiated with residents, for example, with King as to whether or not she wanted to have the laundry done when the staff knew that King would do her own laundry. Dealing with conflict also opened up spaces for negotiation among the stakeholders. Hewlett (2010) highlighted that conflict is a motive for engagement in her study of community participation in decision making, saying that, “the more conflict there is, the more likely there is to be interest…in the stakeholders’ view…and therefore…participation and engagement…that’s inevitable” (p. 258).

Family members, particularly those who spent large amounts of time at Parkview, were also part of this power dynamic to get a tripartite engagement in care. Like residents and staff, if they overstepped their boundaries as others/outsiders, there
could be consequences. This echoes what Said (1978) perceived as the “others” in his post-colonial theory. To give an example, the husband of a resident, who spent the majority of each day at Parkview, told me what happened when he complained about the behaviour of one of the kitchen staff to Lillian, the Director. In my field notes, I have written:

There was a husband supplementing the low staffing by assisting with distributing food and by doing the afternoon tea and snacks. This husband said: “The boss told me family members are not supposed to be behind the kitchen counter, that the only people that are supposed to be behind the counter are the staff.” I brought it to her attention that I just wanted to help. She told me, they would welcome families helping whenever they can, but I said, “you’re telling me I can’t do it there”. I go in there and I always wash my hands before I go near the food or anything and usually staff are in there who put the food on the plates and I just take the plates to the table. Most times I stay around for afternoon snacks as well. Some of the staff are fine, they get the tray ready for the snacks, but a lot of the time, staff are busy. So I said, “well, if they’re not there, how do I get the snacks for my wife?” They said “we’ll ask someone to do it for you”. I said “who do you ask when there’s nobody there?” (field note)

In this example, the director is in the position of having a lot of power, explicitly using her power to control others, thus reinforcing the impression that a hierarchy still exists at Parkview. At times, negotiations could have outcomes that suited all stakeholders and engagement in care was encouraged, but negotiations sometimes invoked demonstrations of power. This power illustrated how individuals in traditional positions of power, such as administrators, used rules and regulations to uphold policies when convenient. Yet, because acts of resistance tended to benefit the smooth caring process through negotiation, it also opened up spaces for engagement in care. Drawing upon Foucauldian epistemology, these acts of resistance and negotiation reflect the dynamic nature of power in the triadic relationships between residents, family and staff. Power is not static, and there were acts of resistance expressed through negotiation in which power relations shifted and tripartite engagement in care was encouraged. In summary, relations of power in the care triad are complex and reflect the hierarchies. In this section, I discussed the impact of tripartite engagement in care which is the basis for effective communication, and together these are the foundation for mutual awareness, respect and understanding, which in turn is the foundation for relationship building in the care triad.
7.3 Development of a “third space” in the dynamic care triad

In addition to the tripartite engagement in care, the development of a “third space” shapes the development of the triadic relationship between residents, family and staff in Parkview.

As shown in the findings, throughout the study there were moments of relational care, but often they took place behind closed doors, witnessed by me during my field visits. In my field notes, I wrote:

I was following Helen (the nurse) on her shift and we walked into Lee Ming’s room and discovered Bing (the nursing aide) was reading Lee Ming’s mail to him and to Sum (Lee Ming’s wife). Lee Ming, Sum and Bing were smiling and obviously enjoying a few minutes of connections that went beyond the daily routines. Another nursing aide had come in to ask Lee Ming if he was ready to go for his shower but Lee Ming said that he wanted to wait a bit longer and then Bing laughingly said to all of us “now get out of here so I can finish the mail for Ming and Sum”. It was an occasion when I saw Bing appearing relaxed, not just focused on completing her duties but enjoying the moment with Lee Ming and his wife, Sum. Some staff took great pride in their work, particularly ensuring that residents were “presentable”. I witnessed Helen suggesting to Po Chun how to dress for her cousin’s birthday party, how to wash her newly bought lingerie, and discussing with Man where the discount shop was. There was also a great desire on the part of the staff to just spend time with residents and their families, despite the demands on their time to complete their work assignments. Yet, the reality of the work situation also meant that there were many external factors that inhibited this kind of relational engagement. (field note)

