Chapter 4
Meanings of Equality: Real and Perceived

Introduction

The preceding chapter provided an overview of the reforms that have occurred in aged care in Australia and highlighted the significance of utilising increasing numbers of AINs in the delivery of aged care. This chapter begins to utilise grounded theory method to examine the microcosm of action and interaction within the nursing home setting and provides some insight into how the AINs construct meaning within their practice. Through interpretation of primary data from the informants' interviews, the chapter identifies the informants' perceptions of equality and the major influences that maintain and reinforce these perceptions within their practice.

The chapter commences with a broad discussion of the concept of equality within contemporary theory by, firstly, defining what equality actually is and how it is utilised on a societal macro level. Secondly, it interprets the AINs' ideas of equality within their practice on an individual micro level. Two philosophical viewpoints, egalitarianism and libertarianism, dominate this discussion of equality and provide a framework in which to interpret the AINs' behaviour in distributing resources among residents in their care.

Apart from the individual AINs' definitions of equality determining their behaviour towards distribution of resources to residents, other influences also exist that could have a marked effect upon this behaviour. This chapter, therefore, provides an examination of structural influences within the workplace, and aged care in general, and discusses the impact of these macro features on the AINs' behaviour at the bedside. The social setting and the internalisation of roles by the informants within the nursing home environment feature as an integral component in the

understanding of this phenomenon. Major structural influences, such as nursing home hierarchy, work routines of the AINs and different types of residents, all made a contribution to the maintenance of the AINs' definitions of equality within the context of nursing home practice. Each of these influences is discussed in this chapter with a view to understanding the behaviour of the informants in terms of distribution of their resources.

Equality and equity

Background

To gain some understanding of how the informants distributed resources on their particular shift of work, an understanding of the notion of equality in general was important to this study as it provided a framework to interpret the informants' own definitions of equality. Interpreting the AINs' definitions of equality within this framework then provided a basis for understanding their decision-making process in the distribution of resources at the bedside.

According to Bulbeck (1993:80), contemporary theory is based on documented debates about the meaning of equality that date back as far as Plato (427–347 BC) and Aristotle (384–322 BC). A number of theorists have contested the many facets of ideology that underpin the way we view the world and define such concepts as equality. The most predominant of these theorists, from the early 1800s through to the 1940s, included Marx, Sorel, Frued, and Mannheim (Sargent 1996:8). Each explored and created theories in relation to the way people think and behave when executing equality. The ideas of equality that each informant held in this study were reflected in their behaviour by an equal or unequal distribution of resources at particular points in time.

Within contemporary theory, as was found among the informants in this study, there are disagreements over the importance and meaning of equality. Some people see the achievement of some sort of equality as essential, some see this as being impossible, and others see it as undesirable (Sargent 1996:53–54). This lack of

agreement is partly due to combining different types of equality into one concept. Basically, equality can be taken to mean that everybody is equally placed and receives the same rewards from society, or at least as other people in a comparable situation (Bulbeck 1993:73). In a similar vein, Sargent (1996:54) defines equality as 'sameness in relevant aspects'. However, the terms 'same' and 'sameness' are modified by the phrases 'similar situation' and 'in relevant aspects'. This means that theorists have to carefully define what is a 'similar' situation, and what is 'relevant' and 'not relevant', when discussing equality. The difficulty inherent in this definition process is another reason for the lack of agreement over the meaning and importance of equality. This difficulty of defining equality posed dilemmas in this study, because the informants stated that they did not often think about equality consciously, although some admitted that the witnessing of unfair treatment or inequality amongst residents made them very uncomfortable. So, in this respect, the informants stated that they thought about inequality more commonly than they did equality, as described by the following:

> *I mean it's not something you think about all the time, it's one of those 'intelligent things' that people like us don't talk about. Mind you, we get pretty annoyed when we see someone getting a raw deal.* (Margaret)

Throughout the study, defining the concept of equality proved difficult for all of the informants. Perhaps this is not surprising, given that the term 'equality' is often used interchangeably with the term 'equity'. Although related to the notion of equality, the concept of equity does not necessarily mean equal. For the purpose of this study, these two terms are not used interchangeably; however, a brief explanation of equity follows for clarification purposes. Equity means that 'like cases should be treated alike, and unlike cases unlike' (Bulbeck 1993:80). That is, equal cases should be treated equally and unequal cases unequally. These different interpretations of equity can be found in the notion of horizontal and vertical equity. Horizontal equity occurs when people who are alike, or in the same circumstances,

are treated equally or in the same way; equal treatment of equals (Mooney 1986:120; Sax 1990:p.58). Vertical equity refers to the unequal treatment of unequals so that the greatest assistance is given to those with the greatest need relative to their incomes (Sax 1990:58). Linked to the different interpretations of equity and equality are two philosophical viewpoints that can be loosely termed 'libertarian' and 'egalitarian'. In this study, for the purpose of interpreting the informants' behaviour in terms of resource distribution, the definitions of equality described by the informants are defined within the broader philosophical framework or viewpoints of egalitarianism and libertarianism.

Philosophical context

To facilitate an understanding of the informants' definitions of equality and their behaviour at the bedside, a discussion of the broader philosophical views that drive health care agendas and distribution of resources, egalitarianism and libertarianism is presented. Particular focus is placed on the beliefs and views underlying the user pays system that was introduced under the aged care reform strategy in 1997.

Proponents of the libertarian view regard health care as part of a broader system of rewards where the receipt of services depends on an individual's willingness, and ability, to pay for services in a market orientated system (Sax 1990:146). Libertarians believe in the importance of individuals taking responsibility for life achievements, including access to health care. The libertarian view of equality in terms of financing health care means relating individual payments for care to the cost of providing services and, where necessary, assisting the poor through income transfers (McClelland 1991:8). This means that by removing some income from the more affluent sections of society, usually by tax, society can use this to provide resources such as cheaper or free access to health care provision for the poorer sections of society. In the context of the user pays model of nursing home care, people who can afford to pay for their care are identified via a means test and their fees adjusted accordingly. Under this scheme, a basic level of care is provided for

those who cannot afford to pay and the government subsidises the industry for providing this care.

In this market-orientated view of equality, as long as everyone has access to some basic level or minimum standard of health care, it is acceptable when people with more resources can obtain superior access or use more services, such as those described as Extra Service Places in chapter three. If these market-orientated ideals of equality are exercised within the provision of nursing home care, then an assumption that the current climate of aged care reforms in Australia is based on libertarian ideals of equality appears feasible. The AINs' definitions of equality then become important at the micro-level because the AINs will ultimately decide how their resources will be distributed under the user pays model. If the informants' ideas of equality sit within the libertarian framework then their behaviour will reinforce the model of user pays under the new aged care reforms, in terms of distribution of resources. This would mean that the distribution of resources at the bedside would vary according to the socioeconomic status of residents. If the informants' ideas of equality do not sit within a libertarian view, then the practice of AINs in terms of distribution of resources will be in conflict with the user pays model. Either way, the impact on the quality of care at the bedside under the new reforms requires exploration.

Egalitarians, conversely to libertarians, view access to health care as a 'right' in a system of public provision that ensures equal opportunity of access to the same kind of care, according to need (Sax 1990:146). They would not accept that people with more resources should be able to have superior access to services or buy extra care, because this would not be fair or equitable. In other words, egalitarians would see equality as equal access for equal need. They would support government intervention that helps unequal individuals to achieve equality of opportunity and more scope for making choices. The informants in this study, if adopting an egalitarian stance, would distribute their resources among the residents in their care

on a strictly needs basis. They would not accept the view that residents with the means to pay should have access to extra care or superior services.

AINs' definitions of equality

Although the informants' perceptions of equality were difficult for them to define within a nursing home context, the definitions and perceptions they provided did not vary a great deal. There was fundamental agreement among the AINs interviewed that the achievement of some sort of equality was essential. All of the informants stated that every resident should be entitled to the same amount and type of care, based on their physical care needs, not on their ability to pay for it, as explained by the following informants:

> *Equality? I think that each person in the nursing home, no matter who you are — sex, race, sexual preference, whatever, religion — should receive the same amount of care by whoever is looking after them, whoever is there to care for them. Whoever is there, they should receive the same amount of care.* (Peter)

> *Okay, if I broke it down into sections, and said equality for the residents would mean that every single one of them could have a single room, if they so wished, if they want it, yes! Equal care, well, that should go without saying.* (Marion)

> *If everyone, within reason, gets the same treatment, the same amount of time, the same, then they are all equal.* (Lynette)

> *They get, well, um, they get their usual pressure area care, attention to continence, or if they want something like a drink, well, they get that attention. Their showering needs, their hygiene needs are all attended to. All that type of thing, general nursing duties would be attended to, by me, for those people, as required.* (Margaret)

These types of comments from the informants suggest that they held the view that all residents should have the same opportunity to receive the same amount and quality of care according to their need. In other words, all residents should have

equal access for equal need and receive equal treatment for equal need. This interpretation is more closely related to the egalitarian view rather than the libertarian approach. The informants' perceptions of equality that 'those with the same needs should receive the same care' becomes useful in understanding their interaction and behaviour in relation to the distribution of resources at the bedside. To the informants, all residents with the same needs should be entitled to the same type and amount of care, regardless of their socioeconomic status or ability to pay for services. How the informants' egalitarian perceptions of equality translated into actual behaviour at the micro-level of the bedside were, however, fundamentally influenced by the macro structures of the nursing home environment that served to maintain or modify the informants' definitions of equality. These structural influences impeded or reinforced the informants' ideas about equality and transpired into particular behaviours within the delivery of care.

Major influences on AINs' definitions of equality

The interviews with the informants identified two major influences that either reinforced or maintained their definitions of equality, or challenged those definitions. Firstly, nursing home structures such as the staffing hierarchy and the routines created strict guidelines in which the informants were required to deliver their care, and this resulted in a reinforcement of their egalitarian sense of equality. Secondly, the development of resident types enabled the informants to justify their distribution of resources to a certain extent. However, in certain circumstances, this process of categorising residents into types also challenged their egalitarian definitions of equality and seemed to indicate a shift in their behaviour from an egalitarian to a libertarian stance. Table 4.1 summarises these major influences and their underlying categories.

In the following discussion, each of these influences will be examined in the context of their underlying categories, and their subsequent impact on the informants' definitions of equality and distribution of resources will be identified.

Table 4.1: Major influences and underlying categories that maintained and reinforced the AINs' definitions of equality

Major influences	Underlying categories	Impact on AINs' definitions of equality
nursing home structures	• staffing • hierarchy • routines	• maintained an egalitarian definition of equality
resident types	• loners • rich • compliant • no family • heavy (dependency level) • reminder of self	• contributed to a libertarian definition of equality

Nursing homes

Staffing and hierarchical structures

Historically, the aged care industry, particularly nursing homes, has had difficulty in acquiring and retaining staff (Courtney 1996). This remains especially problematic for ensuring adequate numbers of AINs, as union membership shows they comprise up to 57% of the aged care industry, with 77% employed in the private nursing home sector alone (Workforce Planning Unit 1994). When interviewed, the informants explained how the recruitment process worked, what types of people the industry had attracted and how selective the industry had become, or not become, as a result of government initiatives since the advent of the Aged Care Act in 1997. Prior to the introduction of the Act, people applying for work as an AIN in aged care often had little experience in working with older people and there was no requirement that people seeking work as an AIN undertook relevant education. The informants related how it was a joke amongst aged care workers that the only criterion to work in aged care was that 'you turned up for work' (Karen, Lynette, Marion and Peter). This attitude has since changed, due to the introduction of TAFE based education for AINs. The Directors of Nursing in the facilities accessed for this study expected staff employed as AINs to undertake relevant educational qualifications (personal communication with the Directors of

Nursing). It is now expected that to work as an AIN, people should have a Certificate Level Three qualification that is VETAB (Vocational Educational and Training Advisory Board) approved under the Australian Qualification Framework (New South Wales Nurses' Association 2000).

Despite the new requirement that AINs possess a relevant education qualification, and the fact that larger numbers of AINs are employed in the aged care industry, the informants did not enjoy much status within the staffing structure of the nursing homes. This structure was identified as having a major influence on maintaining and reinforcing the informants' perceptions of equality in the workplace because the hierarchical nature of staffing arrangements required the informants to adhere to designated roles and responsibilities and comply with established routines and rituals. These requirements structured the work of the informants and constrained the options available to them, particularly in relation to their distribution of resources.

Like other organisations in society, nursing homes have established, but not always acknowledged, hierarchies. Milgram (1974:123–124) proposes that people are not solitary creatures but, rather, they function in hierarchical structures. Within these structures there is a clear definition of people's roles and an acknowledged 'pecking order' which minimises friction and stabilises relationships. The informants in this study considered themselves to be at the bottom of the pecking order and somewhat powerless in the hierarchical staffing structure. They were very aware of the hierarchy in which they worked and related how their perceptions of equality were different to other people, with different positions and status within the hierarchy, as one informant explained:

> *I think everybody, everybody has a different idea ... equality, I mean, is sort of .:. equality would rely on where you stand in the pecking order. Like, if you are the Director of Nursing, you certainly don't think anybody in the place is* ***equal*** *to you! But if*

> *the owner comes along, then you immediately go down in the ranking.* (Trent)

In hierarchical organisations, such as nursing homes, survival of the individual and the organisation depends largely on the potential for obedience (Milgram 1974: 123–124). That is, suppression of individual direction and control is essential to the maintenance and cohesion of the hierarchy or structure. In this study, the maintenance of the hierarchy in the nursing home was dependent on staff, most of which were AINs, adhering to job descriptions that outlined their roles. These job descriptions not only assigned roles and responsibilities, but also defined where particular staff members sat in the social order of the organisation. The assigned roles and social behaviour of the nursing home quickly became familiar to the informants and obedience to delegated roles was essential to minimise the amount of stress in the workplace. The informants in this study made the observation that AINs would not question the appropriateness of their roles and assigned tasks. They felt that AINs who attempted to do so would be punished, for example, by the withholding of desired shifts, as the following informant explained:

> *If you go about and do your work and don't cause too much hassle, well, that is fine, but if you have something to say about things, often you will find yourself short of a couple of shifts.* (Georgina)

The questioning of roles and the status quo of the hierarchical environment by informants created conflict between the informants and their 'superiors', that is, registered nurses, as described by one informant:

> *They run everything. Very much so! ... like, 'get back in your box'. So that is what you feel like, get back to just doing all your mundane other stuff and we will do the more important things.* (Lynette)

This questioning or resistance to roles by the informants in this study impacted on the informants' perceptions of equality as they perceived that not only were they

treated unequally compared to senior staff, but that some residents were also treated unequally by these senior staff. Discrepancies over roles in nursing practice, similar to those observed in this study, have been explored (Festinger 1957; Lecky 1961; Schein 1984) in an attempt to understand, or unravel, how nurses cope with the issues of cognitive dissonance, how system values prevail over individual values, and how nurses accommodate these to lessen distress on themselves. In this study, although the breadth of the roles performed by the informants was limited, their behaviour was nonetheless influenced by system values. Their capacity to distribute care in the manner consistent with their preferred options was, in many cases, constrained by the values of the organisation and this was a source of distress for the informants:

