Chapter 3

PROFILE OF NURSING HOMES, RESIDENTS AND CARE PROVIDERS

INTRODUCTION

The Aged Care Reform Strategy Mid-Term Review (Commonwealth Department of Health, Housing & Community Services 1991:46) provides details of the providers of nursing home beds and the change in the percentage mix between providers. Nursing home bed provision within Australia can be divided into three major areas: the private sector, the voluntary sector and the public sector. The private sector accounts for nearly half of all nursing home bed provision. The voluntary sector (which combines voluntary sector homes which were transferred from the deficit financing arrangements, together with the religious charitable sector which previously operated as participating homes) accounts for approximately one third of bed provision and, finally, the government sector accounts for the remaining 20%.

As at 30 June 1991, there were 1439 nursing homes providing 73 107 nursing home beds in Australia. Table 3.1 provides details of the nursing home provision by sector of providers for the period 1985–1990. A trend is seen in the decline of providers in the Government sector reducing the bed provision from 20% to 18%, whereas an increase is evident in the number of providers in both the private sector and religious/charitable sector of 46% to 48% and 9% to 10% respectively. Overall, however, a decline was reported in the actual number of beds provided, reducing in toto from 75 202 beds in 1985 to 73 107 beds in 1991 (Commonwealth Department of Health, Housing & Community Services 1991:46).

This chapter will provide a brief profile of the nursing homes that formed the field settings for this study together with an overview of some characteristics of the residents and care providers who were interviewed during the study.

Table 3.1
Nursing Home and Hostel Provision by Sector, 1985 and 1990

	1985*				1990			
Nursing home	**Homes**		**Beds**		**Homes**		**Beds**	
sector of prov.	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
Private	750	51	35040	46	705	49	34811	48
Relig/Chart †	141	9	6710	9	157	11	7701	10
Transferred #	410	28	18706	25	386	27	17568	24
Government	170	12	1476	20	191	13	13027	18
Total	1471	100	75202	100	1439	100	47080	100
Hostels	885	100	38929	100	1098	100	47080	100

Notes: * 1985 figures include 3699 beds for the younger disabled.
1991 transferred homes and beds were voluntary sector facilities operating under the deficit financing provisions of the Nursing Homes Assistance Act in 1985.
† Religious and Charitable
Sources: 1986 *Nursing Homes and Hostels Review* and Department of Community Services 1984–85 Annual Report.
1991 DHH&CS Residential Care Planning Database.

(Source: DHH&CS, *Aged Care Reform Strategy Mid-Term Review* 1991:46)

OVERVIEW OF THE NURSING HOMES

In order to conduct this study, three nursing homes were selected from the east coast of Australia. The nursing homes selected were typical of the Australian scene and varied in their type of ownership and funding, type of building structure, bed numbers, location, standards requirements and length of time operating (see Table 3.2). One nursing home was selected from each of the categories of the voluntary sector, the public sector and the private sector. The bed numbers of those aged care complexes selected ranged from 46 beds to 460 beds, ensuring that a small, a medium and a large nursing home were included in the study. Nursing homes were located in both metropolitan and non-metropolitan areas and in different states. As funding for nursing homes is a Commonwealth

responsibility, it was not felt that the selection of nursing homes should be confined to one state or regional health authority.

Neither the nursing homes visited nor residents and care providers interviewed are identified in this study. Therefore, the names of the nursing homes, residents and care providers are fictitious and no similarity between the names used and the location of the homes is intended.

Table 3.2
Variation in Nursing Homes in Study

	Silver NH Everglades	**Heritage House**	**Seaside Vista**
Type of Ownership	Public	Private for profit	Voluntary Private not-for-profit
Type of Building	Re-designed 3 tier complex (total beds: 460)	2 story mansion formerly school (total beds: 64)	Purpose built 3 tier complex (total beds: 221)
Funding	Commonwealth/State	Commonwealth	Commonwealth
Time Operating	49 years	23 years	11 years
Bed Numbers	64 beds	64 beds	46 beds
Location	Queensland	Victoria	NSW
Outcome Standards Monitoring	Non-compulsory	Compulsory	Compulsory

Silver Nursing Home

This 64 bed Government nursing home is part of the 460 bed Everglades Home, a huge aged care complex located amidst beautiful sub-tropical gardens in a non-metropolitan region of Queensland. This home was originally built during the Second World War to house defence personnel. In 1946, it was taken over by the Queensland State Government and converted into a home for old age persons. The original buildings have been progressively adapted, renovated, improved and removed to such an extent that today this nursing home stands as a very well equipped aged care facility seeking to meet the needs of the community in the provision of aged care services.

In 1981, the first stage of the major redevelopment program, a large three story building, was opened. It contained a 140 bed nursing home, comprised of two 70 bed wards which occupied the top two floors of the building. The residents accommodated in these wards were highly dependent aged men and women requiring extensive care and heavy nursing care. The ground floor of the building housed the administration section and the extensive clinic facilities used for both residents and outpatients requiring physiotherapy, occupational therapy, medical and dental consultations, podiatry and minor surgery.

In 1983, another part of the redevelopment program was opened which provided a further 192 beds in three 64 bed units. Each of the three units housed either confused residents, frail residents, or well, though aged, residents. In 1985, the final stage of the redevelopment program was opened which included a further two 64 bed units, an interdenominational chapel, a multi-purpose theatre catering for cinema and live theatre, a library with facility for tapes, books and visual aids, office accommodation, a three hole mini golf course, canteen, dance area, workshops and garages, a bowls club house and post office.

At the time of the study, residents in the complex were accommodated in eight different houses which included: a 70 bed unit for hostel residents; two houses for fully dependent residents; two houses for dementia suffers; and three houses where the frail aged were accommodated. The hostel provided single and shared rooms for male and female residents, whereas all the other areas provided not only single and shared accommodation but also four bed accommodation for male and female residents. My study was carried out in the Silver Nursing Home which was one of the 64 bed houses accommodating male and female frail aged residents.

All the buildings in the complex other than the large three story building which was situated in the centre of the complex were single story. A long, covered walkway stretched the length of the complex, with buildings hanging off on either

side at various points. The covered walkway actually went through the centre of the main three story building. This tree-like covered walkway lying parallel to the coastline weaved its way through buildings for nearly half a kilometre. All the buildings were surrounded by beautifully landscaped, manicured gardens and there were many outside cabana type structures where residents and staff could have quick access to ocean views.

Residents who were at least 60 years of age were eligible for admission and were required to complete an admission application form and provide a current letter of approval for admission to a nursing home following an assessment by the Aged Care Assessment Team in the area. Accommodation fees are established by the Commonwealth Department of Health, Housing and Community Services and are calculated at 87.5% of the pension, whilst the hostel fees are 66.67% of the pension.

There was a formal hierarchical structure within the nursing division of the complex. The Director of Nursing (DON) was in charge of the nursing division and reported to the Chief Executive Officer. The DON previously worked in the central office of the Department of Health and was relatively new to the aged care industry, having moved to the complex following the reorganising of the Department of Health within the state. She had a fairly low profile with residents and staff, and spent much of her time planning and liaising with members of the senior executive within the complex. She was very enthusiastic and approachable and had brought many new, fresh and innovative ideas to the complex. The Deputy Director of Nursing had been employed at the nursing home for approximately ten years and had a very high profile with residents and staff. She was very open and friendly in her interaction with staff and residents and acted as a co-ordinator of their movements within and between the various units of the complex. She also had responsibility for quality assurance activities within the overall complex. The Clinical Nurse Consultants (CNC) were the managers of the

various houses within the complex and each house had Clinical Nurse Specialists, Registered Nurses, Enrolled Nurses and Assistant Nurses.

The Director of Nursing and Deputy Director of Nursing were dressed in ordinary clothes. However, other nursing staff were dressed in white uniforms with different coloured epaulettes on the shoulders denoting different levels of skill of nursing staff: blue for the Clinical Nurse Consultants; green for the Clinical Nurse Specialists and red for the Registered Nurses. The Enrolled Nurses and Assistant Nurses were dressed in white uniforms without any epaulettes at all. Nearly all the units within the complex followed this dress code. However, one of the Clinical Nurse Consultants in a dementia unit was trialling wearing ordinary clothes to work rather than uniforms, though this was meeting with some resistance and disparaging comment from other nurses within the complex.

Silver Nursing Home is a 64 bed house which is divided into two wings each containing 32 residents. Each wing has a nursing station which is situated at the top of a long, winding corridor. A very large dining room and small sitting room/TV lounge is situated between the two wings. A patio leads off the side of the dining room to a relaxing shady area where barbecues are held for residents. All residents are provided with a single cubicle with a curtain at the entrance. Partitions dividing the cubicles go two-thirds up the wall and therefore noise is clearly heard between cubicles. The cubicles are in groups of six and eight and each group of cubicles has its own small TV/lounge area. Each group of cubicles also has its own separate bathroom facilities. The cubicles sometimes are very dark and pokey and although complete privacy is not assured, the cubicles do remove residents from the gaze of staff and other residents.

The nurses' station at the top of the corridor is surrounded by a glass partition. A large treatment room which doubles as an examination room is situated behind the nurses' station. It contains two examination couches and various pieces of equipment. The treatment room also contained the drug cupboard and residents

who are being examined or receiving treatment are in clear view of the nurse preparing medications. Throughout the day, a loud radio can be heard all over the nursing home. It continually broadcasts the races or any other sporting event taking place.

Residents did not choose their own medical doctor but were allocated a doctor who was employed by the complex. A team of three doctors was employed together with a medical superintendent. Two of the doctors worked part-time and were responsible for different houses within the whole complex. The CNC would organise which residents were to be seen and would lay out all the residents' charts on the desk for the doctor to review. The doctor would come into the nursing home and go straight to the charts and whilst reviewing the charts consult with the CNC about the condition of the various residents. Doctors would then proceed to visit the residents. When visiting a resident, doctors were accompanied not only by the CNC, but many times were joined by groups of medical students who trailed behind the doctor on a hospital-like 'ward round'. The permission of residents was sought before the students were allowed to see the residents. However, many times the residents were simply invaded by the 'ward round' and had very little alternative but to agree.

Although most residents were quite capable of communicating with other residents, very few seemed to talk much amongst themselves or to staff. They would sit in chairs in the hallways and just watch the passing parade. These residents were quite capable of carrying out a conversation but simply sat in the chairs without talking to anyone. A number of activities were organised during the time of the study; however very few residents would participate. While there were very few category 1, 2 or 3 residents in Silver Nursing Home, the majority fell into categories 4 and 5 on the Resident Classification Instrument score.

The philosophy of Everglades Aged Care Complex supported the Commonwealth's 'Charter of residents' rights and responsibilities in approved

nursing homes' and each resident was provided with a copy of the Charter on admission. All residents were informed they had the right to freedom and respect and the right to be treated fairly by others. Residents were provided with information regarding the process through which they could make a complaint if they were concerned about the care provided. They were directed to discuss their concerns, firstly, with the CNC of the relevant house, or the social worker employed by the complex. If they were dissatisfied with the outcome, then they were directed to take up their complaint with the Director of Nursing, Medical Superintendent or Chief Executive Officer. They were also given phone numbers for the State Health Department and the Health Rights Commission. A resident/relative committee meeting was held on a regular basis in each house of the complex. All residents and/or relatives were welcome to attend.

Residents were encouraged to bring small items of a personal nature into the nursing home in order to enhance the physical environment of their rooms. Good public transport was available, with a bus stop located at the main entrance of the complex. Recreation officers were employed to arrange and provide recreational programs for all residents and they and their relatives were invited to participate. Unfortunately, bus trips were not frequented by many residents, supposedly due to the shortage of nursing staff to accompany residents, and also due to the difficulty in transferring in and out of the coach.

Silver Nursing Home, being a Government nursing home, is not required by legislation to abide by the Commonwealth Outcome Standards for Non-government Nursing Homes. However, since the introduction of the Commonwealth Outcome Standards, Silver Nursing Home has endeavoured to move towards creating an environment within the home which would comply with the Outcome Standards Monitoring Team accreditation requirements. Yet, the overall atmosphere of Silver Nursing Home remains very formal, sombre and hospital-like. Although most residents were less dependent than those in other

nursing homes in the study and were quite capable of communicating with other residents and were more mobile, very few residents seemed to talk much amongst themselves or to staff. Although activities were organised during the time of the study, very few residents would participate.

Heritage House

Heritage House is an elegant two story mansion located in a small rural town in Victoria. The nursing home is surrounded by large, old, traditional homes in a street which is included on a tourist heritage walk through the town. The main building is surrounded by tall, well established trees with a well kept garden at the entrance. The house was originally built as a school and in the ensuing years the building was acquired by a company which converted it into a 41 bed nursing home. With the growing demand for nursing home beds in the area, the home was further extended to accommodate 64 beds. In the early seventies, the home was purchased by the present owners who also acquired the adjoining properties, on which were erected 10 single self-contained units which were opened in 1985.

This privately owned nursing home is registered in the name of a limited private company, consisting of two directors, the proprietor and his wife. The Director of Nursing is an employee of the nursing home and does not have a financial interest in the nursing home. The Director of Nursing is directly responsible to the proprietors of the nursing home and has one Deputy Director of Nursing who also takes on a clinical load each shift. One part-time administrative officer is employed to maintain the financial records and organise the payroll for the staff; the nursing home also employs a part-time recreational officer, podiatrist and physiotherapist. All staff, both nursing and non-nursing (which includes catering, laundry, administrative and allied health) within the nursing home, are directly responsible to the Director of Nursing. The proprietor does not live in the same

town where the nursing home is situated and only visits on a two to three weekly basis. Therefore, the Director of Nursing takes on total responsibility for the full operation of the nursing home.

The nursing home fees are set and subsidised by the Commonwealth Department of Community Services and Health and the resident's contribution is 87.5% of the full aged pension. The fees provide residents with: complete 24 hour registered nurse care; on-staff physiotherapist and podiatrist care; a choice of their own medical officer; referral to optical, dental, audiologists and all medical specialists; and a varied activities program

The main building of the nursing home accommodates 20 residents on the first floor and 44 residents on the ground floor. There is no lift in the building. The first floor contains predominantly highly dependent categories 1 and 2 residents who are unable to walk, whereas the ground floor contains residents who are less dependent and more mobile. The ground floor of the home was not all on the one level. The west wing extension, which houses 19 residents, was built at a higher level than the original buildings, whereas the dining room, which is also used as the recreation room, was built at a lower level. Therefore, it is necessary to climb up three steps to get to the west wing, whereas access to the recreation room is by way of a long, sloping ramp.