These moments fostered what Bhabha (1990) described as a “third space” in the post-colonial period. Bhabha (1990) introduced the idea of third space to capture a place of cultural hybridity where two forms of culture come together, resulting in the creation of new positions. This third space is interpreted as one where stakeholders from diverse backgrounds can come together to create a new space. It is in this new space that “identities can be recast, negotiated and reorganized, and what becomes the culture is reconstructed in this new space” (Kirkham & Anderson, 2002). Thus I could see a third space emerging in Parkview, places in which residents, families and staff, who come from different social locations and backgrounds, acknowledged but went beyond their differences and created a new pattern of relations care.
In addition, family members also created a “third space” with the residents. For example, as recorded in my field notes:

Man takes Po Chun to the restaurant where the family often went when Man was small to enjoy its signature dish of Swiss chicken wings. Helen confided in Man and Po Chun on one occasion that she also went to this restaurant when she was small. All the stakeholders enjoyed and regained their “lost moment”. (field note)

Staff who participated in this study realised, however, that it was challenging at times to foster the development of a “third space” and to provide care in a way that achieved satisfaction for all. Family members also commented that it was demanding for the staff themselves to meet all of the residents’ personal needs. As such, an alliance was formed to pursue a set of agreed upon goals – a conscious alliance. In Parkview, making residents feel cared for would seem to be a goal of both families and staff, and this conscious alliance was underscored in the situational reality, for example, by the need to complete large amounts of work in a short time. In this study, I witnessed residents, families and staff negotiating with each other so as to complete the task. For example, Bing (the nursing aide) would negotiate with King whether or not she wanted to have breakfast with its limited choice of food when the staff knew that King would refuse. A conscious alliance was formed between King and Bing so as to complete the task with the least amount of conflict.

In summary, this chapter began with an examination of the empowered citizenship of all stakeholders. Then I discussed the impact of tripartite engagement in care at the interface of hierarchy, power relations and resistance. The third section of the discussion focussed on the “third space” that was formed at Parkview. All of these issues are woven into discourses of ageing and ageism, which foster the socio-political milieu in which they exist. As well, within this socio-political milieu, the historically situated intersections of culture, age, class and group situate individuals in a hierarchical structure that persists through formal and informal processes of interaction. As suggested by Foucauldian epistemology, power was not static; there were acts of resistance in which power relations shifted through negotiation and engagement. These acts provided opportunities to open up and create a new culture, a new shared identity in the “third space” which are ultimately played out in day-to-day interactions between those who live in the facility, visit the residents there and work
at Parkview. As I turn to conclusions and recommendations in the final chapter, I am
drawn to the question of what the future holds for Parkview and for the long-term care
facility in the broader context.
Chapter Eight
Conclusions and Recommendations

A long-term residential aged care facility is a microcosm of our larger society, albeit intensified, where people from disparate backgrounds come together to live, visit the residents and work. Such a facility is unique in that, unlike a hospital, it is both a site of health care delivery and a place of long-term residence. The facility is often described as a site of difficult relationships for the residents, family members and staff (Hertzberg, Ekman & Axelsson, 2001). Generally, there is a lack of research on the triadic relationship in the long-term residential aged care facility and no research that took into account that each of the stakeholders affects or is affected by the caregiving relationship in the care triad. Previous research has usually been limited to investigate the factors associated with the quality of life and care in such facilities and the experience from a single or two-way perspective of the three main groups: elderly residents (e.g., Gubrium, 1975; Lee, 1997), family caregivers (e.g., Lee, 1999; Nolon & Dellasega, 2000) and health care workers (e.g., Pursey & Luker, 1995), with little consideration given to the care triad as an interactional, multi-stakeholder whole.

Despite the emphasis on the empowered partnering relationships in the long-term residential aged care environment, as enshrined in the policy paper of the Hong Kong Special Administrative Government called White Paper, Social Welfare into 1990s and Beyond (1991), partnership is yet to be achieved. It is not surprising then that the personal knowledge and individual abilities of residents and families as stakeholders often were unrecognised and/or undervalued, and therefore went untapped. The influence and role of each stakeholder has not been adequately studied, and most tragically, minimised. This has further challenged the success of creating triadic relationships in the stakeholder environment and being engaged in care among all stakeholders of the care triad.

The purpose of this study has been to provide empirical data and a theoretical understanding of this care triad in the context of residential care facilities in Hong Kong. The study has described and analysed the pattern and dynamics of the interaction between the elderly residents, their family and the staff with a view to informing professional practice and enhancing quality of care for residents.
The method of inquiry adopted was Charmaz’s strategy of grounded theory. Throughout the study, I was challenged to observe and listen to the stakeholders in Parkview, which allowed for a constructionist inquiry of the taken-for-granted triadic relationship that exists between residents, family and staff.

