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Title	A concept analysis of autonomy for older people in residential care
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Publication Date	2010-05
Publication Information	Welford, C., Murphy, K., Wallace, M., & Casey, D. (2010). A concept analysis of autonomy for older people in residential care. <i>Journal of Clinical Nursing</i> , 19 (9-10), 1226-1235.
Publisher	Blackwell
Link to publisher's version	http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2702.2009.03185.x/pdf
Item record	http://hdl.handle.net/10379/1964

Downloaded 2021-02-26T20:11:47Z

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Welford C., Murphy, K., Casey, D. and Wallace, M. (2010) A Concept Analysis of Autonomy for Older People in Residential Care. *Journal of Clinical Nursing*. 19: 1226–1235

A Concept Analysis of Autonomy for Older People in Residential Care

Aims and Objectives. To undertake a concept analysis of residential autonomy in order to identify its attributes. To reveal the antecedents and consequences of autonomy for older people in residential care and thus enable this concept to be operationalised.

Background. Globally there is an ageing population. This population and their families demand that services offer choice and recognise the older individual in care relationships.

Design. Concept analysis.

Methods. Using the same search terms, findings from a literature search in 2007 and from a follow up search in 2009 were used to conduct the concept analysis. Rogers (1989) framework was used to develop a model case of autonomy for older people in residential care. The attributes, antecedents, consequences and references were delineated.

Results. Five attributes of autonomy for older people in residential care were delineated. 1) Residents are involved in decision making while their capacity is encouraged and maintained. 2) Residents delegate their care needs based on the right to self-determination and this can be achieved through 3) negotiated care planning which is encouraged through open and respectful communication. 4) The residential unit operates a culture and atmosphere of flexibility within an ethos of maintaining resident dignity. 5) Meaningful relationships are enabled by the presence of regular

and motivated staff and these relationships enhance the residents opportunities to be autonomous.

Conclusions. A concept analysis framework is useful in trying to understand a term in its context and thus make it operational.

Relevance to clinical practice. This concept analysis is the first step required for further research on this aspect of care. This is essential in informing this nursing specialty. The attributes, antecedents and consequences can now be used to operationalise the concept in practice.

Acknowledgement

The author wishes to acknowledge the Health Research Board of Ireland. The author would also like to thank her colleague Dr. Maura Dowling for her advice in relation to this analysis.

Introduction

People are living longer and their healthcare needs are thus becoming increasingly important (Table 1). Evidence suggests that older people feel that autonomy is important for good quality of life (Edwards & Staniszevska, 2000, Edwards *et al.* 2004).

Older people living in long stay care represent a unique group of people largely because care is provided in their place of residence. However, it is apparent that their level of autonomy is often eroded in the very place which they call home (Davies, Ellis & Laker, 2000, McCormack, 2001, Lothian & Philip, 2001, Barkay & Tabak, 2002, Randers & Mattiasson, 2004 & Brown, McWilliam & Ward-Griffin, 2006). Barkay & Tabak (2002) and Murphy (2007) believe that increased levels of autonomy lead to increased levels of resident satisfaction, decreased levels of routinised practice and thus contributes overall to the resident's quality of life (QoL). A consensus has yet to be reached on the meaning of resident autonomy and Davies, Ellis & Laker (2000) recommend that further work needs to be carried out which will operationalise "autonomy". Hewitt-Taylor (2003) recognises that autonomy is high on the current health care agenda but that a universally accepted definition has yet to be adopted or tested in practice. Person-centred care (PCC) is also on the agenda and has been cited as an essential ingredient in maintaining quality of life with autonomy being cited as central in realising PCC. Thus autonomy must be understood before PCC can be

realised and subsequently QoL experienced. McCormack & McCance (2006) outline a framework for operationalising PCC and offer that it requires: pre-requisites such as professionally competent staff, developed interpersonal skills, commitment to the job, clarification of values and beliefs and knowing the self, the care environment needs an appropriate skill-mix, a shared decision-making system, effective staff relationships, potential for innovation and risk-taking and supportive organisational systems. This framework can be utilised when this concept analysis reveals what autonomy is and what autonomy is not.