Residents are accommodated in a number of different sized rooms: seven single rooms, eight rooms containing two beds each, seven rooms containing three beds each and four rooms containing five beds each. Many of the ground floor rooms had external doors leading to a beautiful tree-shaded courtyard area. A security system was maintained by doors fitted with a locking device that allowed internal exit only by the use of panic bolt door handles. All main exit doors of the home were connected to an alarm system to monitor wandering residents. The bathrooms were situated at the end of the corridors on the ground floor and were

cramped with lifting equipment which was difficult to manoeuvre in the confined space.

Although space was at a premium within the home, there were a number of communal areas which were available for residents, including a large dining room/recreation room, two small lounge rooms and a small reception/foyer area. The majority of residents spent their days in the communal lounge rooms where, unless there were activities scheduled, the television was switched on. Each of the lounge rooms was square and residents were lined up side by side in their chairs so that they faced another resident on the other side of the room. If the television was not switched on and there were no activities scheduled, then the residents having been placed in their regular chairs would proceed to fall asleep. Very little talking took place between residents. The remainder of residents would watch television in their rooms.

Prior to commencing my study, the previous Director of Nursing had resigned suddenly because of an interpersonal conflict with the proprietor. She had worked in the home for nearly ten years and had introduced a number of innovative activity and educational programs. The Deputy Director of Nursing (who had not applied for the position of Director of Nursing) was in charge when I commenced my study. She was a friendly and open person with wide nursing experience. She had an extremely high profile with the residents and was held in high regard. The new Director of Nursing commenced employment during the final week of my study. She was very friendly and open and had a number of new innovative ideas for nursing practice. She was new to the town and allowed stability to return to the nursing home.

A Recreational Activities Officer was employed to run a variety of activities. On admission, the nursing home residents were required to complete a therapy form in order to assist the staff in providing a more personal approach to their activity programming. The weekly activities were displayed on a whiteboard in each

sitting area and the nursing home used its own 14 seater bus for community outings. A hairdresser visited the home once a week and charged a small fee for perms, cuts and the like. Volunteers from a local community club provided a weekly lolly trolley allowing residents to purchase a variety of discounted lollies. Purchases were recorded in a book. The Deputy Director of Nursing who held a money tin for each resident would take out individual amounts from the residents' money tins to pay for the lollies. Bingo, a 14 year old white labrador ('pets as therapy') dog, also resided at the nursing home, together with a tank of fish and a small bird.

The philosophy of Heritage House supported the Commonwealth's 'Charter of residents' rights and responsibilities in approved nursing homes' and each resident was provided with a copy of the Charter on admission. Residents were given the right to choose whom their visitors were and whether they wanted to participate in activities provided in the nursing home. A monthly residents' meeting was held and run by relatives and residents. The nursing home was open to comments and welcomed suggestions from residents and relatives on how they could improve life for residents in the home. Residents were also given a phone number contact in the Department of Health to use if they had not gained satisfaction with the complaints process available within the home. Visiting hours were very open and relatives and visitors were encouraged to take an active interest in maintaining the residents' contact with the community, by participating in internal and external activities.

As Heritage House was originally built as a school and later converted into a nursing home, the physical environment of the home placed great restrictions on the mobility allowed to residents. Being a non-government nursing home Heritage House is required by legislation to comply with the Commonwealth Outcome Standards for funding purposes. Therefore, great efforts have been made at Heritage House to create a home-like environment for residents and to ensure

privacy and dignity in all aspects of care for residents within the confines of the physical environment.

Overall, the general impression of the home was that it was friendly, clean, tidy, and endeavouring to provide a homely atmosphere, though the practice of all staff wearing uniforms created a shadow of formality over the nursing home. While the standard of nursing care given was very high, the residents did not seem to mix and many of the mobile residents would keep to their own rooms.

Seaside Vista Nursing Home

Seaside Vista Nursing Home (SVNH) is part of the Seaside Vista Village which is a voluntary private, non-profit facility under the control of a Board of Management appointed by the parish priest, representing the trustees of the Roman Catholic Diocese of the nearest regional centre. The Seaside Vista Village is a three tier complex, comprising 130 self care units, 45 hostel beds and a 46 bed nursing home, all situated on the one site. A separate stand-alone financial management office is situated within the complex. However, the Director of Nursing within SVNH has total responsibility for all activities within the nursing home and is directly responsible to the Board of Management.

The nursing home and hostel occupy the one building that is a purpose built facility situated in natural surroundings. The SVNH has been operating since 1984 and attracts a Commonwealth Government subsidy. The SVNH complex also features a large activity centre which includes a heated hydrotherapy pool, lounge, library, kitchen and a recreation/function hall.

The local area is fairly typical of the non-metropolitan NSW seaboard. The town boasts a population of 15 000 that has seen a fairly rapid influx of retirees and other city-siders over the last decade. Local industry has traditionally been based on forestry, agriculture and fishing. However, the beautiful coastal rainforests, pleasant climate and access to several national parks has seen a dramatic increase

in tourism-related occupations. There are no ethnic groups concentrated within the local population. However, the heterogeneous nature of modern Australian society does make its presence felt with approximately 5% of nursing home residents being of non-English speaking background.

The 46 beds are distributed along two main corridors and feature a mixture of four bed, two bed and single rooms. One four bed room features an ensuite facility. The remaining ablution facilities are spread strategically along both corridors and two large ablution rooms featuring several separate toilets and showers are provided in each corridor. The nursing home does not provide respite services.

The 46 beds attract a higher than average number of Nursing Personal Care (NPC) hours per week due to a predominance of dependent residents. The provision of beds within the local area falls short of the Commonwealth benchmarks and at the time of writing no less than 33 prospective residents are awaiting placement at the Seaside Vista Nursing Home alone; all of these have been approved and listed by the local Aged Care Assessment Team (ACAT). The lengthy waiting list tends to create a vicious circle which is reflected in increasing dependency levels. The current breakdown of residents per Resident Classification Instrument (RCI) categories is as follows:

Category 1 (most dependent)	4%
Category 2	52%
Category 3	37%
Category 4	7%
Category 5 (least dependent)	nil

The relatively high level of NPC hours has provided the Director of Nursing with the opportunity to develop an integrated system of care which has managed to

improve the quality of service provided to the residents. This is partly reflected in the staffing ratios:

Nursing	
RN	252 hours per week 25% of total NPC
EN	202 hours per week 20% of total NPC
AIN	379 hours per week 38% of total NPC
DON	40 hours per week 4% of total NPC
Activities Officer	84 hours per week 9% of total NPC
Rehabilitation Therapy	44 hours per week 4% of total NPC

Therapy hours cover two shifts, seven days per week; the RN component features supernumerary staff who attend special functions such as quality assurance, inservice education and forward planning exercises. The DON has in the past appointed a Clinical Nurse Consultant for a fixed time period. This is an innovative method of gaining full value for the NPC dollar within the flexibility provided by the Care Aggregated Module (CAM) system.

The philosophy of Seaside Vista Nursing Home supports the Commonwealth 'Charter of residents' rights and responsibilities in approved nursing homes' and each resident was provided with a copy of the Charter on admission and required to sign the Charter. The nursing system within the SVNH features aspects of primary nursing modified to the nursing home environment. This provides the vehicle for planning and evaluating individualised care. The daily provision of care is organised under a partnership method which relies upon the physical environment as a methodology for permitting the equitable distribution of allocated residents to pairs of direct care providers under the guidance and supervision of an RN.

A variety of 'high tech' apparatus has been obtained. This equipment is varied and ranges from battery operated lifting devices, to a large array of specialised waterchairs and water mattresses. Other equipment includes a syringe pump for palliative care requirements, an ECG machine, a glucometer and an HB

photometer for baseline and on-the-spot readings when necessary. The residents have a choice of three separate indoor communal areas, an outdoor screened pergola and a secure garden area. Although there are probably insufficient areas for privacy, the residents and relatives always seem to be able to have an appropriate venue suited to their needs.

The Seaside Vista Nursing Home owns a minibus with an hydraulic chair lifter. This is used by nursing home residents twice weekly on a regular basis in order to attend social gatherings, day tours, picnics, and so on. The bus is also used for annual resident holidays. A large variety of activities is provided for the residents' choice, including: cooking, games, craft, exercise, floral arranging, gardening, grooming, massage, mental stimulation, music, quality one-to-one time, room visits, special events and functions, spiritual activities, sunbathing, talking books, theme days, movies, videos and slides, and a plethora of sundry activities. Each activity intervention is documented and included in quality assurance data for ongoing review. Residents and their significant others are encouraged to provide meaningful input into the operation of the home. This is achieved via a system of open communication and periodic surveys aimed at identifying any areas of concern. The nursing home relies heavily on volunteers to add an extra dimension of quality. These range from community sponsored groups such as community visitors and service organisations to individuals who assist with everyday functions. The Ladies Auxiliary constitutes an important part of the operation and success of the home especially via the donation of specialised equipment. In the last two years alone over $12 000 worth of equipment has been donated by this group.

Recruitment of staff is not a problem and the turnover of staff is low. Workers' compensation is lower than the industry average and minimal sick leave is taken. The residents enjoy a current average length of stay of approximately 3.8 years for all admissions. This rate has increased over the last four years despite

increasing resident dependency. Furthermore, resident incidents have shown a consistent decrease.

Being a non-government nursing home, Seaside Vista is required by legislation to comply with the Commonwealth Outcome Standards for funding purposes. Therefore, great efforts have been made to create a home-like environment for residents and to ensure privacy and dignity in all aspects of care for residents. Overall, there was a very pleasant, friendly and relaxed atmosphere in this nursing home. The nursing home was very clean, the nursing care appeared to be of a very high standard and the home had conformed to all the regulatory requirements of the Outcome Standards Monitoring Team.

ORGANISATIONAL PRACTICES WITHIN THE NURSING HOMES

Within this study, all three nursing homes supported the residents' rights and home-like environment philosophy and espoused the benefits of the philosophy to improve the quality of life and standards of nursing care provided for residents. However, the organisational practices used to implement the philosophy within each nursing home were quite different. The organisational structures and lines of authority, leadership style of management, organisation of work practices, time orientation to work, care plan utilisation and the amount of resident participation in decision-making surrounding care provision within each nursing home in the study varied enormously (see Table 3.3).

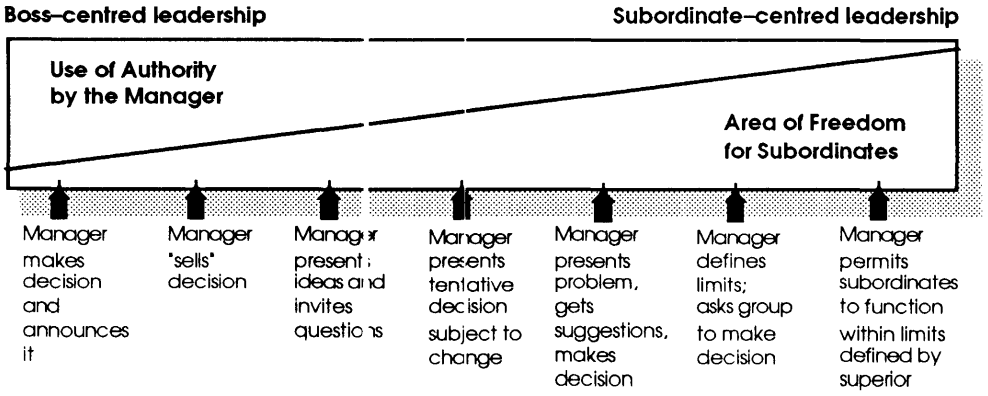
Table 3.3
Nature of Nursing Homes in Study

	Silver NH Everglades	Heritage House	Seaside Vista
Organisational Philosophy	Residents' rights and home-like environment	Residents' rights and home-like environment	Residents' rights and home-like environment
Leadership Style of Management	Boss-centred and Autocratic	Semi-participative	Careprovider-centred participative style Democratic
Organisation of Work Practices	Task Focus	Combined Resident/Task	Resident Focus and Primary Nursing
Time Orientation to Work	Day-to-Day	Period of Roster	Long-term
Care Planning	Limited	Good	Excellent
Resident Participation in Decision-making	Low	Medium/High	High

Leadership Style of Management

Tannenbaum and Schmidt (1973), describing the situational approach to leadership, present a model of leadership behaviour utilising a continuum of leadership behaviour based on decision-making. Managers who display leadership behaviour toward the right of the model are more democratic and are called subordinate-centred leaders, whereas managers displaying leadership behaviour toward the left of the model are more autocratic and called boss-centred leaders. Managers who are more democratic are characterised as leaders who make decisions by exercising little control and allow much subordinate freedom and self-direction, whereas managers who are more autocratic are characterised as leaders who make decisions by maintaining control and allow little subordinate freedom (Tannenbaum & Schmidt 1973). The model presented in Figure 3.1 shows the continuum, or range of leadership behaviour available to managers in making decisions.

Figure 3.1
Continuum of Leadership Behaviour



Within Silver Nursing Home, and indeed throughout the whole of the Everglades complex, the organisational structure is very hierarchical and follows the traditional autocratic top-down approach. The Clinical Nurse Consultant within Silver Nursing Home is responsible for the day to day operation of the nursing home, and is directly responsible to the Director of Nursing of Everglades complex via the Deputy Director of Nursing, who undertakes several rounds of the home daily to monitor and control its activities. The Clinical Nurse Consultant is given no financial responsib lity for the nursing home and levels of staffing and budgets are set at the senior management level.

The leadership style of management throughout Silver Nursing Home is essentially boss-centred (Tannenbaum & Schmidt 1957, 1973). Management maintain a high level of control over care providers, allowing little freedom for care providers to participate in decision-making within the home. Although all staff within Silver Nursing Home espouse the residents' rights and home-like environment philosophy, the atmosphere within the home is very formal, sombre and hospital-like. The grand medical ward rounds with doctors and medical students trailing behind are routine. Visible barriers between the various levels of Clinical Nurse Consultants, Clinical Nurse Specialists, Registered Nurses,

Enrolled Nurses and Assistant Nurses are apparent and nursing staff wear uniforms with epaulettes to denote various levels within the hierarchy.