The findings from this study have been discussed under three key themes. First, an empowered citizenship emerged in this setting that generated three distinctive care triads, namely the resident-driven triad, the family-driven triad and the staff-driven triad. In the resident-driven triad, the elderly residents expect family and staff to conform to their opinions and ways of doing things. In this type of triad, the residents struggle with their desire to retain acknowledgement of their identity and maintain their own independence in the face of institutional expectations of conformity and their own failing abilities. In the family-driven triad, family members reconstruct their sense of identity as a consequence of role changes and taking on new tasks formerly not performed by them. In the staff-driven triad, the residents’ individual preferences and needs are subordinated to the rules of the institution. The residents appear to be willing participants, believing that the staff should be in charge and will help them to meet their needs. The residents are obedient and compliant, while the staff member enacts a traditional hierarchical relationship. Second, the impact of a tripartite engagement in care had important consequences for the relationships between residents, family and staff. Third, conscious alliances emerged in the relationship, fostering the development of a “third space” in the dynamic care triad. All of these themes were underscored in the situational reality by external factors, such as medicalisation of care, relations of power and discourses being influenced by the perceived frailty and vulnerability of the elderly, which were ultimately played out in day-to-day interactions between those who live in the facility, visit the residents and work there.

Although sometimes considered as a place where mundane, institutional routines dominate, this study has illustrated that Parkview is a dynamic site of intersecting forces and power relations. The study’s theoretical perspective provided the opportunity “to move beyond a single axis framework of analysis… to overcome the limitations of the oppressor, in which individuals are characterized monolithically as one or the other” (Alcoff, 1998, p. 484). Unlike previous research in the long-term
care facility, in which solo voices were heard about their experience in the relationship, the triadic relationships found in this study were socially constructed and positioned in the often historically situated intersections of class, the aged, relations of power and examples of resistance and engagement, all reflecting the complex dynamics of bringing together people from different backgrounds to live, visit and work in the same place.

8.1 Conclusions

I have drawn a number of conclusions from this study. First, the long-term residential care facility is a complex socio-political milieu where people from diverse backgrounds come to live, visit the residents and work together. Within this context some residents continued to assert their individuality, whether by disrupting care when it was not respecting their desires and preferences, or through acts of demonstrating their independence despite physical restrictions, or by mobilising the resources of their family advocates. Findings from the study illustrate the complexity of triadic relationships in the long-term residential care facility within the broader socio-political milieu.

As changes in the basic local support networks of the elderly suggest that there will be a growing number of elderly people seeking entry to long-term residential care facilities in Hong Kong, there is a paradigm shift of power relations and advocacy of engagement in care that may begin to shift to authentically reflect the rights of all stakeholders of the triadic relationship.

Fostering consciousness about the discourse of ageing identity requires fundamental changes in the way ageing is viewed. In Parkview’s long-term residential care, relational care occurs in the form of empowered citizenship, tripartite engagement and conscious alliances. The development of a third space provided opportunities to open up and create participatory, inclusive communities with a new, shared identity for all stakeholders of the triadic relationship.

A fresh team should be formed, developed, fine-tuned and restructured with residents, families and staff as members of the team, termed a care triad in this study, to adopt a relationship-centred, empowering approach to enable a partnership of residents,
families and staff in the care triad to contribute their full potential to the optimisation of the quality of care and life in the long-term residential facility.

8.2 Recommendations

Social constructionist analysis of the triadic relationship needs to continue in order to further examine the issues raised in this study. There is a need to continue challenging discourses of growing ageism and identity and its threat in the Hong Kong Chinese community. Furthermore, all stakeholders of the care triad need to reorient themselves regarding how ageing is viewed, for example, regarding the concept of reinventing ageing and active ageing. Consciously fostering a “third space” in the relationship, these “taken-for-granted” moments foster the development of an inclusive community for the diverse populations that live, visit and work in the long-term care facility. The ingrained rules and daily routines aimed at completing task-oriented care to a large number of residents with complex issues and their families by a small group of staff should be held up for further questioning. Scholars in the field of gerontology, particularly critical gerontology, are positioned to continue to examine the disparities in care that are fostered by health care policy and service delivery for the elderly. Greater intersectionality perspectives should be used to provide a framework for critically examining the complexities and conundrums of the underserviced and oppressed groups that operate simultaneously both within the ageing population and between the aged and their families.
References


Anderberg, P., & Berglund, A. (2010). Elderly persons’ experiences of striving to receive care on their own terms in nursing homes. *International Journal of Nursing Practice*, 16 (1), 64-68.