> *I mean, like, mental care doesn't come into the physical overall thing, so long as their bums are allright, and they don't have pressure sores under their feet, it doesn't matter what they are feeling mentally. It doesn't matter if they haven't had anyone visit them and you are the only person that has spoken to them really for six weeks. That is not part of it, and you can't change it! You are just there slapping cream on their bums and feet, dragging them out of bed at 6.30 and that is the thing, that's your role!* (Karen)

The informants recognised that the hierarchical nature of the structure of the nursing home imposed upon their perceptions of equality and their behaviour at the bedside. However, their subordinate position in the hierarchy made it difficult for them to defy authority. This obedience has been described by Milgram (1974:12) as the 'dispositional cement' that binds people to authority. In this case, the obedience of the informants bound them to the authority of the nursing home, to their assigned roles and to the resources that were available to them. As subordinates in the structure, the informants acted as agents, not individuals, and went about executing the wishes of others. As agents, they saw themselves in a social situation in which

others who occupied a higher status regulated their behaviour, as described by the following comments of Peter:

> *Oh, it's a real hierarchy, like its management, RNs, AINs, regardless of whether they are an EN. Yes, on your shifts you are primarily just doing hygiene things and feeding, really. It's what you do.* (Peter)

To gain the approval of those in authority, the Director of Nursing and the registered nurses, the informants focused on completing assigned tasks, not on the appropriateness or desirability of the tasks. Their sense of equality in completing assigned tasks remained grounded in egalitarianism in the sense that the completion of routines meant that residents with the same needs received the same type and amount of care. Because of their perceived lack of control over the daily routines, the informants tended to blame the hierarchical structures of the nursing home when things did not go to plan, or when their behaviour did not fit with their perceptions of equality. In other words, they attributed the responsibility for their actions to the authority of the organisation, and adopted the stand of not being responsible for the tasks they performed that were unpleasant or went against their notions of equality. This behaviour is also consistent with Milgram's theory (1974) of obedience to authority. As illustrated by the following statements, the informants abdicated responsibility for the type of care they delivered by assuming the notion, 'if it was up to me, things would be different':

> *... this is residential care. It is not supposed to be institutional care. And basically they spin you, this is this person's home, kind of thing, but they can't have powder [talc], and they can't have this, and they can't have that ... it should be flattened ... and if they want to hang a picture on the wall in their room they should be allowed to. And that is the way it should be.* (Karen)

When asked what types of things the informants would change, 'if it were up to them', the informants talked about changing the hierarchical nature of the nursing home structure to provide a more flattened type of management structure that would

encourage more equality amongst the staff. They felt that a more egalitarian approach to management practices and the delivery of care would result in higher morale and improved quality of care:

> *It's always there and, I mean, things will never improve as far as morale goes, until they realise that they can't do that, they can't structure it so that these people are second class to the RNs.* (Trent)

> *Things like communicating ... between AINs, between domestics, between cleaners, between the RNs, the management, I think it is a holistic thing, I don't think it is just this group of people or that group of people, meeting this group. I think it is really holistic. I mean, domestics walk around and they see interaction between residents, they see lots of things that maybe you miss because you are used to seeing them every day. So you don't really take notice ...* (Lynette)

Other aspects of what they would change centred on providing more resources for the residents, for example, some sort of activity delivered equally on a 'need' basis. As described by the following informant, a break from established routines, although disruptive, was seen as being essential to improve the residents' quality of life.

> *And, see, they are not stimulated at all. They are just ... you know that picture that you have when you are really little? About all these nannas and grandpas sitting around, just doing nothing all day, well, it hasn't changed. Even though we employ an activities officer, I don't know if they haven't got funds or whatever, but how boring to get someone to come and read the paper, or play bowls. Tuesday you do this, Wednesday you do that — you need a bit of 'come on, let's all pack them up and take them out!' I mean, I know it must be really hard to do but, a bit of enthusiasm and everything. I would just have it so it is, probably in my eyes, they would all be just happy.* (Margaret)

Established routines

The hierarchical nature of the nursing home, and the delineation of clear roles and responsibilities within the structure, required adherence to established routines and rituals. The routines focused predominantly on the physical care needs of the residents and little allowance was made for any other type of care. The requirement that the informants adhere to routines that focused on physical needs reinforced their perceptions of equality as meaning equal care for equal physical need. In the informants' view, if the physical care needs of the residents were met, then equal care had been given.

> *Well, it just depends on which decision you work, which decision you make. I'll say, 'Okay, we will work at this end and as we come to a shower, the person showers.'* (Peter)

In order to complete allocated tasks on an equal basis within a particular time frame, the informants tended to follow the established routines. When asked about whether or not they felt that other aspects of care were important, the informants stated that the designated tasks of the routines limited them in thinking about it. For example, Bridget explained:

> *Yes, because sometimes ... but, to be really honest, in our work, right, we have a set time in what we have to do. And, if we don't do it in that time, and, I always try and make a bit of time in case some drama happens, but in that time you have to do all the things like pressure area care, dressings, and things like that.* (Bridget)

To the informants, this egalitarian approach to resource distribution based on physical needs seemed fair. This is consistent with the view that nursing homes can be viewed as prosthetic (Donnenwerth & Petersen 1992), where adequate care centres on the 'physical', with little attention paid to the notions of privacy, dignity and choice (Nolan & Grant 1993).

The routines that structured the work of the informants not only reinforced the notion of equal care for equal need, but were used by both management and

residents to control the AINs' behaviour. The informants' levels of competence were measured, or defined, by their ability to complete the required routines in a designated time frame, and the completion of the routines was closely related to the informants' sense of having delivered equal care to the residents, as the following informants described:

> *You go for your life. You go from the time you start your shift, 'til when you end, you keep working. You work to your best and you work as fast as you can to give the best care.* (Pauline)

> *In a shift, for the first five hours, I will have about ... there are two AINs to 17 or 18 residents, depends which area you are working in, and then after 7.30pm 'til 11pm there are two AINs for, say, about 30, maybe 40 residents. So you just don't have time.* (Lynette)

As observed in a study by Warner (1997:35), the routines and rituals of the nursing home determined the expected types of behaviour within a certain context of the day and played an important role in determining the choices available to the staff. Although the informants stated that the routines were genuinely allocated on an equal physical needs basis, and allowed them to distribute their resources equally, they also recognised that the routines controlled their behaviour and, in general, they disliked them:

> *It is very boring. Well, I go to work tomorrow and I know exactly who I am going to wash, who is going to be nice, who is going to be awful. That is what I find, I am really bored. I know exactly what I am going to do, who is going to have pressure area care, and all that sort of thing. I am really bored.* (Lynette)

> *Well, you know, it is so mechanical. You go there, you grab a person, you shower them, you dress them, you feed them, you toilet them. You sit them back and feed them again, you toilet again! Like, everything is so structured, unless you take time, to sit down and have a chat and joke with them. You don't have time ... there is an expectation that ten people must be up before 8.30 in the morning and everyone must be up before 11 o'clock in the*

morning! It doesn't matter that you drag them out of bed at 6.30! (Karen)

Although the informants disliked the routines, the need to conform to them enabled them to dampen any tension between their perceptions of equality and the distribution of the care they delivered. By focusing on the routines and tasks at hand, they became so absorbed in completing their allocated tasks equally within a very restrictive time frame that they lost sight of the broader issues such as sleep deprivation and the importance of maintaining the residents' social interaction, skills, independence and choice. For example, two informants explained:

> *It's like upstairs, you know, they're are all bedridden, don't complain or whinge or nothing ... don't s'pose they can, really. No inequality up there ... you just start at one end and finish at the other, no hassles.* (Marion)

> *The routines are never questioned. Well, sometimes when you have to say to the other AIN, 'Look, I think I will leave this person today,' and if this AIN is really strict, she says, 'I think that people should get up and have a shower', even though they are on their death bed, well, that is what is going to happen.* (Peter)

The informants' adherence to the established routines and the completion of allocated tasks was consistent with their egalitarian perception of equality as providing a basic minimum level of care. As long as no resident received different treatment, or any more time and care than others, in the informants' minds, equal care was given. Even when routines became disrupted, for example, on special occasions when families took residents out of the home for the day, the extra time available was not used by the AINs to give extra care to the remaining residents. Rather, it was consumed by another task such as cleaning cupboards. This adherence to routine and sense of equality changed little, even when a resident was close to death, as one informant commented:

Not so much they change, because you still have to give them the same amount of care, I mean, if not a little bit more, but you can always ... you can work around it. Once you have got your routine, you know that you can say, 'Okay, I have done this bit now, I have got this much to do. I have either this much time, I have got to really put the effort in and get flying, or I can still work at this pace.' You have got to know what are you capable of and you have got to know, sort of, what the person you are working with is capable of. And, people say, 'We have got this extra time, we can go slow', but you can't, you never know what is going to pop up. At least if you have got things under control in the washing and cleaning area and things like that, if something pops up or somebody falls over or someone does die within your shift, you can handle that without much stress on you. (Peter)

Peter's comments demonstrated that the routines provided a 'comfort zone' in the sense that everyone knew what everyone else had to do, and they enabled the informants to structure their workloads to allow for disruption so that their distribution of resources would not be compromised. Not being able to follow the routine was seen as a major contributing factor to the stress experienced by the informants because it led to what they perceived to be unequal care. The informants did not like it when some of the residents would miss out on their basic minimum of care due to a mishap or a change to the routine. On these occasions, the informants felt that they had not delivered equal care. To try to prevent this, informants preferred to be ahead of schedule so that they could deal with unexpected disruptions without compromising the distribution and level of care they provided, as Lynette described:

In our work we have a set time to do things and if we don't do it in that time ... I always try and make up a little bit of time in case some drama happens. (Lynette)

This behaviour is consistent with Street's (1992:251–252) observations that nurses often structure their workloads into habitual routines and equate completion of routines with competence and equality of care. Although perceived by the

informants as equal care, this kind of time-structured and inflexible approach enabled the informants to transfer responsibility for unpleasant experiences, for example, showering a resident in the cold early hours of the morning, to routines out of their direct control. In other words, the time that was allocated for the completion of the task was not the informants' 'fault'; their responsibility was to merely carry out the task. Hence, to the informants, the responsibility for their actions lay with the authority that determined the set routines, as explained by the following informant:

> *It's horrible when you think about it. You get them out of bed at some ungodly hour, give them a shower, sit them in a chair and for what? Then at two o'clock in the afternoon you put them all back to bed. No one can stay up 'cause there's no staff here after tea. Then they're expected to sleep all night 'cause there's not enough staff to keep an eye on all of them at night. But that's management for you, just in it to make a buck.* (Karen)

The informants' definitions of equality underpinned this behaviour of adhering to routines. On one level, they did not agree with the routines that governed the care they delivered, but on another level they felt that the care they delivered was equal. The informants ascribed this rationalisation of their work to the recognition that the 'world' of the nursing home was different to the 'real world'. The following section discusses the influence of this notion of the two different 'worlds' and considers the impact of internal socialisation of the nursing home 'world' on the informants' perceptions.

Internal socialisation of roles

Although the informants' perceptions of equality rested on the idea that a basic minimum level of care should be provided to all residents, nursing home practice did not fit with what they believed should happen in terms of caring for older people in general, and with what they believed society expected as well. In general, nursing home work was considered socially undesirable by the informants, as was

living as a fully dependent person. However, by internalising the set of beliefs and values by which social life was conducted in the nursing home, the informants were able to adopt behaviours and practices that they would not adhere to in other settings. That is, they would often participate in activities or behaviours in which they would not participate in the 'real world'. Nonetheless, there was a general acceptance among the informants that some nursing home practices were adopted for the benefit of getting through the tasks of the day and were therefore acceptable within their practice. The following informant talked about such practices:

> *You know, we have to put bibs and things on these people, they mess food everywhere if you don't watch them ... and as for pulling curtains [for privacy] every time you attend to someone, well, what a waste of time that is! As if anyone's going to take any notice. We don't, and besides, we don't have time to be messing about with things like that.* (Margaret)

The acceptance of particular group practices is consistent with Marx's observation that an individual's membership of a particular group produces a picture of the world that is shaped by the experiences of that group (Sargent 1996:p.8). The staff's involvement with the nursing home produces a particular perception of ageing, dependency and nursing home practices. Through this process of socialisation, individuals, or AINs in this case, come to accept the values of the society or group to which they belong. In other words, the social setting in which individuals find themselves determines the broad basis that underpins how they think and therefore behave (Sargent 1996:10). Hence, the social setting of the nursing home determined the broad base from which the informants operated within their practice. Their perceptions of equality were reinforced and maintained within this setting and influenced the way in which they distributed their resources to residents in their care. People outside this social setting cannot often understand why AINs remain in the workplace. The following informant relayed a conversation with others about nursing home practice:

> *People say to me, 'How can you do it?' — work in a nursing home, I mean. I have to say to them, 'It's different, it's the only way these people can survive.' After all, what choice do they have? They get used to it after a while, and us, well, we do the best we can with what we have.* (Peter)

Both Marx and Freud contend that people's beliefs create and maintain an illusion that keeps them deluded and satisfied with a particular, often difficult, situation (Sargent 1996:9). An appropriate analogy is provided by Sargent (1996:10) who argues that people's beliefs are similar to 'blinkers on a horse' which limit the views of the world to what is accepted within that world. The belief systems of the AINs and their perceptions of the accepted social life of the nursing home were indeed formed by the 'world' of the nursing home, as one informant commented:

> *When you work at a nursing home you are into another world. It's a totally different world to what you are used to, I mean, people just don't understand that. I mean, you can talk about things, but they just don't understand, the nursing home is a totally different world. I suppose what you see from day-to-day is not what happens in regular life ... in the real world, or not the real world. I suppose, what we have got in the nursing home is the real world, because that is what is happening, but it is just its own little world within the real world.* (Peter)

The influence of this internal socialisation on the perceptions of equality held by the informants assisted them to accept the work that they did on a daily basis. Acknowledgment of unpleasant experiences in their work was minimised by the informants' beliefs that the care they delivered was equal and therefore of an acceptable standard. The acceptance that it was the nature of the work, rather than their own behaviour, that contributed to the unpleasantness of nursing home practice helped maintain the informants' perceptions of equality that influenced their practice in the workplace.

Hence, the routines of the nursing home contributed significantly to the informants' behaviours and the maintenance of their ideas about equality. The routines were an integral part of the social environment of the nursing home and were used by management and the informants alike to accomplish the required tasks of the day. The ability to exert control over the routines of the day was a powerful tool that could be used to alter the equality of resource distribution at the bedside. Although the routines were decided by management and were based on the physical needs of residents, the distribution of the resources equally within this routine was determined by the AINs on any given shift of work. Apart from the acknowledged social world of the nursing home influencing behaviour, resident control over routines was also a source of tension for informants and it emerged as an important influence in terms of how AINs distributed their resources.

