Chapter 7

RHETORIC OR REALITY: ANALYSIS OF THE DISCOURSE OF QUALITY OF CARE FOR RESIDENTS IN NURSING HOMES

One may have a hold over others' bodies,
not only so that they may do what one wishes
but so they may operate as one wishes with techniques,
the speed and the efficiency which one determines.
(Foucault 1979a:138)

INTRODUCTION

In Chapter Two, a description of the methodological and theoretical framework for this thesis was presented, which included a description of the Foucauldian methodology of archaeology and genealogy. This chapter will now use the four major elements as outlined by Foucault (1972) in his analysis of a discursive formation, in order to analyse the Australian Aged Care Reform Strategy and the discourse of quality of care for residents in nursing homes. The four elements are:

(i) the formation of objects;

(ii) the enunciative modality;

(iii) the formation of concepts and

(iv) the formation of thematic choices.

THE FORMATION OF OBJECTS

Foucault gives us the following series of steps in his endeavour to identify an object. First, we must map the *'surfaces of their emergence'* (Foucault 1972:41) and investigate the phenomena where the various elements are allocated to the discourse and what resultant types of categories it formulates and ask: Where did the discourse begin? Second, we must describe the *'authorities of delimitation'*

(Foucault 1972:41) and ask: Who determines what these categories consist of? Who determines the definitions of the boundaries? Who establishes the phenomenon as an object? Finally, Foucault analyses the *'grids of specification'* (1972:41) by asking: How are the systems divided, grouped, re-grouped, classified or derived from one another? How is the material in the discourse organised?

Surfaces of their Emergence

For Foucault, 'these surfaces of the emergence are not the same for different societies, at different periods, and in different forms of discourse' (1972:41). In the case of discourse on quality of care for aged residents living in Australian nursing homes, the findings suggest that the surfaces of emergence of the discourse were constituted mainly by hospital researchers, academics and the media, who all transferred to the Commonwealth Government, if not the responsibility for providing treatment and cure of diseases as such, at least the burden of providing sufficient funding to provide care for the elderly population of Australia.

Throughout Australia during the late 1960s and early 1970s, as previously discussed in Chapter Six, a number of studies were undertaken by hospital researchers, academics and governmental committees, (Nimmo 1969; Wedgewood,1969; Lawson 1972; Butterworth & Ridgeway 1973; Reynolds & Fleming 1973; Refshauge 1975; Australian Government Social Welfare Commission 1975; Health Commission of NSW 1976). It was these studies that brought to light a number of major problems concerning the care of aged people living in nursing homes.

The media in the late 1960s and early 1970s began reporting on the poor conditions found in nursing homes and, under pressure from the opposition party, reports on the quality of care for the aged living in residential care soon appeared in Parliamentary debate. The elderly and chronically ill who were excluded from

full hospital insurance cover caused the Commonwealth Government, in 1959, to introduce arrangements which allowed the costs of hospital care for the chronically ill to be paid for from a 'special account' by the Commonwealth. However, over the ensuring years these endeavours proved increasingly unsatisfactory.

Butterworth and Ridgeway (1973), conducting a study of 30 ex-patients from Sydney Hospital who had moved into 13 private nursing homes, found there was a need for closer medical supervision of patients who were examined for eligibility for entry into nursing homes as one third of patients were inappropriately placed and they did not need specialised nursing care. They also found that in the majority of cases most patients living in nursing homes required far greater mental stimulation and activity than what was being provided.

Reynolds and Fleming's (1973) study of private nursing homes in the Gladesville Hospital catchment area concluded that although nursing homes were endeavouring to provide a genuine service to their residents, they were prohibited from addressing the main problems of boredom, loneliness and poverty found amongst the residents because of the limitations of funds being provided by the Government. They suggested: that the Government allocate funds for the employment of occupational therapists in nursing homes; that a call for community involvement in the care for the aged living in nursing homes be undertaken; and that the total living environment within nursing homes be inspected rather than simply concentrating on the physical requirements as had been the case.

Refshauge (1975) conducted a major study into every nursing home in the Sydney metropolitan area and reported that a third of the Directors of Nursing surveyed suggested that a stronger emphasis should be placed on rehabilitative care within nursing homes. He suggested that greater co-operation between nursing homes and regional geriatric assessment and rehabilitation units might improve the

appropriateness of some placements of residents in nursing homes and also encourage appropriate discharges from nursing homes where residents are suitably rehabilitated.

In 1976, the Health Commission of New South Wales released a report called *A Study of Nursing Homes in New South Wales* and put forward a list of suggestions 'to both improve the quality of nursing home care and lessen the need for nursing home beds' (1976:59). The major suggestions included: adjustment of subsidies to ensure that pension-only residents have some money remaining to allow for personal requirements as poverty was a major problem for many elderly residents; encourage incentives for rehabilitation and access to occupational therapy, physiotherapy, counselling, chiropody, dental and vision care, transport, outings and entertainment; encourage alternative accommodation for the aged who were not appropriately placed in nursing homes; establish pre-assessment procedures at home by a multi-disciplinary team to prepare a best plan of care to be worked out; and investigate the re-definition of nursing homes as places for 'sick' or intensive care residents rather than for ordinary care residents.

According to Foucault, in *mapping the surfaces* of the *emergence* of a discourse, various elements which are allocated to a discourse form into resultant types of categories within it (1972:41). We see the central focus of the public bureaucratic discourse concerning the care of the aged and chronically ill revolves around two major categories of priorities: first, the cost of funding aged care services and second, the type of provision of aged care service. It is only recently that standards and quality of care for the aged and chronically ill within the provision of services have appeared as a priority within the public discourse.

Regarding the funding priorities within the public discourse, strong evidence may be found in the number of major funding centred reports, such as the Commonwealth Department of Health's report *Relative Costs of Home Care and Nursing Home and Hospital Care in Australia* (1979), the Department of

Community Services' report entitled the *Cost of Nursing Home and Hostel Care Services* (1985) by Coopers and Lybrand, and more recently the Department of Health, Housing, Local Government and Community Services Aged and Community Care Division's *Review of the Structure of Nursing Home Funding Arrangements* (1993b) by Professor Bob Gregory of the Australian National University. With regard to the type of provision of aged care service priorities within the public discourse, strong evidence may be found in the contents of three major Commonwealth reports of the early 1980s: the *Report of the Auditor-General on an Efficiency Audit: Commonwealth Administration of Nursing Home Programs* (1981); the House of Representatives' report *In a Home or at Home: Accommodation and Home Care for the Aged* (1982a); and the Senate Select Committee report on *Private Nursing Homes in Australia: Their Conduct, Administration and Ownership* (1985).

However, standards and quality of care for the aged living in nursing homes have only very recently emerged as a priority within the public discourse. For example (as detailed in Chapter 6), the three lead-up Government reports which were examined by Rees in the *Nursing Homes and Hostels Review* (1986) mentioned standards and quality of care issues only very briefly and in varying degrees. Firstly, the *Report of the Auditor-General on an Efficiency Audit: Commonwealth Administration of Nursing Home Programs* (1981) raised the issue of the lack of defined standards in the areas of nursing care, physical facilities and paramedical services and also criticised the system of Commonwealth inspections which overlapped with State inspections. It also recommended that the Commonwealth establish maximum staffing standards for use by assessors in determining the extent of Commonwealth funding of nursing hours which vary above State minimums (Auditor-General 1981:12).

In comparison, the McLeay Report *In a Home or at Home: Accommodation and Home Care for the Aged* (1982) concentrated more on the number of nursing

hours per resident that should be funded to a uniform standard set by the Commonwealth rather than on the actual standards or quality of care provided in a nursing home (McLeay 1982:xii). The McLeay Report (1982:74)

> did not specifically ment on quality of care in nursing homes but did observe that the avenues of complaint were unsatisfactory and recommended that to overcome the lack of channels of complaint against low standard nursing homes, hostels and domiciliary services an Aged Care Complaints Tribunal should be established in each State to which aged people receiving care or their relatives can take complaints about services (cited in Rees 1986:71).

Finally, the Giles Report of the Senate Select Committee on Private Hospitals and Nursing Homes, *Private Nursing Homes in Australia: Their Conduct, Administration and Ownership* (1985) made a far greater comprehensive study of the quality of care standards in nursing homes and provided extensive evidence of sub standard care. It recommended that program grants be developed to introduce uniform minimum staffing levels throughout Australia and recommended a Commonwealth nursing home standards committee be established to develop uniform guidelines for several standards, including nursing hours (Giles 1984:xxii-xxv).

In 1985, when Coopers and Lybrand recommended the establishment of a standard costing system to fund services provided in nursing homes, they also alerted the Government to the need to provide a monitoring mechanism for the standards and quality of care for residents living in nursing homes if such a standard costing system was to be implemented successfully. A standard costing system is based on the manufacturing industries' *'product management model'* (e.g. the construction of a motor vehicle on a production line). Coopers and Lybrand commented on the difficulties in constructing a standard costing system for a nursing home because of the human element involved in providing different levels of care for different levels of dependent residents and because of the diversity of provision of services across the Private, Government and Religious/Charitable sectors. They provided an overview of the manner by which

a resident could be classified through a dependency system and thus could be funded according to their level of dependency. They reported that a later study by Rhys Hearn looking into *Quality, Staffing and Dependency: Non-government Nursing Homes* (1986) would provide additional information on how this dependency system could operate. Indeed, when the Rhys Hearn study was completed it recommended 'to determine appropriate staffing levels, the dependency of residents must be known' (Commonwealth Department of Community Services 1986b:x).

With funding remaining the central priority within the public discourse on nursing homes, the Commonwealth agreed to the establishment of a standard costing model for nursing homes as a cost containment strategy. However, such moves to establish a standard cost model also encouraged the Commonwealth to devise a quality control mechanism as the Government knew in order to introduce the new funding control measures, they would have to ensure that the quality and standards of care to residents within nursing homes would not be jeopardised. Therefore, for the new funding model to be introduced, a strategy was required to ensure that the quality and standards of care would not be threatened.

We see the emergence of standards and quality of care within the public discourse displayed as a priority with the funding of major Commonwealth studies such as: *Quality, Staffing and Dependency: Non-government Nursing Homes* (1986); *CAM Review* (1990); *A Guide to Living in a Nursing Home: Outcome Standards for Australian Nursing Homes* (1987); *Residents' Rights in Nursing Homes and Hostels: Final Report* (1989). By accepting the recommendations of Coopers and Lybrand (1985), the Commonwealth thereby agreed to the establishment of a documentary apparatus which would require the surveillance, examination, and classification of residents within nursing homes, objectively. For the establishment of such a documentary apparatus to not threaten the level of care

provided to such residents, the Commonwealth sought to establish a monitoring mechanism through which its documentary apparatus could be evaluated.

Therefore, within the public discourse emerged a concern for the quality of care for residents. This was not so much because of a policy direction specifically concerned with an adherence to humanitarian principles of providing quality care to the aged, but because of a concern that a funding priority decision which sought to encourage the establishment of documentary apparatus for objectively measuring a resident might inadvertently encourage proprietors to compromise the level of care provided to residents in order to increase their profits.