Mayseless, O., Bartholomew, K., Henderson, A. & Trinke, S. (2004). I was more her mom than she was mine: role reversal in a community sample. *Family Relations*, 53(1), 78-86.


Appendices
Appendix 1: Notice

Notice: A research study about Residents, families and staff in long-term residential aged care

A study entitled “Residents, families and staff in long term residential aged care” is currently being conducted in this nursing home. The study involves a student investigator, Chung Pui Man, Betty observing everyday life in the facility and interviewing some residents, family members and staff about how they relate to each other.

All information collected will be treated in strictest confidence and neither the name of the facility nor of any individual person will be disclosed. The study has been approved by the Human Research Ethics Committee of The University of Sydney, Australia, and by the Human Subjects Ethics Committee of the Hong Kong Polytechnic University, Hong Kong.

PARTICIPATION IN THIS STUDY IS ENTIRELY VOLUNTARY. At the front desk you will find more detailed Information Sheets. If you do not wish to participate, you can complete a Request Not to Participate form and deposit it in the locked post box located there. If you prefer you may simply advise any staff member that you do not wish to participate and this will be conveyed to the researcher, who will fully respect your choice.

Any person with concerns or complaints about the conduct of a research study can contact the Manager for Ethics Administration, University of Sydney on (612) 9351 4811 or Mr. Eric Chan, Secretary of the Human Subjects Ethics Sub-Committee of The Hong Kong Polytechnic University in person or in writing (c/o Human Resources Office in Rom M1303 of the University).

If you would like to know more about the study or ask any questions, please contact Chung Pui Man, Betty at (862) 2766 6757.
Appendix 2: Participant Information

The University of Sydney

School of Behavioural & Community Health Sciences

Faculty of Health Sciences

Faculty of Health Sciences
Cumberland Campus C42
East Street (PO Box 170)
Lidcombe NSW 2141
Telephone: +61 2 93519228
Fax: +61 2 93519540

PARTICIPANT INFORMATION SHEET
Research Project

RESIDENTS, FAMILIES AND STAFF IN LONG TERM RESIDENTIAL AGED CARE

(1) What is the study about?
The study aims to better understand the relationships that exist between residents, staff and family caregivers in this nursing home and how these relationships are reflected in the kind of care residents receive.

(2) Who is carrying out the study?
The study is being conducted by a doctoral student, Chung Pui Man, Betty under the supervision of Associate Professor Cherry Russell from the Faculty of Health Sciences, The University of Sydney.

(3) What does the study involve?
Betty will observe everyday life in this nursing home and will interview some residents, family members and staff.

The observations aim to produce a description of what people do with and for residents in a normal day. Observations will be made only in public or semi-public areas in the nursing home and only with permission. No observations of personal care activities will be made under any circumstances. Any resident, family member or staff member who does not wish to be included in any observation session can complete a ‘Request not to Participate’ form available at the front desk or simply advise a member of staff that they do not wish to be included.

The interviews will explore what the caregiving relationships mean to the different participants. They will be conducted at a time and place convenient to participants and will involve asking people to talk informally about what they do on an average day in the nursing home, who they talk to, and how they
interact with other residents, family members and staff. Interviews will be tape recorded, with permission.

(4) **How much time will the study take?**
The observation period will last about 6 months. Interviews are expected to last from 45 to 60 minutes.

(5) **Can I withdraw from the study?**
Being in this study is completely voluntary - you are not under any obligation to consent to participate at all, and you may choose to withdraw at any time without explanation or penalty.

(6) **Will anyone else know the results?**
All aspects of the study, including results, will be strictly confidential and only the researchers will have access to information on participants. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

(7) **Will the study benefit me?**
The study will not benefit you directly.

(8) **Can I tell other people about the study?**
Yes, you can tell anybody about the study.