Concept Analysis

Concept analysis (CA) is important for three main reasons. Firstly, in theory development whereby theories are developed by clarified concepts (Chin & Kramer, 1991). Secondly, in operationalising the concept, enabling research and perhaps the development of measuring instruments (Browne, 1993 & Norris, 1982) and thirdly, to improve practice by offering nurses a clearer understanding of what certain terms mean (Mairis, 1994).

Wilson (1963) was the first to put forward an eleven step method for conducting a CA. This method was Socratic in design and used rigorous questioning.

This was refined by Walker & Avant (1988) to an eight step method and later by Rogers (1989) (Table 2) who reduced the process to a 7-step method. This is an evolutionary approach to CA whereby the concepts, use, significance and application are understood over time. This philosophical foundation implies that there is no beginning and no end to concept development but rather that it is a continuous process shaped by time and context. Thus concepts are context dependent and they are

dynamic not static in nature. The model case is identified rather than constructed. This method involves seven primary activities many of which are carried out simultaneously (Table 2).

Rogers' (1989) approach on first glance is only subtly different to other linear approaches to concept development however it is its philosophical underpinnings which make it markedly different. The emphasis is on inductive inquiry and rigorous analysis rather than on beginning with pre-conceived ideas of what a concept might mean and shaping an analysis to those pre-conceived ideas. This evolutionary approach yields results which are not intended to be adopted without question but rather applied and tested as another phase of the concepts development.

Morse (1995) supported the use of Rogers' (1989) model by stating that the Walker & Avant model as developed from Wilson's (1969) model over-simplifies the complexity of concept development and often produces trivial and insignificant results whereas the Rogers (1989) model in its evolutionary approach is more advanced. Thus Rogers (1989) model was used for this CA.

Literature Review

The review of the literature included looking at dictionary definitions, searching the nursing and healthcare databases and reviewing philosophical and ethical texts.

Database results

The literature review was initially conducted in 2007 and again in 2009. Three search strategies were used to identify relevant papers on both resident autonomy and CA.

Firstly, key word and title searches of electronic databases were undertaken

(Databases: Cumulative Index to Nursing and Allied Health literature (CINAHL) and Blackwell Synergy). Search terms were: concept analysis, autonomy, autonomy for older people in residential care, resident autonomy and autonomy for older people and patient autonomy. The search was then reduced to the most recent papers (10 year period and full text). Secondly, electronic searches were supplemented by hand searches of gerontology-focused journals and relevant reports (e.g. National Council for Ageing and Older People). Thirdly, references within appropriate papers were followed up. Data from each text and/or paper was summarised and an iterative analysis process was used to compare and contrast key findings and draw out a number of themes and generalisations.

The literature search for this CA was largely in the nursing domain however the search also extended to the philosophies and related disciplines along with dictionary definitions. From the nursing literature utilised there were two main categories established. Category one: articles which focused on resident autonomy and category two: articles which focused on how to perform a CA. From category one, the author focused on 28 journal articles. Three of the papers were research reports of qualitative studies and the rest were discussion paper. No quantitative studies were found in this literature search.

Dictionaries

Roger's (1989) describes how one source of evidence for concept analysis is dictionary definitions. These are useful because they convey accepted ways in which words are used. A dictionary definition of autonomy states that it is the "freedom to determine one's own actions and behaviour" (Collins English Dictionary, 2000: 103) while a healthcare dictionary definition states that it is "having the ability to function

independently” (Blackwell’s Dictionary of Nursing, 1997: 73). Autonomy is derived from the Greek word “Autonomia” or the freedom to live by one’s own laws - “autos” meaning “self” and “nomos” meaning “rule” thus translating literally into the term “self-rule”.