In June 1987, Ian Lindenmayer, the convenor of the Commonwealth/State Working Party on Nursing Home Standards produced *Living in a Nursing Home: Outcome Standards for Australian Nursing Homes* (Department of Community Services, 1987a). This document sought 'to set out clearly the care and lifestyle objectives which the nursing home industry should strive to achieve for all residents' (1987a:iii). The Outcome Standards were to 'form the basis for monitoring the performance of nursing homes' (1987a:iii). The Commonwealth Outcome Standards were established then to allow Government departments to quantify good quality care and to reward such institutions that provided good quality care and alternatively to provide a means whereby poor standards could be recognised and thus give support to legislative powers to require improvements in nursing home care. Interestingly, the Commonwealth Outcome Standards were produced some two years following the commencement of the CAM funding mechanism and the RCI surveillance mechanism which are integral parts of the Aged Care Reform Strategy.

Arguing from a Foucauldian perspective, providing better care to the aged through more extensive assessment and observation procedures using care plans and patient dependency level tools such as the Resident Classification Instrument (RCI), is not part of the natural evolution of human conduct and concern for

others. Rather it is seen as a new configuration of power which substitutes the more overt disciplinary system of administration of the 15th century of punishment and torture to that of the 20th century by using surveillance, examination, classification and normalisation (Foucault 1977:184-185). Continuing along this line of argument, it is in the nursing home, the subjectification of the elderly and chronically ill individual into a 'docile' body through 'bio-power' and its resulting disciplinary technologies occurs. Therefore, through these various surveillance and disciplinary techniques the disciplinary nursing home produces docile 'resident' bodies.

To a lesser extent, the staff working in nursing homes had a voice within the emergence of the discourse surrounding standards and quality of care in nursing homes, and this was seen through their professional association representatives giving evidence at various government enquiries about the problems of providing quality care to the aged living in nursing homes. However, it was not until the government saw the need to establish a monitoring mechanism for its proposed new funding mechanism that the discourse on quality gained significant priority.

Authorities of Delimitation

According to Foucault (1972 41), we must then describe the *'authorities of delimitation'* and ask: Who determines what these categories shall consist of? Who determines the definitions of the boundaries? Who establishes the phenomenon as an object?

Enshrined in law since 1953, Subsection 61(1) of the National Health Act requires the proprietor of an approved nursing home to maintain 'such records as will enable claims for Commonwealth benefits to be verified and enable compliance with the conditions to which the approval of the nursing home is subject to be verified.' The Commonwealth Government is able to prescribe the type of funding and the form of record keeping required by nursing home proprietors and in 1986, in order to control the increasing costs of aged care provision, the

Commonwealth Government established the Aged Care Reform Strategy which set in train a number of specific funding strategies which previously had not been utilised in the nursing home industry in Australia. The funding system was based on the Care Aggregated Module (CAM) which utilised a dependency system known as the Resident Classification Instrument (RCI) in order to calculate levels of funding for different levels of dependency found in residents. Further funding strategies followed with the Standard Aggregated Module (SAM) for non-nursing salaries and later the Other Costs Revenue Expenses (OCRE) for other costs such as superannuation, long-service leave, and so on.

Therefore, since 1986 the Commonwealth Government has required all non-government nursing home proprietors to use the Resident Classification Instrument to categorise nursing home residents and to provide sufficient documentation and records such as care plans and progress notes which report on the characteristics and behaviours of the nursing home residents in order to validate their funding. The Commonwealth also requires that all nursing homes send the information gathered on residents to central office where comparisons and correlations of residents' characteristics and behaviour may be undertaken on a regular basis.

How is it that the aged person entering a nursing home becomes constituted as an object know as a 'resident'? 'Biopower', according to Foucault (1979a), defines the various aspects of human life capable of being regulated. It also guides knowledge-power which controls and subsequently transforms human life (Foucault 1979a:143). Foucault used the term 'disciplines' to describe the methods through which the operations of the human body are controlled, used, made subject and docile (1977:136-137). According to Foucault, disciplinary institutions have the ability to produce docility of the body from the knowledge/power gained through the examination of the residents' behaviour using methods of observation, recording and training (pp. 136–137).

Numerous examples were found in the interview data of care providers concerning the manner through which RCI assessment forms were engineered in order to ensure that a resident was placed in a higher RCI category for funding purposes. Examples included using computer programs to automatically calculate the RCI score for ease of manipulation of data and undertaking reassessments and redocumentation on residents so as they could be placed into the next highest funded RCI category. Such examples were given of not only the nursing homes in this study but care providers mentioned numerous examples of many other nursing homes where such practices were commonplace. Interestingly, when alteration of documentation to move the resident into the next highest category occurred, no respective changes were made to the actual nursing care plans to reflect the higher intensity of nursing care required for residents.

Prior to the major changes in residential aged care in 1986, few if any assessment procedures were undertaken by nursing home staff on aged people living in a nursing home and if an examination was undertaken it was a non ritualised, casual, unplanned affair. Where an examination was undertaken, no normalisation function occurred as such examinations were undertaken on an *ad hoc* basis and the information was not used for comparative purposes within the nursing home industry. However, in 1986, with the introduction of the Aged Care Reform Strategy and the major changes to funding, the legal requirements enforced by the Commonwealth Government onto nursing home proprietors saw the examination of the 'resident' become more focused and specific. Thus, from a Foucauldian perspective, the Commonwealth Government, being an institution with its own rules and regulations and possessing a powerful bureaucratic arm, being a body of knowledge and practice, being an authority recognised by public opinion, the law and Parliament, has become the major authority in society that delimited, designated, named and established the 'resident' as an object (Foucault 1972:42).

However, the Commonwealth Government has not been totally alone in this delimitation as support for the establishment of the 'resident' as an object has been forthcoming from other areas. First, it was the medical profession who initially lobbied the Commonwealth to establish nursing homes in order to free up acute hospital beds to allow doctors to treat more acute patients in hospital. But this established a separation of the aged resident away from the hospital and consequently a devaluing of the worth of caring for the aged. It also represented a difficulty for doctors who, no longer being able to provide any further treatment to cure the aged and chronically ill, did not wish their failures to be present in the hospital to remind them of such facts. Second, the private proprietors of nursing homes who, being assured of a regular income from Commonwealth subsidies for providing nursing home accommodation to the residents in particular categories, therefore benefit monetarily from being able to manipulate categories of residents to their advantage. Third, the family of the aged or chronically ill person who, no longer wishing to care for their relative at home, seeks to access a service that will take over their responsibility for providing care for their relative. Finally, the nursing profession who welcome the classificatory nature of the hospital (e.g. Diagnosis Related Groups Classification System being established within the acute setting) into the nursing home also share in the delimiting. By doing so they believe they will gain greater professional recognition from not only the medical profession who would see the nursing home nursing staff as being more like the nurses within the acute setting and thus value them more highly, but also from nurses who work in the acute setting who see working in a nursing home as lower level nursing work. Thus, the delimiting and naming the 'resident' as a particular category of dependency allows the nursing home nurses to increase their professional standing at the expense of objectifying the 'resident'.

Grids of Specification

Foucault (1972:41) seeks to analyse the *'grids of specification'* of a discourse through the systems that divide, contrast, regroup, or classify a particular

phenomenon. According to Foucault , 'normalisation' is a disciplinary technique for distributing individuals around a norm through the technique of ranking, grading and measuring interva s between individuals (1977:177-184). The norm not only organises the individuals but also is a direct result of the method of distribution. Any irregularity or abnormality in the social body is identified by the classifying technologies of normalisation and, through corrective or therapeutic procedures (which may be determined by other related technologies), the social body is consequently controlled and normalised. Mechanisms used for the development and collection of knowledge such as techniques of registration, surveillance procedures, investigative and research methods are all tangible examples of the power/knowledge nexus (Foucault 1980:106-107). In the nursing home arena, the major surve llance procedure is the Resident Classification Instrument which collects knowledge through the monitoring and assessment of residents in order to produce extensive documentary findings which are subsequently collated and compared to produce norms.

According to Foucault in *Discipline and Punish*, the accumulation of documentation makes possible 'the measurement of overall phenomena, the description of groups, the characterisation of collective facts, the calculation of the gaps between individuals, and their distribution in a given population' (1977:190). For the Aged Care Reform Strategy to be successful, the Commonwealth required an objective method by which it could be seen to be distributing funding equitably. Documentary techniques which are part of normalising technologies allows the Commonwealth to code nursing home residents objectively.

Thus, how are the systems which have been established within the Aged Care Reform Strategy divided, grouped, re-grouped, classified or derived from one another? How is the material in the discourse organised? The Resident Classification Instrument requires the nursing home staff to maintain the 'resident'

body under constant surveillance in order that they may be able to classify the residents' characteristics and behaviours. Four separate and detailed areas of resident 'needs' are surveyed by the Resident Classification Instrument and include clinical care (continence, maintenance of skin integrity, specialised nursing procedures), social and emotional support (physical aggression, verbal disruption, behaviour), activities of daily living (mobility, toileting, washing and dressing, eating and maintenance of independence) and communication and sensory processes (vision, hearing, speech and comprehension). The information about residents is scored, weighted, grouped and then finally categorised into one of five different levels of dependence — level 1 being the most highly dependent and level 5 being the least dependent. Residents become known to nursing home staff as 'category 1s' or 'category 5s' rather than residents. Numerous examples were found in the interview data of care providers who referred to the number of 'category 1s' or 'category 5s' in the nursing home rather than the actual names or particular characteristics of individual residents.

The proprietors of nursing homes, be they from the Private or Religious/Charitable sectors, go to great lengths to ensure that residents are placed in the correct category on the Resident Classification Instrument as the category that a resident is placed in determines the amount of CAM income that will be received by the nursing home. Residents are constantly under surveillance, as any change in the classification of a resident across two levels will allow the proprietor of the nursing home to seek further funding for the care of the resident. Because CAM ratings now form the major source of income for nursing homes, and rely on the accuracy of RCI classification of residents which are based on the behaviour and characteristics of the resident, nursing home staff are compelled to constantly undertake assessment procedures and examinations. These are needed to maintain nursing care plans, progress notes and other documenting of the characteristics and behaviour of residents for the RCI which inevitably renders the 'resident' body visible to the nursing home gaze continuously.

The documentation of the characteristics and behaviour of the 'resident' body becomes the major focus of discussion about the policy changes to nursing homes rather than the actual philosophy and policies of nursing home management. That is, discussion of issues such as high levels of untrained nursing staff caring for the aged resident and limited provision of funding available to allow nursing staff to undertake inservice education are displaced by the focus on documentation which is an agenda driven by Government legislative requirement via the National Health Act. The National Health Act requires nursing homes to forward the RCI data to the central office where the information on the residents are thus collated and classified, and averages and norms are constructed on a national basis. The Commonwealth then publishes a State by State comparison of dependency levels of residents which is based on the behavioural and bodily characteristics of residents.