(9) **What if I require further information?**
When you have read this information, the interviewer 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 Associate Professor Cherry Russell on (612) 9351 9129 or Betty Pui Man Chung (852) 2766 6757

(10) **What if I have a complaint or concerns?**

Any person with concerns or complaints about the conduct of a research study can contact the Senior Ethics Officer, Ethics Administration, University of Sydney on (612) 9351 4811 (Telephone); (612) 9351 6706 (Facsimile) or gbrriody@usyd.edu.au (Email). This information sheet is for you to keep.
Appendix 3: Consent Form

The University of Sydney
School of Behavioural & Community Health Sciences

Faculty of Health Sciences
Cumberland Campus C42
East Street (PO Box 170)
Lidcombe NSW 1825
Telephone: +61 2 9351 9228
Facsimile: +61 2 9351 9540 or 9112

Participant Consent Form

I, __________________________ (please print name) consent to participate in the research study entitled:

Residents, families and staff in long-term residential care

In giving my consent I acknowledge that:

1. The procedures required for the study have been fully explained to me and any questions I have about the study have also been answered to my satisfaction.
2. I have understood the information contained in the Participant Information Statement and have been given the opportunity to discuss it and my participation.
3. I am aware of the inconveniences associated with this study.
4. I understand that my participation is voluntary and I am free to withdraw my consent and to discontinue my participation any time during the study without penalty or prejudice.
5. I understand that my participation is anonymous and no personal information will be used in any way which reveals the identity.
6. I understand that the data collected in the course of the study will be used for research purposes only.

Signature: __________________________ Date: ____________________________

Name of Investigator: __________________________
Signature: __________________________ Date: ____________________________

Any participants with concerns or complaints about the conduct of the research study can contact the Manager for Ethics Administration, University of Sydney on +61 2 9351 4811.
Appendix 4: Request Not to Participate Form

The University of Sydney
School of Behavioural & Community Health Sciences
Faculty of Health Sciences

Faculty of Health Science
Cumberland Campus C42
East Street (PO Box 170)
Lidcombe NSW 2141
Telephone: +61 2 93519228
Fax: +61 2 93519540

NON-PARTICIPATION IN RESEARCH
Residents, families and staff in long-term residential aged care

I wish to exercise my right not to participate in the research project entitled: Residents, families and staff in long-term residential aged care.

PLEASE TICK AS APPROPRIATE:

☐ I do not wish to be included in the researcher’s observational sessions.

☐ I do not wish my relative ……………………………to be included in the researcher’s observational sessions.

I understand that my refusal to participate will not in any way affect my own or my relative’s treatment in this facility.

Name: __________________________________________

Signature: ______________________________________

Date: ________________________________
Appendix 5: Demographic Information

Parkview

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<td>Age of facility</td>
<td>16 years</td>
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<tr>
<td>Differential charge for private/semi-private rooms</td>
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Resident demographics: N=7

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<tbody>
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<tr>
<td></td>
<td>male</td>
</tr>
<tr>
<td></td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Length of time resident has lived in this facility</td>
<td>5-16 years</td>
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Family demographics: N=7

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<tbody>
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<td></td>
<td>male</td>
</tr>
<tr>
<td></td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Frequency of visit</td>
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<td></td>
<td>&gt; once a week</td>
</tr>
<tr>
<td></td>
<td>Fortnightly/monthly</td>
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<tr>
<td></td>
<td>1</td>
</tr>
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<td>5</td>
</tr>
<tr>
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Staff demographics: N=7

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</thead>
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<tr>
<td></td>
<td>Cleaner</td>
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</tr>
<tr>
<td></td>
<td>Physiotherapist</td>
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</tr>
<tr>
<td>Gender</td>
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<td>5</td>
</tr>
<tr>
<td></td>
<td>male</td>
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</tr>
<tr>
<td>Age</td>
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</tr>
<tr>
<td>Length of time working in the facility</td>
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<td></td>
</tr>
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</table>
Appendix 6: Interview guide

Interview Guide

For residents:
1) Could you tell me what an average day here is like for you?
2) Tell me what a good day is like for you.
3) Who do you talk to during the day?
4) Could you tell me about your relationship with staff? Other residents?
5) What do the staff do for you?
6) What do your family members do for you?
7) Could you tell me what is it like when your family members visit you here?

For family caregivers:
1) Could you tell be about how you spend your time when you come to visit <relative>?
2) How do you feel about the care s/he receives here?
3) How do you feel about your role here?
4) Could you tell me about your experiences with the staff here?
5) What do you usually do for your <relative> here when you visit him/her?
6) How often do you talk to the staff?

For staff
1. Could you tell me about an average day working here?
2. Who do you talk to during the day? (Resident? Visitors? Other staff?)
3. What do you do for the resident?
4. What do you do for their visitors?
5. What kind of resident do you like and why?
6. What kind of visitors do you like and why?
7. Is there anything that you would like family members to do (or not do) when they visit their relative?
Appendix 7: Ethical approval letter