Healthcare Literature

Probably the most important work in aiming to understand autonomy as it relates to older people is by McCormack (2001). However, McCormack (2001) refers to patients not residents and thus the focus of the work is different. It also recommends further analysis of the concept of autonomy and its operationalisation in practice. McCormack (2001) identifies autonomy as “authentic consciousness” and considers this in terms of sustaining meaning in life. McCormack (2001) offers that this consciousness is not a hierarchical ordering of possible desires, but instead is the clarification of one’s values in order to maximise one’s potential for growth and development. A framework is presented consisting of “informed flexibility, sympathetic presence, negotiation, mutuality and transparency”. Informed flexibility is explained as the facilitation of decision-making. Sympathetic presence as an engagement that recognises the uniqueness and value of the individual. Negotiation is defined as patient participation through a culture of care that values the views of the patient. Mutuality as the recognition of the others’ values as being of equal importance in decision-making and transparency as the making explicit of intentions and motivations for action and the boundaries within which care decisions are set.

A CA of patient autonomy by Keenan (1999) states that it is a right and an individual occupation which involves exercising considered, independent judgement in order to effect a desirable outcome. While this is useful the author would like to point out that

patient autonomy is different to resident autonomy because older people in residential care are living in the care unit as opposed to being an in-patient in a hospital setting. Davies, Ellis & Laker (2000) offer that autonomy is affected by the nurse's ability to negotiate care, give information to residents, encourage resident's to maintain physical independence, recognise personhood and individuality, avoid controlling language, be alert to cues and promote individualised care and conclude that autonomy is context dependent, multi-dimensional and includes voluntariness, individuality and self-direction. It is recognised by Davies, Ellis & Laker (2000) that more work needs to be done in order to understand these issues further. Randers & Mattiasson (2004) using participant observation of healthcare professionals caring behaviour in everyday situations, state that respect for patients dignity should be founded on respect for autonomy. Agich (2004: 6) defines autonomy as "equivalent to liberty, self-rule, self-determination, freedom of will, dignity, integrity, individuality, independence, responsibility and self-knowledge", whilst containing the qualities of self-assertion, critical reflection, freedom from obligation, absence of external causation and knowledge of one's own interest (Agich, 2004). These wide-ranging definitions suggest that the meaning of autonomy should be context dependent due to the nature of concepts being dynamic and not static. Horowitz, Silverstone & Reinhardt (1991) believe that autonomy equals self-determination however, Brown, McWilliams & Ward-Griffin (2006) reveal that nurses tend to "do for" the patient thus eroding their abilities. In spite of these discussions autonomy for older people in residential care remains to be operationalised. Lothian & Philip (2001) state that this is a global problem and Aveyard (2000) asserts that autonomy remains an ambiguous term which needs to be replaced by a universally accepted definition.

Ethical Texts

Autonomy has also been discussed as an ethical principle. Beauchamp & Childress (1994) refer to what makes life one's own and how personal preferences and choices shape it. The following four integral ingredients assert to personal autonomy: 1) being free from the controlling influence of others, 2) being free from limitations that prevent meaningful choice, 3) being free from inadequate understanding and 4) being able to freely act in accordance with a self-chosen plan. It is clear how this can be difficult to maintain in healthcare institutions whereby diminished autonomy is often experienced when an individual is controlled by the healthcare environment or is unable to verbalise their needs. Historically, health care was provided in a paternalistic manner however the changes which have taken place in society over time are now challenging the future of healthcare provision to become more empowering and negotiated between healthcare professional and client (McCormack, 2001). For any action to be autonomous there should be a substantial degree of understanding and freedom from constraint, coercion and/or deception. Burkhardt & Nathaniel (2002) believe that in order to achieve the balance between personal autonomy and restrictive health care institutions the following fundamental elements are necessary: a) respect, b) the ability to direct and determine personal goals c) the capacity to be involved in a decision-making process and d) the freedom to act on any choices made. This highlights the need for negotiated care planning between the resident and the health care professional. Most importantly, personal autonomy for the older person is not diminished by their inability to independently perform self-care instead they can still exercise the ability to delegate their care requirements to others.

Quill & Brody (1996) propose an "enhanced autonomy" model which encourages patients and physicians to actively exchange ideas, explicitly negotiate differences,

share power and influence to serve the patients best interests. Quill & Brody (1996) recommend that intense collaboration should be promoted so that patients can autonomously make choices that are informed by both the medical facts and the physician's experience. The author argues that this can be difficult in residential care units which are more frequently being nurse-led rather than physician-led so this collaboration may instead be considered in relation to residents and nurses and care staff.