At Heritage House, the organisational structure is hierarchical with the Director of Nursing being totally responsible for all the clinical and financial operations of the home and reporting directly to the proprietor on a monthly basis. However, apart from the Director of Nursing and Deputy Director of Nursing, the remainder of the nursing staff work as a team to provide the nursing care for the 64 residents of the home. There is a great sense of collegiality amongst the staff in Heritage House. Regular meetings of care providers are held to discuss resident care and staff are encouraged to have input into management decision-making. However, when interviewed, some staff commented that they were sometimes unsure their input into such discussions would ever be implemented. Although the Director of Nursing allows the care providers to participate in decision-making processes and to offer problem solutions (before the Director of Nursing offers a problem solution), the Director of Nursing still identifies the problem in the first place and often makes the final decision Heritage House management would be halfway along the continuum of situational leadership behaviour described by Tannenbaum and Schmidt (1973). Overall, the general impression of the home was that it was friendly, clean, tidy, and endeavouring to provide a high standard of care and homely atmosphere for residents where residents' rights, privacy and dignity were assured.

Within Seaside Vista Nursing Home, the leader's style of management encourages care provider-centred leadership. The Director of Nursing makes decisions by exercising little control over care providers and allows much care provider freedom and self-direction. The Director of Nursing within Seaside Vista has appointed a large number of Project Directors within the home who are each responsible for an individual project (e.g. Incontinence Management, Bowel Management, Aromatherapy, Quality Assurance, Infection Control, Medications

Management, and so forth). These Project Directors conduct meetings of all care providers and research different problems within the nursing home. The Director of Nursing actually becomes an equal member of a problem-solving group. The entire group identifies and assesses the specific problem, and develops alternative solutions to the problem. The group chooses an alternative to be implemented and everyone within the group understands that the group's decision will eventually be implemented. This delegation of responsibility to care providers has not only improved the self esteem of care providers but also has made them feel more involved in the overall management of nursing care within the home.

Organisation of Work Practices

The organisation of work practices differs greatly across the three nursing homes. Within the Silver Nursing Home at Everglades, work practices are organised around tasks. Nursing staff are allocated specific tasks to perform each shift on large numbers of residents. Registered Nurses dispense all medications and undertake all treatments, and Nursing Assistants and Enrolled Nurses are allocated all showers, sponges, changing of bed linen, and so on. Therefore, residents have a large number of different nurses attending to their needs throughout the course of each day.

Within Heritage House the organisation of work practices differed to that of Everglades. All nursing staff are allocated a number of residents to provide total nursing care to each shift. Registered Nurses supervise and give support to Enrolled Nurses and Assistant Nurses in providing medications and complicated dressings for residents. The rostering system allocates certain staff to a week of mornings or evenings, allowing the same staff to remain with a group of residents for the rostered period. Generally, when the roster changes, it is highly likely that staff will be allocated a different group of residents for the next roster. Residents have a number of different care providers throughout the course of their day.

However, the number is less than when the organisation of work is undertaken on a pure task basis.

Seaside Vista is quite different to the other two nursing homes in that they have adopted a modified primary nursing model to provide nursing care. The daily provision of nursing care is organised under a partnership method which allocates residents to pairs of direct care providers under the guidance and supervision of a Registered Nurse. For each shift, all nursing staff are paired up and allocated a group of residents within the nursing home for whom they are totally responsible for their care. Complementing this method of allocation of care provision, when residents are admitted they are allocated a nurse who is responsible for the resident's nursing care throughout the length of the resident's stay. This responsibility includes ensuring the nursing care plan for the resident is current and updated when required and that staff who are caring for the resident while that staff member is not on duty are aware of the care that is required. As part of routine nursing care, Seaside Vista utilises a number of 'high tech' apparatus. This equipment is varied and ranges from battery operated lifting devices, to a large array of specialised water chairs and water mattresses. Other equipment includes a syringe pump for palliative care requirements, an ECG machine, a glucometer and an HB photometer for baseline and on-the-spot readings when necessary. Nursing staff are encouraged to monitor and participate more fully in the management of the residents' care and therefore closer attention is given to the maintenance of nursing care plans, which ensures that staff on different shifts are provided with up-to-date information about the residents to whom they are providing care.

Time Orientation to Work and Planning of Care

The time orientation to work also differs across the three nursing homes. Within Silver Nursing Home, staff concentrate upon the task required for their particular shift and spend little time planning for the long-term care of residents. During my

fieldwork, I observed nursing care plans slowly being introduced into the home by the Clinical Nurse Consultants. However, extra time had not been allocated to complete the care plans and the planning of care provision was seen by nursing staff as just an extra task that needed to be completed during the shift. In practice, nursing staff seldom referred to the nursing care plans which are available for residents. The care required for residents during each shift was passed on to the next group of staff at handover and if a new staff member was appointed they were given a list of things to do for their shift by another staff member.

Within Heritage House, nursing staff work on a rotating roster basis and provide care for a group of residents during the period of the roster. As the roster changes, so does the group of residents and, therefore, the staff eventually rotate throughout the whole nursing home. As part of the Commonwealth Outcome Standards requirements, registered nursing staff prepare nursing care plans for all residents. These are updated on a regular basis at a scheduled meeting of all nursing staff of that day. The nursing care plans are available in each resident's room and both residents and relatives are asked to have input into their preparation. In practice, nursing staff seldom referred to the nursing care plans and commented they would prefer to have the simple tick sheets for each resident which were previously in use, as they believed nursing staff waste time having to read all the notes before they find out what is required for the resident being cared for during the rostered period. Because nursing staff rotate throughout the nursing home, sometimes it was several weeks before they returned to care for a particular resident and if the nursing staff member was not on duty the day when the meeting was scheduled to change the care plans for that particular resident, then staff would be unaware of any changes that were required.

At Seaside Vista Nursing Home, each individual care provider is required to be responsible for the care planning of a particular resident for the duration of their stay. Therefore, care providers are required to take a long-term view of care

provision for the residents within the nursing home rather than simply providing care for a resident on a particular shift or over a certain roster period. A strong health assessment orientation is built into the care planning function, with care providers obtaining baseline readings of weight, height, blood pressure, pulse, haemoglobin and blood sugar levels for each resident upon admission in order that trends can be observed if a resident's condition were to deteriorate. An electro-cardiogram and urinalysis are also undertaken upon admission for each resident. Many care providers interviewed in the study commented on how the health assessment orientation to care planning encouraged care providers to individualise the care plans for each resident rather than treating all residents in the same manner. The care planning also had a strong rehabilitation focus which encouraged care providers to measure if individual care protocols were of benefit to the individual resident or not. Many care providers commented that having a rehabilitation focus to their work gave them a greater sense of direction when providing care to residents and gave them a greater sense of meaning and usefulness to their work.

Resident Participation in Decision-making about Care Provision

The level of resident participation in decision-making regarding the care provision and daily regime was also found to vary across the three nursing homes. Although all nursing homes in the study appear to support strongly the residents' rights philosophy and have formed residents' rights committees, many residents and care providers in all nursing homes believe the committees to be a waste of time because the committees meet infrequently and, when they do meet, any suggestions or complaints which are presented by residents or relatives are seldom implemented. Explanations of shortage of staff and insufficient funding are frequently given as to why certain requested changes cannot be made.

Although the official residents' rights committee concept did not receive wide support from the informants in the study, both residents and care providers within

Heritage House and Seaside Vista did comment upon the increased level of participation available to them in decision-making about their care provision and daily regime since the time of the implementation of the Commonwealth Outcome Standards Policy. Residents commented that they now had more flexibility in their daily regime, more recreational activities available and greater involvement in how their care providers would deliver their care. However, in Silver, residents commented that little change had taken place regarding their involvement in decision-making about their care provision or daily regime. Residents commented that they had to fall in with what the care providers wanted because it was the routine of the nursing home.

Speaking from a Foucauldian perspective one would question what are the intentions and motives of the Commonwealth Government 'experts' who have introduced resident's rights committees into nursing homes and may suggest that having resident's rights committees in nursing homes gives the perception to those external to nursing homes (such as relatives and friends), that residents have greater freedom of choice and input into decision-making when in reality such committees have relatively modest achievement. This will be expanded upon more fully in Chapter 7.

THE RESIDENT INFORMANTS

For this study, eight residents were interviewed in each of the three nursing homes. From the 24 resident interviews undertaken, two interviews were not suitable for use due to tape recording error. A total of 22 residents formed the resident sample for this study, of whom 14 were female and eight male. The age of the residents in the sample ranged from 64 years to 104 years (see Table 3.4).

Three-quarters of the residents (16) were widowed (see Table 3.5) and the high age of many of the residents meant the majority of residents' relatives and friends of similar age were deceased and therefore few residents received regular visitors.

Residents lived in various different locations prior to admission. Only three (13%) of the residents lived in their own home prior to admission, with three (13%) living in relations' homes. Other nursing homes and hospitals featured high on the list of locations prior to admission, with six (27%) residents living in another nursing home and five (22%) residents residing in hospital (see Table 3.5).

Residents were admitted to nursing homes for reasonably similar reasons and they were easily grouped into five major areas: cardio-vascular accident, chronic obstructive pulmonary disease, arthritis, broken limbs and increasing frailty (see Table 3.6). The Resident Classification Instrument was used to score the dependence of all residents interviewed, with Category 1 being the most dependent and Category 5 the least dependent. There were no Category 1 residents interviewed. However, nine Category 2 (41%), six Category 3 (27%), four Category 4 (18%), and three Category 5 (14%) were included (see Table 3.7). The length of time residents had lived in nursing homes ranged from nine months to eight years (see Table 3.8).

Table 3.4
Residents by Age Range and Sex

Age Range	Male	Female	Total
55–64	0	1	1
65–74	3	2	5
75–84	3	5	8
85–94	2	5	7
95–104	0	1	1
TOTAL	8	14	22

Table 3.5
Residents by Marital Status and Location Prior to Admission

Location Prior to Admission	Married	Never Married	Widowed	Divorced/ Separated	Total
Own home	0	0	3	0	3
Relations' home	1	0	2	0	3
Hospital	0	1	4	0	5
Hostel	0	0	3	1	4
Rooming house	0	0	0	1	1
Other nursing home	2	0	4	0	6
TOTAL	3	1	16	2	22

Table 3.6
Cause of Admission of Residents

Cause	No.	%
CVA	8	36
Frail	4	18
Fractures	2	9
Arthritis	3	14
COPD	4	18
Other	1	5
TOTAL	22	100

Table 3.7
RCI Score of Residents

Category	No.	%
1	0	0
2	9	41
3	6	27
4	4	18
5	3	14
TOTAL	22	100

Table 3.8
Length of Stay of Residents

Range of Length of Stay in Years	No.	%
<1	4	18
1–1.9	2	9
2–2.9	4	18
3–3.9	2	9
4–4.9	3	9
5–5.9	3	14
>6	4	18
TOTAL	22	100

THE STAFF INFORMANTS

Foucault (1972:88) was interested in what 'experts' say when they are speaking as 'experts'. Whilst the doctor experiences the greatest control over both residents and other health workers speaking as a medical 'expert', the Director of Nursing of a nursing home controls the overall operation and activities in the nursing home, and is recognised as speaking as not only a nursing 'expert' but also as a management 'expert'. In the majority of nursing homes, proprietors and Boards of

Management have little or no input into the day-to-day running of nursing homes, leaving such activities for Directors of Nursing to organise.

In each of the three nursing homes selected, the Director of Nursing as well as five staff were interviewed. Therefore, a total of 18 staff formed the care provider sample for this study, of whom 17 were female and one male. The age of the care providers ranged from 30 to 58 years, with 11 (61%) being over 45 years of age (see Table 3.9). Over three-quarters (78%) of the care providers were married (see Table 3.10) and the high numbers of care providers being female meant that the majority had many social commitments outside their work environment, for example, running a household and looking after husband and children.

Table 3.9
Staff by Age Range and Sex

Age Range (years)	Male	Female	Total
<29	0	0	0
30–34	0	2	2
35–39	1	1	2
40–44	0	3	3
45–49	0	5	5
50–54	0	3	3
55–59	0	3	3
>59	0	0	0
TOTAL	1	17	18

Table 3.10
Marital Status of Staff

Status	No.
Married	14
Never Married	1
Widowed	1
Divorced/Separated	2
TOTAL	18

Table 3.11
Qualifications of Staff

Qualification	No.
Registered Nurse	10
Enrolled Nurse	3
Assistant in Nursing	3
Other	2
TOTAL	18

Table 3.12
Overview of Staff History

	Mean	Standard Deviation
Years of experience nursing the elderly	14.5	8.4
Number of years qualified	23.0	6.5
Number of hours of inservice attended over last 12 months	15.7	12.0

This study included not only Registered Nurses (10) but also Enrolled and Assistant Nurses (6) as well as Recreational Officers (2). Only four of the care providers interviewed had achieved a tertiary qualification and only two had undertaken any type of post-registration certificate (see Table 3.11). The mean number of years since care providers had qualified was 23 years and the mean number of years of experience in nursing the elderly was 14.5 years (see Table 3.12). Care providers had undertaken nearly two days (15.7 hours) of inservice over the last 12 months. This inservice had included a variety of activities which included back injury prevention, pharmacology in the elderly, dementia care and aromatherapy in nursing homes.

SUMMARY

The interview data for this study were obtained from 22 residents and 18 staff in three nursing homes. Each nursing home varied in the type of ownership and funding, type of building structure, bed numbers, location, standards requirements and length of time operating, thus facilitating maximum variation in the data collected. The type of residents selected for the study differed in age, length of stay, RCI dependency level, cause of admission, and so on, which also maximised the variation in data collection.

Although each nursing home in the study expressed strong support for the outcome standards resident rights and home-like environment philosophy, within

each institutional setting, the organisational practices used to implement the resident rights and home-like environment philosophy varied enormously. The organisational structures and l nes of authority, leadership style of management, orientation to work practices, ime orientation to work, care planning utilisation and the amount of resident participation in decision-making about care provision across the three nursing homes was quite different.