Resident control of routines

The informants in this study stated that residents would attempt to disrupt the notion of equal care based on equal needs through manipulation of routines. It was frustrating for the informants to have their work routines interrupted by anything, apart from what they saw as the legitimate needs of the residents. The routines of staff were well known to the residents and interruption of these was used to exert control over the informants. Some residents exercised control over the informants through their insistence that the AINs follow the residents' preferred routines. For example, the following informant talked about the residents having their own routines, and their disregard for the priorities of other residents:

> *They are demanding, they are jealous of each other — I don't know if that is the right word — but they are, yes, on buzzers [call bells], if one starts, they all start. You come on at 2.30 and in the lounge room, it is just 'chock a block' [overflowing] with residents and they all want to go to bed at 2.30. And they just start! It is like magpies, that is what I always say, baby magpies. Soon as they see their mother ... they do, they just start ... and, if 'She has gone into bed before me, what's she doing in bed? I*

want to go to bed now!' And if one has a drink, they all have a drink! (Lynette)

Attempts by the residents to control routines conflicted greatly with the AINs' egalitarian perceptions of equality as being equal care for equal needs. The informants stated that some residents' ideas about equality were different to their own because these residents all wanted more care than their physical needs required. On occasion, the informants stated that residents were passively aggressive or punished the informants if they did not adhere to the residents' demands:

> *You can go in and say, 'Can I give you a wash and put your nightie on now?' And she will say 'no', and then it is time for us to go to tea, and she knows our routine, she knows our afternoon tea, evening meal and all of that, and she will say, 'Oh I want to go to the toilet now.'* (Margaret)

> *Well, with the last lady, if she has to have a pan. If you are clearing up the dishes from the meal, she will sit in the doorway and wait, and wait, and wait, if you let her wait any longer, she will chuck a mental with you and won't talk to you for the rest of the day! And then if you put her into bed, there is a particular routine that you have to follow ... she has to have this done, and that done and it all has to be done in an order that they have been having it [this type of care] done since they have been to the place. And if you ever change it, it is like, you have cut off her left hand!* (Trent)

The attempts of the residents to control routines conflicted greatly with how the informants believed resources should be distributed. They felt that the residents' ideas about equality were in conflict with their own and residents failed to understand that, on some days, work time frames were different because of mishap or emergency. In general, the informants resented the resident control of routines because it interfered with their own sense of what should happen, in terms of equality and distribution of resources, as described by the following informant:

> *I dread going in to Mrs Jones, because I know I will be in there forever, 'fix this, fix that'. But if I don't go in on time I will pay for it [be punished] for the rest of my shift. She thinks it's a motel and we are there for just her. She doesn't think of the other residents who need care.* (Pauline)

The informants felt this disruption to routine by some of the residents undermined their practice and interfered with the AINs' capacity to distribute their resources equally. Particular residents were thought about and treated differently by the informants as a result of pressure from the residents for the AINs' to comply with their preferred routines. Because the informants felt that some residents tried to manipulate them through their disruption to routines, it became especially important to the informants that they hold onto their notion of equal care for equal needs, particularly when it came to distributing their resources to the 'nice' residents. These 'nice' residents did not disrupt the routines of staff and the informants felt that they valued their work. One informant explained this sense of being valued, saying, '... probably because they accept us and accept what we do' (Lynette).

The behaviour of the 'nice' residents did, however, influence the informants' perceptions of what constitutes equality of care. In the informants' view, the 'nice' residents deserved more time than the demanding residents who tried to manipulate the routine because the informants felt the 'nice' residents valued the care they received from AINs and, more importantly, they valued the person delivering the care. Although the informants remained unwavering in their definition of equality as meaning equal care for equal need, the informants' categorisations of residents into types clearly influenced their distribution of resources.

By devaluing and labelling the 'not so nice' residents as demanding, uncooperative or time consuming, the informants were able to justify the lack of equality these residents actually received. This behaviour is consistent with Milgram's (1974:138) observation that compliance with authority, or social rules, is generally rewarded, while non-compliance is frequently punished. The informants did not consider,

however, that they punished anyone. Rather, they believed that their resources were better spent on the residents that valued them, as described by the following informant:

> *They [the 'nice' residents] are probably low maintenance because they don't say a lot, and so it's easy to relate to them because you are so sick of the ones that are yelling and screaming and wanting all the time, that is so nice to see these little people that you will attempt to try and do extra for them.* (Karen)

However, although the informants acknowledged that they treated 'nice' residents differently, their stated egalitarian perceptions of the meaning of equality did not translate into them allowing individual choices by the residents or diversity of care. If, for example, all residents were placed in bed by 8.30pm, that represented equal treatment. In the informants' view, to allow individual residents to do anything different would be seen by other residents, and staff, as favouritism and inequality of care.

Nonetheless, although the informants regarded the provision of a basic minimum level of care as representing equal care, in reality they did not treat all residents 'equally'. The type of care and resources they were willing to give to the residents depended on how they categorised them. This categorisation of residents into different groups led the informants to be willing to deliver different types of care to different types of residents.

Resident types

The informants stated that AINs grouped residents into categories, based on particular characteristics, on a daily basis. Although all informants participated in this categorisation process, it was not often thought about or readily acknowledged, as the informants realised that placing residents into generic groups was incongruent with the notion of caring for people as individuals. Karen described the automatic, or unconscious, aspect of categorising residents:

> *That's funny that I say that, because I never really grouped them before. But, I mean, I do ... you have your people who are a bit mobile, they don't talk, they just lie down in a chair all day. You give them pressure area care and that is it. And then you have people that you like to walk with, you know they can walk and if they don't, they are going to just stop. Then you have people who you can sit and have a really good conversation with, and then you have people you basically leave alone because they don't want you near them. So I guess, yes, there are different group structures in the nursing home, although, like I said, I never really thought of it before.* (Karen)

Other informants described how the process of categorising residents in their care occurred out of necessity. They stated that it was essential to group residents according to the number and 'heaviness' of tasks, and behavioural problems, to enable staff to accomplish their tasks on any given shift of work. Two informants explained:

> *... you don't mean to [categorise residents], but, then again, sometimes you have to. Like, you will have the ones that take the longest and the hardest to get through, and you have the ones that are easy to get through.* (Marion)

> *... like, you can have a resident that is easy to do things with, but is very demanding. Then you have some that are very hard to do anything with.* (Margaret)

According to the informants, the categorisation of residents was essentially performed to organise their workload so that they could complete it in an efficient and timely manner. When the informants had a particularly heavy workload, the categorisation of residents became imperative. It was not clear whether involvement in the categorisation process was motivated by a requirement by management that allocated tasks had to be completed within a particular time frame, or, whether it was valued by the AINs as a mechanism to improve their efficiency and, thereby, provide them with more time in which to enjoy their work. However, according to

the informants, the categorisation process did give them a sense of control in terms of how they distributed their resources, and it influenced the type of care the residents received. Six main categories of residents emerged from the informants' interviews:

- loners
- compliant
- heavy
- no family
- reminder of self
- rich.

The categories of residents were based on ideal types. However, the informants indicated that some individuals did not completely fit one category only but, rather, displayed the characteristics of one or more resident type. For example, a resident categorised as being 'compliant' could also display some of the characteristics of residents categorised as 'no family' or 'reminder of self'.

Loners

Residents categorised as loners were self-reliant and established their own routines. Attempts by the informants to interact with these residents were not reciprocated as they tended to disassociate themselves from people and events. The interactions that occurred with staff were built around the residents' needs for specific goods and services. For example, if the residents needed assistance with showering, toileting or meals, then some interaction occurred with staff. However, if there were no requirements for assistance, the residents would keep to themselves and not welcome interaction. Nay (1995) describes this distancing of residents during the process of relocation into a nursing home. It appears that people entering nursing homes experience loss of identity and possessions and a sense of future. To reduce the negative impact of this situation they often distance or disassociate from the

experience and carers. The following informants described this reluctance to interact with others:

> *... I think that you sort of feel sorry for them when you know that they come in here away from their own home and ... they sort of feel as if they are not worth anything because they are in a nursing home ... and they don't want anything to do with you.* (Margaret)

> *Then you have some that are very hard to do anything with and they don't want you, they don't need you.* (Lynette)

Studies that have examined patients who distance themselves from staff (Kitson 1987; Pursey & Luker 1995) found that rejection by a patient made nursing staff feel inadequate because it was in conflict with their belief in benevolence and their desire to provide care. In this study, however, the informants accepted that this distancing was the way the residents preferred things to be. In their view, there was little point in trying to engage 'loners' in interaction they did not welcome. In general, the informants were sympathetic to the needs of 'loners' and they, in turn, rarely created difficulties for the informants.

Compliant

Compliant residents were also considered as 'nice' residents because they created 'no hassles'. These residents treated the informants with respect, took the least amount of time to care for and thanked the informants for their care. They usually occupied a multiple-bed room (an average of four beds per room), and this indicated to the informants that the resident was not affluent. The informants regarded multiple-bed rooms as 'second rate' accommodation because in these types of rooms, residents were crowded and enjoyed very little privacy. This lack of privacy and space was particularly problematic during visiting hours and when people were dying. The small amount of bed space in multiple-bed rooms restricted the number of items a resident could possess and, because of the presence of other residents, personal possessions were often interfered with or misplaced.

Despite the difficulties these residents experienced, the informants found that the residents in multiple-bed rooms often accepted their situation and were compliant to the AINs' wishes. Lynette, for example, made the following comment:

> *Well, look at Eunice, for example, she is just beautiful. I don't know how she does it. Squashed in there with those lot! Mary's always into her things and her husband, well ... the poor man just sits there and feels guilty and embarrassed ... but even then, nothing is too much trouble, whatever we need her to do, no problems.* (Lynette)

Studies that have explored the compliance or disruption of residents in residential care (Donnenwerth & Petersen 1992; Warner 1997) indicate that residents tended to view themselves according to the dependency roles they were assigned. Compliant residents often internalised a 'sick' role and therefore were grateful for any assistance that confirmed their dependency. Donnenwerth and Petersen (1992) have described how compliant residents are more likely to accept and participate in nursing home processes such as routines. Residents' 'dependency states are created iatrogenically within institutionalised settings' (Warner 1997:38) and their self esteem and their assigned dependency levels are directly related, as stated by the following informant:

> *You know, you take Mrs Smith, for example. The poor little thing. When she first came in she would try and do things for herself, but she kept getting in trouble. She wasn't allowed to walk on her own, had to always get help so she didn't fall, we told her, couldn't eat her meal fast enough, so now we feed her, couldn't get to the toilet quick enough because she had to wait for us, and now we stick a pad [incontinence pad] on her. Why would anyone try? Why wouldn't you just give up? Now she doesn't think she can do anything and tells us that she is useless, a bother.* (Marion)

Although the informants in this study recognised that the encouragement of dependency had a negative effect on residents, they, nonetheless, welcomed the

compliant resident into their routine tasks of the day. Compliance to the routine by the resident often resulted in a reciprocal understanding between the AIN and the resident, as Peter described:

> *... it's like they understand that this is not the most pleasant job in the world and they appreciate that we are there ... so, in a way, we appreciate them.* (Peter)

Heavy

Heavy residents were described as being bedridden, obese, demanding, incontinent, and often aggressive. They also often occupied a multiple-bed room. Although this indicated to the informants that the resident had limited financial resources, unlike the compliant residents who also occupied a multiple-bed room, the informants did not particularly look forward to caring for these people, as stated by Lynette:

> *... and then you get the ones, on the other end of the scale, who are very, very, heavy. I think they are bored with being there and they have become set in their own ways and so, of course, they are put into the hard to manage group ... well, because they are! [laughs]* (Lynette)

The care needs of heavy residents were high, and because of their physical condition, they required the use of a mechanical lifter to change their body position. These residents also often needed feeding. The informants found these residents difficult to manage physically and very time consuming. For example, Margaret stated:

> *Some of them are really physically draining! They really are. Personally, I would rather handle someone that is violent ... than someone who is physically draining, because you can handle their violence ... but with physically draining, it is harder to handle.* (Margaret)

The 'heavy' physical condition of this category of residents primarily resulted from strokes, amputations or fractured bones that made it impossible for them to mobilise. Chenitz (1983:94) has described how it is much more difficult for residents to legitimise and accept their need for care if they enter a nursing home simply because they can no longer care for themselves, rather than because they are terminally ill. The health problems that led to the admission of heavy residents in this study were largely related to difficulties with mobilisation and the duration of their admission was, therefore, not of a predictable short-term nature. This can create some difficulties for residents, as it seems that 'knowing how long one has to tolerate a particular situation can make an otherwise intolerable situation tolerable' (Baum, Singer & Baum 1982; Schumaker & Reizenstein 1982, cited in Nay 1995:325). Lack of knowledge about how long their current circumstance would continue has been identified as a major stressor for residents (Nay 1995:325).

No family

The residents without families, or families who did not take an interest in them, easily became attached to an informant and could become difficult and demanding if the informant was unable to spend sufficient time with them. They would often become possessive of the informant's time and resented the informant attending to the needs of other residents. As described by the following informant, the AINs often felt sorry for these residents:

> *If another resident seems to be getting more attention from nurses ... a resident has needs that we need to take care of ... they whinge and carry on, and it's hard because you know they don't have family and you feel sorry for them.* (Lynette)

The AINs tended to become attached to residents without family contact and sometimes became 'surrogate' family members. This notion of surrogate family bonds has been described by Fulton (1987, cited in Sumaya-Smith 1995:448) as 'the unique bond' that occurs between the caregiver and the resident. These bonds mimic those normally shared between the 'resident and biological family members'.

In long term care, where residents rely on the caregiver for their daily survival, a situation may arise where the caregiver becomes emotionally reliant on providing care for the resident's physical and psychological needs and thereby, either consciously or subconsciously, enhance the opportunity for the development of surrogate family bonds (Sumaya-Smith 1995:447), as explained by Bridget:

> *... you know, you become very attached to the people in a nursing home. It's not as though they're just someone that you take to the shower and feed lunch everyday. You become very attached to them.* (Bridget)

The informants became attached to particular residents regularly and the formation of 'surrogate' family bonds between the informants and those in their care occurred frequently. This is consistent with the findings of a study by Heiselman and Noelker (1991) which revealed that 95% of nurses' aides expected to be regarded like a family member to the resident. Other authors such as Benner and Wrubel (1989), Morse (1991) and Stein-Parbury (1993) discuss the 'over involvement' of nurses with patients that can lead to the nurse being seen as one of the family by significant others. Patients that are very dependent and vulnerable will particularly seek out individual relationships with nurses and this can lead to a distortion of the amount of caring that the nurse distributes among patients (Benner 1984:209). In this study, the informants found it difficult to detach from the 'no family' type of residents and, as a consequence, it affected their distribution of resources to other residents. Margaret described this difficulty in the following comment:

> *... a lot of their families don't take interest in them and then you have to try and fill that gap, and then you get too attached to them ... and sometimes they need extra help ... and you just have to give to them.* (Margaret)

Reminder of self

Residents who reminded the informants of themselves caused problems for the informants similar to those described above in the formation of surrogate family

bonds. Stein-Parbury (1993:216) discusses the ways in which nurses become involved with patients. She states that nurses form a 'personality click' with patients they sense as having a similar personality to their own. A similar process was evident in the relationship between informants in this study and residents who reminded the informants of themselves, as the following informants explained:

> *... I don't know, there is just something about a resident that will send a brainwave to the AIN or RN or EN, or whatever, that reminds them of someone in their own family, or themselves ...* (Margaret)

> *Yes, I think that you can relate to residents the more you see a bit of yourself in, more familiar ... I don't know, I guess it is just, like, a personality thing. Maybe you can see some of you in them, or that you relate them to your grandmother, or your grandfather.* (Trent)

This type of resident made it difficult for the informants to 'detach', or not get involved on a personal level, while performing unpleasant tasks and procedures. For example:

> *... then you are really in a bit of a bother, because you start having a bit of trouble. They start getting upset, they get confused, they ... then they do make your life miserable. It does upset us, and it does upset them.* (Peter)