THE ENUNCIATIVE MODALITIES OF STANDARDS AND QUALITY OF CARE DISCOURSE

Foucault (1972) seeks to define the *'enunciative modalities'* in terms of three different factors. The first of these factors includes the 'speaker's position'. We need to ask: *Who is speaking*? (p. 50) Who is accorded the right to speak? Who is qualified to speak? What is the status of the speaker? Who derives some prestige from speaking? and to whom, in return, presumes what the speaker says is true? (Foucault 1972:50). Secondly, we need to relate to the *'institutional site'* (p. 51) from which the speaker makes her/his discourse, asking questions such as: From which institutions does the discourse emanate? Finally, we turn to the *'positions of the subject'* (p. 52), asking: 'What position or status does the speaker occupy in relation to the discourse and the manner in which it is controlled? (Foucault 1972:53).

Who is Speaking?

In Australia, the Commonwealth Government is the major contributor to the discourse on standards and quality of care for residents living in nursing homes. Many examples of Commonwealth contributions may be seen in the reports of the various governmental enquiries and Commonwealth funded research projects. However, the Commonwealth Government is not the sole contributor to the standards and quality of care in nursing homes discourse as we find other contributors to the discourse, though to a lesser extent, emanating from groups such as: academics and researchers; professional associations; consumer associations and finally the media. Thus, contributors to the discourse include:

a) Commonwealth funded enquiries and reports of the early 1980s together with Commonwealth funded research by academics and researchers during the late 1980s and early 1990s. For example:

1981 Auditor-General *Efficiency Audit: Commonwealth Administration of Nursing Home Programs.*

1982 McLeay Report *In a Home or at Home: Accommodation and Home Care for the Aged,* the House of Representatives Standing Committee on Expenditure.

1983 Kendig, H.L. et al. *Health, Welfare and Family in Later Life,* Ageing and the Family Project.

1985 Giles Report, *Private Nursing Homes in Australia: Their Conduct, Administration and Ownership,* Senate Select Committee on Private Hospitals and Nursing Homes.

1985 Coopers & Lybrand WD Scott, *Cost of Nursing Home and Hostel Care Services,* Department of Community Services.

1986 Rees, G., *Nursing Homes and Hostels Review,* Commonwealth Department of Community Services and Health.

1986 Rhys Hearn, C. *Quality, Staffing and Dependency: Non-government Nursing Homes.*

1987 Kendig, H., Parkes, C. & Anderton, N. *Towards Fair Shares in Australian Housing,* report prepared for the National Committee of Non-government Organisations International Year of Shelter for the Homeless, Canberra.

1989 Ronalds, C., Godlwin, P. & Fiebig, J. *Residents' Rights in Nursing Homes and Hostels: Final Report.*

1989 Kendig, H. *Directions on Ageing in NSW,* NSW Office on Ageing, Sydney.

1990 Pearson, A. et al., *Optimal Skills Mix for Desired Resident Outcomes in Non-government Nursing Homes.*

1991 Commonwealth Department of Health, Housing and Community Services, *Aged Care Reform Strategy Mid-Term Review 1990-91.*

1992 Braithwaite, J. et al., *The Reliability and Validity of Nursing Home Standards.*

1993 Braithwaite, J. et al., *Raising the Standard: Resident Centred Nursing Home Regulation in Australia.*

b) Articles appearing in the literature as a result of the Commonwealth funded research projects undertaken. For example:

Braithwaite, V. et al. 1992, Assessing the quality of Australian nursing home care, *Australian Journal of Public Health*, 16(1):89–97.

Braithwaite, J. & Makkai, T. 1993, Can resident-centred inspection of nursing homes work with very sick residents? *Health Policy*, 24:19–33.

Gibson, D., Turrell, G. & Jenkins, A. 1992, Evaluating quality of care in Australian nursing homes, *Australian Journal on Ageing*, 11(4):3–9.

Gibson, D., Turrell, G. & Jenkins, A. 1993, Regulation and reform: Promoting residents' rights in Australian nursing homes, *Australian and New Zealand Journal of Sociology*, 29(1):73–91.

Pearson, A. et al. 1993, Staff in Australian nursing homes: Their qualifications, experience and attitudes, *Contemporary Nurse,* 2:15–22.

c) Professional associations, for example, the Australian Nursing Homes Association, the Australian Medical Association, and the NSW Nurses' Association providing submissions to governmental inquiries and reviews as well as disseminating the results of reports and inquiries to their membership.

d) Consumer associations, such as the Australian Consumers' Association providing submissions to governmental enquiries and undertaking the publication of research findings. For example:

Australian Consumers' Association 1991, Nursing homes: A crisis in care, *Consuming Interest*, October:18–23.

Freytag, K. 1986, *'If only I'd known': A Study of the Experience of Elderly Residents in Boarding Houses, Hostels and Self-care Units.*

Social Welfare Action Group 1982, *A Report on the Phone-in on Abuse of the Elderly.*

e) Published monographs, articles and books which deal with aspects of standards and quality of care for residents living in nursing homes. For example:

Chenitz, W. 1983, Entry into a nursing home as status passage: A theory to guide nursing practice, *Geriatric Nursing*, March/April: 92-97.

Gibb, H. 1990, *Representations of Old Age: Notes Towards a Critique and Revision of Ageism in Nursing Practice.*

f) Postgraduate honours, masters and doctoral students within universities whose studies on aspects of standards and quality of care are lodged in libraries. For example:

Nay, R. 1994, Benevolent Oppression: Lived Experience of Nursing Home Life, unpublished PhD Thesis, University of New South Wales, Sydney.

Institutional Site

There are a number of institutional *sites* from which the Commonwealth Government makes its discourse on the standards and quality of care of the aged and it is from these institutional sites that this discourse obtains its legitimate source and point of application. These institutional sites confirm the objectivity of the 'resident' and act as instruments through which the discourse on standards and quality of care of the aged is established, substantiated and justified. There are probably three major sites within which the discourse occurs and they are: the

nursing home, the university or 'experts' in the field and the 'library' or documentary field.

The Nursing Home

The nursing home is constituted as a disciplinary institution where the objectification of the 'resident' takes place. For Foucault (1977:205), a disciplinary institution emerges through the creation of physical or spatial surroundings that delineate a particular space for a particular body. It classifies, regulates and categorises the body through various disciplinary techniques and technologies. A Foucauldian view would see the creation of the nursing home into a disciplinary institution occurring in 1954, when the Commonwealth enacted the Aged Persons Home Act. We have seen in earlier chapters of this thesis, that this Act was initially intended to encourage charitable and religious organisations to establish homes for the aged who otherwise had no other place to live (Nursing Homes and Hostels Review Committee 1986:104). Consequently, the nursing home has formed into a new disciplinary institution through the delineation of a particular space for the aged within our society. The practice of providing a segregated space and the use of panopticon power has seen the disciplinary institution of a nursing home join other such disciplinary institutions such as hospitals, asylums and prisons. Therefore, over the last decade, since the introduction of the Aged Care Reform Strategy in 1986, the nursing home industry in Australia has seen unprecedented control measures put in place through the introduction of surveillance, regulation and classification measures prescribed through Commonwealth legislation.

The University or 'Experts' in the Field

The role of an academic within a university involves not only teaching but also includes research, service to the university and service to the community. Many academics undertake research for the sheer pleasure of expanding their field of knowledge. However, research and grantsmanship (sic) also feature very strongly

in measuring the performance of academics and researchers within universities and their prospects for career progression through promotion rest firmly on the volume and calibre of research they undertake, together with the amount of research dollars granted. Academics and researchers within universities put enormous amounts of effort into acquiring research funds to undertake their research and applying for research funds can be an extremely time consuming endeavour. Therefore, an academic tries to prepare research proposals which are tailored to a particular research granting agency agenda. For example, various research granting agencies such as the Commonwealth Department of Human Services and Health's Rural Health Services Education and Training committee (RHSET); the Research and Developmental Grants Advisory Committee (RADGAC); the National Health and Medical Research Council (NH&MRC); and the Australian Research Council (ARC), all have explicit agendas they wish to follow and in fact these agencies encourage applicants applying for funds to target particular groups and particular types of projects in order to have a greater likelihood of success. So, the Commonwealth granting bodies to some extent, are able to manipulate academics and researchers within universities into preparing applications to undertake research which is specifically focused on the Commonwealth agenda.

The 'Library' or Documentary Field

This 'library' or documentary field refers to the books, articles, monographs and reports which would be legitimately accepted as documents of the discourse as well as the huge amount of statistical information which is gathered on databases concerning various aspects of the aged. Examples of this type of information would include: the Directory of Research into Ageing compiled by the Commonwealth; the series of reports published by the New South Wales Council on Ageing covering health, housing, transport, retirement, and so on; the separation data collected by the Australian Institute of Health and Welfare, Canberra; the compiled and collated Resident Classification Instrument data

collected by the Commonwealth Government; mortality and morbidity data collected from the National Health Surveys and census collections conducted by the Australian Bureau of Statistics.

Prior to the Aged Care Reform Strategy (1986), the nursing home was considered more a peripheral site in the discourse surrounding standards and quality of care as the acute hospital setting had been at the forefront of undertaking accreditations with the Australian Council of Health Care Standards who required specific quality assurance procedures to be in place. However, following the introduction of the Australian Outcome Standards in nursing homes as part of the Aged Care Reform Strategy, the nursing home from a Foucauldian viewpoint, becomes:

> the site of systematic, homogeneous observations, large-scale confrontations, the establishment of frequencies and probabilities, the annulation of individual variants, in short, the site of the appearance of disease, not as a particular species, deploying its essential features beneath the doctor's gaze, but as an average process, with its significant guidelines, boundaries, and potential development (Foucault, 1972:52).

Positions of the Subject

From a Foucauldian viewpoint one might ask the question: What position or status does the speaker occupy in relation to the discourse and the manner in which it is controlled? (Foucault 1972:53). The Constitutional powers vested in the Australian Commonwealth Government gives it major responsibility for the social welfare of the aged and chronically ill. The Constitution allows the Commonwealth to make payments to individuals, and it does so through social security payments such as unemployment benefits and pensions. The National Health Act (1953) Subsection 51(1), allows the Commonwealth to prescribe the type of funding, the manner through which it is distributed and the form of record keeping required by nursing home proprietors for verification. In the provision of services for the elderly, the Commonwealth provides a subsidy to every aged or chronically ill individual living in a nursing home. Hence, when Commonwealth policy statements are disseminated into nursing homes, for example, through

Commonwealth Circulars such as the Department of Community Services and Health's (1988) *New Nursing and Personal Care and Staffing and Funding Arrangements*, (24 June, CNH 88003 NG), they cannot be dissociated from the statutorily defined institution from which they emanated. It is also a fact that they cannot be dissociated from the fact that such an institution has the right to make such statements, and claim from them the power to distribute funds to residents who require nursing home care

Obviously, those bureaucrats and politicians who steer major government enquiries and those academics and researchers who undertake Commonwealth funded projects, are placed in a very strong position to influence the flow of discourse. As well, the Directors of 'centres' on ageing have a powerful role in the regulation of the discourse on standards and quality of care. Therefore, within the discourse, some *speakers* assume a higher profile and come to be regarded as 'experts' within their defined area of the discourse. For example, academics and researchers who have a successful track record in obtaining research funding are more likely to be successful in subsequent applications to funding bodies. Therefore, these 'experts' are likely to be sought out in relation to any major new additions to the body of knowledge in its progression.