In Silver, where there was a formal hierarchical organisational structure; work practices were organised hea ily towards performing tasks on residents. The orientation towards work was organised more on a day-to-day basis than a long-term basis; limited care planning was undertaken and the participation in decision-making by the residents was low. Although a residents' rights committee was available to residents, it met infrequently and comments from residents during interviews suggested that many complaints and suggestions from residents were not acted upon and, therefore, residents did not see any benefit in going to the meetings when they were held.

In Heritage House the organisational structures were semi-hierarchical and the staff used a combination of res dent focus and task focus orientation in their work practices, depending upon dif erent staffing level situations. The orientation to work revolved around the set roster period and although care planning was undertaken, care providers displayed little enthusiasm for its use. Residents were given far greater input into the decision-making within the home. However, because of the limitation of the physical environment, full implementation of residents' requests was impossible.

Within Seaside Vista, the organisational structures were non-hierarchical. Staff at all levels participated regularly in the planning of resident care and the implementation of a modified primary nursing model meant that staff took more of a long-term view of providing care for the residents within the nursing home rather than simply providing care for a resident on a particular shift or over a

particular roster period. Work practices were strongly orientated to residents and staff took a holistic approach to providing nursing care. Although Seaside Vista contained a far greater number of Categories 4 and 5 (higher dependency level) residents than the other two nursing homes in the study, residents in Seaside Vista had a high level of participation in decision-making about their care provision. Regular meetings of residents' committees were held and every effort was made to ensure that resident suggestions were acted upon. Care providers undertook the health assessment/rehabilitation focused care planning with much enthusiasm as it not only gave them a greater sense of direction in providing resident-centred care but also provided more meaning and usefulness to their work.

In order to identify the major characteristics of quality care from the residents' viewpoint, the life experiences of residents in nursing homes were examined in order to determine the relevance of current nursing home outcome standards for promoting quality care and thus the analysis of the discourses of those residents interviewed became the focus of the following chapter.

Chapter 4

DOMINANT DISCOURSE OF RESIDENTS

Well, they've got to get rid of their old ideas about a home and all that sort of thing, and come in here and take what comes.
That's all you can do. You can't do much else about it. You can't alter these things. You can't do what you wanted, although some of them get the best beds!
There's always the pets in these places, always.
(90 year old male resident, interviewed 19.1.94, RE8, Text-unit:97)

INTRODUCTION

In order to identify the major characteristics of quality care from the residents' viewpoint, life experiences of residents in nursing homes were studied to determine the relevance of current nursing home outcome standards for promoting quality care within nursing homes.

Factors identified by residents that were integral to the quality of their nursing home experience were not limited to their period of residence within the nursing home. The lead-up period to admission appeared to have a considerable effect on a resident's view of life within the nursing home and although admission in a number of cases had been many years prior, it was still foremost in the minds of residents and vivid descriptions of their experiences were provided.

The quotation above, from one of the residents in this study, exemplifies the attitude that is held by many residents in nursing homes today about the amount of freedom and control over their lives in nursing homes. Residents continue to experience loss of control over their lives through institutionalism and the rigidity of nursing home routine.

The overriding theme found in the discourse of residents living in nursing homes I have called *Giving over of control of life*. This theme does not simply appear

when a resident is first admitted to a nursing home; rather it builds up sequentially from the period when the prospect of requiring nursing home care becomes a reality. Giving over of control of his/her life is not something that an individual sets out to do; rather it is presented to them, it is inflicted upon them, and finally it is accepted by them because of lack of known alternatives. An individual does not suddenly give over the control of his/her life to others, but rather, an individual sequentially passes through a number of phases during the giving over of control of their life. In order to present this sequentially, the theme *Giving over of control of life* in the discourse of residents is linked to three major phases through which an individual passes:

- Phase 1 — the period of 'passage from home to nursing home';
- Phase 2 — the period of 'settling in to nursing home life'; and
- Phase 3 — the period of 'resignation to life in a nursing home'.

(Table 4.1 provides a diagrammatic representation of each of these phases.)

Within each of these phases lies a component of *Giving over of control of life*; that is, Phase 1 contains the giving over of control of lives to relatives/close friends/doctor; Phase 2 contains the giving over of control of lives to care providers; and Phase 3 contains the realisation of finality of nursing home existence. Finally, each of the components of the major theme *Giving over of control of life* contains a number of different sub-themes. The overriding dominant theme together with the dominant sub-themes found in the language of residents interviewed in nursing homes will form the content of this chapter.

Table 4.1
Dominant Discourse of Residents in Nursing Homes

Overriding Dominant Theme: ***Giving over of control of life***

Phase 1—Passage from Home to Nursing Home

Theme: Giving over of control of lives to relatives/close friends/doctor

Sub-Themes:
- Traumatic lives through illness/grieving for lost partner prior to entering the nursing home
- Limited previous knowledge of nursing homes
- Limited control over selection or decision to enter the nursing home
- Beliefs of nursing home life to be hospital-like with reduced freedom

Phase 2—Settling in to Nursing Home Life

Theme: Giving over of control of lives to care providers

Sub-Themes:
- Vulnerable frame of mind as grieving for loss of house/belongings/partner
- Relinquish what little independence they may have had at home in order to 'fit in' to fast pace of nursing home routine

Phase 3—Resignation to Life in a Nursing Home

Theme: Surrender to the finality of nursing home existence

Sub-Themes:
- Favourable aspects
  - being cared for
  - no responsibilities
  - good quality of nursing care
- Unfavourable aspects
  - problems with other residents
  - dissatisfaction with food
  - difficulties with care providers
  - lack of privacy
  - lack of freedom
- Limited knowledge of complaints process
- Fear of complaining and being labelled a 'whinger'
- Nowhere else to go and take whatever comes (i.e. routine/lack of privacy/lack of independence)
- Feelings of waiting to die

PHASE 1—PASSAGE FROM HOME TO NURSING HOME

The dominant theme within the discourse found during this phase is the *giving over of control of life to relatives or close friends* who take charge of the process of moving into a nursing home. A number of sub-themes explaining the context of this theme were found within this discourse:

1) traumatic lives prior to entering a nursing home;
2) limited previous knowledge of nursing homes;
3) limited control over selection or decision to enter a nursing home; and
4) beliefs of nursing home life to be hospital-like with reduced freedom.

Traumatic Lives Prior to Entering a Nursing Home

To gain an understanding of the status and standing of residents in a nursing home, it is worthwhile to recognise the manner in which an ordinary individual becomes a resident of a nursing home. Many residents experience extremely traumatic periods in their lives prior to their entering a nursing home. It may not be their own illness that triggers their move into a nursing home, but often it may be the death of their carer (husband or wife or close relative) that necessitates their move. Therefore, the individual not only has to cope with grieving for their loved one but also with grieving for the loss of their home and all their worldly belongings. The following is an example:

> *Well, my wife died. There was nowhere else to go, was there? You know, everything goes -- your house goes, your car goes, your wife goes, the dog goes, the cat goes, and your garden and all the orchids — everything goes, and there you are, you're left. What are you to do? I tried to live on my own, but I couldn't do it. A woman can do it, but a man can't do it.*
>
> (19.1.94, RE8, Text-unit:27–29)

> *My first hubby passed away while I was so ill. I remember that ... I remember them coming and telling me he'd passed away and that was the reason I didn't want to live. I just refused to eat. And the nurses at ... would often laugh and tell me how I used to clamp my jaws shut*

and wouldn't open my mouth for them to feed me. I didn't want to live, that was the thing. My mate had gone and that was it.
(18.1.94, RE5, Text-unit:55)

How did I come to live here? Well, I was living with ... I have one son and he went to England and I had my sister and my niece both dying at once. I was teaching music at the Convent, and I was retired from there at the end of '83, and straight after that I shifted back down here, and I was there three weeks when my sister — she had leukaemia but she got dangerously ill then — and my niece, they discovered, had a brain tumour. Well, I ran myself ragged for about eighteen months or so, and then they both died. Well, after that I just slumped. I woke up one morning with arthritis all over me, you know? I was in agony. So I went then to live with a cousin who lived just a few doors away and I stayed there for a while. I was much better then. Well, then I decided that I'd better decide to do something, you know, because she's elderly also. So we set to work between us and her daughter drove us to various nursing homes and that sort of thing, and I finally got placed here. See, I just felt it was time. I have no other close relations, only cousins and, you know, nieces and that sort of thing, but they were all busy with their own lives.
(18.1.94, RE1, Text-unit:15)

Well, I was living in a rooming house with three other men and those three were also invalids — not physically invalid, but mentally. One was a ... what do they call them? It's common ... Schizophrenia.
(18.1.94, RE2, Text-unit:14)

Limited Previous Knowledge of Nursing Homes

In the majority of cases, residents have very little, if any, previous knowledge of nursing homes or what life would be like living in a nursing home. Not only had most residents not visited a nursing home prior to admission, but most residents had not visited the actual nursing home in which they were living, prior to admission. A number of reasons were given for this: residents had not known anyone living in a nursing home previously and therefore did not have the necessity to visit a nursing home; long lead-up periods of illness and incapacity

had reduced their mobility; and unexpected illness presenting itself suddenly, did not allow the individual to make adequate preparation.

Residents' lack of knowledge about nursing home life featured predominantly in the discourse as did their requirement for assistance from relatives and/or close friends to undertake the task of organising their entry into a nursing home. When asked about their previous knowledge of nursing homes, residents provided the following examples:

> *I'd never even been inside one!*
>
> (6.12.93, RC4, Text-unit:30)

> *Nothing. It was only my daughter who advised me very strongly to come here. She's gone overseas now, but she'll be home for Christmas.*
>
> (6.12.93, RC3, Text-unit:38)

Limited Control Over the Decision to Enter and the Selection of Nursing Home

Prior to entering a nursing home, many elderly people experience lengthy periods of illness and may not be sufficiently mobile to visit the various nursing homes which may be available. Often it is a close relative and/or friend who undertakes the task of visiting the nursing homes and providing feedback to the elderly person. Therefore, the elderly person is totally reliant on the integrity of the relative and/or friend to recommend the best placement, and even if the elderly person does have input it is based on another person's interpretation of what the nursing home is like. As one resident explained:

> *Oh, I've had a lot of sickness. She'd been working for a long time — it must have been twelve months — to try and get me in, because I wasn't well at home and I said, 'Oh, all I want to do is go somewhere and be looked after.'*
>
> (18.1.94, RE6, Text-unit:49)

> *She* [her sister] *was in charge of everything because I couldn't get around.*
>
> (18.1.94, RE4, Text-unit:47)

A compounding factor is that often many elderly people would prefer not to move into a nursing home; rather they would prefer to remain in their own homes for as long as possible, examples of this being:

> *Had I have known what I know now — I didn't know it — they didn't tell me at the time. Well, if you are still able to look after yourself a little, you don't need to go ... you could knock that back and wait till, you know, another vacancy ... They didn't tell me that.*
>
> (18.1.94, RE3, Text-unit:33)

The decision to enter a nursing home is mostly made by the elderly person's doctor in consultation with relatives and/or close friends rather than the elderly person themselves. Therefore, the decision to move into a nursing home was often taken out of the hands of the elderly person by concerned relatives and/or friends. Many residents interviewed explained the lack of consultation as follows:

> *I didn't do anything to come in here, I was just put in here.*
>
> (22.10.93, RH6, Text-unit:137)

> *Well, I had no choice, really, because I had to go somewhere. So I came in here.*
>
> (20.10.93, RH2, Text-unit:24)

Residents often explained they realised their health was deteriorating and it had become increasingly difficult for their carers to provide the level of care that was required in the home. In many cases, the carer in the home was their partner, who was elderly and unwell themselves and battling to provide sufficient care to their loved one. The strain placed on carers at home was a major concern as one resident explained:

> *It's easier in here, being in a nursing home, because people here know how to handle you, whereas your carers struggle at home and you struggle too, so ... it's a lot harder ... you have more falls and one thing and another.*
>
> (5.12.93, RC1, Text-unit:66)

In other instances, where residents previously lived with their children, when their health deteriorated they moved into a nursing home reluctantly because they did not wish to be a further burden on their families. An example is:

> *I said, 'Put me in a home,' I said, 'you've got to rear your family. It's not fair to you,' I used to say. I knew how tied down I was and I wasn't going to be a burden to them. They had a girl and a boy and ...*
> (18.1.94, RE5, Text-unit:19)

> *Oh, well, I really didn't want to come in here but I didn't have any choice.*
> (22.10.93, RH7, Text-unit:25)

The lead-up to the move into a nursing home can be lengthy, as often a bed is not available in the nursing home that has been chosen as being the most suitable for the relatives and friends to visit. Finding a placement that is in close proximity to the area where the resident's relatives and friends live can prove rather difficult. In a number of instances, residents are required to enter nursing homes that are not in the area where they wish to be placed. This is a major factor in some rural centres. This results in residents being moved back and forth from respite care beds to home and then to a nursing home that does not suit them. As one resident explained:

> *Oh, I had a nervous breakdown and I was in hospital for quite a long time and I was waiting to get in here and I had to go into other homes, and respite. It was terribly upsetting, having to move all the time.*
> (18.1.94, RE6, Text-unit:14)

Beliefs of Nursing Home Life to be Hospital-like with Reduced Freedom

All residents interviewed had previously experienced an admission to hospital at one time or another during their lives. When asked what they thought life would be like in a nursing home, many believed that living in a nursing home would be similar to living in a hospital. An example is:

Well, I didn't know actually — just that it would be like a hospital or something. But they're wonderful things, they really are. My poor family couldn't look after me.

(5.12.93, RC1, Text-unit:70)

The majority of residents believed it was not possible for them to experience the same amount of freedom in a nursing home as when living at home and believed they had to do what they were told and to not question staff in the nursing home in order to obtain the care they require. In other words, they were willing to accept a reduction in their freedom in return for the provision of care. As one resident explained:

Oh, no, it's not like living at home! You see, you can do what you want to do at home. But you see, you've got to do what they tell you to do here. And they do the things for you that you want done, so ... yes. So, they're pretty good here.

(22.10.93, RH6, Text-unit:51)

Oh, for me, personally, I must say, I knew ... not as free. Do you understand how I mean?