Benner and Wrubel (1989:373) explain that when nurses see aspects of themselves in patients, they no longer retain a sense of 'otherness' that helps them maintain a sense of control. By identifying themselves 'in patients', they involve themselves in the patient's experiences on a personal level (Benner 1984:209). In other words, because nurses find it difficult to disengage from the patient's experience they tend to identify with whatever the patient is experiencing on a personal level. The informants in this study, when dealing with residents who reminded them of themselves, or their significant others, found it very difficult to detach from the

resident when performing unpleasant tasks. This resulted in high levels of stress amongst the informants, as Georgina explained:

> *... then you think it is really horrible that this woman has to be showered and pulled apart every day because we think she needs it. She starts groaning and pleading with us to stop hurting her, she doesn't understand that it's our job ... some job ... keeping these people alive ... and for what ... I couldn't stand it if it was me!* (Georgina)

Rich

The 'rich' type of residents mostly occupied a single room and possessed extensive personal belongings. These possessions and occupancy of a single room suggested to the informants that the resident had considerable wealth. The informants stated that staff senior to the AINs in the nursing home hierarchical structure more often inquired about the wellbeing of the 'rich' type of residents and commonly spent considerable time communicating with them and their families. Many of the informants regarded the 'rich' type of residents as being disrespectful and rude, and believed they had an expectation that they should receive superior, or a higher standard of care in return for the financial contribution they made to the cost of their care. That is, the informants felt that the 'rich' type of residents believed that their status, or class, prior to entry into the nursing home should translate into their needs receiving a higher priority than the needs of other residents in the nursing home. They would speak in what the informants described as a 'complicated' language, which made the informants feel inferior. In addition, the informants felt these 'rich' residents used buzzers, or call bells, more often to obtain attention and obedience from AINs. The following comments by the informants provide examples:

> *... there are the ones that pay for their own care and accommodation, like have a single room most of the time ... and they are treated differently by management. I mean, management will make a point of conversing with their relatives, every time they see them. There are people who are pandered to, like, their every 'whim' is met ... you can tell the ones that are obviously*

> *paying more in funds, like, because they get better services, not necessarily from the AINs, but definitely from management.* (Melissa)
>
> *... she just rules the roost and she is very wealthy and she is in a room of her own and, she doesn't think that she has to fit in with us at all!* (Lynette)
>
> *They are very demanding. They are much more demanding. They expect it yesterday, not now!* (Karen)

The informants resented the attention that these 'rich' type residents demanded and perceived their behaviour as a disregard for the needs of other residents. They believed the illegitimate demands of this group of residents restricted their ability to care for other residents. The informants felt that the demands of the 'rich' residents impacted negatively on their ability to give equal care to all residents with equal needs, and were, therefore, regarded as an attack on their sense of the meaning of equality.

Summary

The informants' definitions of equality embraced the notion that all residents should be provided with an equal basic minimum level of care. This interpretation of the meaning of equality fits most closely with the egalitarian view of equality. The egalitarian approach revolves around the idea that no one should receive any more care than any other person, except by medical need. Unlike the proponents of libertarian philosophy, egalitarians do not accept that people should be able to access superior services and care because they have more resources. Thus, although the informants focused on a basic minimum level of care that is similar to the minimal standards approach of libertarian philosophy, they did not accept the view that residents with the ability to pay should have greater access to superior care and services.

The informants' interpretations of the meaning of equality underpinned how they believed resources should be distributed within the context of the nursing home. However, their behaviour was influenced by factors other than their beliefs about the meanings of equality. For example, the acceptance of the informants of their place in the social order of the organisation, and their need to adhere to routines, both influenced and justified the type of care delivered. In order to complete their assigned tasks, the informants placed residents into types and categories that in turn influenced the type of care they delivered. Hence, despite the informants' stated beliefs that all residents should receive equal care, they did not give equal care to all residents. All residents appeared to receive a basic minimum of physical care, but some residents were given 'extra care'. It was through the informants' acts of caring that new dimensions to their perceptions of the meaning of equality and their distribution of resources occurred. The following chapter explores the AINs' perceptions of equality in response to the act of caring for residents, the impact of resident types on the process and the significance of 'extra care'.

Chapter 5
Distribution of AIN Resources

Introduction

The informants' definitions of equality, discussed in chapter four, encompassed the notion of a basic minimum level of care, in the sense that no one resident received any more care from the informants than any other resident, except on the basis of physical or medical need. The definition utilised by the informants underpinned their construction of resident types and provided the dominant paradigm in which they practised. Particular workplace structures, such as staff hierarchy and routines of the day, provided the parameters in which the AINs could distribute their resources. In addition, the categorisation of residents into types influenced the informants' behaviour at the bedside. Hence, in terms of an equal distribution of resources at the bedside, the informants' behaviour varied considerably, despite their perceptions of equality as a basic minimum level of care for all residents. This chapter will identify the resources of the AIN and further explore the AINs' perceptions of equality in response to the act of caring for residents. The chapter aims to compare and contrast the AINs' perceptions of equality with their behaviour.

This chapter commences with a discussion of the resources available to the informants and the characteristics of the different acts of caring they described. This is followed by an examination of the typologies of care they constructed and the consistency of their behaviour with their stated perceptions of equality in terms of resource distribution. The chapter concludes with a discussion of the core category that determined how the informants' perceptions of equality translated into behaviour at the bedside.

Available resources

The informants in this study defined their major resource as the time they had available to spend with residents in their care. Although the time available to spend with residents was largely determined and structured by the routines of the nursing homes, the informants stated that they were able to give 'real care' or 'extra time' to particular residents they thought deserved it. All informants described caring time as a valuable aspect of the interaction at the bedside, although their allocation or distribution of this resource varied. Their ideas about equality played an important role in both the construction of caring and in the distribution of their resource of time to particular residents. To fully comprehend this process, an understanding of what the AINs perceived as acts of caring was established. The characteristics of the different acts of caring described by the informants are discussed in the following section.

Caring time

Milne and McWilliam (1996) have described the resource of nursing as 'caring time'. They identified two elements of caring time: *being with* and *doing to/for*. The *doing to/for* category of care refers to the quantifiable components of the nurses' work descriptions which were similar to the 'bed and body work' described by Gurbrium (1975). It involved aspects of nursing such as assisting with physical needs and providing physical comfort (Milne & McWilliam 1996:814). The *being with* element of caring time involved sharing 'humanness', 'connecting' with residents and understanding and being and sensitive to their emotional needs (Milne & McWilliam 1996:813). It largely focused on the aspects of 'nurturing the personhood' of residents. This study draws on Milne and McWilliam's categories of *being with* and *doing to/for* to explore the informants' meaning of caring and how this was influenced by their perception of equality. The characteristics of Milne and McWilliam's categories are similar to what the informants in this study

described as *money care* and the *clean, dry, fed (doing to/for)* types of care and *quality time (being with)* type of care.

Acts of caring

The two different acts of caring and their characteristics, as defined consistently by the informants in this study, are illustrated in Table 5.1. The characteristics associated with each construction of care were developed through interpretations of the informants' interviews.

As the table illustrates, the *doing to/for* category of caring focused on the physical needs of residents; was acknowledged in job descriptions and routines; was quantifiable and funded; was valued by the organisation; and was considered core components of equal care. The *being with* category focused more on the social interaction between the residents and informants; was not acknowledged in job descriptions and routines; was not quantifiable, documented or funded; and did not fit the traditional definition of a 'good nurse'.

Table 5.1: Constructions of caring developed through interpretation of interview data from the informants

Act of caring	Characteristics
doing to/for (bed and body work)	• physical tasks driven by physical needs of residents • routine orientated • acknowledged in job descriptions • funded and documented • considered necessary • maintained the notion of the good nurse • increased dependency of residents • expected by residents • maintained negative societal discourse about nursing homes • considered equal care
being with	• social interaction not driven by physical needs • not routine orientated • not acknowledged in job descriptions • not funded or documented • not considered necessary • did not fit the notion of the good nurse • reflected a weakness in the AINs • considered as laziness • considered as unequal care or favouritism

Studies of interactions between nurses and patients (Kitson 1987; Nolan & Grant 1993; Salmon 1993; Wells 1980) found that the actual proportion of time nurses spent with residents ranged from a low 11% to 23% and that most of this time focused on the physical needs of patients (Armstrong-Esther & Browne 1986; Salmon 1993). In this study, the periods of interaction between informants and residents also largely focused on the physical needs of residents. The informants believed they were only considered to be 'working' when they were involved in this type of care. In some cases, if the informants spent too much time on *being with* residents, they were considered by other staff, including other AINs, to be lazy, as Marion explained:

> *You know what it's like. You're stuck with someone who is crying, who's having a really bad day and you get this, 'Come on, what are you doing! We've got beds to make and pans to clean yet ... come on, get moving! The afternoon girls will kill us if we don't have this done.' So what do you do? You just have to keep moving, 'cause if you don't the others complain and you get cut back on your shifts.* (Marion)

This experience is consistent with the observations of Milne and McWilliam (1996:817) that nursing resources are allocated to the measurable dimensions of the *doing to/for* type of care, rather than the *being with* type of care. The informants were aware that they engaged in these different types of care and they clearly valued the time they spent *being with* the residents. Karen described the value placed on the *being with* type of care:

> *... I mean, occasionally, I know a couple of times I've grabbed someone and given them a hug, and it's like you have given them a million dollars. Because they don't have that, there is none of that tactile kind of thing, there is none of that, give me a hug, you can't relate to that person as anything except, someone on a production line and that is how I feel it is, anyway.* (Karen)

Nevertheless, although they valued the *being with* type of care, most of the informants' time was consumed by the *doing to/for* type of care. Similar to the findings of Milne and McWilliam's (1996) study, most of the care in this study pivoted on tasks such as assisting residents to shower, to dress, to eat, to walk and to go to the toilet. The distribution of this resource or type of care followed the routines of the nursing home and, as it provided a basic minimum level of care to all residents, the informants perceived that equal care was indeed given.

Although the informants saw the provision of a basic minimum level of care as providing equal care, the inability to provide *being with* type of care created considerable tension for them. Because the AINs were required to adhere to the strict routines of the nursing home, their resource allocation was prioritised to the quantifiable *doing to/for* type of care, with the result that the *being with* type of care often had to be provided simultaneously. As explained by the following informant, the need to provide both types of care simultaneously created some difficulty.

> ... *but you never get time to just sit down and have a little chat. You can do that while you are feeding them but even then you can't ... how can you sit talking while you are feeding? Really!* (Marion)

The delivery of a basic minimum level of care that met the physical needs of the residents remained the priority of the nursing home routines and, therefore, the major focus of the informants. The provision of the *doing to/for* act of caring was deemed to be the essential element in the delivery of appropriate resources to ensure that the informants provided equality of care. However, although the *doing to/for* type of caring for the residents' physical needs was the main focus, other types of care were also provided by the informants. The following typology of care was developed from the informants' descriptions of the type of care they actually delivered. It involved elements of both the *doing to/for* and *being with* type of care described by Milne and McWilliam (1996).

Typology of care

Typologies, as utilised by Powers (1992:1336), provide a means for examining the differences or similarities between different types of care. In this study, a typology comprising three different types of care was constructed through interpretations of the informants' experiences. These were termed: *clean, dry, fed; quality time* and *money care.*

Clean, dry, fed

The first typology of care encompassed the *doing to/for* type of care described by Milne and McWilliam (1996) and it provided the basic minimum level of care for every resident. This was referred to as the *clean, dry, fed* type of care and it was the major focus of the informants' work. For example:

> *It is clean, dry, fed. That's what we do.* (Lynette).
>
> *... they are all dressed and dry and pressure area care and that sort of thing. Everybody gets that and that goes without saying.* (Peter)
>
> *Yes ... you are primarily just doing hygiene things and feeding. It's what you do.* (Georgina)

Wells (1980) describes meeting 'minimal universal needs' of patients as providing similar tasks described by the *clean, dry, fed* type of care in this study. The informants felt that their ability to become a competent AIN hinged upon their ability to get through the set tasks associated with the *clean, dry, fed* type of care. In their view, if the residents in their care were *clean, dry and fed,* and they helped other AINs to achieve the same, then management and peers were very content with their work. They stated that the ability to not only have the resident *clean, dry and fed* but also to complete other 'priority' tasks, such as having the beds made and residents' clothes put away, was considered part of being a good AIN. This notion of a 'good nurse' based on completion of these types of tasks was reinforced through the informants' experiences in the nursing home environment. The priority the nursing

home routines placed on distributing resources to *doing to/for* type of care over the delivery of *being with* type of care encouraged and reinforced the AINs' practice when caring for residents. This task-oriented approach of defining 'good care' in the terms described by the informants remains indicative of nursing home care delivery despite initiatives introduced as early as the 1980s, such as the Commonwealth Outcome Standards, which have required providers to provide more 'homelike', flexible approaches to care (Courtney 1996:112). From the informants' perspectives, their approach to care that was built on routines and the *clean, dry, fed* approach to care ensured equality in the delivery of care.

Quality time

The second typology of care, *quality time,* developed out of the informants' preference to be ahead of their work schedule. If the informants managed to complete the *clean, dry, fed* activities of their care ahead of schedule, they were able to spend the available 'extra time' or *quality time* in *being with* the residents who, they felt, needed it, as explained by the following informants:

> *... like, say, today I got an extra ten minutes or five minutes, I would probably go and sit in the lounge room and talk to three or four of them. Or I will go down and I will talk to someone that is in bed and not well. You sort of spread [distribute resources] yourself out.* (Pauline)

> *You have had an easy run, you have not got to put away three weeks' laundry, and you have got time to sit down with each person, then you can sit down, and you can spend time with each of them. Whereas, on most days, most normal days, you might have five minutes with one or two people. So, depending on how the day pans out, depends how equal the care is, I guess. I think they all get basic care. It's not what I am saying, it is just that extra care is given to some people if there's time.* (Joe)

> *... and the thing I like is that if you have got ten minutes to spare, then you can have a chat and do things [brush their hair for example], and spend a little bit of time with people.* (Lynette)

Unlike the *clean, dry, fed* type of care, the informants determined which residents received this 'extra time'. That is, in the case of *quality time*, the choice of residents who would receive this type of care was not dependent on the resident's need for physical care, but rather on a shared attachment between the informant and the resident. The informants described *quality time* as a 'special treat' for residents and stated that residents who did not receive *quality time* became jealous of the attention that informants provided to others. For example, Lynette explained:

> *It all depends which sections you are working in. Like, the west wing section, they all have their wits about them, they are all very demanding. They really are, and if you spend more time with one, then someone else knows it. It is really bad!* (Lynette)

The informants valued *quality time* as they were able to spend time with residents outside the required parameters of the *clean, dry, fed* type of care and believed that it contributed to the wellbeing of both the informants and the residents' day-to-day existence. Although they remained focused on the notion that all residents should receive equality of care, inequality of care actually occurred as a result of their distribution of *quality time*. Hence, the informants' behaviour in the distribution of 'extra time' or *quality time* appeared to reflect a somewhat different perception of the meaning of equality than their previously defined egalitarian approach to care. When deciding which residents should receive *quality time*, the informants seemed to differentiate between routine care for all residents and 'extra care' for residents they saw as more deserving. The rationale behind the informants' choice of which residents were more deserving of *quality time* was the key to understanding the differences in the equality of care they delivered. This rationale is explored later in this chapter.