THE FORMATION OF CONCEPTS IN THE STANDARDS AND QUALITY OF CARE DISCOURSE

In *The Archaeology of Knowledge* (1972) Foucault provides a lengthy list of categories to investigate the organisation of and relations between statements which provides the groundwork for his study of concepts. He commences with a discussion on the *'orderings of enunciative series'*, outlines a *'field of presence'* which provides details of the manner in which statements formulated in other discourse areas are further utilised in other separate discourses; and describes a *'field of concomitance'* as including statements from completely different domains of objects and completely different types of discourse which may be

found in the statements of a discourse under study. He describes the *'field of memory'* which relates to the statements in a discourse no longer sanctioned and which have been removed from the arena of discussion and which therefore no longer explain a body of truth or a domain of validity. Lastly, he defines the *'procedures of intervention'* which relate to techniques of writing, to methods of translating quantitative statements into qualitative statements and vice versa, to methods of transcribing statements from natural into formal languages, to ways of transferring a statement to a new field of application and finally, to the methods of systematising statements (Foucault 1972:56-80).

Orderings of Enunciative Series

Over the past decade, it is noteworthy that the Commonwealth Government, being presented with a series of major reports from speakers on various aspects of operations of nursing homes, has subsequently established review committees to bring the various recommendations of different speakers together in order to formulate strategies for change. Two major examples of the Commonwealth establishing review committees following the completion of three major reports are the *Nursing Homes and Hostels Review* (1986) chaired by Glen Rees, which brought together the three previous reports undertaken by the Auditor-General (1981), McLeay (1982) and Giles (1985) and more recently, the *Nursing Homes Consultative Committee Report* (1994) chaired by Sir William Keys which brought together the three previous reports on the structure of nursing home funding by Professor Bob Gregory (1993b), Professor John Braithwaite's (1993b) review of outcome standards and the report by Mrs Sue Macri (1993) on RCI documentation requirements.

Field of Presence and Field of Concomitance

The discourse surrounding care of the elderly draws extensively in its use of other discourses and I will now discuss a number of these areas.

Legal Discourse

Legal discourse is interwoven extensively through quality of care and quality of life issues. A major example is seen in stage five of the Aged Care Reform Strategy which was 'concerned with protecting and promoting the rights of elderly people who live in nursing homes and hostels' (Ronalds, Godwin & Fiebig 1989:ix). In May 1989, the Department of Community Services and Health released the report *Residents' Rights in Nursing Homes and Hostels: Final Report* (Ronalds, Godwin & Fiebig 1989) which contained recommendations in 43 major areas and although a large number of recommendations were made, three particular priority areas were identified for focused government action over the first 12 month period. These were:

- the implementation of a Charter of Residents' Rights and Responsibilities
- the introduction of legislation which will make funding dependent upon a number of conditions including the execution of a formal resident-provider contract by all new residents, including coverage for resident participation structures and internal complaints mechanism; and
- to significantly strengthen the departmental complaints mechanism and publish the guidelines which govern its operation (Ronalds, Godwin & Fiebig 1989:xi).

Subsequently, an extensive legislative framework containing a Residents' Rights Charter, Residents' Contracts and complaints mechanism have been created which focus on protecting and promoting the rights of residents living in nursing homes.

A further example of the manner in which quality of care issues are entwined in the legal discourse may be seen within the *CAM Nursing Home Management Manual* (Commonwealth Department of Community Services & Health 1990). The Manual gives lengthy attention to the legal responsibility and accountability from both a common law and a legislative perspective, concerning the failure to

provide adequate clinical records. Attention is focused on legal issues to such an extent that when referring in Section 6 of the *CAM Nursing Home Management Manual* to 'Documenting Care' (Commonwealth Department of Community Services & Health, 1990:6.21), rather than referring nurses to reference books which deal with *Clinical Records for Australian Nursing Homes* (Australian Nursing Homes' Association, 1988) or to references dealing with the *Nursing Process and Nursing Diagnosis* (Iyer, 1986), the Manual directs nurses to two textbooks focusing on nursing and the law. Interestingly, in a later section when dealing specifically with 'Clinical Records: Use and Availability', the *CAM Nursing Home Management Manual* (1990:6.22) provides no proformas or guidelines to guide nurses in the preparation of the clinical records preferring to direct nurses to 'network with other nursing homes and see what they are utilising and how' (Commonwealth Department of Community Services & Health, 1990:6.22). This demonstrates the emphasis placed on funding priorities by the Commonwealth in that the *CAM Nursing Home Management Manual* focused on providing information to Directors of Nursing about how to manage CAM funding by explaining and illustrating the monitoring of hours and expenditure and the reconciliation process through the provision of numerous proformas of tables to monitor the budget. The Government's clear intention was to provide specific direction to Directors of Nursing about the process by which the new CAM funding mechanism should operate. However, the responsibility for providing direction about the process to achieve quality outcome standards was not as forthcoming. The introductory statement of the Commonwealth Outcome Standards document (Commonwealth Department of Community Services, 1987a:ix) clearly explains that it was not the intention of the Commonwealth to provide any direction about the process to achieve the outcomes and in particular it consciously avoided doing so in the document:

> Standards which prescribe means of achieving outcomes have been avoided. These are considered to be the responsibility of professional

and other groups (Commonwealth Department of Community Services 1987a:ix).

Accounting Discourse

Accounting discourse interweaves itself throughout various aspects of providing quality of care to the aged and chronically ill. An example is found where difficulties of not having sufficient information about nursing home costs caused the Government considerable concern leading to the commissioning of Coopers and Lybrand to undertake a study on the *Cost of Nursing Home and Hostel Care Services* (1985). The overall aim of the study was 'to obtain validated information on the costs of Nursing Homes to enable standards of funding to be set which recognise the different roles and levels of services provided by different nursing homes' (Coopers & Lybrand 1985:3).

Coopers and Lybrand commented on the various interpretations and inconsistencies Australia wide of what constituted an adequate level of service and suggested that the Commonwealth Government define what was meant by 'an adequate quality of care, either in terms of the services (inputs) required to achieve this or in terms of an output measure (e.g. comfort and quality of life of the patient)' (1985:20). The consultants were quick to point out that any model of funding would need to be defensible in terms of the adequacy of the level and quality of patient care provided as some nursing home proprietors may be tempted to provide a level of service that required a lower level of inputs in order to achieve higher profit margins.

Economic Discourse

Economic discourse is also extensively interwoven through the various aspects of providing aged care. Elderly people have become linked with incapacity, illness and disease (Matthews 1979) and therefore are perceived as not being capable of making responsible economic decisions about their own lives. The economic responsibility of providing services for the elderly person and making decisions

about where they should live has thus been transferred to their relatives and to the Government. Within this discourse we also find that providing for the physical care of the elderly takes precedence over providing for their psychological wellbeing. Economic priorities within the bureaucratic discourse identify the tangible material needs of the elderly that can be measured in dollar terms, for example, nursing home bed provision. However, because the cost of providing services to cater for the less tangible needs (e.g. catering for the psychological wellbeing of residents in nursing homes) is more difficult to measure, such needs are not included in the planning exercise. Therefore, the characteristics of a modern capitalist technocratic society (in which signs of material wellbeing are valued more highly than less tangible indicators) sit well with the view that nursing home institutions are the final refuge for people 'no longer economically productive' (Gibb 1990:15). Many examples were found in the interview data of care providers concerning the worthlessness of the residents living in the nursing homes.

Nursing Discourse

In the early 1990s, four major Commonwealth Government studies into various aspects of nursing homes were undertaken by leading nursing researcher Professor Alan Pearson. The studies were: *Optimal Skills Mix for Desired Resident Outcomes in Non-government Nursing Homes* (1990); *Inservice Training in Non-government Nursing Homes* (1991); *Home and Community Care Funding Review* (1991); and *Review of the Training and Education of Assistants in Nursing in Non-government Nursing Homes* (1991). These studies have provided a wealth of information regarding the education needs of nurses working in nursing homes.

Professional nursing practice requires that nurses maintain adequate clinical records as evidence of the nursing care provided to residents. Such clinical records which record strategies used to manage or improve a resident's health

status are essential to meet State regulations as well as the Commonwealth Outcome Standards Policy guidelines. Standards monitoring teams draw on the clinical records maintained during professional nursing practice in order to verify the Resident Classification Instrument (RCI) claims. However, using the technical language of 'the nursing process' (which is essentially a problem solving technique used by the nurse to give organised and individual care), needs which are identified as requiring a nursing response are translated into a 'nursing problem'. In other words, once an individual's need is identified, it becomes problematised. A series of tasks are constructed whereby the problem can be overcome and therefore provides a reinforcement for the task orientation approach to care delivery.

There are contradictions inherent in allowing the continuation of task orientated approaches to providing care. While the task orientated approach to care delivery revolves around working to a pre-determined schedule of activities (organised around a series of physical tasks in which all residents are required to conform to the routine), we are provided with the Commonwealth Outcome Standards Policy rhetoric of 'normalising' the environment of nursing homes to the individual resident's need. The Commonwealth Outcome Standards were supposedly introduced to improve the quality of care and quality of life of residents in nursing homes. However, by not requiring nursing homes to change from their traditional task orientated approach to work routines, we need to question whose needs are being served by the introduction of the Outcome Standards Policy — those of the residents or those of the Commonwealth. Gibb (1990:40) in providing a critique of gerontological nursing, argues that the discourses of medicine and bureaucratic management have played a major role in shaping nursing practice in the care of the elderly. The imposition of economic management from Commonwealth directives together with traditional nursing values of efficiency provide motivation for the continued control over the daily routine within nursing homes (Gibb 1990).

Field of Memory

In the earlier part of the 20th century, nursing homes were established as a cottage industry. It was not uncommon for a 'Matron' who wished to move out of the hospital system to acquire a large boarding house and convert it into a rest home or convalescent home. These early forms of nursing homes ran as small private businesses with the Matron having full control over who would be admitted. If a family sought admission of their elderly or chronically ill relative they could liaise with their doctor and approach the Matron directly. The Government took very little interest in the admission procedures or the standards or quality of care provided. Today, it is widely accepted that this earlier cottage industry nature of nursing homes has disappeared from the discourse and this was found to be the case in the three nursing homes in this study. Now, the nursing home operates in an environment where access to entry is monitored and controlled by the medical profession who are required to sign an admission form for approval of entry; where the Aged Care Assessment Team (ACAT) encourages a greater emphasis on the organisation of social welfare within the community by acting as gatekeepers for nursing homes within their jurisdiction; and where the nursing home is open to a highly structured system of monitoring of standards and quality of care from various State and Commonwealth Government agencies, in particular the Commonwealth Outcome Standards Monitoring Teams.