(20.10.93, RH5, Text-unit:28)

PHASE 2—SETTLING IN TO NURSING HOME LIFE

The major theme within this phase is the *giving over of control of lives to care providers.* This theme is seen in a number of examples of the discourse of residents which may be grouped under the following headings:

1. vulnerable frame of mind as grieving for loss of house/belongings/partner; and
2. relinquish what little independence they may have had at home in order to 'fit in' to fast pace of nursing home routine.

Vulnerable Frame of Mind

Many residents experience a long period of illness and/or trauma in their lives prior to entering a nursing home. The initial reaction can often be one of relief

that they will finally have a permanent full-time care provider that is well equipped and capable of prov ding the care that they realise they now require. However, after a few weeks of settling in to the home, the reality of lack of control and lack of independer ce in their lives sets in. This leads to a feeling of helplessness as the very peop le who are submitting them to the measures of control are also the very ones who are the only contact point of relief from the control.

When residents were asked how they felt when they first moved into a nursing home the majority of respons es included feelings of being upset about selling their homes and belongings, lonesome for family and friends, shy about being in new surroundings with new people, and miserable and unhappy. Some examples of the discourse include:

> *Miserable and unhappy. And I've been miserable and unhappy ever since I've been here. You can't say I am happy — nobody could be happy ... It couldn't be happy in a nursing home.*
>
> (22.10.93, RH8, Text-unit:72)

> *I was very upset, of cou se, having to sell my home because you've had your home for so long, all your belongings and things you've treasured, you couldn't store them all, you'd have to store the whole place. You couldn't keep a home and live in a nursing home at the same time, so I was very upset ... and then I thought to myself, 'Well, this has come that I have to go to a nursing home.' So I put my home on the market, sold it in the May and came in here on the 22nd of the following August.*
>
> (19.10.93, RH1, Text-unit:40)

> *Oh, well, it makes you feel a bit shy for a while but ... until you get your bearings and, you know, find out where everything is and all that sort of thing.*
>
> (22.10.93, RH7, Text-unit:56)

> *Well, I felt a bit lonesome in the first place because I didn't know anybody, and being dark, it was only all just the white ladies, but I made friends with them and I was alright.*
>
> (22.10.93, RH6, Text-unit:55)

Relinquish Independence n Order to 'Fit In'

Trying to settle in to the life ar d routine of the nursing home proved difficult and at times frustrating for many esidents. The need to become familiar with new surroundings and a new rout ne was foremost in the minds of residents and therefore residents became pa ssive recipients of the control being exercised by their new care providers in order that they fit into the routine quickly. Some residents were stronger in expr essing their feelings about their arrival in a nursing home. As one resident explains:

> *Hated it! But as you get u sed to the routine, it falls into place.*
> (6.12.93, RC3, Text-unit:50)

The imposition of a code of di scipline also featured in the discourse of residents, some examples being:

> *Disciplines. Well, I used to get up about six times ... and I've worked it out, I only get up once. They discipline you.*
> (6.12.93, RC3, Text-unit:55–56)

> *Oh, yes, for me, the nu rses are pretty good. They make you say 'please' and 'thankyou' jor everything (laughs).*
> (19.10.93, RH1, Text-unit:78)

Such discourse from residents provides examples of the Foucauldian position which would argue that in the nursing home, the subjectification of the elderly and chronically ill individual into a docile 'resident' body through 'bio-power' and its resulting disciplinary te chnologies occurs. The nursing home becomes the space where homogeneous gr oups of elderly and chronically ill individuals are placed and where technologies of normalisation are used as a form of control and classification of the anomalies within the individual in society.

PHASE 3—RESIGNATION TO LIFE IN A NURSING HOME

The major theme within this phase is the *finality of nursing home existence*. This theme is seen in a number of examples of the discourse of residents which may be grouped under the following headings:

1. favourable aspects of nursing home life;
2. unfavourable aspects of nursing home life;
3. limited knowledge of complaints process;
4. fear of complaining and thus being called a 'whinger';
5. take whatever comes as nowhere else to go; and
6. feelings of waiting to die.

Favourable Aspects of Nursing Home Life

A number of favourable aspects of nursing home life were found in the discourse of residents. Being cared for featured predominantly, as did the removal of worries and responsibilities associated with the upkeep of a home and the purchase and preparation of meals. Residents realised they were no longer able to care for themselves in their own homes, and therefore learned to tolerate the nursing home routine in order to obtain care. The quality of the nursing staff was also a major feature in the discourse of residents. Examples of these are as follows:

Provision of Care

> *Oh, you're cared for in the proper way. It gets very boring, but you're cared for.*
>
> (6.12.93, RC3, Text-unit:129)

> *Oh, well, like, they look after me — they do everything for me and I reckon that's the best thing that's ever happened to me, because when I was home I had to do those things myself. And they do everything for me now.*
>
> (22.10.93, RH6, Text-unit:88)

> *Oh, you've got your regular meals, you're being looked after, made comfortable and that, and if you've got any pain or anything, here's*

the buzzer. You buzz and the nurse comes to see what's happened and she tells Sister.

(20.10.93, RH5, Text-unit: 50)

No Responsibility or Worries

Well, you don't have to pay rates or electricity or do your own washing or anything.

(5.12.93, RC1, Text-unit:117)

No responsibility — as far as meals.

(18.1.93, RE5, Text-unit:92)

Well, there's everything for your convenience. The attendants are very, very nice and understanding. There's always a doctor on hand. I think they've got just about everything. Sometimes we whinge about the food, but that's not serious, it's just a, you know ... Although, they did try to do more ... we've got a menu now that at least you have a choice with your meals -- that made it a lot better. But bulk cooking, you know, it's not like home.

(18.1.94, RE1, Text-unit:42)

Quality of Nursing Staff

The nurses ... great crew they are. Good girls.

(5.12.93, RC1, Text-unit:111)

Well, I think the best thing is to have good nurses, like we have, because they are very considerate, always willing too, if you're not feeling very well, or you need treatment, something applying or something, they're there for your comfort to do anything they can for you to make you more comfortable, and for the Sisters to be nice and friendly and to have a good Sub-Matron.

(19.10.93, RH1, Text-unit:140)

Unfavourable Aspects of Nursing Home Life

Many unfavourable aspects of nursing home life were found in the discourse of residents and included: problems with other residents; difficulties with care providers; dissatisfaction with food; lack of privacy; and lack of freedom. Examples of the discourse are as follows:

Problems with other Residents

Makes you feel sad

And I am very fortunate because I have a room to myself. Because I don't like mixing with these poor half-witted people. They make me sad. I used to go ... they have lots of celebrations for them ... they do lots of things to make them happy. Now, this afternoon, this lady, this Mrs Smith I was speaking of, they'll be down there in the rec. room — you've heard of the rec. room — they're playing bowls and things like that. And other days they have sing-songs and, oh, all sorts of things, but I went down once or twice and sat at the table and you speak to somebody and they just stare at you, and they don't answer you. You can't get into conversation, so ... and it makes you feel too sad. So I'd sooner sit here by myself. And I read.

(22.10.93, RH8, Text-unit:136)

Taking ways

Yeah. They're entitled to live here too, I know, but some of them should be in special places. Some are very noisy, some have got taking ways ...

Yeah, they come in and take things.

(5.12.93, RC1, Text-unit:159–163)

Makes you frightened

They make you frightened, take things that go missing, you know.

(18.1.94, RE1, Text-unit:165)

Dissatisfaction with Food

Food

Yeah, that's about the worst part of it. Sometimes the meals are pretty horrible.

(5.12.93, RC1, Text-unit:19)

Well, the meals could be better, the meals could be better cooked. The vegetables are never cooked very well. The only time you can eat the vegetables is when they're mashed. (laughs) And, you know, you get beans and peas, cauliflower and all that sort of thing and it's hard as a rock — you can't eat it. They're never cooked sufficiently, you know?

(19.1.94, RE8, Text-unit:83)

Difficulties with Care Providers

Older staff get cranky

Oh well, I think some of the staff could be better. See, the young ones are really nice, but the old-timers, you know, the ones that have been going for years, the middle-aged people, they're a bit cranky.

(19.1.94, RE8, Text-unit:85)

Residents left unattended

And they have an hour off for tea and dinner and there's nobody on duty. They are short staffed. There should be a nurse on duty all the time.

(19.1.94, RE8, Text-unit:84)

Residents' buzzers not answered

Oh, well, you ring the bell, and if I rang that now, they mightn't come for half an hour. They should answer the bell straight away, I think.

(18.1.94, RE1, Text-unit:82)

Residents jealous of favourite residents

You can't alter these things. You can't do what you wanted, although some of them get the best beds! (laughs) Yeah, There's always the pets in these places, always.

(19.1.94, RE8, Text-unit:97)

Lack of Privacy

The worst things? Lack of privacy. See, we don't have doors and the whole world can walk in on you, you know? Not that they do you any harm, I mean, but sometimes you just don't feel like it.

(18.1.94, RE1, Text-unit:53)

Just to cope with different people. You know, the people here are not the best — they're just not, that's all. They're some of the greatest stickybeaks in the world, you know?

(19.1.94, RE8, Text-unit:79)

You know, I've had somebody come in and go to my chest of drawers and I said, 'What are you doing there?' 'Oh, I'm looking for something.' 'Well,' I said, 'you won't find what you're looking for there.' You know, they really don't know what they're looking for. I used to have a man come in here and take my cushions and take them along the hall, and then leave them along the hall. Well, he didn't know what he was doing, so you couldn't tell anybody to be careful of

that — you wouldn't know what was going to happen. Poor fellow, he died. I got to quite like him. He sat on that pouffe one day and fell off! He couldn't get up. No, there's nothing I've got against him.

(22.10.93, RH8, Text-unit:124)

Lack of Freedom

Oh well, the freedom ... your freedom's curtailed. You can't really go out when you want to, you know? You've got to have someone to take you and all that sort of thing.

(18.1.94, RE5, Text-unit:60)

Limited Knowledge of Complaints Process

A distinct lack of knowledge of the appropriate complaints process within the nursing home is found in the discourse of the residents interviewed. Residents within nursing homes endure whatever situations arise, because to their way of thinking, there is no avenue for complaint or resolution of a problem. They simply put up with the situation. When residents were asked what would they do if there was something within the nursing home they would like to change, responses included:

I'd put up with it.

(19.10.93, RH1, Text-unit:90)

Well, how are you going to do it? This is the thing ... there's things that I want to change, but can't.

(18.1.93, RE3, Text-unit:188)

Well, what could you do?

(6.12.93, RC3, Text-unit:183)

I don't know. I don't know what I'd do if there was something I didn't like.

(19.1.94, RE7, Text-unit:103)

For a number of residents the first avenue of complaint was to the Registered Nurse on duty at the time.

I'd talk to the sister and see what she could do.

(18.1.94, RE1, Text-unit:119)

Residents believed there was very little they could do to change anything they did not like within the nursing home. One resident whose health had improved since moving to the nursing home requested a transfer back to the hostel from which he came. He met with strong opposition from the management of the nursing home and was told he should remain where he was as, if he moved back to the hostel, he would eventually have to return to the nursing home when his health deteriorated. This resident was helpless against the inflexibility of nursing home practice and policies. He explains:

> *No, I don't think you could change anything. It's got to go through the Matron, it's got to go through the Management if you wanted to change things. You don't change things on your own. I wanted to get back over to the other side* [the hostel] *where I was happier, but I tried twice — there was no way in the world. I've just got to stop here. Sister said, 'No, Jim, I didn't want you to go. I didn't want you to go in the first place, but,' she said, 'I got orders from above.' And that's it — you obey orders.*
>
> (19.1.94, RE8, Text-unit:93)

Fear of Complaining and Thus Being Called a 'Whinger'

Many residents did not wish to complain about anything within the nursing home for fear of being called a 'whinger'.

> *Everybody gets full and plenty here. They always get treated very well. If they don't, it's their own fault ... Oh, well, if they were whingers or something like that, well, they mightn't get on so good. But there are whingers, you know, isn't there, like, in everything. I always try to keep on the happy side — sing a song, do a little bit of whistling ...* (singing) *'If you were the only girl in the world.'*
>
> (22.10.93, RH7, Text-unit:97–101)

The 'whinger' featured again in the discourse of residents in their advice to someone contemplating moving into a nursing home. As one resident explains:

> *I don't think* [I'd have any advice] *other than not to be a bloody whinger! (laughs) Which is apparently quite often the case.*
>
> (7.12.94, RC5, Text-unit:72)

Take Whatever Comes as Nowhere Else to Go

The attitude of 'take whatever comes' was pervasive through the discourse of residents. For example:

> *Well, they've got to get rid of their old ideas about a home and all that sort of thing, and come in here and take what comes. That's all you can do. You can't do much else about it. You can't alter these things. You can't do what you wanted ...*
>
> (19.1.94, RE8, Text-unit:97)

When residents commented on the quality of care received, they predominantly referred to such things as dissatisfaction with food and difficulties with wandering residents; however, the technical care provided by care providers featured very little in their discourse. For example:

> *Well, it's a case of having to put up with it ... what is the best for you. You can't do anything for yourself and so ... meals are regular, the girls look after you, you wash yourself and what you can't do, they do for you ...*
>
> (22.10.93, RH8, Text-unit:63)

When residents did speak of the quality of care provided it was always done in an extremely guarded manner. One day, when undertaking an interview with one lady, we heard cries coming from the bathroom area. A resident had been wheeled into the bathroom area for a shower. She had been undressed and left in the shower area 'to do what she could for herself'. She started to call out and it was some ten minutes before the nurse returned to complete her shower and dress her. The lady being interviewed was not surprised with the noise coming from the bathroom, saying that 'she didn't make as much noise as she usually does'. She also commented that 'they came back to her faster today'. She explained that this happens nearly every day.