Related texts and papers

The Irish report on "The End of Life Care for Older People in Acute and Long-stay Care Settings in Ireland (2008)" recognises that autonomy is important for older people and that there is a need to test new models and approaches which link gerontological knowledge with long-stay care practices. It links autonomy with QoL. It states that the care environment including the degree of autonomy, control, choice and independence that older people have in long-stay care can affect QoL. This includes control over choice of food, clothing, personal possessions, getting up in the morning, going to bed at night and whether the older person has to fit into a routine generally. The older persons relationship with staff (and family and friends) is crucial, reflecting the fact that they are often reliant on care staff to complete the activities of living. Finally, having access to meaningful activities is considered important for the QoL of this group.

In philosophy, Immanuel Kant (1789) believes that there is a difference between "basic autonomy" and "ideal autonomy". Basic autonomy enables the minimal status of being responsible, independent and able to speak for oneself while ideal autonomy enables a person to be maximally authentic and free of manipulative influences. In

other words autonomy at its most basic level enables a person to speak freely while in its ideal state it enables the person to act on that spoken choice.

Feinberg (1989) claims that there are at least four different meanings of autonomy in moral and political philosophy. These include the capacity to govern oneself, the actual condition of self-government, a personal ideal and a set of rights expressive of one's sovereignty over oneself. This capacity is also recognised by social workers who believe that autonomy is a form of personal liberty which recognises liberty and capacity (Abramson, 1985). Reflecting on these opinions it is possible to relate autonomy to personhood and to how well we really "know" the residents. It is suggested in these philosophical texts that whether or not a person is autonomous depends upon the processes by which they came to be that way and requires the social embeddedness of life histories (this biographical approach is increasingly being used in older person care planning).

Also in philosophy, Gillon (1995) states that autonomy is the capacity to think, to decide and to act freely and independently and without hindrance. To live autonomously is to be allowed to govern oneself. Outsiders who may possess power over another person are exercising illegitimate power with the autonomous person being the only one with authority to determine what governs their lives. In other words it is understood that individual autonomy refers to the capacity to be one's own person, to live one's life according to reasons and motives that are taken as one's own and not the product of manipulative or distorting external forces. Thus the challenge to maintain resident's autonomy is immediately obvious when the organisation of the health care environment is considered. Gillon (1995) offers that autonomy must be

distinguished from “freedom”. Freedom concerns the ability to act, without external or internal constraints while autonomy concerns the independence and authenticity of the desires that move one to act in the first place. Conceptions of autonomy that see only “desires” as the focal point will also be too narrow, as people can exhibit autonomy relative to a wide variety of personal characteristics, such as values, physical traits and relations to others.

According to Atkins (2006) a conception of autonomy focused on freedom of the will alone is inadequate. Atkins (2006) questions the functionality of the philosophical identification of autonomy as freedom of choice when this freedom is often eroded by oppressive forms of socialization. Atkins (2006) reminds us that the case for autonomy was first made by Mill (1975) who believes in common humanity. Mill (1975) put forward the idea that autonomy is the right to self-determine for oneself one’s interests, goals and values, and one’s own conception of a good life free from unwarranted interference. Mill (1975) believes that being autonomous means being able to enjoy productive and enabling relations with others rather than being subjected to the deleterious effects of power, whether exercised by an individual group or the state. Thus Atkins (2006) offers that underpinning this conception of autonomy is the conception of persons, who are radically individualistic and who determine one’s own beliefs, values, tastes, aspirations and actions in an activity of individual free and rational will. The only legitimate reason for interference in another’s actions is if those actions present clear and immediate harm to another person’s equal liberty. Atkins (2006) commends Meyers (1989) view that autonomy is relational and practical, consisting of a set of socially acquired practical competencies in self-discovery, self-definition, self-knowledge and self-direction. Meyers (1989) believes

that personal choice is fundamental to autonomy and that autonomy is fundamental to ethical life. It makes the distinction between choices that express the internalisation of oppressive social forces and those that express one's genuinely reflective considerations. Meyers (1989) states that in order to live a harmonious existence and acquire autonomy one must possess a life plan and in order to do this one must possess certain skills to make decisions and thus realise the life plan.