Money care

The third typology of care that the informants discussed also related to a type of care that delivered more than the *clean, dry, fed* type of care. *Money care* was the generic term used by the informants to refer to the type of 'extra care' given to the

residents they perceived were more affluent, or wealthier, than other residents. The informants stated that 'the hierarchy' (Director of Nursing and the registered nurses) initiated this type of care, and most informants felt that this care was often unnecessary:

> *Some RNs, they will just, they will migrate there [toward wealthy residents]. They will all just seem to 'can I fluff this [pillow] for you?', or 'can I put this here for you?' or whatever, and things like that, and then tell us to do ... unimportant type things. Yes, some of them with ... and there again it goes back to money, and not those who have got a really, really nice personality. They [RNs] will expect us to spend a lot more time with those residents [with money]. I'm not saying all, but I'm saying some RNs will do that.* (Marion)

The informants felt pressured from within the hierarchy of the nursing home to perform extra things for the more affluent residents, 'not just the *clean, dry, fed* like everyone else got' (Margaret). As AINs, they resented this pressure and alteration to their routine. As explained by the informants, it delayed and undermined their ability to provide the *clean, dry, fed* care equally to all residents, and ultimately robbed them of the chance to spend *quality time* with the residents of their choice. Although both *quality time* and *money care* involved extra care, the informants valued *quality time* but most regarded demands to provide *money care* as an attack on their values and their notion of equality.

Typology and perceptions of equality

The different typologies of care that the informants actually delivered reflected a marked divergence from their perceptions of the meaning of equality of care. Despite their stated position that equality of care meant that everyone received equal care, this seemed to only apply to one type of care, the *clean, dry, fed* type of care. If the informants adhered to the established routines and the job descriptions, then every resident would at least receive a basic minimum level of care. In this sense,

the *clean, dry, fed* typology of care appeared to have the essential element of equality because all the residents received this care from the informants.

Quality time and *money care*, however, shared the characteristics of being unequal. These two types of care were not part of established routines, or formal job descriptions, and were not delivered to all residents. Different people were involved in the decision making process that determined which residents would receive these types of extra care. The identity of the person or persons who decided which residents would receive extra care was an important influence on how the informants classified the type of care provided and how they saw it in terms of equality.

Quality time was considered particularly valuable by the informants because they felt that they 'owned' the decision to choose which residents they could spend time with. Conversely, most informants resented *money care* because others in the hierarchy instructed its delivery rather than it being given at their own discretion. The informants believed the provision of *money care* often prevented them from providing the *clean, dry, fed* type of care they considered essential to providing equality of care. It was perceived by the informants as providing 'luxury' items, because to them it often involved 'non essential' tasks such as 'putting on hair spray' (Peter). From the informants' perspectives, *money care* took precedence over the essential tasks of caring for physical needs, such as helping residents to use the toilet, as described by the following informant:

> *Silly little things that are not necessary, but because they have got money, they just ... Yes. It is just stupid extra care that you have got to give them!* (Margaret)

The typology of care the informants assigned to particular practices reflected their interpretation of the meaning of equality. How they perceived equality seemed to influence how they classified the different types of care they delivered to residents. Some types of care focused on equality, whereas other types of care appeared to

limit the informants' distribution of equality of care. Figure 5.1 illustrates the relationship between the informants' distribution of care and their perceptions of equality. The typologies of *quality time* and *money care* are, firstly, represented as inequality because only some residents receive them, whereas the typology of *clean, dry, fed* care, which all residents received, represents equality. The typology of *money care* is, secondly, represented as being resented by the informants, whereas the typologies of *clean, dry, fed* and *quality time* are represented as being welcomed by the AINs.

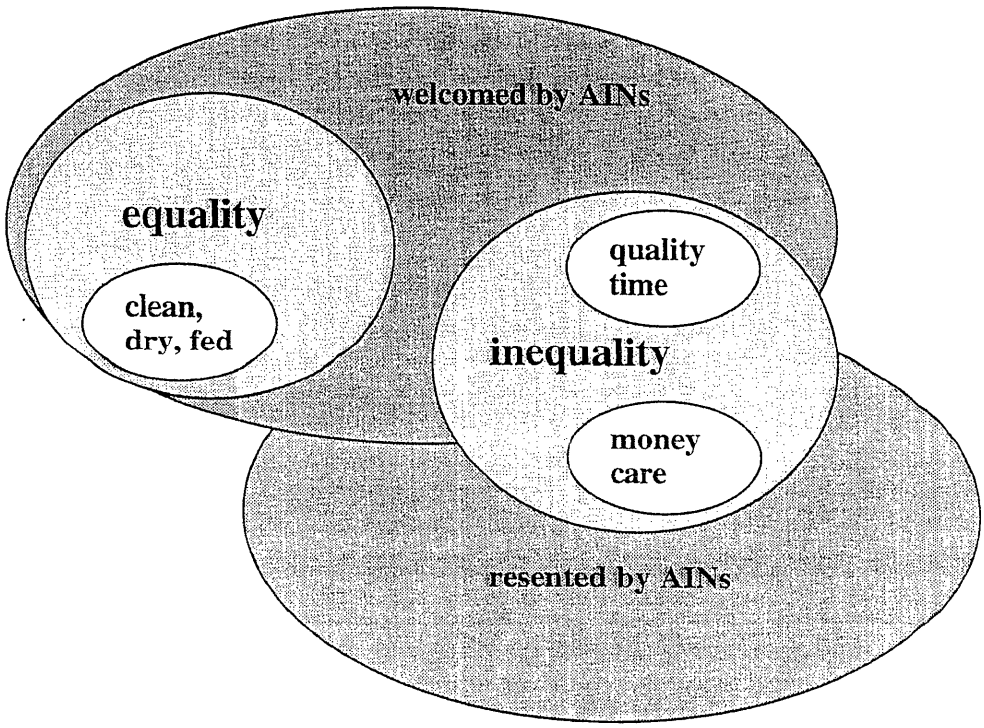

Figure 5.1: Typology of care and perceptions of equality and inequality

Quality time, although recognised by the informants as representing inequality or favouritism, was still considered very valuable for both the resident and informants, because it fitted their ideology surrounding quality of life for older people. Quality of life issues, as discussed briefly in chapter four, were based on the values and attitudes underpinning each informant's practice, particularly their perception of equality. The ability of the informants to own *quality time* as a resource in their care-giving role enabled them to give extra time to those residents they saw as

disadvantaged and more deserving of that time. The value the informants placed on *quality time* and its importance to job satisfaction was explained by the following informant:

> *And, see, they are not stimulated at all. They are just, you know that picture you have when you are really little ... about all these nice old people sitting around doing nothing all day. Well, it hasn't changed. If you just came to work to do the clean, dry, fed stuff, then it wouldn't be worth it. It's the other things, the quality time that makes the job bearable.* (Peter)

The ability of the informants to distribute their resource of time in a manner that upheld their basic principles of providing a basic minimum level of care to all was an indisputable element of their practice. However, unlike the *clean, dry, fed* type of care, the informants' distribution of *quality time* was not based on the physical needs of residents, but rather on the way the informants appeared to construct the act of caring.

Constructions of caring and distribution of resources

The informants' behaviour, in terms of their distribution of resources, pivoted on different constructions of care. As described by Ellis (1999:160), individuals construct and interpret their own meanings of behaviour regarding different types of care, and their perceptions evolve into subsequent behaviour in the delivery of that care. The typologies of *clean, dry, fed; quality time*; and *money care* within the informants' work evolved into two distinct constructions of caring: job caring and real caring. The findings in this study are similar to those suggested by Salmon (1993:18). Salmon found that nurses' perceptions about caring determined or predicted the level and quality of their interaction with elderly residents. In this study, there was a discrepancy between the informants' stated perceptions of equality as meaning equal care for all, and the level and type of care they actually delivered. That is, some residents received real caring while others only received job caring. Real caring involved *being with* the resident. Job caring, conversely,

involved the *doing to/for* type of care associated with *clean, dry, fed* care and *money care*. The *clean, dry, fed* type of care involved the informants following set routines and performing required tasks within allocated time frames, and *money care* provided what was often regarded as unnecessary care directed by others.

Table 5.2 illustrates the attributes associated with the two constructions of caring, job caring and real caring, within the framework of care that the informants delivered. It compares and contrasts the typologies of care, the act of caring and how these relate to the distribution of resources by the informants. The descriptors of basic minimum care and extra care combined with dependent variables of these constructions of caring explain the informants' interpretations of the meaning of the type of care they delivered, and the value they placed on the different types of care they delivered. The *clean, dry, fed* type of care that focused on the physical needs of residents was deemed essential care. *Money care* was seen as a luxury as it was often considered to be unnecessary. The delivery of *quality time*, although valued by the informants as their preferred type of care, remained secondary to the delivery of the *clean, dry, fed* type of care.

Table 5.2: Framework of caring developed through interpretation of interview data

	Job caring		**Real caring**
Typology of care	Clean, dry, fed	Money care	Quality time
Act of caring	Doing to/for	Doing to/for	Being with
Description	Basic minimum of care	Extra care	Extra care
Distribution of resources	Equal	Unequal	Unequal
Dependent upon	Routines Physical needs	Direction by others Unnecessary needs	Time left over after routines Emotional/human and social needs
Value	Essential	Luxury	Preferred

Job caring

The informants explained job caring as the type of care that was seen as being part of their job. It involved the *clean, dry, fed* tasks of care and was considered by the informants as part of the *doing to/for* act of caring. The time allotted for job caring was structured by job routines that provided a framework for carrying out the *clean, dry, fed* tasks of the day. Adherence to this rigid framework allowed no time to become attached to residents or to become involved in real caring. The risk to the delivery of equality of care this study highlighted is that staff might hasten through job caring in order to allocate more of their resources to real caring. That is, through their desire to allocate time to real caring, staff could jeopardise the amount of time allocated to the *clean, dry, fed* type of care and, thereby, inadvertently lower the standard of the basic minimum level of care delivered to all residents. However, this is not to suggest that the informants in the study did not give adequate care. Rather, it highlights the potential influence insufficient time allocation for participating in real caring may have on the delivery of the *clean, dry, fed* type of care. *Money care* was also considered to be job caring because it was directed by someone else and not given at the discretion of the informants. It was, therefore, seen as being part of the job.

Real caring

Real caring was considered to be a true exchange of affection between the informants and the resident for which they cared. Real care involved more than the *clean, dry, fed* type of care and provided individual informants with some ownership or control of the caring process. Real caring had some emotional meaning and its delivery was contingent on the informants' ability to acquire and distribute the resource of *quality time*. The notion that the distribution of *quality time* meant unequal care was provided was justified by the informants' perception that by providing *quality time*, they were able to make a resident feel special, and somehow improve the resident's quality of life. That is, the informants seemed to believe that some residents should be compensated for the inequalities they

experienced in society because of their lack of equal opportunity to secure or retain financial resources that may have resulted in their achievement of a higher standing or status. In other words, the informants' perceptions of equality seemed to mean that everyone should be equally placed to receive the same rewards, or kinds of care, or at best the means to access the same resources as others in a similar situation. This perception is consistent with the egalitarian views of equality discussed in chapter four.

Participation in real care was not talked about openly by the informants, as it implied that they were favouring some residents, not performing their work in an appropriate manner, or that they were 'weak' because they had a special relationship with a resident. The importance of being able to provide real care, however, was demonstrated by the fact that this type of care was often performed in the informants' own time. For example, the informants would sometimes visit the nursing home on their days off work to participate in the affection of real care, usually under the premise of attending a staff meeting or seeing a fellow AIN. In real care, the informants stated that they would often shop for the resident, or mend their clothing and would secretly participate in the exchange of gifts for special occasions such as birthdays and Christmas. The informants did not consider this behaviour as a deviation from their ideas about equality, but rather as fulfilling a need for a particular resident of which they were fond. The following informant described this behaviour:

> *The thing that gets me is that we are not s'posed to get close to them, the residents, I mean. We're expected to feed them, change them, shower them, but God forbid we get close to them! The poor old things, of course we all do extras for them, especially the ones we like ... and sometimes we'll treat each other [the resident and the AIN], just little things ... after all, if we don't spoil them, who else have they got? It's like when you come on duty, they sometimes look at you and it's relief on their face, that it's you on today ... it's worth a million bucks [dollars]!* (Georgina)

The notion of real caring made issues of equality paramount in the minds of the informants. They all had their favourites and their non-favourites among the residents. The informants found the provision of 'extra care' to non-favourite residents and unequal care to favourite residents equally upsetting. The categorisation of residents into favourites and non-favourites was closely related to their categorisation of residents into the types outlined in chapter four. Particular resident types such as 'lack of family involvement' or 'seeing a bit of yourself' in a resident were a contributing factor to informants engaging in real caring. The informants openly spoke of their affection for some residents. For example, as stated by the following informant:

> *There is a lot of people that you meet and you click with them and you think, yes, I like you, and, I mean, even though they don't have to be verbal towards you, you can still get that [affection] from someone just through their gestures, and their actions, and their facial expressions and things, whether they like you, and I wish I had known you 20 years ago when you were still you.* (Marion)

Although the informants did not readily talk about it, they offered *quality time*, or real care, to particular residents regularly. As indicated earlier, the informants' distribution of the resource of *quality time* was invariably driven by the construction of caring that each informant held, which in turn resulted in a decision of whom to spend their extra resource of *quality time* with. In other words, the choice of whom to spend *quality time* with was not based on the residents' physical needs, as with the basic minimum level of care, but was underpinned by the informants' construction of caring as real caring or job caring.

Within this process of the construction of caring, the informants were influenced by many variables. The resident type, the hierarchical structures of nursing homes, the values that informed their interpretation of equality, and the time available to them all played significant roles. Within this process, however, the informants'

perception of the socioeconomic status of the resident was the key to understanding how the informants distributed their resources at the bedside, and how they chose residents to spend *quality time* with. This relationship between socioeconomic status and the type of care the informants delivered led to the emergence of the core category in the study: the perceived socioeconomic status of residents.

Influence of socioeconomic status

The perception of the residents' socioeconomic status (SES) compared with that of the informants was the most influential factor in determining how the informants' perceptions of equality translated into behaviour at the bedside. Although other variables tempered the influence of the core category to a degree, socioeconomic status was the single most important factor that influenced and determined the manner in which the informants distributed their resources and the type of care they delivered.

In this study, the informants' self-definition of their socioeconomic status and that of the residents was not directly based on the conventional measures of occupation and income level. Although there is no agreed-upon definition of the term 'socioeconomic status' it is commonly taken to include indicators such as occupation, income level and educational level (Bates & Linder-Pelz 1987:18; Bulbeck 1993:453; Sax 1990:23). Occupation has been seen to be particularly useful as a measure of social and economic position because it incorporates a number of factors such as social prestige, income level and educational level. However, it has limitations as an indicator of socioeconomic status because it omits people not in the workforce, such as people who are retired or disabled, the unemployed, and others such as women performing unpaid work (Bates & Linder-Pelz 1987:19).

It is not surprising, then, given that the residents were no longer part of the workforce and the informants, as AINs who were employed in low paid work, used non conventional measures for ascribing socioeconomic status to themselves

and to the residents. As pointed out in chapter two, the informants were asked to define their own socioeconomic status. To measure their socioeconomic status, they used as indicators their educational background, their social networks outside the work environment, and their partners' occupations. Although they had no formal knowledge of the residents' actual socioeconomic status, the informants openly claimed that they could determine this. In this case they used indicators such as the residents' personal possessions, the residents' ability to pay for goods and services, the level of attention that residents received from senior staff and management, in addition to the residents' patterns of speech.