Feelings of Waiting to Die

Many residents in nursing homes do not have any plans for the future. They do not have any sense of meaning in life and give up their will to live. An example of this is:

> *No, I'm not interested really, not now. There's only one thing I'll say about these places — you come in and you wait to die. That's what these places are. You simply wait to die, don't you?*
> (19.1.94, RE8, Text-unit:111)

> *I don't think I've found anything really difficult except I'm living. (laughs) I mean, I don't really care, only, I suppose my daughter would be upset, but ...*
> (6.12.93, RC4, Text-unit:57)

SUMMARY

The overriding dominant theme of *Giving over of control of life* emerged from the analysis of the descriptions provided by residents during interviews. This theme builds up sequentially and is linked to three major phases through which the individual resident passes: firstly, Phase 1, the period of passage from home to nursing home; secondly, Phase 2, the period of settling in to nursing home life; and finally, Phase 3, the period of resignation to life in a nursing home. Within each of these phases, a number of components of the dominant theme emerged together with a number of individual sub-themes.

Phase 1—Passage from Home to Nursing Home

Residents' descriptions of the overall process of admission into a nursing home was found to be an important part of their overall nursing home experience. Residents interviewed clearly linked their admission to a nursing home with their perceptions of quality of care provided by a nursing home and analysis of these descriptions allowed for a closer

examination of the impact of the admission process on the quality of life of residents living in a nursing home.

Prior to entering a nursing home many residents may have lost their partners or may have experienced severe illness which has led to their requiring nursing home care. In the majority of cases, residents have limited knowledge of nursing homes and believe life in a nursing home to be hospital-like and therefore expect to have their personal freedom severely restricted upon entering the home. Residents in the study had limited control over the selection of a particular nursing home and the decision to actually move to a nursing home was in most cases made by someone other than the resident.

The finding that a resident's entry into a nursing home was not a single event which was linked to a particular day, is supported by Chenitz (1983) in her work involving entry into nursing homes as a status of passage. Similarly, the finding that residents had very little control over the admission process into a nursing home is consistent with the research undertaken by Minichiello (1987) and Corden (1990).

We see the recurrent theme of surrendering of personal independence by individuals in many studies of residential care provision in both Britain (Clough 1981; Willcocks, Peace & Kellaher 1987) and the USA (Tobin & Lieberman 1976; Vladeck 1980). The finding that residents had limited control over the selection or decision to enter the nursing home is consistent with Minichiello (1987) who found that residents in nursing homes who had originally made their own decision to enter a nursing home had a positive attitude to living in the home, whereas residents who had no input into the decision to enter a home and had the decision made for them found the experience of moving to a nursing home very difficult and indeed found it extremely difficult to 'settle in' and adjust to life in a nursing home. In a

study by Stein, Linn and Stein (1985) into patients' anticipation of stress in nursing home care, they concluded that if appropriate support was offered to new residents and anticipated stresses were identified then the anxiety about moving into a nursing home could be significantly reduced.

Phase 2—Settling in to Nursing Home Life

Many residents enter nursing homes in a vulnerable frame of mind. Long periods of illness, the loss of a partner, loss of home, possessions and independence can often precede entry. Trying to settle in to the life and routine of the nursing home can prove to be difficult and at times frustrating for residents because of the juggling of different passages of their lives (Glaser & Strauss 1971). Tobin and Lieberman (1976), in their study into the nursing home as a last home for the aged, used the term 'environmental discontinuity' to describe the experience for residents when moving into a nursing home.

Residents in this present study provided descriptions of the difficulties experienced in getting used to the routine of nursing homes. Taking meals at set times, lack of choice and variety of food, specific times for various treatments and nursing care procedures (e.g. showering, dressing, bed making) and adapting to new regimes for taking medications were among the most difficult for residents to adapt to. Residents ultimately became passive recipients of the control being exercised by their care providers in order to fit into the routine of the nursing home quickly. Residents were thus willing to accept a reduction in their freedom of choice and independence in return for the provision of care. This trade-off is a significant factor in the relinquishing of freedom.

Phase 3—Resignation to Life in a Nursing Home

Residents provided numerous descriptions of aspects of life in a nursing home which were important to them and impacted on the quality of their

nursing home experience. The findings from this part of the study suggest that while favourable aspects of nursing home life such as gaining the provision of nursing care and the removal of worries and responsibilities associated with maintaining a home and preparation of meals featured prominently in the discourse of residents in the nursing homes, there were still many unfavourable aspects of the institutional regime of nursing home life which residents' descriptions provided. These included: difficulties with wandering dementia residents; specific difficulties with care providers and a lack of personal interaction with care providers; continual lack of privacy and lack of freedom; and dissatisfaction with the variety and choice of food and mealtimes. A lack of knowledge of the complaints process available within the nursing homes was also evident in the residents' descriptions, as was the fear of being labelled 'a whinger' if complaints were made. The various factors associated with the institutional regime found in this study are consistent with those reported by Wilkin and Hughes (1987) in their work on consumers' views of residential living.

According to Foucault (1980:98), the individual is shaped into a subject through the exercise of power and knowledge. Therefore, from a Foucauldian perspective, the threat of permanent visibility, the lack of knowledge by residents of complaints procedures as well as the utilisation of surveillance and documentary techniques by care providers in nursing homes to record, categorise and classify residents assures the automatic functioning of power over residents and assists those in power in maintaining control over residents. Thus, through various surveillance and disciplinary techniques the disciplinary nursing home produces docile 'resident' bodies who will not challenge the status quo.

CONCLUSION

This present analysis highlights the continuing need to provide prospective residents with information about nursing home life, as well as including them in the decision-making process when entering a nursing home. It also highlights the need to provide support to prospective residents during their passage from home to nursing home. If such information, support and input into the decision-making process were forthcoming then traumatic experiences described by residents (of moving into nursing homes) would be reduced and residents' perceptions of quality of care in nursing homes and their quality of life would be vastly improved. Although enormous improvements have taken place within nursing homes as a direct result of the Commonwealth Outcome Standards Policy (Braithwaite et al. 1993b), this present analysis highlights the deficiencies still apparent in nursing home care provision and therefore demonstrates a need for policy-makers to ensure that Standards Monitoring Teams (who are responsible for monitoring the implementation of the Commonwealth Outcome Standards Policy) look more closely at organisational regimes and routines of care within nursing homes as a means of improving the quality of life of residents even further.

In order to analyse the reaction to and implementation of the Aged Care Reform Strategy in relation to quality care provision, the beliefs and practices of nursing care providers regarding quality care were examined and thus the analysis of the discourse of those care providers interviewed becomes the focus of the next chapter.

Chapter 5

DOMINANT DISCOURSE OF CARE PROVIDERS

Well, all the amount of documenting will never get you someone that's going to care for an old person. I mean, you can document all day and you won't get that person cared for. Because caring for people does not come from a piece of paper, it comes from within that person, that personality that is employed here. So no matter what piece of paper or how much documenting you do, it's the personality of the person that works here that is the success as far as looking after people.

(Registered Nurse, interviewed 15.11.93, SH4, Text-unit:76)

INTRODUCTION

In order to analyse the reaction to and implementation of the Aged Care Reform Strategy in relation to quality care provision within nursing homes, the beliefs and practices of nursing care providers regarding quality care were examined.

The quotation above, from one of the care providers working in a nursing home in this study, exemplifies the overriding *Documentation Driven Nursing Care* theme found in the discourse of care providers in this study, when describing the Commonwealth Outcome Standards. The present requirement by the Commonwealth Government, to provide documentary evidence of resident assessments using the Resident Classification Instrument (RCI) categorisations to legitimate levels of funding within nursing homes, is described by care providers as driving the Aged Care Reform Strategy, and thus overshadowing the real need, namely, to provide qualified and experienced care providers who are committed to providing quality care to residents. As well, there is a need to change the focus of care delivery from one of 'task orientation' to one of 'resident-centred care' in order to improve the quality of care and quality of life of residents living in nursing homes.

Beliefs About Quality Care Provision

When the various levels of care providers in this study were asked what they believed providing quality care meant to them, the responses were markedly different between Registered Nurses, on one hand, and the Assistant Nurses and Enrolled Nurses on the other. The usual response from Assistant Nurses and Enrolled Nurses centred around such things as comfort, cleanliness and the like:

> *Being able to maintain all their needs ... making sure that they're pain free ... and just making sure they're comfortable.*
> (19.1.94, SE4, Text-unit:71)

> *... giving the best care that you're capable of. Doing everything you can to make them comfortable and seeing that they're well looked after, and at any time always make sure there's plenty of privacy for the resident.*
> (15.12.93, SC1, Text-unit:78)

> *I guess it's probably the same as in a hospital—just their basic comfort. You know, you try ... if you think someone's not comfortable some way you try and make them comfortable.*
> (2.11.93, SH1, Text-unit:47)

However, when Registered Nurses were asked what they thought providing quality nursing care meant, they emphasised a more wholistic approach to care provision that was not present in responses from Assistant Nurses and Enrolled Nurses. Examples from Registered Nurses were:

> *Well, you've got to look wholistically. You can't just look at bandaging an arm or doing a shower or something. You've got to look wholistically and I think most RNs look that way. I think the Assistant and Enrolled Nurses don't agree with it too much.*
> (16.12.93, SC2, Text-unit:54)

> *Need to provide individual care for each resident and giving them the best you can to their ability. If they take all day getting outside for a walk, I mean, giving them that opportunity. Making them feel that they've got a purpose in life, as well as providing all their necessary care ... just giving them that little bit extra.*
> (19.12.93, SC5, Text-unit:80)

Derived from care providers interviewed in this study, four major areas which influenced care providers' quality care provision are identified:

1. organisational regime;
2. level and commitment of staff to caring for the aged;
3. social interaction; and
4. physical nursing care.

(Table 5.1 provides a diagrammatic representation of each of these phases.)

Each of these four major areas will now be discussed.

ORGANISATIONAL REGIME

Nearly all care providers in the study emphasised the importance of nursing homes providing a home-like environment where privacy and dignity were assured for residents to live out their last days. Their views were in-keeping with the home-like environment philosophy espoused by the Commonwealth Outcome Standards. Although the philosophy of providing a home-like environment was repeatedly espoused by care providers within all nursing homes, the reality found in much of their task-oriented method of work was far removed from what would be required to achieve a home-like environment.

Table 5.1
Dominant Discourse of Care Providers

AREAS WHICH INFLUENCED CARE PROVIDERS' QUALITY OF CARE PROVISION	BELIEFS AND PRACTICES
ORGANISATIONAL REGIME	Focused on task-orientated care rather than resident-centred care.
LEVEL & COMMITMENT OF STAFF	i) Inexperienced and untrained nursing assistants still employed, rather than experienced and qualified staff due to financial constraints. ii) Nursing staff seek employment in nursing homes as a refresher course replacement or because of lifestyle factors, rather than because they wish to pursue a career in aged care nursing.
SOCIAL INTERACTION	Focused on organised activities and outings rather than talking socially with residents.
PHYSICAL NURSING CARE	Fostering of a protective and dependency nursing environment rather than a challenging and rehabilitative environment.

Task-Orientated Nursing Culture

Many senior Registered Nurses explained the difficulty in trying to change the old task-orientated nursing culture found amongst care providers within nursing homes. Formerly, many care providers considered nursing homes to be mere workplaces for staff, where activities such as showers, sponges, making beds, and mealtimes were undertaken in line with a carefully constructed time schedule. With the introduction of the Commonwealth Outcome Standards, the focus within non-government nursing homes has changed, requiring proprietors to provide care to residents in a home-like environment based on individual resident's needs.

However, the reality of the nursing home workplace in many cases still reflects the former view. The following comments provide illustrations:

> *The staff are very task-orientated in what they do and everything's done to a time schedule, and I could probably go into a clinical unit now and see someone saying, 'Come on, Pop, you don't have time for this,' and dragging them off, so, yeah, it's a matter of reinforcement when you see that happening and explaining. It's a matter of providing education which is a big component here, for the untrained staff. You can see, because we've had such a big component of untrained staff in the Assistants in Nursing for many years, the Registered Nurses have slipped into that same mould. There's a great culture in this organisation that overtakes people, I've noticed, and you've really got to fight your way out of it.*
>
> (21.1.94, SE7, Text-unit:29)

> *I find it hard with the untrained staff too, because a lot of them have been here and they're very task-orientated, where everything's done now —'This is done and that's done, and as long as I've got this, this and that done by ten o'clock, I'm going really well.' It's not the extra bits, so ... yeah. That's when I have my case studies and I'll talk about all the other little bits and pieces we should be trying to do.*
>
> (21.1.94, SE6, Text-unit:55)

Many senior Registered Nurses described the ideal environment for residents as being one in which residents were afforded the opportunity to experience choice and flexibility within their nursing home life. As one senior Registered Nurse explained:

> *We encourage the residents to bring in some of their own things from home, like photos or ornaments or their own bedspread and doonas — but nothing too big like furniture — we just don't have the room. We also allow residents to have their showers at whatever time in the day they prefer and we also allow them to have their meals in their own rooms if they don't want to go down to the dining room. But it's a lot of extra work for the nurses if everyone decides to do that! We also provide lots of different activities and outings.*
>
> (2.11.93, SH1, Text-unit:50)

Interestingly, however, when residents were asked about the choices that were available to them, they generally referred to keeping in with the routine of the nurses as they did not want to ask for anything different for fear of getting a bad reputation for complaining.

The need for change and innovative ideas was mentioned by all senior Registered Nurses. However, putting ideas into practice had been undertaken in varying degrees within the nursing homes in the study. Seaside Vista Nursing Home and Heritage House had moved a long way to changing the attitudes of the care providers within the nursing home. A flexible work schedule had been organised to allow residents to be bathed at whatever time of day they wished and mealtimes were flexible, with residents being provided with a breadth of choice on menus. Uniforms had been dispensed with at Seaside Vista Nursing Home where care providers wore a range of comfortable and colourful shorts, culottes, slacks or skirts, together with non-slip runners, and residents frequently commented on the relaxed family environment created by not having everyone in white uniforms looking like hospital staff. In stark contrast, the staff of Everglades Nursing Home maintained a strict daily work routine and care providers wore hospital style white uniforms with epaulettes of varying colours to denote different levels of seniority.