Nursing has not only lost control over defining who enters a nursing home for nursing care but also has lost control over how nursing is defined within a nursing home. The ACATs do liaise with nursing homes and present Directors of Nursing do have a certain element of choice as to whether they will accept the resident who is referred to them by the ACAT. However, since the introduction of the Resident Classification Instrument and CAM funding, when required to fill an empty bed, the Director of Nursing is in the awkward position of endeavouring to find a resident who is in the same category as the resident who previously vacated the empty bed as a change to a lower category of resident will affect the amount

of funding received from the Commonwealth. Also, the sex of the new resident has to be considered, as in many instances residents share rooms and it may be inappropriate to place a new female resident in a room with men. Therefore, in a number of cases Directors of Nursing may be required to wait a number of days before the ACAT finds a suitable resident and having a bed empty in the home means reduced funding.

Therefore, the Aged Care Reform Strategy with its objective to have only highly dependent residents cared for in nursing homes has not only caused a major change to the level of nursing care provided in nursing homes but also changed the very nature of nursing home provision in Australia. Nursing homes have become places where nearly all residents require very high levels of nursing care. Previously, residents with a broad range of dependency levels lived in nursing homes. However, today, the less dependent residents are encouraged to remain in their homes or if unable to do so are directed to less costly forms of accommodation, such as hostels.

Procedures of Intervention

Foucault's final element in the analysis of the conceptual rules of discourse is the *'procedures of intervention'* which may be applied to statements (1972:58). Such procedures may include techniques of rewriting, translating and transferring a particular type of statement from one field of application to another or from one discourse to another or between sub-discourses. Exploring the various discourses of interest to standards and quality of care discourse earlier in this chapter, demonstrates how important *'procedures of intervention'* appear at an interface with the public bureaucratic discourse.

At this interface, the nursing care provided to residents within a nursing home is classified, weighted, categorised and summarised in order to provide a simplification and systematisation of events in terms that may be manipulated and controlled to satisfy funding priorities of the Commonwealth Government. This

simplification and systematisat on of nursing care provided to residents in nursing homes into hours/resident/day/category of dependency allows the Commonwealth to allocate its limited funding resources more simply, equitably and objectively.

However, what effect does this gross over-simplification and systematisation of nursing have on residents living in a nursing home? We see the body of the resident immersed in a web of power relations which examines their body and categorises it. The 'resident' body is reclassified, recategorised and rearranged according to some ritualised documentation and examination procedure prescribed through Commonwealth legislation. Through the process of normalisation, the aged 'resident' body is rendered a docile body. The docile body is far easier to manipulate and control than a complaining body. A docile 'resident' body is not only easier to manipulate and control but consequently becomes an essential ingredient in the formula for achieving the highest level of funding and maintaining the long term financial survival of the nursing home (Foucault 1972). Numerous examples were witnessed during the period of participant observation during this study concerning the extensive monitoring, assessment and documentary processes undertaken on residents.

THE FORMATION OF THEMATIC CHOICES

The fourth element used by Foucault to identify discursive formations examines the development of 'themes and theories' which Foucault calls 'strategies' (1972:64). Foucault questions whether it is necessity that brings these strategies together or mere chance encounters between different ideas or is there simply a certain regularity between strategies that defines the mutual system of their formation (1972:64). Within the development of 'themes and theories', Foucault describes the *'points of diffraction* of discourse' which are characterised as *'points of incompatibility ... points of equivalence ... and link points of systematization'* (1972:65–66). The *'points of incompatibility'* relate to the contradictory nature of statements in discourse where we might find two contradictory or opposing

objects, enunciations or concepts appearing in the same statements of a discourse. The *'points of equivalence'* relate to the situation where two or more alternatives are formed, even though they emerge under the basis of the same rules. Finally, the *'link points of systematization'* refers to the new sub-discourse that is derived from these equivalences or alternatives and incompatibilities or contradictions (1972:64). Thus Foucault seeks the 'rules for the formation of ... theoretical choices ... A discursive formation will be individualised if one can define the system of formation of the different strategies that are deployed in it; in other words, if one can show how they all derive ... from the same set of relations' (pp. 65–68).

Points of Incompatibility (Contradictions)

There is strong tension between several of the objectives of the Commonwealth Outcome Standards and the situation which presents itself in nursing homes in Australia today. Within the discourse of quality of care for residents in nursing homes there appears a number of contradictory statements which are presented below:

1. A major contradiction is established by the fact that even though nurses are essentially responsible for providing care to residents living in nursing homes, they are largely excluded from the bureaucratic decision-making processes which establish the number of standard hours of nursing care required to actually care for a resident allocated to a particular category of care via the Resident Classification Instrument. This situation results in the amount of nursing care required by residents in certain levels of dependency being defined through the bureaucratic process rather than from within nursing itself. One way of managing this contradiction is for bureaucrats to assert that senior peak nursing organisations have been eligible to participate on committees. However, clinical nurses at the bedside are far removed from the decision-making being undertaken by formally constituted committees and this has in effect worked against the

participation of clinical nurses in the decision making process (Marles 1988:164ff). Numerous examples were found in the interview data of care providers concerning the perceived lack of input into the decision-making process by the nursing profession, in the calculation of standard hours of nursing care required to care for residents in nursing homes.

2. A further contradiction is established by Directors of Nursing (DONs) of nursing homes being primarily responsible for ensuring that the standards and quality of care within the nursing home meets the Commonwealth Outcome Standards, whereas the broad policy and financial projections are set by proprietors or executive management committees. Directors of Nursing are generally placed in a subordinate position to the nursing home proprietor who largely restricts the DONs access to budget and revenue information of the nursing home as was the case in the nursing homes in this study. As well, DONs often do not have access to information concerning the number of staff being funded by the Commonwealth and do not have access to information regarding the amount of surplus generated by their proprietors. Access to budgetary information would allow the DON greater flexibility in the employment of different levels and categories of staff within the nursing home in order to improve the quality of care and quality of life for residents. It is not unusual for the staff complement of a nursing home to be specified by the proprietor with the DON being subsequently expected to manage the nursing home around that number of staff. In many cases, fear of dismissal discourages DONs from complaining or demanding budgetary information.

3. Another major contradiction is established by the fact that while the Outcome Standards Policy espouses resident centred care, sufficient funding is not provided to the nursing homes in order that work routines can be altered to deliver such individualised care in a home-like environment. Essentially, if care providers change their work routines from task orientation to individualised care,

the workloads of care providers increase. Numerous examples were found in the interview data of care providers concerning the extra time required by nursing staff in order to allow residents to alter the normal routine of the nursing home. Examples where extra time is required include if a resident is allowed to have a meal in their own room rather than the dining hall or have a meal earlier or later than is normally the case; or if a resident is taken out into the garden for the day rather than staying in the sitting room. All care providers reported on the extra time required to satisfy such individual resident's requests. Having residents situated in different places to supervise meals, to give medications, undertake treatments and so on rather than having all residents located in the one place (e.g. in the dining room or day room) was reported to be far more time consuming for staff and made it far more difficult to provide all the care required during the course of their shift.

4. A further contradiction is established by the Outcome Standards Policy in espousing a home-like environment for residents. The Policy outlines a number of areas to be considered in the creation of a home-like environment including: building design and layout; decor; arrangement of furniture; personal possessions; pets; protective clothing; routines; and security of accommodation (Commonwealth Department of Community Services 1987a:v). The Outcome Standards Policy encourages placing of pictures on the walls, hanging curtains in the residents' rooms and changing the fabric on the chairs, and so on, in order to create a home-like environment and we see that nursing homes have been quick to take up such suggestions with the result being that the external appearance of nursing homes has greatly improved. However, the encouragement of the replacement of traditional nurses' uniforms 'with less clinical and more personalised protective clothing in order to enhance the home-like atmosphere' (Commonwealth Outcome Standards, Department of Community Services 1987a:29), and suggestions that 'to ensure that the nursing home environment does not adopt rigid routines, staff should try to adopt the rhythms, customs and

routines of the outside community' (1987a:29), have been very slow to be considered by nursing homes, as these later suggestions do not form part of actual Outcome Standards 4.1 or 4.2 (1987a:31) which are monitored by the Standards Monitoring Teams. Therefore, such suggestions have not been seen as a requirement to meet the standards, and consequently have not been taken up by many nursing homes. Even if nursing homes sought to change their work practices in order to improve the quality of care and quality of life for residents, because such changes result in additional work for the staff, and because no extra resources are provided for the extra time involved in additional individualised care provided for residents, therefore nursing homes have been slow to move to change from their task orientated work practices. In this study, only Seaside Vista Nursing Home and to a lesser extent Heritage House had taken up these suggestions.

5. A further contradiction is seen in the privacy and dignity provisions for residents within nursing homes which is espoused by the Outcome Standards Policy (1987a:35-39). The Outcome Standards Policy describes many facets of privacy and dignity, for example: staff attitudes; modes of address; right to privacy; private space and belongings; privacy in bathing and toileting; privacy to maintain friendships; privacy from unwanted sound; confidentiality of information; dignity in dying and death (Commonwealth Outcome Standards, Department of Community Services 1987a:vi). The Outcome Standards Policy notes that privacy for residents can 'be achieved by having doors rather than curtains over doorways, and by providing full screening for each bed in multiple bed wards' (1987a:36). Outcome Standard 5.3 (1987a:38) provides a consideration concerning screening residents from view of other residents, visitors and staff during bathing, toileting or dressing. However, no consideration is given in this Outcome Standard to single rooms for residents. The content of this standard only refers to providing screening from the view of other residents, visitors and staff. The content of Outcome Standards 5.1 through to 5.6

(1987a:38-39), I would argue, do not sufficiently cover community expectations of what a privacy provision would include in an individual's own home. Within nursing homes, it is not uncommon to have a number of residents living in the one room. However, sharing rooms is certainly not what an individual would expect if they were living in their own home. An individual would expect to have a single room or else to share the room with their husband/wife/partner.

Where four bed-fast residents are located in one room, the process of providing privacy and dignity to residents is supposedly undertaken by the provision of curtains between one individual's bed and the next. However, when toiletting activities are undertaken, the dignity of residents is often challenged when they know that someone on the other side of the curtain can hear every word and action between themselves and the staff in attendance. Also, conversations with relatives or friends are heard by all residents in the room. Even though these situations exist, nursing homes receive a 'met' result by the Standards Monitoring Team for ensuring privacy and dignity for residents. While it may be argued that residents may be taken to the bathroom for toileting or be taken to the sitting room or to the garden when visitors are present, in reality, such extra movements of residents create extra work and take up extra time for the care providers within the nursing homes, and therefore, seldom do bed-fast residents have the opportunity to leave their rooms for such activities.

I would argue that the Outcome Standards do not go far enough in order to provide residents with an environment where they can be assured of complete privacy. Satisfying higher expectations of a privacy definition would have severe funding implications for the Commonwealth Government. Therefore, although privacy and dignity principles are central to the Outcome Standards, in reality, a minimalist approach has been adopted by the Commonwealth such that the Outcome Standards do not challenge nursing homes significantly enough to

change their work practices or the layout or design of buildings to improve the quality of life or quality of care for residents.