Thus one must possess a minimal understanding of how one's motives, values, beliefs, emotional disposition, desires and weaknesses can be related together and how they might influence one's choice and attitudes. Meyers (1989) argues that this is a basic requirement for comprehending and negotiating one's needs, wants, and responsibilities in the many different circumstances one faces in life. Atkins (2006) offers that this presents new challenges to nurses to both identify processes that facilitate autonomy and to address those that obstruct it. Atkins (2006:206) states that "a nurse who can understand how a patient's personal choices can be underpinned by unreflective conventional gender or age roles can, in dialogue with the patient, provide the opportunity for the patient to express unconventional and genuinely felt aspects of self-conception". Atkins (2006) concludes that enabling patients to be autonomous will make higher demands on nurses who will need specific training in counselling-type communication skills and the patients themselves will need emotional, linguistic, cognitive and communicative competencies. Together the nurse and patient should articulate the patients desires. The nurse helps the patient to find the words and descriptions needed to articulate beliefs, emotions, desires and values, secondly the nurse helps the patient to examine, evaluate, and prioritize those

phenomena and finally helps the patient to bring their beliefs, values, emotions and desires into a point of view (Atkins, 2006).

In addition to free will and equal relationships, autonomy is often confused with “independence”. Independence is about the individual’s level of physical functioning and ability to perform activities of daily living unaided (Davies, Ellis & Laker 1997). Independence is understood as the individual’s ability to independently function and make choices (functional independence) or to direct care and negotiate care requirements as in “executorial” independence. It is revealed that independence does not contain all of the attributes of autonomy and therefore there is a difference between independence and autonomy. Furthermore, independence and autonomy must not be confused with “capacity” which is an important ingredient in the ability to be autonomous. The older person in residential care should experience “the functional approach” whereby capacity is assessed on an issue-specific and time specific basis so that having capacity for one decision does not necessarily imply the requisite capacity for another decision which might have different requirements (End of Life report, 2008).

Finally, another concept often related to or confused with autonomy across the disciplines is that of “dignity” but Fenton & Mitchell (2002: 21) offer that dignity is a “state of physical, emotional and spiritual comfort, with each individual valued for his or her uniqueness and his or her individuality celebrated”. This clarification of what autonomy is not further helps to clarify the model case which has emerged in this concept analysis.

This literature review has revealed the autonomy discussions which have taken place in nursing, philosophy, social care and ethical texts. It is now necessary to analyse how autonomy can be understood and thus operationalised for the older person living in residential care.

A summary of the main findings of definitions and discussions of resident autonomy are presented in figure 1. Four main categories emerged and these include environment, people, ethics and observable outcomes.

Next Step

The next step in CA includes identifying the attributes, antecedents, consequences and references of the concept (Figure 2).

A concept by definition is a cluster of attributes. The attributes of the concept constitute a real definition, as opposed to a nominal or dictionary definition that merely substitutes one synonymous expression for another (Rogers, 1989).

These attributes should be present in all examples of autonomy for older people in residential care.

Feinberg (1989) and Burkhardt & Nathaniel (2002) discuss the need for residents to be involved in decision making while their capacity is encouraged and maintained. Keenan's CA (1990) recognises that patients delegate care needs based on the right to self-determination while Feinberg, (1989), Beauchamp & Childress, (1994) and Quill & Brody, (1996) offer that this can be achieved through negotiated care plans encouraged through open and respectful communication. McCormack & McCance,

(2006) and Davies, Ellis & Laker, (2000) add that a culture and atmosphere of flexibility within an ethos of maintaining resident dignity can motivate both staff and residents and ultimately contribute to staff retention and meaningful relationships thus enhancing opportunities for resident autonomy. Thus these are the attributes of autonomy for older people in residential care.

Identifying antecedents, consequences and references of the concept can further help in explaining how the concept is used in the social context. The antecedents answer the question “what happens before?” the concept and the consequences answer the question “what happens after?” the occurrence of the concept (Rogers, 1989).