Using the measure of material wealth, for example, the informants all stated that through observation of residents' possessions they could determine the residents' socioeconomic status, particularly those with high socioeconomic status, as the following informants explained:

> *... the material things, you would probably see a lot of cupboards and something that is quite swanky or antique type things coming in [to the resident's room], they probably even have a single room. They [Director of Nursing/registered nurses] seem to go and swap people about if someone is coming in who has got money. They will swap people out of a room and things like that and change things about. I mean, I used to think speech used to be [an indicator of SES], but I don't think that is quite a way of classifying someone, but, yep, that is basically how I would see it. Also the grapevine [gossip], you usually hear it along the grapevine at work ... 'um this person has got money'.* (Peter)

> *The way I tell [SES status] is, those who are poor have shabby clothes, shabby underclothes, can't afford to have their hair done every week, things like that. Whereas with the others, if there is a bit of money there you know it straight away because you only have to suggest that maybe 'Mr or Mrs so and so' needs something and you have half a dozen of them!* (Marion)

Most of the informants resented the presence of residents' personal possessions in the nursing home. These possessions not only suggested the resident's socioeconomic status to the informants, but the informants stated they often 'got in the road' (Peter, Margaret, Lynette) when they were delivering care. For example, Peter explained how these possessions interfered with the delivery of care:

> *... but also, you have got to think that if you have to have lifters [to lift residents] in there [the resident's room] and they have got their things in there, you are going to break things. These lifters are not little things, they are fairly big cumbersome machines. They are going to get hurt, things are going to break.* (Peter)

The possession of personal items in a nursing home environment has been reported as being important to retaining a sense of self for residents (Prentice 1987, cited in Cram & Patton 1993:19–20). Possessions enable residents to participate in preferred activities such as reading, listening to music, aromatherapy, talking to relatives and letter writing. Hence, to a certain degree, they enable residents to control and manipulate their own environment. The informants in this study did not identify an association between the residents' personal possessions and control over their own environment. However, they did note that residents with many possessions, the 'rich' types, were more difficult to manage and less likely to comply with nursing home routines.

> *... they ['rich' residents] come in here and expect to get all this attention, these rich ones ... and they have so much stuff. They look down on us like bits of dirt sometimes. I don't go out of my way to give them anything extra, that's for sure!* (Margaret)

In the informants' view, the more possessions and control the residents appeared to have, the more likely they were able to disrupt the AINs' routine. In general, they did not like the routines disrupted by these non-compliant, selfish types of residents, as the following informants' comments demonstrated:

... you know, you're stuck where you are and you don't get away quick enough ... they'll find something, 'Oh, can you fix up that picture?' or 'That pillow's not right, can you pull it out and fluff it up a bit more?' or ... they'll find little things, you know? ... 'Oh, that's not in the right drawer, can you put it up in that drawer?' ... just little things ... just to keep you there! (Peter)

They [wealthy residents] all have definite opinions. They are usually the ones that demand all the attention and the ones who tell us there should be more staff on ... and to make things worse, they never want to do what they're told! (Trent)

The informants also stated that they could tell a resident of high socioeconomic status by the behaviour of others towards them, particularly members of management and registered nurses. The informants talked about this behaviour often and most resented the extra attention these residents received, as described by the following informants:

I have seen a person in high ranks, you know, a big boss, go in and feed a lady because, I mean, well, I know this lady has got a few dollars, but I have never seen her do it with somebody else, when I know that she could have ... you know, I've seen her take out dirty bed pans and things like that out of the woman's room that's got a few dollars, but never out of anyone else's. (Melissa)

... the ones that are treated a lot different than the average other ones, like, I mean, I believe, myself, that money can talk. I mean, if there's someone there that's got a few more dollars then the bloke next to him, of course he's going to get the special treatment, you know, he's going to get fussed over ... and they're going to allow for them more than they will the common people. (Peter)

I mean, if you're a little bit important, they will, you know, they'll fix it so that you can be treated differently, you get pampered a bit. (Lynette)

I get 'pissed off' [very annoyed] that the people who perhaps aren't as well off aren't treated as well by the management. I think

> *that everybody that's in a nursing home deserves the same treatment, be they rich, poor or anything else. You know, it annoys me that the richer people tend to get the better treatment ... It's becoming an elitist thing ... so therefore they're getting more richer residents in.* (Katrina)

The informants' perceptions of the residents' socioeconomic status and its similarity to that of their own influenced the type of care the informants delivered to different residents. All residents, regardless of their socioeconomic status, received the basic *clean, dry, fed* type of care. However, the provision of *quality time* and *money care* was influenced by the socioeconomic status of the informants and residents. The delivery of *quality time* or *being with* type of care occurred most frequently when the informants perceived the socioeconomic status of the residents to be similar to their own. Only residents perceived to have a high socioeconomic status received what was termed *money care*.

The relationship between the informants' socioeconomic status, the perceived socioeconomic status of the residents, and the distribution of resources by the informants is illustrated in Figure 5.2. It illustrates that although all residents received the *clean, dry, fed* type of care, the distribution of the two other types of care, *quality time* and *money care*, was influenced by socioeconomic status of the residents and, in the former case, the socioeconomic status of the informants. As Figure 5.2 demonstrates, the informants who regarded their own socioeconomic status as being low, tended to provide *quality time* to residents they perceived as also having a low socioeconomic status.

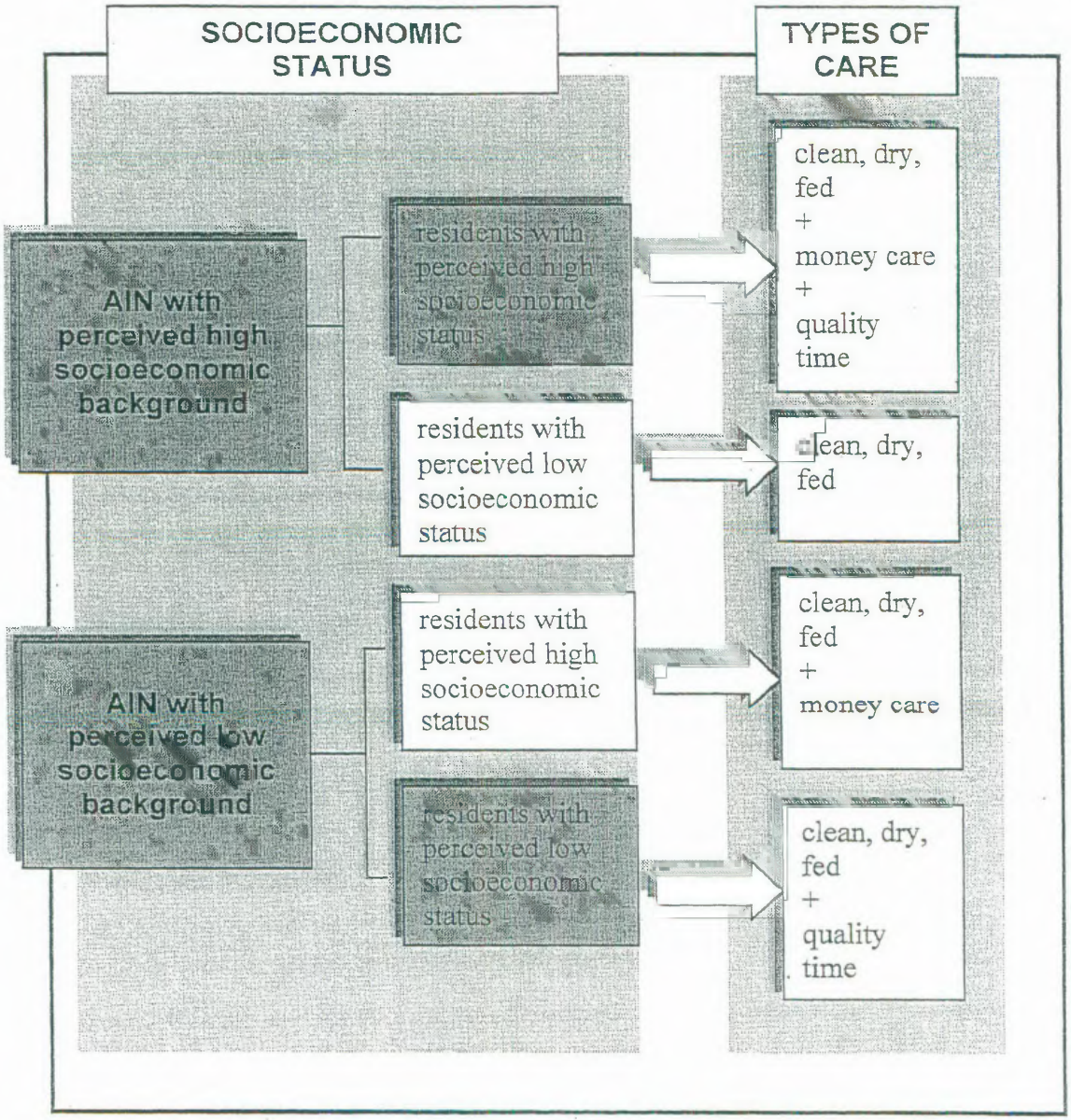

Figure 5.2: Distribution of resources and types of care delivered as determined by AINs' perceptions of socioeconomic status (SES)

The following examples are typical of the comments made about residents perceived to have a low socioeconomic status by informants who also identified as having a low socioeconomic status:

> *Of course there's going to be the ones that you do favour, I mean, as I said, you don't show that you favour them, but you do get rather close to them because they don't have much and management never worry about them ... they don't have a choice about anything.* (Melissa)

... they understand the situation, they don't blame us for being in there. Their families are probably easier to get along with. They [the low SES residents] are just, sort of like 'nannerish' [like grandparents]. They [the low SES residents] are sort of like ... familiar, so you like to spend time helping them out. (Carol)

I suppose that they respond to me and even though some of them can't talk, they can still make it known to me if they don't really like me around them or if they prefer someone else. (Trent)

... like, one in particular that I am thinking of, is really rough, I love her. She swears and everything, but then, there are others that are really 'lady like' and don't appreciate us. They think we are just there to, I mean ... I know that it is our job, but we have to be considered a bit! (Carol)

Conversely, the informants who regarded their socioeconomic background as high tended to provide *quality time* to those residents whom they perceived to also have a high socioeconomic status. Although the number of AINs who identified as having high socioeconomic status was small in this study, they behaved quite differently towards residents with high socioeconomic status. On occasions they also provided what was termed *money care* but they appeared less resentful of this type of care than their low socioeconomic counterparts. In their view, residents with higher socioeconomic status were not well understood by AINs of lower socioeconomic background. The following comments demonstrated the different attitude the high socioeconomic status informants had towards residents of similar socioeconomic status, and their willingness to provide these residents with 'extra care' or *quality time*.

Most of the others don't understand them ... they feel ... I don't know, really, jealous maybe? So they tend to stay away from them ... or they label them as 'snobbish'. They get kind of lonely, so I try and go out of my way to talk to them if I get the chance. (Georgina)

Imagine though, all your life being able to do what you wanted with enough money to not have to worry, eating in all the nice places having great conversations, and then all of a sudden your world is gone and you are forced to live in 'mass housing' with people tending to you who don't even speak 'proper' English, and being fed mashed food and listening to popular music! It's no wonder they become demanding! I can't think what it must be like for them, the poor old dears ... so, if I get the chance I try and do things for them. (Jenny)

... you would expect these people to socialise more, but when you see them listening to the paper reading, for example, and the person reading says 'adver-tise-ment' rather than 'adver-tis-ment' ... well, you can understand! (Jenny)

The informants who self-identified as having a low socioeconomic status resented the extra attention residents with high socioeconomic status demanded and the way in which they believed the behaviour of management favoured these residents. The following comments illustrated this resentment:

Yes, they do, they expect more, they just expect you to be able to be there on demand, when they buzz [use the call bell] and just do whatever they want you to ... (Steven)

... I don't know whether it's the luck of the draw or the colour of the money that gets them a single room ... (Katrina)

... the higher fee paying ones ... they tend to want more ... their family's there constantly and they [the family] tend to have an ear of the person who's in charge. (Katrina)

Although some informants felt that residents of higher SES should contribute to the cost of their care, they did not believe this contribution should translate into extra or superior care. For example:

... I can understand people who are independently wealthy perhaps contributing more than those that aren't, but I think it should be an across the board thing, you know, like, I don't think

that people who can't afford to pay fees should be treated any less than people who do. (Katrina)

I think if they've got the money ... I'm not saying make the fees tremendously expensive, but ... if they've got a few dollars more than the average person that doesn't have much at all ... If you've got the money, you should pay a little more than the poor people who don't. I mean they've [the poorer residents] worked half their life to have what they've got. (Melissa)

I mean, if you give them an inch, they'll take a mile! I mean, you try and be happy, you know you try and come across to them like you do everybody else, but, I mean, they ... myself, I think they get special treatment, and, well ... I'm not going to give them the special treatment. I don't treat them any differently than what I do anyone else, but I just don't like the fact that they get fussed over and, I mean, their money is the same as anyone else's. (Margaret)

The informants' willingness to distribute their resource of *quality time* to some residents and not others would seem to suggest that their behaviour was based on libertarian views of equality and equity rather than egalitarian views. As outlined in chapter four, the libertarian view suggests that it is acceptable for some people to obtain access to superior, or more, services, provided that a minimal standard of care is available to everyone. Holders of this view therefore believe that people who are able to pay for access to extra or superior services should be provided with the opportunity to do so.

However, in the delivery of care to residents perceived to have a low socioeconomic background, the informants' decision to provide 'extra care' or *quality time* was not based on the residents' possession of superior financial resources to pay for these services. Rather, the delivery of 'extra care' or *quality time* to these residents was related to their unequal possession of financial resources: their inequality of circumstances and opportunity to access superior services. The informants with similar low socioeconomic backgrounds tended to view these residents as being

more deserving of 'extra care' than those who they believed had superior financial resources.

The behaviour of the informants with low socioeconomic backgrounds seem to exhibit a desire to disrupt what they perceive to be an existing social order that favours high socioeconomic status in society in general, and in the nursing home. That is, the informants with low socioeconomic backgrounds aimed to 'level the playing field' in terms of how resources were distributed by providing any extra resources they had to the residents of lower socioeconomic status. Indeed, informants with low socioeconomic backgrounds seemed quite determined to ensure that a resident who paid fees, and was considered to have a high socioeconomic background, should not receive extra or special care. For example, Bridget talked about the way residents with high socioeconomic backgrounds were often treated:

> *You have a lot of people who don't like doing things that inconvenience them. If Jane Doe [high SES resident] wants to go to the loo and they're [AINs] busy doing something else not quite as important, well, they'll do what they're doing instead of taking this person to the toilet. It's sort of ... you look at it as though to say ... well, tough, I'll get to you when I get a chance to. It's basically ... well, yeah, that's just the way it comes across to me anyway.* (Bridget)

On the other hand, the behaviour of informants considered to have a higher socioeconomic status towards residents with a similar status demonstrated a desire to maintain what they perceived in general to be the appropriate social order of society. These informants prescribed to the libertarian view that as long as a basic minimum level of care was available to all residents, it was acceptable for residents with superior resources to seek and receive additional care and services. Their provision of *quality time* to residents of higher socioeconomic status, and their greater acceptance of *money care,* was, therefore, consistent with their perceptions of the existing social organisation of society:

> *Again, it [type of care] gets back to who this person was before they came here. These people had standing in society and were very influential ... had a lot of money and respect. Now they're in here and everyone expects that to be gone! I don't know how I'd cope ... I would die if someone tried to put a bib on me! ... We should try and make an effort for these people.* (Georgina)

The behaviour of the informants considered to have a low socioeconomic background towards residents of a similar background was consistent with the concept of vertical equity: unequal treatment of unequals (Sax 1990:58). In this case, the informants gave the greatest assistance to residents who had the greatest need relative to their social and economic resources. Their willingness to provide the most assistance to those whom they believed were the most disadvantaged fits most closely with an egalitarian view, that people should be provided with an equal opportunity to access equal care, regardless of their ability to pay.