6. The Aged Care Reform Strategy has introduced many new nursing home management practices which require high levels of management and financial skills. However, large numbers of Directors of Nursing who are required to hold senior management officer's positions in Australian nursing homes, have no financial or managerial qualifications and more importantly no gerontological qualifications (Pearson et al. 1990). Therefore, many Directors of Nursing have neither the financial management skills, nor, more importantly, the gerontological skills to bring about the changes required to truly implement the objectives of the Outcome Standards. Many Directors of Nursing have no nursing experience other than that of the old task orientated nursing culture. Although the Outcome Standards objective of caring for the individual resident's needs is espoused by many nurses working in nursing homes, in reality, the task orientated nursing culture is perpetuated. This is not only because of the lack of time to undertake such individual care but also, more importantly, because of the real lack of knowledge and skills of nurses to allow them to initiate other work practices such as undertaking health assessments of the aged, establishing systems of nursing care plans, and linking daily reporting requirements to the care plans to satisfy documentation requirements for monitoring teams.

7. An increasing source of discursive contradictions is seen where, on the one hand, the Outcome Standards Policy espouses that nursing homes should be home-like environments where residents are assured of their own private space, whilst on the other hand, the discourse clearly is dominated by increasing levels of observation and documentation which requires residents to be placed under surveillance and measured, sorted, classified, and assessed. The emphasis placed upon surveillance and documentation in order to collect data for the Resident Classification Instrument categorisations for funding and Standards Monitoring

Team verification purposes is clearly in contradiction with the communities' notion of living in a private home-like environment.

8. Finally, another potential conflict of interests is recognised between the duty of care and professional responsibility of the care providers to *know what is the best* for residents on the one hand, and the rights of residents to be independent and to make decisions and choices for themselves as individuals, on the other. Many care providers interviewed expressed concern for the safety of residents who under the new Outcome Standards Policy are now allowed to wander more freely. Allowing residents more participation in decision-making in actual effect diminishes the power base of care providers. As care providers are already themselves dominated by proprietors and management committees, it is not surprising that changes to work routines within nursing homes, which allow residents more choice and input into decision-making and, in effect, reduce the control of care providers over residents, have not been introduced widely within nursing homes.

Points of Equivalence (Reconciled Alternatives)

With consideration of the first element of Foucault's analysis complete, we will now turn to the 'equivalences' within the discourse. These 'equivalences' describe how two or more alternatives are formed within the discourse under the basis of the same rules and how these alternatives are reconciled. While a considerable number of the contradictions within the discourse on quality of care for residents in nursing homes (as mentioned in the previous section) continues to remain largely unresolved, there are a couple of areas in which reconciliations have emerged and these are mentioned below.

1. While there is strong agreement amongst nursing home staff that providing resident centred care in a home-like environment where residents' rights are central is a good idea in theory the actual reality of practice presents difficulties for care providers. While on the one hand, the introduction of the Aged Care

Reform Strategy has resulted in the population of nursing home residents becoming more highly dependent, on the other hand, little recognition has been given to the need to have a more highly skilled workforce to care for such increasingly dependent residents. This present study found nursing homes continued to employ large numbers of untrained nursing assistants who learn their skills on the job with varying amounts of educational support. Nursing homes endeavour to provide inservice education to their staff. However, the amount and level of education in many cases is dependent upon the goodwill and enthusiasm of the Director of Nursing as well as the availability of monetary resources.

2. The conflicting demands of residents' rights versus the rights of nursing home care providers does not appear to have created marked contradictions within the discourse. As part of the Aged Care Reform Strategy, an extensive legal framework has been set up to protect the rights of residents through the Residents' Rights Charter as well as residents' rights contracts (Ronalds, Godwin & Fiebig 1989). While the rhetoric of residents' rights has indeed become quite unmistakable as was the case in the nursing homes in this study, the reality is one of relatively modest achievement (Gibson, Turrell & Jenkins 1993:85). For instance, the growth in the number of residents' committees from 1986 to 1991 has been quite dramatic (see Table 7.1). However, one must question if the growth of residents' committees is evidence of an increase in the amount of freedom of choice and decision-making amongst residents. Gibson, Turrell and Jenkins (1993) in discussing the findings of the Nursing Home Regulation in Action Project provided the following details of the nature of these residents' rights committees.

> Most committees (68%) met on a monthly basis, with one per cent meeting more often. The remainder met less frequently. Most committee meetings (57%) were attended by 12 or fewer residents. Directors of nursing were asked about the kinds of issues discussed by their own residents' committee. The most commonly discussed were food (84%), activities (51%) and outings (52%). Issues of nursing home policy had been raised by 33% of committees, and those pertaining to the structure of the nursing home or its equipment by

31%. The specific and sensitive issue of complaints against staff had been raised by 14% of committees, and comments pertaining to departmental policies on nursing homes by 10 per cent (Gibson, Turrell & Jenkins 1993:82).

Table 7.1
Proportion of Nursing Homes with Residents' Committees

State	1986	1989/90	1991
New South Wales	29%	85%	89%
Queensland	3%	79%	90%
Victoria	9%	25%	63%

Source: 1986 Data: Rhys Hearn, C. *Quality, Staffing and Dependency: Non-government Nursing Homes*, Commonwealth Department of Community Services, AGPS, Canberra.
1989/90 & 1991 Data: Nursing Home Regulation in Action Project.

Ronalds et al. (1989:x) noted proprietors of nursing homes had generally sympathetic attitudes to the introduction of residents' rights legislation but 'there was some concern about the methods proposed in some of the recommendations, the effects that they would have on their (nursing home) operations, and the practical implications of their implementation.' He continues:

> the only issue where the opinions of the residents differed markedly and consistently with those of service providers was in relation to proposals for financial disclosure of annual accounts of nursing homes and hostels, with some providers considering that any disclosure was unacceptable and others concerned about the actual amount of information to be made available (Ronalds, Godwin & Fiebig 1989:x).

It is not so much 'that providers set out deliberately to disenfranchise and exploit the elderly, but rather that the individual (resident) feels totally powerless to control those aspects of daily life which are considered to be normal and desirable by the wider community' (Ronalds, Godwin & Fiebig 1989:x). Generally, instances where the rights and responsibilities of care providers come into conflict with residents' rights, and in cases of verbal or physical assault from residents, the discourse is more concerned with the legal ramifications rather than the quality of care.

Link Points of Systematisation (Emerging Sub-Discourses)

Finally, we will move to the *'link points of systematization'* which Foucault (1972:66) describes as being the means by which discursive sub-groups form within a discourse. He argues, such sub-discourses are derived from the discontinuities, alternative concepts, equivalences, contradictions and incompatibilities within the discourse (p. 68). Thus, an emerging sub-discourse or theme of *Documentation Driven Nursing Care* will now be discussed.

Documentation Driven Nursing Care

The Commonwealth Government allocates funding for nursing and personal care staffing using the five category classification system know as the Care Aggregated Module (CAM). Funds are allocated to nursing homes based on the relative care needs of their residents and therefore, residents with similar needs are provided with the same level of funding for the same level of care. The CAM system relies on the Application for Resident Classification Form (NH4), known as the Resident Classification Instrument (RCI), in order to determine the relative nursing and personal care needs of residents living in nursing homes.

In order to verify RCI claims for funding, Outcome Standards Monitoring Teams visit nursing homes and review documentation maintained by nursing homes in assessing, planning and recording residents' care within the clinical record system. Therefore, documentation has become a central issue within nursing home practice since the introduction of the Aged Care Reform Strategy. The *CAM Management Development Manual* (Commonwealth Department of Community Services & Health 1990:6.22) clearly outlines the importance of the well-documented clinical record system (using the five step nursing process problem-solving technique based on assessment, diagnosis of problem, planning course of action, implementation of plan into action, and evaluation of the effectiveness of the plan) and states, 'It makes good business sense, not to mention sound medical and nursing practice, to have a well-documented clinical record, in meeting legal

requirements and ensuring that the nursing home is managed both efficiently and effectively' (Commonwealth Department of Community Services & Health 1990:6-22).

Thus, it is no wonder that many care providers in this study believed the introduction of the Outcome Standards Policy into non-government nursing homes has 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.

Matthews (1979) notes that stereotypes of old age people as being incapacitated, cognitively insufficient and dependent are more likely to be accepted by care providers who use the technical language of 'the nursing process' to identify needs which require a nursing response to an identified problem. The Aged Care Reform Strategy's introduction of the Resident Classification Instrument has allowed the nursing home to become a place of measurement and classification of the 'resident' body. According to Foucault (1979a:190), through examination and documentation, an individual is constructed as an 'object'. Thus, in the nursing home, the aged body through examination and documentation using the Resident Classification Instrument (RCI), becomes the 'resident' body. Objectifying the aged body into the 'resident' body (using RCI levels) becomes a useful means for the Commonwealth Government to allocate funding to nursing homes. However, at the same time, it dominates and controls the aged body living in a nursing home as the aggregations of RCI data, once collated, become a body of knowledge which subsequently becomes a source of power which controls the activities a resident is capable of undertaking. It also controls those care providers working in the nursing home because it defines how and where resources will be allocated and therefore impacts upon the manner through with resources may be used.

SUMMARY

This chapter uses the four major elements as outlined in Foucault (1972) in his analysis of a discursive formation, in order to analyse the Australian Aged Care Reform Strategy and the discourse of quality of care for residents in nursing homes. The four elements outlined by Foucault (1972) are: the formation of objects; the enunciative modality; the formation of concepts and the formation of thematic choices. Table 7.2 provides a summary of the major issues from the analysis of the discourse of quality of care for residents in nursing homes as presented in this chapter.

In closing this chapter and in preparation for the concluding chapter, the words of Lavinia Lloyd Dock, an early 20th century feminist, suffragette and nurse, provide a useful summary to the assumptions behind the framework of my thesis which seeks to effect change in terms of improving conditions. She wrote:

> I would be glad to present the different points that seem to me important, and hope that in doing so I shall not seem to be criticising persons, for what I wish to do is only to draw attention to conditions (Dock 1906:109).

Table 7.2
Major Issues from the Analysis of the Discourse of Quality of Care for Residents in Nursing Homes

THE FORMATION OF OBJECTS	
a) Surfaces of their emergence	Hospital researchers Academics Government Professional Associations Consumer Associations Media
b) Authorities of delimitation	Government Medical Profession Private proprietors of nursing homes Families of residents Nursing Profession
c) Grids of specification	Resident Classification Instrument
THE ENUNCIATIVE MODALITY	
a) Who is speaking?	Government Academics and researchers Professional Associations Consumer Associations Media
b) Institutional site	Nursing home University The 'library' or documentary field
c) Positions of the subject	Constitutional Powers of Government 'Expert' knowledge, academics, researchers & professional associations Lack of strong base of consumer knowledge

THE FORMATION OF CONCEPTS		
a)	Orderings of enunciative series	Series of documents reviewed in major review
b)	Field of presence and Field of concomitance	Legal Discourse Accounting Discourse Economic Discourse Nursing Discourse
c)	Field of memory	Formerly cottage industry Nursing control of entry Nurses defining nursing care
d)	Procedures of intervention	Categorisation of standard hours/resident CAM/SAM
THE FORMATION OF THEMATIC CHOICES		
a)	Points of incompatibility (contradictions)	Nurses responsible for delivering quality care to residents but excluded from bureaucratic decision-making regards determining standard of nursing hours required to give such care. DONs denied access to budgetary information while being required to be responsible for funding. Outcome Standards suggest changes to work practices to improve care. However, provide insufficient funding to do so. Outcome Standards require the provision of a home-like environment. However, have no requirement for nursing homes to change work practices in order to do so. Outcome Standards require the provision of privacy and dignity for residents. However, Standards Monitoring Teams give 'met' reports to homes where residents are required to share rooms. High level of financial and gerontological knowledge required by DONs of nursing homes. However, such qualifications are not a pre-requisite for employment as DONs in nursing homes.