Burkhardt & Nathaniel (2002), McCormack & McCance (2006) & Quill & Brody (1996) reflect on how resident autonomy can be enhanced if staffs attitudes are positive in relation to ageing and older people. The values and beliefs of staff should be person-centred and non-paternalistic (Davies, Ellis & Laker (2000), Burkhardt & Nathaniel, 2002). Beauchamp & Childress (1994) believe that in order for resident autonomy to exist, staff must communicate effectively with each other, with residents and with visitors. This open communication leads to resident assessments which are robust and involves gathering life histories, recognising the biography of the resident and how this may indicate their values, needs, wishes or desires. Thus an atmosphere of openness, motivation and flexibility must exist (Berofsky, 1995, Beauchamp & Childress, 1994) and respect for dignity and for fellow human beings will be evident between staff and between staff and residents (Randers & Mattiasson, 2004, Beauchamp & Childress, 1994).

Barkay & Tabak (2002), Murphy (2007) and McCormack & McCance (2006) state that residents who feel autonomous express an enhanced QoL, increased satisfaction

in daily routine and participate in social activity. McCormack & McCance (2006) suggest that a transformational care environment may contribute to staff retention as nurses and health care assistants work in a supportive and innovative culture. This retention enables the residents to develop meaningful relationships with staff. Lothian & Philip (2001) report on older person care facilities which are neglectful and inadequate and suggest that a more homely atmosphere can preserve autonomy and minimise distress among residents. The consequences of an open attitude to care planning are evidence of negotiated care plans which include a focus on the resident's social and recreational needs. Life histories of the residents and knowing the person is evident in this documentation (Feinberg, 1989, Beauchamp & Childress, 1994 & McCormack, 2001). An outsider, a family member or a researcher will observe effective communication between staff, residents and visitors (Burkhadt & Nathaniel, 2002).

Following the identification of the attributes, antecedents, consequences and empirical referents (Figure 2). the author identified the model case for the concept.

Model Case

The identification of the model case (Table 3) enables the concept to be measured for its existence in the real world. A model case is used to represent the best understanding of the concept at the time of analysis. It should include all of the defining attributes and present an indisputable and unequivocal illustration of the concept in the context of which it is being examined (Rogers, 1989).

Having worked through this CA framework utilising the available literature the following definition for autonomy for older people in residential care settings has been produced:

An older person living in residential care chooses and negotiates how they would like to spend their day. Staff recognise that the past and present lives of cognitively impaired residents may shape their desires. The resident's sense of belonging in a homely atmosphere encourages autonomy.

Discussion

This CA extends our understanding of what autonomy for older people in residential care is and what it is not. It focuses on older people as residents not patients as previously explained by Keenan (1999) & McCormack (2001). A CA of resident autonomy is different because older people living in residential care are not patients but are receiving care in an environment that is now their home. The attributes of this environment are flexibility within a culture which maintains dignity and capacity. Reflection on the role autonomy plays as an integral ingredient in person-centred care and subsequently quality of life has been presented. The differences between PCC and autonomy are now clearer. PCC is about the organisation, the culture and the care environment (McCormack & McCance, 2006) but the key ingredient within this is resident autonomy. Thus this CA focuses not only on the environment but also on the resident within that environment. Resident autonomy must be understood first in order for PCC to be realised. There is considerable evidence that autonomy has not been understood (Davies, Ellis & Laker, 2000, McCormack, 2001, Lothian & Philip, 2001, Barkay & Tabak, 2002, Randers & Mattiasson, 2004 & Brown, McWilliam & Ward-Griffin, 2006). This CA enables practitioners to be clear about what autonomy is and

what it is not and subsequently aids in the operationalisation of the PCC framework. The key differences between PCC and autonomy are evident in the attributes where residents have meaningful relationships with care staff who are recruited and retained based on their motivation to work with older people and maintain and encourage the older persons capacity and involvement in decision making.