The willingness of the informants from a higher socioeconomic background to provide *quality time* to residents from a similar background was also consistent with the notion of unequal treatment of unequals. However, in this case the high socioeconomic background informants' distribution of extra resources to residents perceived to have the most resources was based on an acceptance that people with superior resources should be able to access superior or more services. This belief and the informants' behaviour is most consistent with libertarian views of equality. In both cases the informants displayed a willingness to favour, in terms of resource distribution, those residents who shared a similar socioeconomic background to their own and reminded them most of themselves, or family members.

Summary

This chapter has demonstrated how the informants' perceptions of equality and the meaning they attached to the care-giving experience influenced their behaviour at the bedside in terms of distribution of resources. The caring time available to the AINs was their most valued resource. Most of this time was allocated to the measurable

dimensions of caring that were dictated by the physical needs of residents, job descriptions and the routines of the nursing home. However, they also engaged in what they termed *quality time* and *money care.* Unlike the *clean, dry, fed* type of care, these two types of care represented unequal care. The informants desired and enjoyed the social interaction they experienced with residents through their delivery of *quality time.* However, most resented what they termed *money care* because it was given to the 'rich types' under the direction of management.

The three typologies of care described by the informants evolved into two distinct constructions of caring: job caring and real caring. Job caring involved the *clean, dry, fed* type of care and *money care.* Conversely, real caring involved *quality time* with residents and was highly valued by the informants. The informants' construction of caring was influenced by factors such as the categorisation of residents into types, the hierarchical structure of the nursing home, the informants' underlying values, and the time available to them. Their belief that all residents should receive a basic minimum level of care, the *clean, dry, fed* type, parallels with required outcome and accreditation standards and the general philosophy of nursing home practice. However, the informants' perceived socioeconomic status of the residents impacted on how they interpreted the meaning of equality and the equality of care they actually delivered. It emerged as the major influence on the informants' decision in terms of resources distribution, by determining how the informants chose which residents for whom they would provide 'extra care' or *quality time.*

Chapter 6
Discussion and Conclusion

Introduction

This study investigated the bedside practice of assistants in nursing (AINs) employed in nursing homes within the New England health region of New South Wales between early 1998 and late 2000. The overall aim of the study was to examine the AINs' perceptions of equality and how these influenced their distribution of available resources to residents in their care. To do so, the study identified the AINs' perceptions of the meaning of equality and explored the factors that influence these perceptions and the types of care they delivered. The study utilised the method of grounded theory to generate theory that explains the practices of AINs in terms of the types and quality of care they deliver.

Grounded theory method was particularly suitable for this study because it enables the discovery of meaning and the interpretation of behaviour in areas about which little is known. As a method, it is seen to be particularly useful for examining the minuate of action and interaction within social processes, but it is criticised for paying insufficient attention to macro-level influences on these processes. This study has sought to address this criticism by taking account of the broader structural influences on the distribution of resources in nursing homes.

This chapter reviews the findings of the study within the context of broader structural influences on aged care and practices in nursing homes. It identifies and discusses the influence that the AINs' perceptions of equality had on their resource distribution, the factors that maintained and challenged those perceptions, and the overall effect the interplay of these factors had on the type of care the AINs distributed to residents in their care. The chapter concludes with a discussion of the implications of the findings of the study for nursing home residential aged care.

Context of nursing home practice

The care that people in nursing homes experience is caught between the need to comply with government regulation and funding mechanisms and the proprietors' interest in containing the costs of providing care. Decisions at the governmental level have had an impact on the organisation of aged care in Australia, the structure and nature of the nursing home industry, the resources available to carers, and ultimately the type of care the elderly receive in residential care. The introduction of the Aged Care Reform Package in 1997 introduced consumer cost sharing arrangements to assist government funding of residential aged care. These changes introduced income-tested daily care fees and means-tested accommodation fees for residential care and, in some facilities, higher charges for luxury accommodation and superior or extra services. The introduction of cost sharing arrangements under this user pays system meant that residents could now be categorised by staff according to the level of care they required and their ability to contribute to the cost of their care. These funding changes, therefore, raised the important issues of equity in access to care and services and the equality of the care delivered in aged care facilities.

The incorporation of potential macro-level influences on delivery of care to residents was quintessential to an understanding of the microcosm of interaction and action at the bedside. The recognition that macro level factors may influence the delivery of care resulted in this study widening the parameters of its investigation to consider the potential impact of macro-level variables, such as the broader political and social context of aged care structural reform and nursing home structures, on the distribution of resources at the bedside. The changes introduced under aged care reform strategies, the introduction of user pays fees, and the increasing emergence of consumerism in aged care all influenced the organisation and structure of the contemporary nursing home industry and had the capacity to impact on delivery of care at the bedside.

This study, therefore, examined not just the characteristics of a group of AINs, but also the structure, organisation and culture of the nursing homes and the aged care industry in which they worked. In doing so it explored the influence of these factors on the AINs' perceptions of equality and the care they deliver. By providing a broad contextual backdrop and an opportunity for the AINs to talk freely about the perceptions that underpinned their practice, this study has been able to generate a theory about the reality of bedside practice in nursing homes.

The practices of AINs were examined because they make up the majority of workers in the aged care industry and they participate in the most interaction with residents. In order to examine the types of care residents receive, it was, therefore, imperative that the study focused on this group of staff. Dependency on lesser skilled workers, such as AINs, has been a feature of institutionalised care in Australia and elsewhere. Fears that demographic changes would substantially increase the numbers of frail elderly requiring residential care and escalate the costs of aged care have led to the employment of these less skilled and lower paid group of workers. However, despite the large numbers of AINs employed in aged care, little is known about their practices. By gathering information about the practices of AINs, their perceptions of equality and how these influence the distribution of resources at the bedside, this study begins to address the shortfall of knowledge about AINs and the delivery of bedside care in nursing homes.

Perceptions of equality and resource distribution

In order to examine the practices of AINs and how these impact on the type of care delivered in nursing homes, this study focused on the AINs' perceptions of the meaning of equality and how these transpired into behaviour in terms of resource distribution. The study revealed that a number of factors either reinforced or modified these perceptions and this in turn influenced the type of care the informants delivered.

The informants' definitions of equality were difficult to define within the context of contemporary theory, as terms such as 'equity' and 'equality' are often used interchangeably by theorists. However, the definition of equality that the informants described in this study was grounded within the contemporary theories of egalitarian and libertarian ideologies. Their definition or interpretation of equality fitted most closely with the egalitarian notion that all people should have an equal opportunity to access the same kind of care, according to need. This interpretation translated into a belief that all residents should receive a basic minimum level of care. In general, most of the informants' stated views of equality did not accept the libertarian view that people with superior financial resources should have access to superior services and care. However, extra care was indeed given in particular instances and this was largely dependent upon the informant's perception of the resident's socioeconomic status. This 'extra care' was different to the forms of care that focused on the physical requirements of residents.

Despite the value the informants placed on providing 'extra care' to some residents, their behaviour in terms of resource distribution was in keeping with the government's funding arrangements prior to the Aged Care Reform Act in 1997. That is, the dominant paradigm in the delivery of care remained focused on the physical care needs of residents. As pointed out in chapter three, the introduction of the single funding tool, the Resident Classification Scale, was designed to liberalise routines and staffing allocations by funding the time required to address social and emotional needs, as well as physical needs. However, despite these funding changes and greater emphasis on caring for all the needs of residents, there was little evidence to suggest a major change in the type of care staff delivered. The routines of the AINs remained entrenched in providing a basic minimum level of care, the *clean, dry, fed* type of care, to address the residents' physical needs. The delivery of this type of care was supported by the contemporary nursing home practice of requiring strict adherence to established routines that centred on meeting the physical care needs of the residents.

The AINs' perceptions of the equality of care as providing a basic minimum level of care for all residents was maintained and reinforced by the hierarchical structure of nursing homes and the need to comply to established roles and routines. The AINs' most abundant and valued resource was time. Their use of this time, however, was largely determined by routines centred around assisting residents in the activities of daily living such hygiene, toileting, dressing, eating and mobility. Although the requirement to adhere to routines structured the AINs' work and allowed them to allocate their resources on what they saw as an equal basis, they did not particularly like the routines. Nonetheless, the need to conform to the routines and allocated tasks was beneficial in the sense that it reinforced their perceptions of equality of care as meaning the provision of a basic minimum level of care, and it relieved any tension between their beliefs about equality and the care they delivered.

Although the AINs in this study believed their provision of a basic minimum level of care to all residents represented equality of care, in practice, they did not treat all residents equally. The categorisation of residents into different groups, or types, translated into the AINs being willing to provide different types of care to different types of residents. For example, by categorising some residents as 'heavy', 'demanding' and 'uncooperative', the AINs were able to justify the lack of time they wished to spend with these types of residents. The AINs saw the demands of these types of residents as illegitimate because they believed they interfered with their routines and their capacity to provide equal physical care to others. On the other hand, compliant residents, for example, were perceived to be more 'deserving' of the AINs' time because they did not disrupt established routines and they valued the staff and the care they received. Residents who reminded the AINs in some way of themselves, or family members, were particularly regarded as being more deserving of the AINs' time.

Residents who did not comply with the AINs' routines were disliked in general by the AINs. This was particularly the case for residents who were categorised as

'rich' types. The AINs resented the attention this group of residents demanded and perceived their behaviour as preventing them from meeting the necessary care needs of other residents. So, although the AINs sought to provide a basic minimum level of care for all residents, and believed this represented equality of care, in reality they sought to provide 'extra' or different care for some types of residents. How they categorised residents had an impact on the type of care they actually delivered, and their ideas about equality played an important role in shaping their construction of the act of caring and how they distributed their most abundant resource, time. Although most of the AINs' time was distributed to meeting the physical care needs of residents, the AINs welcomed the time they could use to interact socially with the residents of their choice. The AINs valued this 'extra' time they had to distribute to the residents because they determined which residents would receive this time.

To explore the AINs' meaning of caring and how this was influenced by their perceptions of the meaning of equality, this study drew on Milne and McWilliam's (1996) categories of *doing to/for* and *being with* types of care. The two different acts of caring described by the AINs in this study, *clean, dry, fed* and *quality time*, shared commonalities with the types of care described by Milne and McWilliam (1996). In the former case, this care involved the quantifiable components of nurses' work descriptions that focused on the physical care needs of residents. In the latter case, the care involved unquantifiable aspects of care such as sharing human experiences, connecting with residents, and being sensitive to their emotional and social needs. The third type of care the AINs in this study described was that of *money care*. Most of the informants resented this type of care because it was directed to the 'rich' type of resident at the discretion of others.

The different types of care the AINs described suggested inconsistencies between their interpretation of the meaning of equality of care and the actual care they delivered. Despite their stated belief that equality of care meant that everyone received equal care, this seemed to only apply to the *clean, dry, fed* type of care.

The two other types of care described, *quality time* and *money care*, shared the characteristic of being distributed unequally. The ways in which the informants constructed the act of caring were central to understanding the relationship between their perceptions of equality and its influence on their behaviour in terms of resource distribution.

The AINs' willingness to provide *quality time* to some residents and not others appeared inconsistent with their stated perception of equality as meaning equal care for all residents, according to need. At face value, this would seem to suggest that the AINs were subscribing to the libertarian view that it is acceptable for some people to have superior access to resources or services as long as a basic minimum standard of care is provided for everyone. However, the AINs' distribution of *quality time* was not related to the superior financial resources of residents but, rather, to how 'deserving' the AINs judged the residents to be. In general, the AINs did not approve of providing the 'extra' care they saw as *money care* to residents they perceived as having superior financial means. In providing *quality time* to residents of their choice, it seemed that the informants were trying to 'make-up' for the disadvantage they believed some residents faced.

The different types of care that the AINs delivered evolved into two distinct constructions of caring: job caring and real caring. Job caring involved *the clean, dry, fed* or *doing to/for* type of care and *money care.* The *clean, dry, fed* type of care was dictated by the roles and responsibilities of the job and was structured by the routines of the nursing home. *Money care* was dictated and directed by the AINs' supervisors in the hierarchy and, although it was resented, it was seen as being part of the job. Real caring involved *quality time* that involved *being with* the resident and was distributed at the AINs' discretion to residents of their choice. The AINs' construction of the act of caring was influenced by a number of factors. Figure 6.1 illustrates the varying factors and their influence upon their distribution of resources.

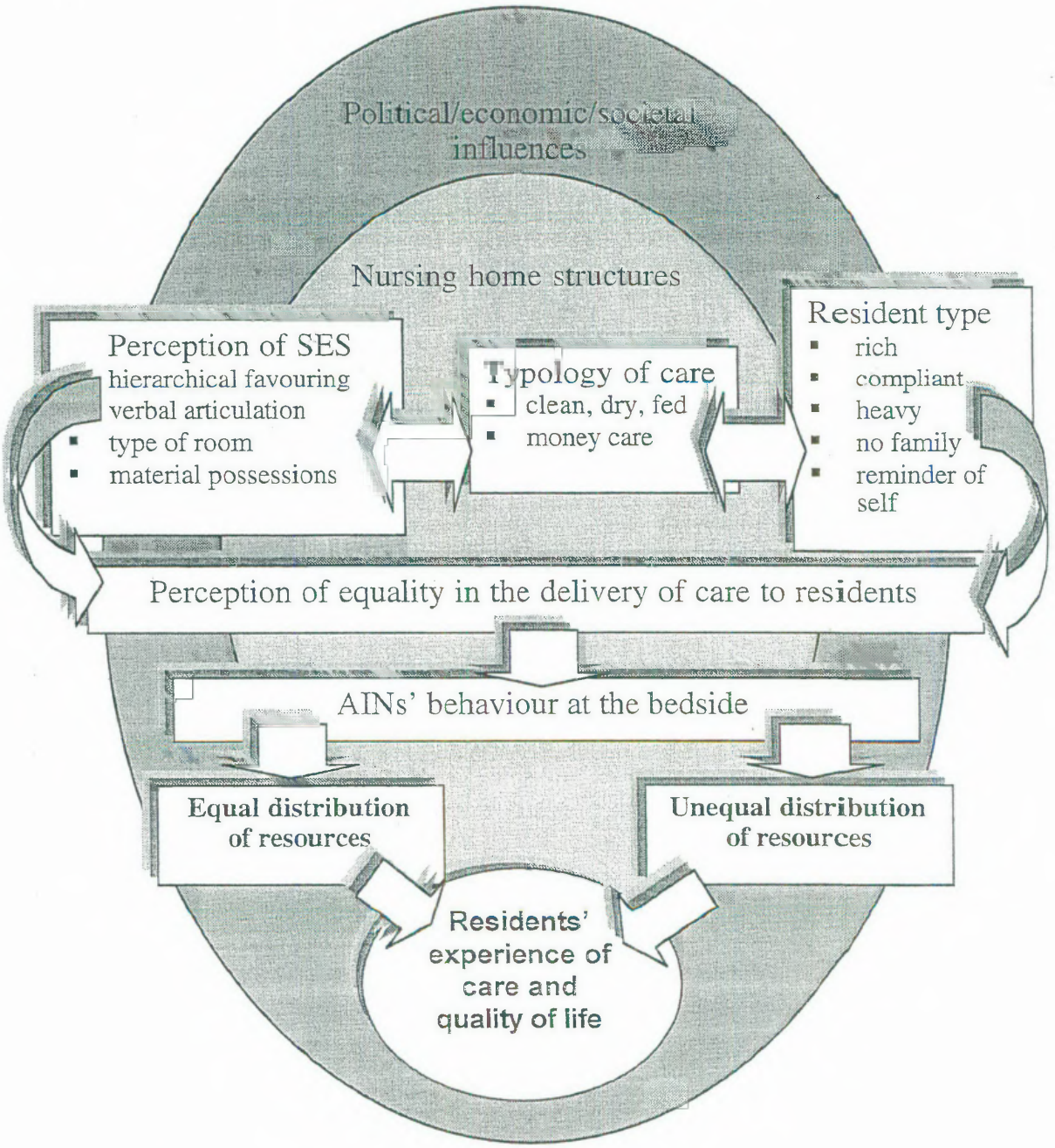

Figure 6.1: Influencing factors on the AINs' distribution of resources at the bedside

Factors such as hierarchical structures of the nursing home, established routines, resident types, and the values that informed the AINs' interpretation of equality all played a significant role. However, the key to understanding how the informants distributed their *quality time* was their perception of the socioeconomic status of the residents compared to that of the informants.