LEVEL AND COMMITMENT OF STAFF TO CARING FOR THE AGED

Many senior Registered Nurses interviewed emphasised the importance of having experienced nursing staff who enjoyed caring for the aged in order to provide a high standard of care to residents. The reality of this view was that in many cases Assistants in Nursing with no previous experience were employed on the understanding they would have on-the-job training with a more experienced staff member. During fieldwork in this study, new, inexperienced nursing assistants were observed undertaking showers, feeding confused residents and lifting and

toileting immobile residents without having undertaken any prior inservice instruction. As one Registered Nurse explained:

> *For the first few weeks it can be quite difficult on the residents when we have a new assistant nurse start. They come in straight off the street, you know, with no training whatsoever. They are generally desperate for a job and a lot of them just make up a story about wanting to work with the elderly just so they can get the job. We usually sort them out after a few weeks and if they look good we usually let them stay. The poor residents are the ones who suffer you know, when one of our experienced staff leaves.*
>
> (19.1.94, SE1, Text-unit:60)

When care providers were questioned as to their initial reason for choosing to work in a nursing home, very few displayed a preference for working in a nursing home, with many preferring to be working in the acute or community sector if it were possible. The standard response of the few who displayed an interest in aged care nursing was usually:

> *I just like old people.*
>
> (15.12.93, SC1, Text-unit:7)

> *Well, caring for the aged. You get quite a bit of satisfaction out of caring for the aged.*
>
> (12.11.93, SH3, Text-unit:7)

The major reasons given by care providers for choosing to work in a nursing home were: firstly, the lifestyle factors of convenient working hours and closeness to work; and secondly, to act as a replacement for a refresher course in order to ease the transition back into the workforce after a considerable period of absence.

Refresher Course Replacement

The reasons given for working in a nursing home were far from having a genuine interest and desire to care for the aged. Nearly all care providers interviewed who had been out of the workforce prior to gaining employment in a nursing home

originally aimed to move back into the hospital setting and considered obtaining a job in a nursing home as a stepping stone back into the acute care hospital setting. They considered taking up a position in a nursing home would ease their transition back into the workforce and act as a refresher course replacement. However, once employed in a nursing home, many care providers continued to acknowledge their lack of confidence to move back to the hospital setting and assurance of permanent employment became of higher importance than their career goals and job satisfaction. Comments included:

> *Well, nursing homes ... I'd been out of nursing for eight years and I was fed up with my life and I just picked up the paper and there it was, staring me in the face. I thought, 'This is for me. I'll get my foot in the door,' because I thought a nursing home was just a way back into the public system.*
>
> (16.12.93, SC2, Text-unit:7)

> *I couldn't really get a job in the general system because I'd been out of it for a while, and this was my opportunity to get back into the workforce. I lacked general nursing experience since my training.*
>
> (19.12.93, SC5, Text-unit:6)

Lifestyle Factors

In many instances, working in a nursing home was the only type of employment available and therefore the care provider did not have any choice other than to take the position even if they had not wished to do so. The major reasons for working in a nursing home centred around two major lifestyle factors:

1. convenience of working hours; and
2. working within close proximity to place of residence.

The following care providers' comments provide illustrations:

> *I worked once in a nursing home so I could do part-time work, and now I'm working in a nursing home so that eventually I can do call-in work for social reasons really.*
>
> (19.1.94, SE2, Text-unit:7)

I suppose the job was available and the hours weren't as difficult. I started off working part-time because the children were small and I gradually sort of worked longer and longer and got more and more work and that's how I liked it, I enjoyed it.

(15.11.93, SH5, Text-unit:6)

It was the hours here; if you want me to be honest. (laughs) I was working in acute surgical and I needed to work full-time and to have a position that suited, where I could adjust shifts. So that's the initial reason why I came here, and since I've been here I don't want to leave, actually. Yeah, I really like it now, yeah.

(21.1.94, SE6, Text-unit:7)

Oh, well, because of the hours, and I have three children, so, where I was working, that extended past three o'clock, so I thought, 'Well, who needs to rush around like this?' because I knew that here they had more staff, you had plenty of everything here. So I thought, 'I'll come across and I'll work here.'

(19.1.94, SE4, Text-unit:18)

It was a Monday to Friday job, and one week of mornings and one week of evenings, which was great. That's what I was offered when I was offered the job. And that's fine because I wouldn't like to do all the same, you know, mornings all the time or evenings all the time. So I like a week of each. And that's ... they're my shifts and I really enjoy that, because I think it gives you a bit of variety. Because you have different staff of a morning and different of an evening, and you get used to the same group of people. So, it puts you with everybody, so you get to know everybody.

(2.11.93, SH1, Text-unit:13)

It wouldn't be my first choice obviously because I'm trained in different areas. The job became available and I really enjoy it. I've worked in nursing homes before. My job of choice would not be a nursing home.

(15.11.93, SH4, Text-unit:8)

Well, I didn't decide. I was actually ... it was the only job available to me, and I thought I probably had the skills for the job that I'm doing in particular. I was concerned initially — I'd never, ever been into a nursing home before I applied for the job, and I actually came and had a bit of a look around, but I was terrified when I was taken down

the corridor. I thought, 'Oh God, what am I going to see?' But I really love it. Since then, I really, really enjoy working with older people.
(20.12.93, SC4, Text-unit:6)

SOCIAL INTERACTION

All Directors of Nursing and the vast majority of Registered Nurses in the study emphasised the importance of social aspects of nursing home care in improving the quality of nursing care provided to residents. Interestingly, social aspects of care were usually described in relation to the various outings and activities programs which were organised in each nursing home, rather than in relation to actually spending time listening or talking to the residents during the course of their general daily routine.

Although all Directors of Nursing prided themselves on the extensive nature of organised outings and activities, the opportunity for all residents to participate in such outings was extremely limited. In reality, the actual number of residents who were capable of participating in outings was very small and usually the same people would go on all the outings. In Everglades Nursing Home, the outings had been suspended because there was insufficient staff to accompany the residents on the coach. Residents of all nursing homes described the difficulty of getting on and off the coach and commented they did not wish to be a burden on the driver and saw this as being a barrier to their participating in such outings. Also, many residents did not like the types of activities organised and therefore would not participate.

Because of the busy time schedules and task-orientated focus of many care providers, talking to residents was not valued highly. Many care providers commented they did not have sufficient time to talk to residents as they had to get all their work completed by a certain time. For example:

There are some doctors' rounds and there are a lot of extra showers in the morning, but unfortunately for the Registered Nurses on the

evening shifts, when they're looking after thirty-two patients, the routines that are involved with dressings and medications and eye drops and things like that are never ending and there is even less time for a Registered Nurse to spend on a personal interaction with a patient on that shift. The girls are tremendously busy on that shift.

(19.1.94, SE2, Text-unit:63)

Indeed, on a number of occasions during the study, care providers were observed to be extremely busy during morning shifts, and would work very fast in order to complete a certain number of showers or make a certain number of beds before lunch. Even though the Director of Nursing did not require the staff to have such activities completed before lunch, care providers still sped through their work in order to have an extended relaxing period of time over lunch. Some care providers were also concerned about reprimands from doctors who visited in the afternoons. As one Enrolled Nurse commented:

The matron says we can shower some in the morning and some in the afternoon, but I would rather get it all done in the morning to give us all a bit of extra time to relax over lunch. You know it is very heavy work that we do, ... lifting residents and pushing them to and from the bathroom. At least if we get everything finished before lunch, then we won't get into trouble from the doctors. You know the doctors generally come after lunch and they don't like it if we are still showering residents.

(19.1.94, SE2, Text-unit:90)

A large number of care providers commented they felt uncomfortable talking with residents when they were not performing some task, for fear of being labelled by other staff and residents as 'not doing any work'. As long as the conversation was associated with performing some task, such as making a bed or having a shower, care providers commented that it was legitimate for them to be talking to the residents. In one nursing home, residents were described as 'difficult' if they tried to engage care providers in conversations when a task was not being performed. Care providers would warn new employees of the 'difficult' residents, so they would be on their guard and be ready to make a quick escape if

the resident initiated a conversation. Such strategies as speeding through the task to get away or purposefully not talking to the resident when actually performing a task were used by care providers when caring for such 'difficult' residents. From a Foucauldain perspective, such strategies would be examples of technology for disciplinary power ensuring the spread of power efficiently whilst utilising a limited workforce at minimal cost; increasing the amount of visibility of those under surveillance whilst disciplining individuals with the least amount of overt force by operating on their souls (Dreyfus & Rabinow 1982).

The findings that care providers give greater emphasis to providing material care to the detriment of social care is supported by the work of Bartlett (1993) and Weaver, Willcocks and Kellaher (1985) in the UK and more recently by Nay (1994) in Australia. Whilst all nursing homes espoused the importance of social aspects of care to enhance the quality of nursing care provided to residents, in reality, the findings of this study suggest little attention was given to ensuring that social care was provided by care providers to all residents.

PHYSICAL NURSING CARE

Keeping residents clean and tidy, dry and odour-free were described by all Directors of Nursing as being highly relevant to both the quality of care and quality of life of residents. Basic nursing duties such as bathing, showering, dressing, toileting, feeding, and pressure area care were observed as important aspects of the daily care provision routine and all three nursing homes in the study prided themselves on the high standard of nursing care provided to residents.

However, the reality of this view was somewhat different. Indeed, in all nursing homes, the activities of daily living such as bathing, showering, feeding, dressing, and so on, were carried out with much enthusiasm and the basic standard of care provided was high. However, a strong culture of dependency and protection was

observed throughout the nursing homes which denied residents the opportunity to undertake simple exercise in order to enhance their quality of life. For example, residents who were still capable of walking, even though somewhat slowly, were required to use wheelchairs when moving from place to place. Lack of staff and lack of time was the reason often given by care providers as to why they used wheelchairs to transport residents. As one Enrolled Nurse explained:

> *It's a shame we can't walk them more often, even just outside occasionally. But we would never get all our work done on the shift if we did that. So we quickly get them showered in their wheelchairs and then take them outside and they stay there sitting for an hour or so and then we just wheel them back in. At least they get out for some fresh air, which is better than nothing, I suppose.*
>
> (21.1.94, SE5, Text-unit:70)

Within all the nursing homes, the majority of activities of daily living which were performed by nursing care providers encouraged dependency amongst residents and led to inactivity and disuse of residents' limbs. Even though Activity Officers and Physiotherapists were available to all residents in all nursing homes, the actual number of residents who received physiotherapy or participated in activities was generally very small. From a Foucauldain perspective, such encouragement of inactivity would assist in producing the docile 'resident' body.

These findings are supported by the work of Peisah (1991), who observed that nursing homes which have a protective attitude towards residents prohibit any challenge and rehabilitation activities which would benefit residents' quality of life. Similarly, the work of Kane and Kane (1981) described the positive results of rehabilitation exercises for nursing home residents whose functional disabilities were associated with inactivity and disuse. Whilst all nursing homes in this study espoused the importance of providing high standards of nursing care to enhance the quality of care and quality of life experienced by nursing home residents, it turned out to be, in reality, a different picture. The findings here suggest that although the standards of delivery of basic nursing care were high,

greater attention is required in the manner through which care is provided in order to avoid the fostering of a culture of dependency which leads to a lack of mobility and consequent functional impairment amongst the elderly and produces docile residents.

REACTION TO THE IMPLEMENTATION OF THE OUTCOME STANDARDS POLICY

The Directors of Nursing in each of the three nursing homes in the study believed the Outcome Standards Policy had led to an enhancement of the quality of nursing care and quality of life experienced by nursing home residents. They believed the implementation of the Outcome Standards had encouraged care providers to stand back and review the type of care being provided to residents within their nursing homes.

Benefits from the Introduction of the Outcome Standards Policy

The descriptions the Directors of Nursing gave explained how they use the Outcome Standards as a means by which they can defend the need for improvement in the quality of care for residents. The Outcome Standards not only allowed care providers to question more closely the profit-making practice of owners, but they also acted as the impetus for many Directors of Nursing in nursing homes to examine more closely their nursing practices and to act as advocates for the welfare of residents.

At the time of this study there was no requirement for State Government nursing homes to implement the Commonwealth Outcome Standards. However, the mere introduction of the Outcome Standards Policy into the non-government nursing home sector had sufficiently motivated the Government sector nursing home staff in this study into reviewing their procedures and protocols in preparation for a hypothetical standards monitoring team visit.

Interestingly, Directors of Nursing and Registered Nurses described three major benefits to care providers working in nursing homes following the introduction of the Outcome Standards Policy. These included:

1. the improvement in the professional status of care providers working in nursing homes;
2. the increasing level of personal growth in care providers as seen in their increasing levels of assertiveness and improved self-esteem; and
3. providing a 'leverage tool' for care providers in acting as an advocate for residents.

Benefits to Care Providers

Improvement in Professional Status

Many care providers described the Outcome Standards as assisting in the raising of their professional status within the overall nursing profession. Because the Resident Classification Instrument (RCI) now allows care providers to measure the levels of dependency of the residents living in nursing homes in a similar manner to that utilised in the acute hospital setting, many care providers believe their credibility and status as nurses has improved. As one Registered Nurse explains:

> *This place didn't have any structure and now with the Outcome Standards we're expected to ... and fair enough ... to be run more like an acute hospital, with changes in the health care system there are new policies. So there's been a lot of changes here. This nursing home didn't have the proper structures — there was no policy or practice manual ... we have now put that into place. There was nothing here when I arrived. We now know what types of residents we have and know how much care we are supposed to deliver. My friends working in the hospital were really surprised when I told them about all the documentation we now have to do on the residents. They were pretty impressed at what we have to do now.*
>
> (19.1.94, SE1, Text-unit:44)

Increasing Level of Personal Growth in Assertiveness and Self-esteem

During this study, care providers supplied details of their personal growth since the introduction of the Outcome Standards Policy. This was described in terms of improved assertiveness and higher self-esteem.