Recognising, the meaning of the word autonomy in Greek history as “self-rule”, the CA looked at the ethical debate which will possibly always exist between paternalism and autonomy. Quill & Brody’s (1996) “enhanced autonomy” model was presented and the author suggests that this collaboration between resident and healthcare professional should be considered in terms of nurse-led rather than physician-led residential units. Beauchamp & Childress (1994) and Burkhardt & Nathaniel (2002) also suggest collaboration as key to the balance between personal autonomy and restrictive health care institutions where Brown, McWilliam & Ward-Griffin (2006) suggest that healthcare staff tend “to do for” residents. Hence the attributes of residents delegating their care needs based on the right to self-determination and achieving this through negotiated care planning which is encouraged through open and respectful communication. Philosophically, the notion of “ideal” and “basic” autonomy was discussed and it was concluded that “knowing” the resident – their biography and life plans reflects a common humanity and enables even the cognitively impaired resident to be autonomous. It is offered that this approach can enable a resident to remain autonomous until their “end of life”. Finally, McCormack’s (2001) extensive work in relation to older people and autonomy introduced a useful understanding of autonomy as “authentic consciousness” however this does not specifically refer to residents instead he refers to patients. This author

has established that patients are quite different to residents who are older people living in a healthcare environment which is now their home. McCormack (2001) recognises all the people involved in the care relationship but also talks about boundaries and the author questions why these boundaries are pre-determined by the healthcare organisation and not by the older person. Thus it is argued that this CA while recognising the role that organisation and environment plays, is more focused on the resident perspective of what autonomy means rather than on the healthcare professionals boundaries of what autonomy may mean.

Conclusion

This CA adds to previous work on autonomy and enables the concept to be operationalised in residential care for older people. It adds new insights in relation to the resident perspective and produces five attributes of autonomy for older people in residential care. It draws together the numerous debates and discussions about autonomy in order to produce a succinct understanding of what it means for the older person living in residential care. If autonomy and subsequently PCC and QoL are to be achieved then there needs to be a move away from current approaches to care delivery which are often rooted in old traditions and are bound by routine, staff rosters and lack of recognition that the older person is not a patient but a resident in a unit which is now their home.

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Country	Statistics	Comment
USA	By 2020 7 million =/+ 85yrs. 35 million =/+ 65yrs	Projected growth of 74%
Australia	By 2021 2-3% will be over 85yrs	Projected increase from 1.5% to 2-3% of population
Sweden	By 2030 1 in 4 will be over 65yrs	23% were over 65yrs in 2000 this will increase to 31% by 2050
UK	By 2031 27.2 million will be over 50yrs	20 million were over 50yrs in 2003
Ireland	By 2036 23.4% will be over 65yrs	4.3% will require residential care

Table 1: Global Ageing Statistics

1. Identify and name the concept of interest.
2. Identify surrogate terms and relevant uses of the concept.
3. Identify and select an appropriate realm (setting & sample) for data collection.
4. Identify the attributes of the concept.
5. Identify the references, antecedents and consequences of the concept if possible.