In general, the AINs were more likely to distribute *quality time* to residents they perceived to have a similar socioeconomic status to their own. For example, informants who classified themselves as having a low socioeconomic background provided *quality time* to residents they perceived to have a similar background. Conversely, informants who classified themselves as having high socioeconomic status were more likely to choose to spend *quality time* with residents of high socioeconomic status. In the case of residents with a low socioeconomic background it seemed the low socioeconomic background informants were attempting to compensate for the disadvantage experienced by this group of residents. In the case of residents with a high socioeconomic background, it seemed the informants with a similar background were trying to sustain the position they believed the resident held in society prior to entry into the nursing home. This categorisation of residents into levels of socioeconomic status influenced the AINs' construction of the act of caring and their subsequent distribution of resources, which, in turn, ultimately shaped the experience of care the residents received.

In summary, the findings of the study indicate that the most abundant resource available to AINs is their time. It found that the AINs distributed a basic minimum level of care to all residents equally on the basis of physical needs, and the definition of equality that underpinned this distribution was primarily egalitarian. However, extra care, known as *quality time* and *money care*, was distributed unequally by AINs on the basis of their perceptions of the similarity of the residents' socioeconomic status with their own socioeconomic backgrounds. The distribution of this type of care was not based on the notion of providing equal time for equal needs. Rather, the definition of equality that seemed to inform this distribution of 'extra' care appeared to be libertarian, in the sense that it was acceptable for some residents to access superior services, provided that a basic minimum level of care was given to all.

However, the informants considered to have a low socioeconomic background resented the distribution of money care. In addition, their distribution of *quality time* to residents with perceived low socioeconomic status was not based on the superior financial resources of residents but rather on what the AINs saw as a lack of resources. Their willingness to provide greater assistance to those without the means to purchase extra or superior services was consistent with egalitarianism in the sense of wanting to provide equality of opportunity to access extra care. Informants with high socioeconomic status, on the other hand, were willing to spend *quality time* with residents who they considered to have a similar status. The behaviour of these informants can be described as libertarian because they seemed to believe that, providing a basic minimum level of care was available to all residents, it was acceptable for residents with superior financial means to receive additional care and services. Their greater acceptance of the delivery of *money care* appeared to be underpinned by a similar belief.

Implications for practice

The quality of life that the institutionalised elderly experience is very much reliant on how available resources are distributed at the bedside. Therefore, as the majority of employees in nursing homes are AINs, how they distribute the resources available to them has an important impact on the daily lives of residents.

Although the informants in this study valued the *quality time* they spent with residents, resource allocation focused predominantly on providing the measurable dimensions of the *clean, dry, fed* type of care to meet the physical care needs of residents. Despite the introduction of the Residential Classification Scale, the dominant and established view of providing care in the nursing home context remained one that valued the quantifiable elements of care above the *being with* aspects of *quality time*. The experiences described by the AINs in this study suggest the allocation of resources for care needs to be consciously and intentionally focused on incorporating all elements of care, including resources for staff to spend

quality time with residents. By providing time in the AINs' routines for types of care other than those determined by the physical needs of residents, such as *quality time*, the standard of basic care delivered to all residents may be lifted above the *clean, dry, fed* tasks of the day.

Assistants in nursing need to receive education about the social and emotional needs of residents. However, to introduce flexibility into their routines to address these dimensions of care, as well as the basic minimum *clean, dry, fed* type of care, they need the encouragement and support of management. As demonstrated in chapter four, even though all of the informants participated in *quality time* with residents, it only occurred when the physical tasks of the day that dominated the routines were completed. This behaviour and the informants' beliefs about equality, which determined their distribution of resources, were continuously reinforced by the structures of the nursing homes that insisted on strict adherence to routines. The roles assigned to staff and the routines of nursing homes, therefore, need to take account of the value of *quality time* in the residents' experience of care and its value to staff in terms of job satisfaction. Creative management structures that provide flexibility in care and less 'task-orientated' approaches in delivering that care are required. This will potentially enhance the quality of life for residents in nursing homes and the quality of the work experience for staff.

Nonetheless, although the informants in this study expressed a desire to have more time to spend *quality time* with residents, when extra time was available they tended not to spend it interacting with residents but, rather, on tasks such as storing linen. This is not to suggest that the performance of such tasks is an unimportant aspect of nursing home work. However, it does suggest that a mere provision of more time will not necessary result in staff spending more time with residents. What is required is the development of an institutional culture that better recognises and values caring for the 'human' condition of residents. Managers and Directors of Nursing can encourage and support the expression of caring for the elderly as a

resource which includes not only the *clean, dry, fed* activities but also the *being with* or *quality time* dimensions. This will require the support of the proprietors of nursing homes and a change in attitude that defines the competence and value of 'nurses' by their capacity to complete a set routine of tasks in a designated time frame. The AINs in this study also tended to judge the competence of their peers by this criterion. They, along with managers and registered nurses, need to confront the culture that accepts and encourages the view that caring for the elderly can be delivered as a technically competent, mechanistic and cost-effective service that lacks the dimensions of real caring time. In this respect, AINs, like other levels of carers of the elderly, require education about the social and emotional needs of residents as well as their physical needs.

The type of care the AINs delivered was heavily influenced by the structures and organisation of the nursing home, the categorisation of residents into different types, and the perceived socioeconomic status of the resident. The core category, socioeconomic status, became the overriding factor in the AINs' construction of caring and determined how they distributed resources to care other than the *clean, dry, fed* type of care. This observation has important implications in the context of the introduction of a user pays system and the capacity of some facilities to provide extra service places in nursing homes. The overall tendency of the majority of informants in this study to discriminate against the residents with perceived high socioeconomic status, in terms of the distribution of AINs' resources, was apparent in the different types of care delivered. This was particularly the case in this study as the majority of informants classified themselves as having low socioeconomic status. When they judged the socioeconomic status of particular residents to be high, the majority of informants displayed an unequal distribution of any surplus resources away from these residents. Ideally, to counterbalance this, the employment of AINs from a mix of socioeconomic backgrounds is needed to complement the diverse range of the residents' backgrounds so that *quality time* is distributed equally to residents of varying socioeconomic status. This would be a

tremendous challenge, however, given the financial incentives to employ the lowest paid and least educationally prepared staff to care for elderly people in nursing homes. In addition, the employment of staff with similar backgrounds to those in their care would prove no less difficult than it is in other healthcare settings where staff and consumers share a diverse range of backgrounds.

Summary and concluding comments

The emergence of support workers such as AINs has risen to such proportions that an exploration into the bedside care they deliver and how it affects the overall quality of care the residents receive is long overdue. The resources at the AINs' disposal and their distribution at the bedside are rarely considered at a macro-level, although, at the micro-level this distribution impacts importantly on the quality of care and daily lives of the residents currently living in nursing homes. AINs are the group most directly involved with resource distribution at the bedside. How equally the AINs distribute their resources in nursing homes affects the day-to-day lives of residents. It is primarily this group who decides on a daily basis which residents will be treated with respect, whose needs will be attended to promptly, and whose needs remain not met or left until last. Examining the AINs' perceptions of equality and how these influence their distribution of resources, therefore, is of extreme importance to the many individuals who live their final, and often most vulnerable, days in nursing homes across Australia.

This study, by examining the factors that affect the distribution of resources at the bedside, may provide a basis for continued examination into the dynamics of care delivery in Australian nursing homes. Although the study is embryonic in terms of generating theory regarding the practice of AINs within the broad agenda of aged care reform, the importance of this research into the practice of the staff who make up the majority of the aged care workforce cannot be understated.

Although it is not claimed that the findings of this study undertaken in the New England area of New South Wales should be generalised to the broader AIN

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Appendix one: Flyer

Researcher: Michele Chandler
Masters Nursing(Hons)
University of New England
Phone: 67721744

Research proposal

AIN practice and perceptions of care at the bedside

This research project is concerned with examining the Assistant in Nursing; their role, environment and thoughts about their day to day practice. Of particular interest is the AINs perception of care and the nursing home structure in which they operate. In other words this research is looking at what an AIN is, and where they fit into the scheme of nursing home practice.

I am looking for AINs to participate in this research by being interviewed by myself. Confidentially is assured and the only people who know that you are interviewed are yourself and myself. This information may not be disclosed at any time.

If you have an interest in contributing knowledge about AINs and their practice, please call me for further information. Ph :67721744 (please leave a message if I don't answer).

About the researcher: I am currently a masters (honours) student at the University of New England and have been conducting this research project for 18 mnths. I currently work in aged care with dementia specific clients and I also teach the Certificate three (assistant in nursing) and certificate three (working with older people) at TAFE in Armidale, Glen Innes and Tamworth. I was employed as an AIN for three years whilst I undertook my Bachelor studies at UNE and remain keen in understanding the experiences of AINs.

Demographic sheet

Please answer the following questions

1. What is your current position? (please circle)

- AIN
- other (please specify)_____

2. How long have you held this position? _____ yrs

3. What facility of aged care do you work in? (please circle)

- Hostel
- Nursing Home
- Other (please specify) _____

4. Do you work? (please circle)

- Full time
- Part time
- Casual

5. If casual or part time, do you have a second job? (please circle)

- yes
- No If yes what is the occupation? _____

6.Circle the following answers that best describe your situation. (you may circle more than one)

- Single wage earner household
- Double wage earner household
- Children under 16
- Mortgage
- Rent
- Person over 16 whom is dependent on you

7. How much take home pay (after tax) per fortnight do you receive? (please circle)

- $200-$299
- $300-$399
- $400-$499
- $500-$599
- $600-$699
- $700+

8.How far from work do you live? (please circle)

- 0-5 km radius
- 6-10 km radius
- 11-20 km radius
- 20+ km radius

9. How do you travel to work? (please circle)

- Car
- Bus
- Walk
- Bicycle
- Train
- Other (please specify)_____

10. On what shift do you mostly work? (please circle)

- Mornings
- Evenings
- Nights
- Rotation

11. What are the lengths of your shifts? (please circle)

- 8 hours
- Less than 8 hours
- More than 8 hours

12.Do you work weekends? (please circle) Yes/No
If yes, how often?

- 1 in 4
- 1 in 2
- Every weekend
- 1 in 3
- Occasionally

13.Age (please circle)

- 17-19
- 20-29
- 30-39
- 40-49
- 50-59
- 60+

14.Gender (please circle) Female/Male

15. Please indicate the number of years of equivalent full time practice you have had in your current position? _____yrs

16. Do have any formal qualifications for your current position? (please circle) Yes/No
If yes, please specify_____

17.Are you enrolled in any educational course/s at present for your current position (please circle) Yes/No
If yes, please specify_____

18.If yes to either questions 16 and 17, which educational institution/ group did you utilise? (please circle)TAFE/College of Nursing/University (please specify)_____
Other (please specify) _____

19. Do you plan to complete any education specific to your work? (please circle) Yes/No
If yes, please specify_____

If no, please specify
Too expensive
No appropriate courses available locally
Cannot get time off work
Not interested
Do not have the ability
Other (please specify)_____

20.Have you attended any in-service courses? (please circle)
Yes/No
If yes, please specify_____

21. Do you find in-services? (you may circle more than one answer)

- Relevant
- Not relevant
- Interesting
- Not interesting
- Management focussed
- Other (please specify)_____

22. Do you find your work (you may circle more than one answer)

- Satisfying
- Unsatisfying
- Interesting
- Not interesting
- Resident focussed
- Other (please specify)_____

23. Name_____
Contact number_____

Plain Language Statement

Title of Project: Assistants in Nursing's perceptions of equality and the user pays initiative in Australian nursing homes; a qualitative study.

This study aims to explore the thoughts or perceptions of assistant in nursing about equality and how this influences their bedside practice. Assistants in nursing will be involved in this study to gain a picture of the type of care delivered to residents on a day to day basis.

My name is Michele Chandler. I have a keen interest in the practice of assistant in nursing within the aged care setting. Of particular interest to myself is the practice of caring within long term residential care. I would very much appreciate your time and participation in this study.

If you decide to participate in this study, you will be interviewed for about 30 minutes. The interview will be taped. You have the opportunity at any time to stop the interview and the tape will be erased in your presence. You will not be identified in any way. All tapes will be stored in a locked cabinet. Interviews will be held in private at a place of your choice. Your place of employment and your name will remain confidential. I will ask you questions about yourself, such as how long you have been working in the area, your current grade/salary and your views about care since the introduction of resident fees into nursing homes. If you agree to participate, please sign under.

Persons responsible

Michele Chandler
(Principal Investigator)
of Dept of Health Studies UNE
ph: (02) 67 721744

Associate Professor Irene Coulson
(Principle Supervisor)
Dept of Health Studies UNE
ph: (02) 67 733722

Consent Form

The following contact number may be used to answer any questions, for complaints or praise that the participants may have concerning their interviews, transcripts or research procedures. Participants may also seek advice on when the research is likely to be completed and on how they might discover the results. Inquiries can be directed to:

Michele Chandler
(Principal Investigator)
(02) 67 721744

I ..... have read the information above and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realising that I may withdraw at any time. I agree that research data gathered for the study may be published, provided my name is not used.

....

Participant Date

....

Investigator Date

Should you have any complaints concerning the manner in which this research is conducted,
please contact the Human Research Ethics Committee at the following address:

The Secretary
Human Research Ethics Committee
Research Services
University of New England
Armidale, NSW 2351.
Telephone: (067) 73 2352 Facsimile (067) 73 3543