> *There's been a lot of personal growth of especially the RNs in the last few years. I think that's something ... their assertiveness has improved, with each other and with the doctors; and they're more inclined to be analytical ... But I think, on the whole, there's been a definite improvement.*
>
> (20.12.93, SC6, Text-unit:28)

Providing a 'Leverage Tool' to Act as Resident Advocate

In descriptions concerning the usefulness of the Outcome Standards to improve the quality of care provided to residents, nearly all Registered Nurses commented they chiefly used the Outcome Standards as a 'leverage tool' in a range of various discussions with owners of nursing homes, with staff and with families of residents. For example:

> *I think it's helped get the ideas across to the owners. Before, the owners ... it was just very much a money making concern, I think, for a lot of owners in private nursing homes. They were run, I guess, a little bit like hospitals and I think it's helped the staff a lot because, you know, you can sort of say, 'Well, you know, this is something we have to do,' and it sort of backs you up as well and you can see ... I can see a lot of really good things that have come out of that.*
>
> (15.11.93, SH5, Text-unit:79)

> *I think it gives you a little bit more ... influence with the families, to say that they should be taking more interest in their family. I mean, with care plans coming in, the families of the residents are meant to be involved in that, because often families will come and just leave them and go away.*
>
> (15.11.93, SH5, Text-unit:91–93)

Focusing Attention on Quality Care Provision

Directors of Nursing believed the introduction of the Outcome Standards Policy had focused their attention on providing good quality care for their residents. However, the Outcome Standards were described by many Registered Nurses as being merely a simplified list of commonsense principles of good nursing care and many care providers referred to them as minimum standards rather than Outcome Standards and believed nursing homes should be striving for higher standards than those outlined in the Outcome Standards Policy. Many care providers believed having baseline data (RCI categorisations) by which they could measure the progress of residents had improved their professional accountability. The following comments provide examples of these:

Commonsense Principles of Nursing Care

> *I think the Outcome Standards are just a load of commonsense principles which are just part and parcel of good nursing care. I think we always have provided good nursing care here, but the trouble is that some nursing homes didn't give good basic nursing care to their residents so the Outcome Standards has made those bad nursing homes sit up and take notice, I suppose.*
>
> (20.12.93, SC6, Text-unit:22)

Minimum Standards as a Baseline Data

> *I think you've got to look at the Outcome Standards as a baseline. I think it's minimum standards and you've got to aim for higher than those. You know, just looking at them, they're really just basic standards and I think they're sort of in there just to keep everybody happy, for the residents, and I really think that is just the minimum standards.*
>
> (16.12.93, SC2, Text-unit:48)

Focus Attention on Quality

> *All I know is that they are good because they're a focus and they're a uniform focus for everyone throughout the nursing home industry. And I think the standards ... if you look at standardisation ... that's the way of looking at them, that they standardise the industry because*

they're uniformed and focused and it does make sense to me, but in terms of their impact, I think that if anyone had a charter to go in and provide good nursing care, all those elements within the Outcome Standards would be met anyhow. They might be worded slightly differently or whatever but they would be part and parcel of a philosophy of care anyhow.

(20.12.93, SC6, Text-unit:2)

Being Accountable for your Professionalism

We had the Outcome Standards team here recently and I was on duty that day. The ideology's really good because you have to have a baseline for quality of care because not everybody has the same principles. Not everybody has the resident's benefit at heart, do you know what I mean? And we all hear stories about other places and it's like the old psychiatric hospital thing. You know, we all heard stories, 'Oh don't ever be a psych nurse.' But, no, I think they're good. You have to be accountable for your professionalism, so I think they're necessary.

(17.12.93, SC3, Text-unit:45)

Documentation Driven Nursing Care

While the positive view of the Outcome Standards initiative was espoused by the Directors of Nursing of the nursing homes, the reality was that the vast majority of care providers working in the homes did not approve of the introduction of the Outcome Standards Policy as they perceived it required too much documentation and wasted valuable time which could be used to care for residents. The introduction of the Outcome Standards was described by care providers in terms of the documentation, rather than in relation to any actual positive changes to nursing care delivery which had improved the quality of care and quality of life of residents.

Many care providers believed that the Government only wanted nursing homes to document the levels of care in order to use the information for funding purposes. They believed the Government simply wanted to reduce the costs of running nursing homes and all the documentation was a way for them to prove what levels

of care should be funded in each nursing home. The following comments of care providers explain further:

> *If we don't get the nursing notes right, then when the standards monitoring team visits, they might say the residents are in the wrong categories and our funding could get cut and people could lose their jobs.*
>
> (16.12.93, SC2, Text-unit:64)

> *All this extra paperwork takes us away from giving nursing care to the residents, but you see, we have to get all the nursing notes down correctly, or else, when the standards monitoring team visits, then they could say Mrs X should not have been a Category 1, she should be a Category 3 and then we would lose lots of funding and would have our staff reduced.*
>
> (19.11.93, SH2, Text-unit:64)

Apart from being able to bring in some of their own things, such as bedspreads, pictures, ornaments, and small pieces of furniture, and so on, and having Activity Officers and Physiotherapists available, many care providers believed that the actual nursing care provided to residents in the nursing homes had not changed. Rather, they saw that the requirement for documentation had just been added to the list of duties which was required of them during their shift. For example:

> *I think the nursing care we provide to our residents is just as good as it was before the Outcome Standards came in. It's just that now we have to write everything down to show that we are actually providing all the care we give. It's a bit of a nuisance at times but if it means that we will get the money we deserve and we won't lose our jobs then I don't really mind doing all the extra documentation of care.*
>
> (2.11.93, SH1, Text-unit:103)

> *The care we give the residents is very much the same as before, but you can see tremendous changes in the look of the nursing home: being able to bring in their own things, their own bedspreads and things. Before, all the beaspreads were the same and ... like hospitals.*
>
> (15.11.93, SH5, Text-unit:83)

Difficulties with Providing Documentation

Prior to the implementation of the Outcome Standards, nursing home staff seldom undertook formal health assessments of residents and very little documentation of actual care provision was undertaken, let alone care planning for the future stay of residents. Therefore, not surprisingly, foremost in the descriptions of all care providers in the study were a number of major difficulties experienced in the preparation of documentation for standards monitoring teams. These included:

- the lack of training given to nursing home staff who were required to undertake the health assessments needed for verification of the RCI categorisation;
- the lack of clear direction as to what specifically was required to be documented in the nursing notes to verify RCI categories;
- the lack of clear direction as to what specifically was required in nursing care planning which would satisfy the standards monitoring team visits; and
- the inappropriateness of a three week assessment period.

As one Registered Nurse explains when describing the implementation of the Outcome Standards:

> *Well, I do the documenting, yes. I think it could be streamlined. I think it's a lot of time on our part, to document for three weeks, I think it is, especially on a new admission. I think the system needs overhauling. I really feel there should be simpler ways to assess how much nursing care is required by each resident without the time and effort put in by people. Some RCI categories are fairly grey, though, and you might do a continence assessment on someone, and if you've known that person for a year, you may find that nights may be ... more often than not they're incontinent, and just when you do that week, they might have a good week. So that's frustrating because obviously it's legal. So they might go away in a lower category than you're giving them care for. And if you've categorised someone, two months later they may break a hip or something and need intensive care for two or*

three weeks, not intensive as hospital but a lot more care here. You know, you're never really claiming that.

(15.11.93, SH4, Text-unit:68–72)

Difficulties in Changing Care Provision Attitudes of Care Providers

The full implementation of the Outcome Standards has required not only a major change of the documentary work practices of care providers but also has required care providers to re-focus nursing home care provision to allow residents more control and choice about their care provision. Rather than fostering dependency amongst residents, the Outcome Standards Policy challenges care providers to allow residents to maintain their independence and control over their lives through flexibility and choice of care provision.

While the implementation of the documentation requirements have been undertaken through establishment of formal assessment, measuring, classifying and recording procedures in nursing homes, the actual change of the attitudes of care providers to see residents as being in control of their own lives has not been easy to implement. The implementation of the policy has proved to be a continual challenge to Directors of Nursing and senior Registered Nurses working in nursing homes, especially in light of the fact that residents are now under more observation, classification and categorisation than was previously the case.

All Directors of Nursing within the study commented on the difficulty of changing the care provision attitudes of staff within their nursing homes. Ingrained hospital-like work routines were seen as **the** major hurdle to overcome in achieving the overall objectives of the Outcome Standards. The following comments explain further:

We are still trying to break down that thing about everybody being up and dressed and showered by nine o'clock. You know, that sort of thing. You just say, 'Look, it doesn't matter if the beds aren't made until later or Mrs Kerfoops wants to stay in bed until lunchtime.' I mean, why shouldn't they? I mean, if you don't want to get up,

imagine when you're eighty and someone says, 'Oh no, you can't do that. You've got to get up. We've got to make your bed. The room's got to be tidy.' I mean, that's awful.

(15.11.93, SH5, Text-unit:87)

I guess it's really hard for them because they've got a lot of work. They've got to shower X number of people; they've got to make beds; and they've got to sort of co-ordinate that around and get it done. In between times, you've got morning tea; you've got lunch and you don't have an over abundant staff. It is hard for them. I mean, I can understand why they think, 'If we get them all up and make the beds, then we can do all these other things.' That's how nurses have been trained, isn't it? Tidy everything up and then we'll get on and do the other things. But the important things are if someone wants to stay in bed, or if they'd rather have breakfast in bed ... I mean, that's a lot of extra work. You've got to actually sit them up. You've got to go and get their table napkin ... I mean, you've got to actually go into the room and it is more work because otherwise they'd all be sitting in a room and you'd be there with them all. So it's just another way of thinking and we've got to start from the beginning. But then, when you get into a hospital, you can't really work that way, can you? I mean, if they've come from a hospital it's different again.

(15.11.93, SH5, Text-unit:89)

SUMMARY

In order to analyse the reaction to and implementation of the Aged Care Reform Strategy in relation to quality care provision within nursing homes, examined here were the discourses and practices of care providers regarding quality care provision. Four major areas which influenced care providers' quality care provision were revealed as follows:

Organisational Regime

Nearly all care providers in the study strongly supported the 'resident-centred' philosophy of the Aged Care Reform Strategy and emphasised the importance of providing a home-like environment where privacy and dignity were assured for residents. However, the reality of the 'task-orientated' nature of the majority of

care providers working in the nursing homes was far removed from what would be required to support 'resident-centred' care and to achieve a home-like environment. This 'task-orientated' focus of care providers in nursing homes is a major challenge for Directors of Nursing to overcome in order to improve the quality of care and quality of life of residents living in nursing homes.

Level and Commitment of Staff Working with the Aged

The importance of having experienced and qualified nursing staff who enjoyed caring for the aged was emphasised by Directors of Nursing and many senior Registered Nurses. However, the reality was that inexperienced and untrained nursing assistants continued to be employed in nursing homes rather than experienced and qualified staff due to severe financial constraints. As nursing assistants provided such a large proportion of the care to nursing home residents, this is of great concern because of the impact this has on providing quality care to residents. As well, large numbers of care providers continue to seek employment in nursing homes as a means by which to regain employment in the acute hospital sector (that is as a refresher course replacement) or because of lifestyle factors such as having convenient working hours or working in a location which is in close proximity to where they live. Therefore, their level of commitment and satisfaction with working with the aged is not high. Under such circumstances, Directors of Nursing are challenged to ensure that care providers who are employed in nursing homes receive adequate education, support and encouragement for the delivery of quality care for the aged.

Social Interaction

While all Directors of Nursing and the vast majority of Registered Nurses in the study emphasised the importance of social interaction with residents to improve the quality of care provided, the reality was that Assistant Nurses who spent the majority of their time with residents did not place a high value on social interaction with residents. Because of the busy time schedules and task-orientated

focus of many of the Assistant Nurses, talking to residents was not given a priority. Social aspects of care in the nursing homes mainly were discussed in terms of organised activities and outings programs within nursing homes, which overshadowed the importance of interacting socially and talking with residents on a day-to-day basis.

Physical Nursing Care

While all nursing homes espoused the importance of providing high standards of nursing care, in reality, the findings of this study suggest that although the standards of delivery of basic nursing care were high in all the nursing homes in the study, greater attention is required to the manner through which the care is delivered in order to avoid the fostering of a culture of dependency which leads to a lack of mobility and consequent functional impairment amongst the elderly. Nursing homes are challenged to provide a rehabilitative environment for their residents, rather than fostering dependency and docility.

Reaction to the Implementation of the Outcome Standards Policy

Although not required to do so, the introduction of the Outcome Standards Policy into non-government nursing homes in Australia sufficiently motivated the Government sector nursing home in this study to review its protocols and procedures concerning quality of care for residents. All Directors of Nursing in the study believed that by encouraging nursing home staff to focus their attention on quality, the introduction of the Outcome Standards Policy had enhanced the quality of nursing care and quality of life experienced by nursing home residents. Care providers believed the Outcome Standards had:

1. improved the professional status of care providers working in nursing homes;
2. increased the level of personal growth of care providers as seen in increased levels of assertiveness;
3. improved self-esteem of care providers; and, finally,

4. provided care providers with a 'leverage tool' to act as an advocate for residents.

While Directors of Nursing and many senior Registered Nurses believed the introduction of the Outcome Standards had led to an enhancement in the quality of nursing care and quality of life experienced by nursing home residents, the reality view held by the vast majority of care providers working in nursing homes was that the actual care provided to residents had not changed but, rather, the requirement for documentation had just been added to the list of duties which they were required to undertake during their work. While there was recognition that the overall physical environment of the nursing homes for residents to live in had improved through the addition of individual bedspreads, pictures, ornaments, and so on, and that the employment of Activity Officers and Physiotherapists had been of assistance to some residents, the overall view of care providers was that in the main, nursing care provided to residents in the nursing homes had not changed.

Many care providers believed the introduction of the Outcome Standards Policy in non-government nursing homes had made nursing homes focus attention on quality, not so much for the sake of improving the care provided to residents, but rather because of the threat of reduction to their funding if Outcome Standards are not met. They believed the Commonwealth Government required nursing homes to document the levels of care using the RCI, in order to use the information for funding purposes, rather than any real wish to improve the quality of care provided to residents. They believed the Government simply wanted to reduce the costs of funding nursing homes and the RCI was a way to prove what levels of care should be funded in each nursing home.

Although care providers considered the introduction of the Outcome Standards as being highly related to the extra documentation required, it seems there has been a

trade-off with the extra benefits which they believe to have accrued not only to residents living in nursing homes but also to the staff who work there.

While the major emphasis in the early phase of implementation of the Outcome Standards Policy within the nursing homes in this study has been the establishment of appropriate documentation systems, the challenge for the later phase of implementation is for nursing homes to move to change the manner through which care is delivered in order to move from a 'task-orientated' approach to that of 'resident-centred' care in order to improve the quality of care and quality of life of residents living in nursing homes.

In order to identify the means by which aged care policy directions and goals are accomplished, the next chapter will examine the public discourse on aged care policy in Australia during the period 1963 to 1993 in relation to quality care.