6. Identify concepts that are related to the concept of interest.

7. Identify a model case of the concept.

Table 2: Rogers (1989) Method for Concept Analysis

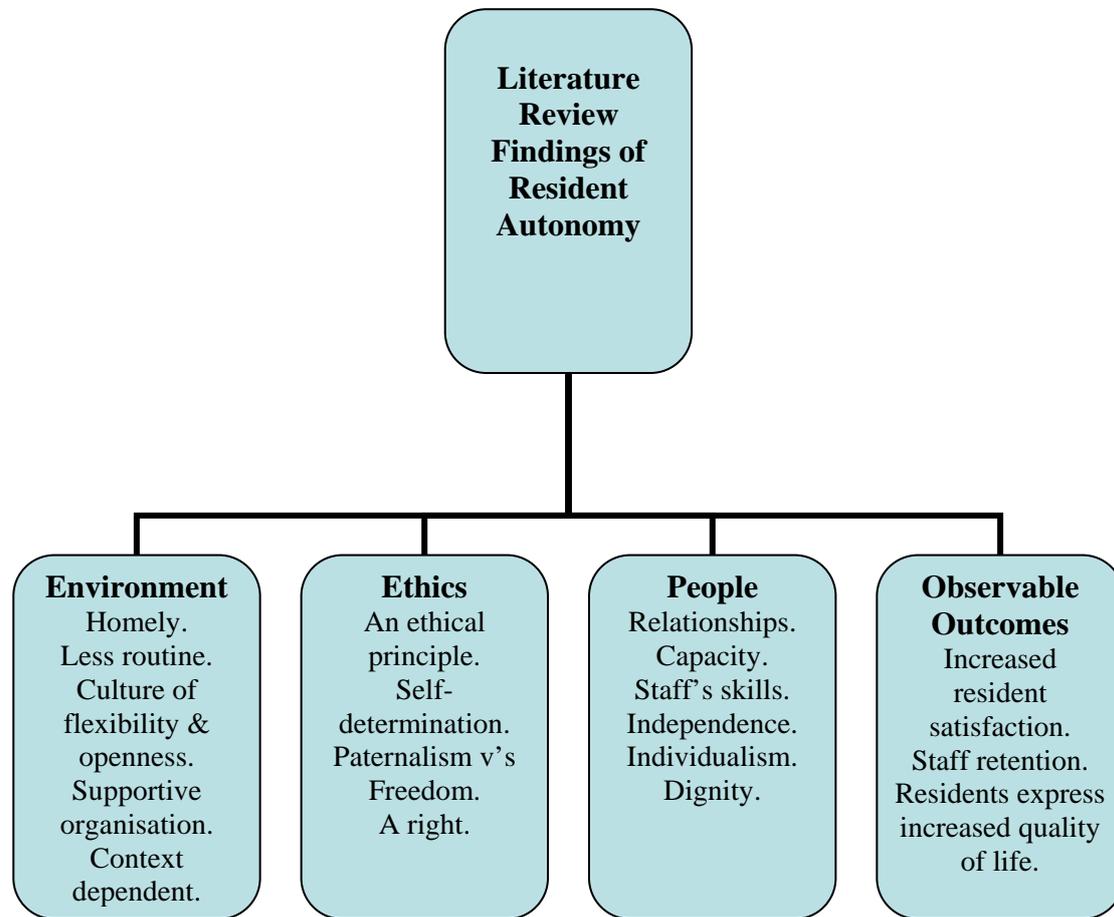


Figure 1: Literature review findings on resident autonomy

Model Case 1

Jack is 85 years of age and is living in residential care since his wife passed away 18 months ago. He was not managing at home and having recently been diagnosed with prostate cancer; leading to some confusion and mild signs of dementia or brain secondaries he agreed to enter residential care. On admission, the staff perform various assessments such as nutritional assessment, falls risk assessment, pressure sore risk etc. As staff begin to get to know Jack they combine this information with “who” Jack is and slowly begin his care plan. The staff of the unit have chosen to work with older people and Jack has developed relationships with them as he recognises the familiar faces on a daily basis. Staff negotiate with Jack how he would like to spend his day and social activities are designed around his hobbies and interests. Friends and family are always welcome and Jack even has his old arm-chair from home moved in with him. When his friends or family visit he can be heard telling them how content he is with his care and his general demeanour affirms this. There are times when the unit is short staffed or under resourced and this is explained to Jack if his daily care needs cannot be met or if all expressed choices cannot be achieved. Jack likes to smoke his pipe and always informs the staff when he is going outside for a smoke. The kitchen-staff are aware of what Jack likes to eat and drink and he has no hesitation telling them if the tea is too weak!

Model Case 2

Nancy is a 91 year old lady admitted for residential care due to her increasing dependency. She has end-stage dementia and is no longer able to walk or talk. Nancy requires assistance with all activities of living. On admission, the staff perform various assessments such as nutritional assessment, falls risk assessment, pressure sore risk etc. As staff begin to get to know Nancy they combine this information with “who” Nancy is and slowly begin her care plan. The staff of the unit have chosen to work with older people and their commitment is evident by the length of time they have worked in the unit. Friends and family are always welcome and are essential in helping the staff to get to know “who” Nancy is – what she likes and dislikes. Due to her dementia it is recognised that Nancy may wish her care to be based on who she was in the past as well as what her needs are now in the present. Staff learn to communicate with Nancy non-verbally and begin to understand her cues for restlessness or discomfort. All opportunities for social participation are maximised and Nancy’s room is surrounded by pictures and memorabilia which help her to feel at home. Music therapy plays a big part in Nancy’s daily life as she was a well known accordion player in her day.

Table 3: The model case