		Outcome Standards require private space for residents, however, encourage observation, surveillance etc through RCI and Standards Monitoring Teams. Care providers have duty of care and professional responsibility for residents which encourages them to make decisions for residents to protect their safety, while Outcome Standards require residents to have freedom of choice and independence.
b)	Points of equivalence (reconciled alternatives)	Care providers recognise residents' rights as being important. However, only relatively modest achievements are apparent. Care providers reconciled to having a more highly dependent resident population in line with government policy. However, level of skills required to care for residents remains unchanged.
c)	Link points of systematisation (emerging sub-discourses)	The new sub-discourse of *Documentation Driven Nursing Care* emerges rather than one centred on providing quality of care. Care providers recognise need for ensuring quality care provision. However, documentation techniques for ensuring quality are employed at the expense of providing a home-like environment. The nursing home is transformed into an environment of examination and classification where the nursing home resident becomes objectified into the docile 'resident' body.

Chapter 8

CHALLENGES FOR THE FUTURE: DISCUSSION AND CONCLUSION

INTRODUCTION

This study investigated the development and implementation of the Aged Care Reform Strategy, in particular, the Commonwealth Outcome Standards Policy and its subsequent impact on the quality of care provided in nursing homes. The aims of this research were to review the public discourse on aged care policy, to analyse the meaning of quality care for elderly people in nursing homes from the residents' viewpoint and to compare the residents' view of quality with that of care providers and policy-makers within the public discourse on aged care. The discussion of these aims is of current importance in Australia following the introduction of the Commonwealth Outcome Standards Policy for non-government nursing homes which is linked via Outcome Standards Monitoring to the approval of nursing home funding.

The theoretical background which informs this study is one of critical sociology which includes the examination of both the historical and social context of the phenomena under study. Within this critical analysis the concepts of power, language, subjectivity, space and normalisation technologies are applied. The ethnographic methods of key informant in-depth interviews and participant observation are used in this study. In line with Foucault's analytical framework as presented in *The Archaeology of Knowledge* (1972), discourse analysis is also used in order to derive central themes from the written and spoken discourse.

It is not claimed that the results of this research should be generalised to the broader nursing home resident population. However, the findings of this research will not only contribute to the understanding of quality and how it might be more effectively operationalised within the nursing home industry in Australia, but will also assist in the identification of a number of implications for policy-makers and care providers. It was not the intention of this thesis to evaluate the Commonwealth Outcome Standards program but rather to contribute evidence concerning the implications for policy-makers and care providers in nursing homes, in relation to the development of standards and the future management of regulation for ensuring quality in nursing homes in Australia.

The Commonwealth Outcome Standards program, through funding of Standards Monitoring Teams, has essentially increased the monitoring resources available in Australia. The Commonwealth Government's delegation of the authority to Outcome Standards Monitoring Teams to approve nursing home standards has, in effect, given Outcome Standards Monitoring Teams the authority to approve or deny the continuation of funding of nursing homes. Therefore, the mandatory Outcome Standards Monitoring Teams' visits to non-government nursing homes become of great importance to the proprietors of nursing homes who realise that unless the standards are 'met' then funding could be withdrawn.

Prior to the introduction of the Commonwealth Outcome Standards program in Australia, various standards monitoring mechanisms existed both at the State and Commonwealth level. Whether the replacement of these other mechanisms by the Outcome Standards program results in the anticipated benefits, this thesis argues, remains open to question. This study examined how the 'rhetoric' of public bureaucratic discourse has obscured the 'reality' of nursing home life as it is experienced by residents living in nursing homes and care providers working in nursing homes. This present study has given nursing home residents and care

providers working in nursing homes the opportunity to define their own 'reality', based on their own experiences of nursing home life.

In this final chapter, the findings of the research recorded in earlier chapters are briefly reviewed and discussed in the context of the Commonwealth Outcome Standards program and challenges for the future are outlined. The findings of this study in relationship to the three major objectives of this research are presented below.

QUALITY CARE FROM THE RESIDENTS' PERSPECTIVE

In order to identify the major characteristics of quality care from the nursing home residents' viewpoint, an examination of the life experiences of residents was undertaken using in-depth interviews and participant observation in the three nursing homes in order to determine the relevance of current nursing home outcome standards for promoting quality care (see Table 4.1). 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 described the overall process of admission into a nursing home as being 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 partner 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, perceived that they 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 linked to a particular day is supported by the work undertaken by Chenitz (1983) involving entry into nursing homes as a status of passage. 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 hard 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 in this study entered the nursing home in a vulnerable frame of mind. Long periods of illness, the loss of a partner, loss of home, possessions and independence often preceded entry. Trying to settle in to the life and routine of the nursing home proved 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 a nursing home. Taking meals at set times, lack of choice and variety of food, specific times for various treatments and nursing care procedures (eg 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 to 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 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. The descriptions provided by residents of

unfavourable aspects of nursing home life 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 the 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 present study are consistent with those reported by Wilkin and Hughes (1987) in their work on consumers' views of residential living.

Challenges for the Future

This study highlights the continuing need to provide prospective residents with information about nursing home life, as well as to include them in the decision-making process when entering a nursing home. It also highlights the need for administrators and carers 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 was forthcoming, then traumatic experiences described by residents of their move into nursing homes would be reduced and residents' perceptions of quality of care provided by 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.

IMPLEMENTATION OF THE AGED CARE REFORM STRATEGY: CARERS' PERSPECTIVE

In order to analyse the reaction to and implementation of the Aged Care Reform Strategy in relation to quality care provision within nursing homes, this study examined the beliefs and practices of care providers regarding quality care provision through in-depth interviews and participant observation in three nursing homes. Four major areas which influenced care providers' quality care provision (see Table 5.1) were revealed and these four areas, together with the reactions of care providers to the implementation of the Aged Care Reform Strategy, will now be discussed.

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 orientation' 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. Redressing the 'task orientation' 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 owing to severe financial constraints. As nursing assistants provide 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 (ie 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 them, 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 orientation 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. Emphasising the importance of the social aspect of care to care providers is a major challenge for Directors of Nursing in order to improve the quality of care and quality of life for residents living in nursing homes.

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

All Directors of Nursing in the study believed, by encouraging nursing homes 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. As well, the majority of care providers believed the introduction of the Commonwealth Outcome Standards had:

- improved the professional status of care providers working in nursing homes;
- increased the level of personal growth of care providers as seen in increased levels of assertiveness and improved self-esteem of care providers;
- provided care providers with a 'leverage tool' to act as an advocate for residents; and, finally,
- motivated government sector nursing homes, to review protocols and procedures concerning quality of care for residents in line with the requirements of the Commonwealth Outcome Standards document.

While all 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 quality of 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 quality of the overall physical environment of the nursing homes had improved through the addition of individual bedspreads, pictures, and ornaments, for example, and that the employment of activity officers, physiotherapists, and so on, had been of assistance to some residents, the general

view of care providers was that the overall quality of 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 were 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. While 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.

Challenges for the Future

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 nursing care is delivered in order to move from a 'task orientation' 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. A major implication of moving from a 'task orientation' approach to that of 'resident-centred' care is that carers are required to learn to exercise a facilitatory role rather than taskmaster role. Nursing homes are challenged to provide a rehabilitative environment for their residents rather than fostering dependency, and emphasis needs to placed not

only on the physical aspects of care but also on the social aspects of care to improve the quality of care and quality of life of residents living in nursing homes. Directors of Nursing and policy-makers 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.

THE PUBLIC DISCOURSE ON AGED CARE POLICY IN AUSTRALIA

In order to analyse the public discourse on aged care policy in Australia, relevant Commonwealth/State documents and Hansard reports of Parliamentary debates during the period 1963 to 1993 were examined in order to identify the means by which policy directions and goals are accomplished. This study was concerned with the public bureaucratic discourse of aged care, where priorities and values are expressed in policy behaviours, in spoken language found in Parliamentary debate and in the written word found in official government policy documents. This study has attempted to examine and unpack the powerful and influential public bureaucratic discourse in order to uncover some of the social interests which are characteristic of its make-up.

The political and economic context of the period under study was examined in order to understand the major shifts in aged care policy that have impacted on nursing homes. Major policy shifts were found throughout the various policy phases which exhibited the different economic systems that reflected the values and beliefs central to the community at the time. The history and evolution of aged care policy formation and implementation was described previously in Chapter 6 through the use of six major policy phases which were linked with the ideological approach favoured by the Commonwealth Government in power at the time. The six major policy phases of aged care policy as described were:

Phase 1	Insurance-based health service— *Laissez-faire* Approach	(Prior to 1962)
Phase 2	Minor Subsidy Intervention Approach	(1962 to 1968)
Phase 3	Major Cost-sharing Subsidies, Minor Regulations, Minor Inquiries	(1969 to 1971)
Phase 4	Minor Regulatory Approach	(1972 to 1981)
Phase 5	Major Public Inquiries and Reports	(1981 to 1985)
Phase 6	Major Regulatory Approach— Aged Care Reform Strategy	(1986 to 1993)

The task of achieving equity of funding between the states as well as between the various types of nursing homes has been a major priority within the public discourse. This is well displayed in the report from the Auditor-General (1981) which saw funding and equity priorities as central to the public discourse on nursing homes, with the Government concerned mainly with the problem of equity of nursing hours across the various states rather than looking at the quality and standards of care being provided by these nursing hours. The McLeay Report (1982) also focused centrally on funding priorities, devoting very little attention to the area of quality and standards of care and preferring to concentrate on the issue of transferring the responsibility of funding from the Commonwealth to the states. The release of the *Senate Select Committee on Private Hospitals and Nursing Homes* (1984) report saw the emergence of a fuller discussion on issues of quality and standards of care in nursing homes, with the Government undertaking to establish nursing home accommodation in the context of an overall plan for providing quality care for the elderly rather than in the piecemeal fashion of previous policy-making. Previously, nursing homes were viewed more as independent operations that provided a separate service to the community with minimal accountability for quality. However, nursing homes are now being seen as but one part of an overall comprehensive integrated geriatric service rather than as independent private operations as was the former case. A new focus on quality

and standards of care began to emerge within the framework of an integrated service provision and planning framework.

Not suprisingly, the release of the Coopers and Lybrand Report (1985) saw funding priorities remain central to the public discourse on nursing homes, with the government undertaking to establish a standard costing model for nursing homes. However, moves to establish a standard cost model encouraged the establishment of a quality control mechanism. The government knew that in order to introduce the new control measures, they would have to ensure their critics that the quality and standards of care to residents within nursing homes would not be jeopardised. Therefore, for the new funding model to be successful, the quality and standards of care priorities gained a high profile. It was not through the action of various interest and pressure groups such as consumers, academics or professionals that saw the item of quality move to the top of the policy agenda, but rather the necessity for the economic rationalists and bureaucrats to legitimise and substantiate their proposed new model of funding which would be based on the 'independent point of reference' method using indices rather than the previous actual current costs of operation. An adequate level and quality of care provided to residents needed to be assured in order that the government could introduce its new model of funding. So we see the issue of quality and standards piggy-backing on the funding roller coaster.

The public discourse on aged care during the last decade has not been so much ideologically driven, with short term quick-fix solutions, but rather priority centred. This has provided a long term strategy in order to address the problems of containing costs at the same time as providing quality care in nursing home provision through the formulation of a long term strategy which includes a series of funding and quality outcome mechanisms. While a long term approach was being taken, funding priorities continued to remain central in the public discourse of the Commonwealth Government and this is demonstrated through the

introduction into non-government nursing homes of the CAM/SAM and OCRE funding mechanism, together with the compulsory RCI dependency system for classifying residents into levels of care to provide funding. Although quality care and standards of care priorities have emerged more strongly in the public discourse through the establishment of the Commonwealth Outcome Standards and Standards Monitoring Teams, this quality of care and standards monitoring emphasis is more a result of the government seeking to ensure that its funding mechanisms are not abused by nursing home operators rather than because of any adherence to humanitarian or social justice principles.

Prior to 1986, a submission driven funding system existed which created marked inequities between regions. The recommendations from the *Nursing Homes and Hostels Review* (Department of Community Services & Health 1986) which were subsequently taken up in the Aged Care Reform Strategy saw the move to a needs based planning approach which sought to produce a more equitable distribution of services across and within states and territories. Therefore, the themes which have dominated the public discourse throughout the Aged Care Reform Strategy have revolved around providing a better balance of services between nursing home and hostel accommodation and community services provision. Benchmarks for the ratio of nursing home beds to hostel beds were established by the *Nursing Homes and Hostel Review* (1986) and were implemented as part of the Aged Care Reform Strategy in order to control the growth of costly nursing homes. Since 1991, these benchmark ratios were extended to include increased services by way of Community Packages in order to encourage people to remain in their homes rather than move into hostels and nursing homes.

Prior to the introduction of the Outcome Standards requirements, there was very little nursing care planning in existence within nursing homes and due to the lack of knowledge about nursing care planning amongst the staff of nursing homes, the implementation of the Outcome Standards Policy has proved extremely difficult.

Sadly, since the introduction of the Outcome Standards Policy, discussion by nursing staff within the nursing home industry has centred around the volume of documentation required to provide care rather than the more important overall issue of how to improve the quality of care and quality of life of the increasingly dependent population of residents now living in nursing homes. That is, very little attention has been given to major issues such as the continuing number of untrained nursing staff working in nursing homes as well as the paucity of gerontologically trained Registered Nurses and Directors of Nursing and both of these factors have a major impact on the quality of care provided to residents living in nursing homes (Pearson 1987).

In New South Wales it is mandatory under the *Nursing Homes Act* that a person carrying out the duties of a 'chief nurse' of a private nursing home, must be a Registered Nurse, with at least five years' post-basic or postgraduate experience and have at least two years' full-time experience in an administrative position more senior than that of Nursing Unit Manager (Nursing Homes Act NSW 1988: Section 37–39; Nursing Homes Regulation Act, 1990:reg.11). However, there is no legal requirement for staff to have a gerontological qualification or management qualification, let alone gerontological experience. In 1990, a study of the educational background of Directors of Nursing in Australian nursing homes reported that only 24% of the respondents possessed a Certificate in Gerontological Nursing while only 15% possessed a diploma and 7% a degree (Pearson et al. 1990:102). It is argued here that the *Nursing Homes Act* fails to go far enough by not ensuring that the Director of Nursing of a nursing home has completed a post-basic or postgraduate qualification in gerontology as well as a management qualification. In other specialities, for example, midwifery, it would be sacrilege to even think of appointing a Director of Nursing who had not completed a midwifery qualification.

With the introduction of the Aged Care Reform Strategy, the Commonwealth has moved to 'outcomes' standards monitoring of care, while the states continue to monitor various 'input' measures for quality. However, the actual 'process' through which quality of care is to be delivered has not been specifically addressed by Government. The actual process through which nursing home staff were to prepare the documentation required to support the RCI and the requirements of monitoring teams was not prescribed by Government Circulars in order to allow nursing homes the opportunity to develop their own models of documentation which best suited their individual setting. However, lack of knowledge about nursing care planning amongst nursing staff as well as the fear that if they did not document all the care given then the resident might not be placed in the correct category of care and thus the level of funding for the nursing home would be reduced, has seen a huge amount of over documentation taking place within nursing homes.

Although some two years after the introduction of the CAM funding, the Commonwealth Government funded the production of a CAM Management Manual to explain the methods through which the CAM/SAM/OCRE process would operate within nursing homes. However, no such manual was prepared to explain the methods through which the Standards Monitoring Team process would operate. It is only recently, with the release of the findings of the Macri Report (1993), that a Documentation and Accountability Manual was commissioned and is due for release in March 1995. Although Government Departments prepare circulars concerning new policies, which are then forwarded to nursing homes for implementation, it would seem there is a serious need to ensure that any future policy changes which affect nursing home staff should automatically have an accompanying manual which not only explains the changes to the nursing home staff but also gives details of the processes which are required to be implemented in order to achieve the desired policy. Because of the high numbers of untrained nursing staff working in nursing homes, it would seem

that this is an important poin. to address in any future policy implementation within the nursing home sector

Challenges for the Future

Over the last decade, shifts in aged care policy have heralded the beginning of a new era for the nature of nursir g home care provision. Previously, nursing homes admitted people of varying dep endency levels and nursing home staff cared for a mix of residents. However, today, nursing homes have become places which provide care for only the highl y dependent, with less dependent people requiring residential care being direct:d into less expensive hostel accommodation. Increasingly, nursing staff are required to provide care for highly dependent residents and therefore the edu cational and clinical needs of nursing home staff need to be addressed.

From a Foucauldian viewpoint as presented in Chapter Seven, the establishment of nursing homes has in eff:ct created a 'space' whereby the elderly and chronically ill are not only continually under the medical gaze of health professionals but also since the introduction of the Aged Care Reform Strategy, are now continually under the public bureaucratic gaze. Since the introduction of the Aged Care Reform Strategy, the elderly and chronically ill individual living in a nursing home has become immersed in a web of power relations which examines, categorises, classifies and rearranges the aged body according to some predetermined and prescribed documentation examination protocol. This examination, categorisation, classification and ranking of the elderly and chronically ill body leads to normalisation which thus renders the body 'docile'. Care providers in nursing homes are now required to collect data on residents in order to categorise each resident into a Resident Classification Instrument level which is subsequently forwarded to the Commonwealth Government in order to allocate funding. Therefore, the 'docile' resident body becomes extremely useful and indeed essential for the funding and continual financial survival of the

nursing home industry. Prior to the major changes in residential aged care in 1986, few if any assessment procedures were undertaken by nursing home staff on aged people living in a nursing home. Even if an examination was undertaken it was a non-ritualised casual affair and no normalisation function occurred. Examinations were performed on an *ad hoc* basis and the information was not used for comparative purposes. However, in 1986, with the introduction of the Aged Care Reform Strategy and the major changes to funding, the legal requirement enforced by the Commonwealth Government onto nursing home proprietors saw the examination of the 'resident' become more focused and specific. The themes generated from the Foucauldian analysis presented in Chapter Seven would suggest that the emphasis of care within nursing homes has focused on documentation preparation for funding purposes rather than for the purposes of improving the quality of care for residents.

A regulatory process of establishing Standards Monitoring Teams to monitor nursing homes has been put into place in order to monitor the Outcome Standards of nursing homes. However, I would argue that the Commonwealth Government has not gone far enough in the monitoring of outcomes of care of nursing homes by not investigating enough to ensure quality treatment and nursing care are really being provided for residents. Difficulties with establishing the process of documentation for the Outcome Standards has distracted attention from the very issue of providing improved quality care to residents. How do residents know when a member of the Standards Monitor Team asks them if they are being provided with the correct care when they may not know what correct care is? Clinical indicators including the incidence of decubitus ulcers, urinary tract infections and skin tears are some simple indicators that could be recorded and compared across various different types of nursing homes in order to provide more information about the care being provided within nursing homes. Such data would provide additional information which would be of enormous benefit to not only potential residents but also to staff in order that they could see how their

nursing home was performing in comparison to other nursing homes of similar size.

CONCLUSION

Changes introduced as a result of the Aged Care Reform Strategy have greatly affected the role and function of the Directors of Nursing and the management practices of nursing homes in Australia. As a result of growing financial constraints, nursing home operators increasingly have adopted an economic approach to management, endeavouring to obtain the highest possible productivity from staff with available resources. Before the introduction of the CAM Scheme, the Director of Nursing was principally involved in the provision of health care and rostering of staff within the nursing home. Responsibility for budgetary management was mainly undertaken by either the owner or general manager. Today, Directors of Nursing have far broader responsibilities which are extending their previous role. They are faced with the task of organising a workforce within a nursing home shaped by a range of social, economic and political forces which extend well beyond the confines of the institution.

Developing skill and expertise in documentation of residents' care needs through the use of care planning, as well as developing work practices which are not task orientated but focused on residents' needs, have provided a great challenge for Directors of Nursing of nursing homes in Australia since the introduction of the Commonwealth Outcome Standards. Indeed, it is acknowledged much progress has been made through the introduction of the Commonwealth Outcome Standards in improving the quality of care and quality of life of residents living in nursing homes in Australia. However, there are a number of policy issues which require further attention in order to ensure that residents receive the type of care that they want rather than the care which care providers want to provide.

For the Aged Care Reform Strategy to be truly successful in achieving its objectives within Australian nursing homes, extensive educational support is required for not only nursing staff but for the whole range of staff associated with the nursing home. Nursing homes today require nursing staff with sound gerontological nursing knowledge and require finely tuned financial and human resource management skills in their Directors of Nursing. Requiring Directors of Nursing to obtain (or be studying towards) a health services management qualification would be a good start in assisting the successful implementation of the overall Aged Care Reform Strategy in the future.

Suggestions for future research could focus on: assessing the gerontological and management needs and skills required of carers and administrators of nursing homes in order that such information could be feed into the policy process; documenting what core criteria comprise 'correct nursing care' in nursing homes and to suggest to policy makers and administrators how best to incorporate these into policy and how to make them transparent to stakeholders; and third, to quantify a range of quality clinical indicator rates for decubitus ulcers, urinary tract infections, medication errors, resident falls, and so for within Australian nursing homes in order that such information could be fed into the policy process.